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**gestalt** A whole which is more than the sum or average of individual elements. Gestalt models of IMPRESSION FORMATION hold that each of a person's attributes affects the meaning of others such that the positivity of the final impression is not algebraically predicted from the individual attributes.

*See also*: IMPRESSION FORMATION.

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**gossip** Scholarly interest in gossip largely begins with Gluckman's (1963) functionalist argument that gossip is, contrary to popular wisdom, a rule-governed activity serving group-defining and social control functions. Insofar as gossip presupposes shared acquaintances who may be the subject of gossiping it serves to mark the boundaries of a social group; outsiders cannot participate. Gossip also sustains collective VALUES by drawing attention to instances of their violation (thus making them concrete) and subjecting offenders to criticism and censure. Its social control function derives additionally from its role in evaluating the character of group members and thus their suitability for positions of trust, responsibility, or LEADERSHIP.

Paine (1967) criticized this view, arguing that gossip serves firstly as informal COMMUNICATION and secondly as a means to promote individual interests. Other arguments are that gossip serves the same interpersonal bonding function for humans that social grooming serves for apes, and that it is the basic means by which humans monitor the reputations of others and manage their own. As yet there has been little systematic research which might shed light on these various interpretations or indeed on the truth of one of the most widespread of popular beliefs about gossip, namely that it is largely a female activity.

*See also*: COMMUNICATION; LEADERSHIP; VALUES.

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**grief** This is primarily an *emotional reaction* to the loss of a loved one, usually following a death (although grief-like reactions can follow other types of loss). It is typified by intense personal anguish, not limited to negative affects or expressions, such as sadness, distress, and crying, but comprising a complex emotional syndrome. Manifestations of grief extend to physiological changes and bodily complaints. Recent studies are beginnng to identify a variety of *cognitive and behavioral coping processes and strategies* used by bereaved people for coming to terms with grief. Thus, grief has come to be regarded as a multidimensional phenomenon.

In everyday language the term grief has been used interchangeably with mourning and BEREAVEMENT. Conceptual distinctions have, however, been made in the bereavement and emotion literatures to differentiate these terms (Parkes, 1986; Stroebe & Stroebe, 1987; Stroebe, Stroebe, & Hansson, 1993). Thus, bereavement refers to the situation of an individual who has recently experienced

the loss of someone significant through that person's death, mourning refers to 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). (Note that these definitions differ from those of the psychoanalytic school.)

## SYMPTOMATOLOGY

Patterns of normal grief responses have been extensively studied, and assessment instruments have been developed. Frequent affective symptoms include distress and DEPRESSION, ANXIETY, guilt, ANGER and HOSTILITY, anhedonia and LONELINESS. Behavioral manifestations include agitation, fatigue, and crying. Grief is often accompanied by changes in attitudes toward the SELF (e.g., self-reproach, low SELF-ESTEEM) and RELATIONSHIPS with others. Not all symptoms appear in every bereaved person, nor at any one time across the duration of bereavement. Symptomatology also differs from culture to culture. While grief is most frequently identified with prevailing negative affect, not all "symptoms" of grief have negative connotations (relief can be felt alongside sadness; creative activity can be increased).

While most people recover from their grief and its accompanying symptoms over the course of time, for a few, mental and physical suffering is extreme and persistent. Bereaved persons are at greater risk than the nonbereaved from a variety of mental and physical ailments and disorders, including depression, anxiety disorders, somatic complaints, and infections. The relative risk of mortality from many causes, notably suicide, is also excessive (Stroebe, Stroebe, & Hansson, 1993).

## PHASES

The close relationship between manifestations of grief and time since death has led some investigators to suggest "phases" or "stages" of grief (Bowlby, 1981). Most have postulated 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.

Such phasal descriptions have been understood too literally. Almost without exception they have been introduced as descriptive guidelines, yet they have frequently been regarded as set rules or "prescriptions" regarding where the bereaved ought to be in the "normal" grieving process. Recently developed "task models" take more account of the richness of idiosyncratic manifestations of grief than do phasal models. Well known is Worden's (1991) task model, in which the grief process is taken to encompass four tasks (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 work through these tasks.

## COMPLICATING AND MITIGATING FACTORS

Grief does not affect all people equally and much effort has been invested in identifying so-called "risk factors." High risk subgroups of bereaved persons can be classified according to:

(1) *sociodemographic variables* (e.g., younger bereaved, widowers);
(2) *personal history factors* (e.g., ambivalent and dependent marital relationships; previous losses);
(3) *causes and circumstances of death* (e.g., sudden death; child loss); and
(4) *circumstances after loss* (e.g., absense of support; additional stresses).

However, further methodologically sophisticated research on these aspects and, particularly, on mediating processes is needed. 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.

NORMAL VERSUS PATHOLOGICAL GRIEF

Grief is a normal reaction to the death of a loved one and as such does not usually require the help of professional therapists. However, a minority of bereaved people suffer so intensely that intervention is called for. Yet distinctions between normal and complicated grief are difficult to make, first of all, due to lack of clarity with regard to the definition of complicated grief. 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). 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 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 norm in the time course or intensity of specific or general symptoms of grief.

Grief has only recently begun to receive attention from social psychologists. This is surprising in view of the fact that bereavement typically involves the disruption of significant interpersonal relationships.

*See also*: DEPRESSION; LONELINESS; RELATIONSHIPS; SELF; SELF-ESTEEM.

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**group cohesiveness** One of the most basic properties of a group is its cohesiveness (solidarity, esprit de corps, team spirit, morale) – the way it "hangs together" as a tightly knit self-contained entity, characterized by uniformity of conduct and belief and by mutual support among members. Cohesiveness is a variable property: some groups are more cohesive than others, and the same group can be more or less cohesive in different contexts and at different times. Groups with extremely low levels of cohesiveness appear hardly to be groups at all, and so the term may also capture the very essence of being a group – the psychological process that transforms an aggregate of unrelated individuals into a social group. Cohesiveness is, therefore, a descriptive term used to describe a property of the group as a whole. But it is also a psychological term to describe the individual psychological process underlying the cohesiveness of groups and the psychology of group membership. Herein lies a problem – it makes sense to say that a group is cohesive, but not that an individual is cohesive.

THEORY AND RESEARCH

After almost a decade of informal usage, cohesiveness was first formally defined by Festinger, Schachter, and Back (1950). They believed that a psychological field of forces, deriving from the attractiveness of the group and its members and the degree to which the group helps to achieve individual goals, acts upon the individual. The resultant valence of these forces produces cohesiveness that is responsible for group membership continuity and adherence to group standards. Because concepts such as "field of forces" are difficult to operationalize, and also because the theory was not very precise about exactly how to define cohesiveness operationally (i.e., in terms