WHAT IS GRIEF?

Grief is a healthy, normative response to the highly stressful experience of losing a loved one, and can consist of disruptions in functioning in a number of areas, including: (1) dysphoric emotions, including sadness, anger, anxiety, irritability, fear, hostility, loneliness, and guilt, as well as pining for the lost loved one; (2) transient cognitive disorganization, such as confusion and preoccupation with the deceased, identity disturbances (“a piece of me is missing”), feelings of uncertainty about the future, and a compromised sense of life’s underlying meaning or purpose; (3) health problems, such as somatic difficulties, new or worsened illnesses, and additional or increased use of medications; and (4) impaired social and occupational functioning, including social withdrawal, difficulties meeting work and home obligations, and difficulties initiating and maintaining new intimate relationships (Bonanno & Kaltman, 2001).

Patterns of grief reaction. It should be emphasized that, as with acute stressors generally (e.g., Lucas, Clark, Georgellis, & Diener, 2003), bereaved persons vary greatly in the degree to which they experience such difficulties in reaction to loss (Bonanno & Kaltman, 1999, 2001; Wortman & Silver, 1989, 2001). A small minority of bereaved persons suffer from acute feelings of distress that can persist for years after the loss. However, others suffer less acutely and then gradually return to their former level of functioning, while still others show short-lived reactions and a relatively rapid return to their previous levels of functioning (Bonanno & Kaltman, 2001). The range of reactions people exhibit when a loved one dies has led to considerable controversy about what might be the “normal” course of bereavement, and who might need or benefit most from a grief-focused clinical intervention (Bonanno, 2004; Mancini, Pressman, & Bonanno, 2005).

Recent research has mapped these divergent grief reactions onto three primary trajectories or patterns (Bonanno, 2004; Bonanno, et al., 2002): chronic or complicated grief (acute and/or persistent and disabling grief symptoms), recovery (acute symptoms that gradually subside), and minimal grief or resilience (few, if any, symptoms that quickly resolve). The great majority of bereaved persons will demonstrate either a recovery pattern or a minimal grief pattern (for a review, see Bonanno & Kaltman, 2001) and regain psychological equilibrium relatively quickly after the loss (Bonanno, 2004). Such individuals are not likely to require and may even be harmed by clinical intervention (Jordan & Neimeyer, 2003; Raphael, Minkov, & Dobson, 2001). However, a small subset of bereaved persons experience severe and protracted symptoms that can endure for years after the loss. It is increasingly recognized that persons suffering from this chronic or complicated pattern of grief should be the principal focus of clinical concern (Jordan & Neimeyer, 2003; Mancini et al., 2005; Schut, Stroebe, van den Bout, & Terheggen, 2001).

Identifying chronic grief. Although investigators have developed diagnostic criteria for what has been variously described as chronic, complicated or pathologic
grief (e.g., Horowitz et al., 1997; Kim & Jacobs, 1991; Prigerson et al., 1995), these efforts have had substantial methodological limitations, so that no clear, empirically based criteria for chronic or complicated grief are widely endorsed in the field. Indeed, the DSM-IV classifies bereavement as a “V code,” or a stressor that may be a focus of clinical concern but that is not considered a diagnosis in and of itself, even in its most severe or chronic forms (American Psychiatric Association, 1994).

How, then, should clinicians identify persons suffering from chronic grief? An obvious but perhaps principal difference between the conventional recovery pattern and chronic grief reactions is the duration of symptoms and their impact on functioning. However, duration of symptomatology does not appear to be the only factor to distinguish chronic reactions; severity of symptoms even in the initial months of bereavement also appears to inform such reactions. Recent research has shown, for example, that bereaved individuals who ultimately developed chronic reactions had more acute symptom levels in the early months of bereavement compared to bereaved individuals who evidenced a recovery pattern (Bonanno et al., 2002). Put another way, bereaved persons who show the recovery pattern may struggle with moderate levels of symptoms and experience difficulties carrying out their normal tasks at work or in the care of loved ones, but they somehow manage to struggle through these tasks and slowly but gradually begin to return to their preloss or baseline level of functioning, usually over a period of one or two years. By contrast, chronic grievers evidence substantial symptomatology and a reduced ability to perform well at work, to maintain relationships with friends or intimates, and to meet parenting obligations. These difficulties may persist for years after the loss, but, at a minimum, should endure for at least 1 year after bereavement to warrant the label chronic grief. One final consideration, not discussed in the DSM-IV, is that the apparent symptoms of chronic grief may, in fact, represent an unresolved depression that predated the loss, with important implications for treatment (Bonanno et al., 2002; Mancini et al., 2005). We will take up this issue of chronic grief vs. chronic depression in greater detail later in this chapter.

**BASIC FACTS ABOUT BEREAVEMENT**

*Prevalence of types of grief reaction.* Approximately 80–90% of bereaved persons will exhibit either a recovery or minimal grief pattern that will resolve on its own, while about 10–20% of persons will suffer from chronic or complicated grief, which, by its nature, can persist for years after the loss (Bonanno & Kaltman, 2001).

*Clinical diagnosis and comorbidity.* Available empirical evidence indicates that chronic or complicated grief is best understood in terms of symptoms associated with existing diagnostic categories for Generalized Anxiety Disorder, Major Depressive Disorder and, in some cases, Posttraumatic Stress Disorder (Bonanno & Kaltman, 2001). As mentioned, this typology is consistent with the DSM-IV’s classification of bereavement as a “V code” (American Psychiatric Association, 1994). Some evidence also suggests that persons with chronic or complicated grief may be more likely to suffer from symptoms associated with Dependent Personality Disorder (Bonanno, et al., 2002; Bonanno, Wortman, & Nesse, 2004).

*Hypothesized grief reactions.* Other hypothesized grief reactions commonly invoked in the research and clinical literature on bereavement are delayed grief (a severe grief reaction years after loss) and absent grief (the pathological failure to grieve). However, these grief reactions have not been supported empirically. The relative absence of distress following the death of a loved one appears to be neither rare nor pathological; rather, as discussed, such a pattern has been observed with