

© Springer International Publishing AG 2016

Virgil Zeigler-Hill

and

Todd K. Shackelford

Encyclopedia of Personality and Individual Differences

10.1007/978-3-319-28099-8_531-1

Bereavement

Egon Dejonckheere¹ and Eiko I. Fried²

(1) Faculty of Psychology and Educational Sciences, Research Group Quantitative Psychology & Individual Differences, KU Leuven, Leuven, Belgium

(2) Department of Psychology, University of Amsterdam, Amsterdam, The Netherlands

Egon Dejonckheere (Corresponding author)

Email: egon.dejonckheere@kuleuven.be

Eiko I. Fried

Email: eiko.fried@gmail.com

Synonyms

[Grief](#)

Definition

The timeframe of mourning after a loss, especially after the death of a loved one.

Introduction

Losing a loved one is one of the most painful occurrences in life and thus considered an adverse life event in the psychological literature. The common reaction to such a loss is called bereavement or grief, which is often accompanied by a considerable decrease in psychological and physical well-being. Although grief is experienced as adversity, in most cases it is a normal response to a difficult life situation. In case grief persists for a prolonged time beyond what is considered an appropriate response and causes significant disturbances and impairment in daily life, this is called *complex grief* (CG). Synonyms are *prolonged grief disorder* and *persistent complex bereavement disorder*. Multiple factors determine whether a person is more likely to transition from a normal grief response to CG, such as personal characteristics and coping strategies, the type of relationship to the lost person, the consequences of the loss, and the reaction of the broader environment. It is not always easy to distinguish CG from major depression (MD) or post-traumatic stress disorder (PTSD), and various therapeutic and pharmaceutical interventions are available to help individuals affected by complex grief disorder.

Acute Grief: A Normal Reaction to Losing a Loved One

Losing a loved one is among the most stressful life events a person can experience (Holmes and Rahe [1967](#)). This will often lead to a period of grief with psychological, physical, and social consequences. A bereaved person can experience higher levels of dysphoria, anxiety, sadness, and even anger, accompanied by thoughts and images of the deceased person; it is also common to disengage from usual daily activities (Shear [2015](#)). Physical symptoms are often related to stress response and can encompass increased heart rate, blood pressure, and cortisol levels, along with sleep disturbances and weight loss (Stroebe et al. [2007](#)). A goal of contemporary grief research is to elucidate the biological pathways involved in grief (e.g., neurological, inflammatory, immunological, and cardiovascular). Reactions to loss are usually most intense in the beginning and can disrupt everyday life considerably; over time, normal functioning is restored while symptoms gradually decline. It is important to note that everybody grieves differently – for some it may be hardly noticeable, while others may react very strongly. And while some fundamental manifestations of grief appear to be universal across cultures, there are some differences across ethnic groups and religions, for instance, whether the display of overt grief, like crying, is considered appropriate (e.g., Rosenblatt and Wallace [2005](#)).

Grief is recognized as a normal mourning process following loss, and not a psychological disorder; most people will adjust to the new life circumstances without requiring professional help (Bonanno et al. [2004](#)). Some scholars have even argued that grief may be a universal adaptive response that leads to a cascade of homeostatic mechanisms, helping the bereaved to recoup with the life event and adapt to it (Zisook et al. [2014](#)). Nonetheless, losing a loved one is an adverse life event and can lead to intense suffering (like other events such as losing a job or divorce). There is evidence that grief increases the risk for developing mental and physical problems, that bereaved individuals are more prone to falling sick, that they experience higher levels of physical pain, and that they are more likely to self-medicate (Stroebe et al. [2007](#); Shear [2015](#)).

Many models of grief have been suggested. A simple model distinguishes between an initial period of *acute* grief that is bitter but transient and a period of *integrated* grief that is less burdensome (Zisook et al. [2014](#)). While bereavement cannot be “cured,” most people are able to move on with their lives at some point and look forward to the future again. If grief lasts longer than normal or if the symptoms are not proportional to the loss experience, the reaction can turn into a clinical problem that requires help. This can happen when maladaptive thoughts, feelings, or behaviors occur that derail the mourning process, i.e. when there is no transition from acute grief to integrated grief. In this case, the normal grief response (also called *ordinary* grief) can instead be considered *complicated* or *pathological*.

What is considered normal is difficult to define, and some scholars have observed a trend in the last decades toward pathologizing grief. The third version of the Diagnostic and Statistical Manual for Mental Disorders (DSM–III) introduced a so-called bereavement exclusion (BE) that conceptualized grief as a normal response to loss and not as a mental disorder. The DSM-IV narrowed down the BE substantially, and in the DSM-V, the BE was replaced by a mere footnote that “caution[s] clinicians to differentiate between normal grieving associated with a significant loss and a diagnosis of a mental disorder” (p. 161). A number of clinicians and researchers have expressed their concern that the removal of the BE brings the dangers of misdiagnosing normal sadness as pathological depression and medicalizing a normal condition (The Lancet Editorial [2012](#)).

Complicated Grief or Prolonged Grief Disorder: An Inability to Cope with the Loss

When no healing process occurs, and the person does not readjust to the new situation after a sufficient amount of time, this is referred to as *complicated grief* (CG). The prevalence of CG is difficult to estimate because of the varying definition of CG in the contemporary literature. Neither is there full agreement as to what criteria reliably distinguish ordinary grief from CG, such as specific symptoms or time course (e.g., Prigerson et al. [1999](#)). However, important signs that can help clinicians distinguish the two are the intensity and the persistence of the symptoms that impair functioning in important domains of living. This means that CG is usually not considered something entirely different from grief but as a more severe and prolonged form at the upper end of the grief continuum. Some characteristic symptoms of CG include intense and prolonged yearning, emotional pain, frequent preoccupying thoughts and memories of the deceased person, a feeling of disbelief or an inability to accept the loss, and difficulty imagining a meaningful future without the deceased person (Shear [2015](#)). What is considered pathological varies with social norms – for example, a longer grief response may be more normal in some societies than others.

The Multifactorial Etiology of Complicated Grief

In what cases is a normal grief response more likely to become prolonged and pathological grief? There are numerous personal and environmental variables that influence the etiology of CG, of which gender plays an important role. Women are more likely than men to develop CG, similar to other mental health conditions like depression. However, gender interacts with the type of relationship to the lost person to predict CG. When losing a child, mothers are disproportionately more affected than fathers, but after losing a spouse, widowers are more vulnerable than widows (Stroebe et al. [2007](#)). A number of important factors need to be taken into account to explain a person's very individualized grief response.

Some extreme ways to cope with the loss also make it more likely to develop CG. For instance, avoiding to be reminded of the loss at all costs may not be helpful, but neither is to constantly reminisce about the deceased person, or go through his or her belongings over and over again (Shear [2015](#)). People with current or previous mental disorders, especially anxiety and mood disorders as well as alcohol and drug abuse, also seem at a heightened risk to transition to CG (Stroebe et al. [2007](#)). Likewise, multiple losses increase the risk to be unable to properly cope with a loss. There is some preliminary evidence that sudden deaths, for instance, due to suicide, homicide, or a car accident, may put the bereaved person at an increased risk to develop a complicated grief response compared to situations in which the death was anticipated, for example, due to cancer. It also seems more difficult to cope with losing a loved one in a situation of financial hardship or a drop in economic resources. Finally, the size of the social network and support moderates the probability to develop CG. For a comprehensive overview of the investigated risk factors associated with CG, we refer to Stroebe et al. ([2007](#)).

From the perspective of protective factors, one could summarize that supportive friends and family, sufficient financial resources, and mental health (including being optimistic about the future, a good self-esteem, and perceived control over daily activities) help coping with loss and transition from acute to integrated grief. Overall, experiencing a loss event will be different for each person, and the specific life situation along with a dynamic interplay of protective and vulnerability factors will lead to a very specific, individual process.

Differentiating Complicated Grief from PTSD and Major Depression

It is not only difficult for a clinician to distinguish acute grief from CG – many symptoms of CG are common among individuals suffering from MD and PTSD. Since the latter are more common, there is the possibility that patients with CG are mistakenly diagnosed with MD and/or PTSD (and vice versa). The question to which degree these disorders overlap is a topic of current research and not very clear at the moment. But comorbidity is substantial, and recent research found that for treatment-seeking individuals with CG, about 50 % were diagnosed with MD or PTSD, and about 35 % were diagnosed with both MD and PTSD (Stroebe et al. [2007](#)).

Nonetheless, there are some guidelines that can help clinicians distinguish these related disorders. In CG, the predominant affect is likely pining and yearning, and individuals are preoccupied with the loss. While patients with CG can be sad, this comes and goes and is usually related to reminders about the deceased person. For depressed people, sadness and anhedonia are more severe and persistent, along with pronounced feelings of hopelessness or helplessness. Lastly, especially if the death of the loved person was sudden and brutal, like a car accident witnessed by the partner, the probability is somewhat higher for the bereaved to develop PTSD (instead of, or along with, CG). For PTSD, fear is the prime affect, and they are often concerned about potential threats. Shear ([2015](#)) provides an extensive overview that helps to distinguish CG from MD and PTSD. Of note, the question whether individuals after experiencing a loss event are more prone to developing anxiety disorders apart from PTSD – such as generalized anxiety disorder or panic disorder – is comparably understudied in the scientific literature and deserves more attention.

Prevention and Intervention

Since grief itself is not pathological, it is not surprising that there is little evidence for the efficacy of clinical interventions (or prevention) after a loss event. The two main indicators that such interventions may be beneficial are in case of a complicated loss event, and if individuals themselves actively seek help. In such cases, treatment can effectively diminish symptoms of CG (Stroebe et al. [2007](#)).

Treatment of CG is focused on the restoration of future outlook and plans, as well as strengthening the person's ability to cope with the death. A number of randomized controlled trials have provided support for the efficacy of psychotherapy for CG, along with strategies for accepting the loss and for restoring a sense of the possibility of future happiness (Wittouck et al. [2011](#)). Especially when individuals show a severe avoidance pattern of stimuli that are reminiscent of the deceased person, reducing the avoidance pattern and initiating activities that are reminders of the loss are effective strategies. Pharmacological therapy can be used in some cases to stabilize patients and may reduce the probability that people will discontinue psychotherapy (Bui et al. [2012](#)).

Conclusion

Despite the fact that bereavement can be considered a very burdensome and painful experience, in the end most people will come to terms with their loss and regain their ability to engage in ongoing life.

With sufficient social resources and support, resilient people will be able to redefine the sense of who they are in the period following their loss. However, for a vulnerable minority, the loss experience can mean the onset of complex grief, depressive feelings, or trauma. In this case professional interventions may be necessary.

Cross-References

[Post-Traumatic Stress Disorder](#)

[Within-Person Variability of Personality and Individual Differences](#)

References

Bonanno, G. A., Wortman, C. B., & Nesse, R. M. (2004). Prospective patterns of resilience and maladjustment during widowhood. *Psychology and Aging, 19*, 260–271.

[CrossRef PubMed](#)

Bui, E., Nadal-Vicens, M., & Simon, N. M. (2012). Pharmacological approaches to the treatment of complicated grief: Rationale and a brief review of the literature. *Dialogues in Clinical Neuroscience, 14*, 149–157.

[PubMed PubMedCentral](#)

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research, 11*, 213–221.

[CrossRef PubMed](#)

Prigerson, H. G., Shear, M. K., Jacobs, S. C., Reynolds, C. F., III, Maciejewski, P. K., & Davidson, J. R. T. (1999). Consensus criteria for traumatic grief: A preliminary empirical test. *The British Journal of Psychiatry, 174*, 67–73.

[CrossRef PubMed](#)

Rosenblatt, P. C., & Wallace, B. R. (2005). *African American grief*. New York: Routledge.

Shear, M. K. (2015). Complicated grief. *The New England Journal of Medicine, 372*, 153–160.

[CrossRef PubMed](#)

Stroebe, M., Shut, H., & Stroebe, W. (2007). Health outcomes of bereavement. *Lancet, 370*, 1960–1973.

[CrossRef PubMed](#)

The Lancet. (2012). Living with grief. *Lancet*, 379(589), 1.

Wittouck, C., Van Autreve, S., De Jaegere, E., Portzky, G., & van Heeringen, K. (2011). The prevention and treatment of complicated grief: A meta-analysis. *Clinical Psychology Review*, 31, 69–78.

[CrossRef](#)

Zisook, S., Iglewicz, A., Avanzino, J., Maglione, J., Glorioso, D., Zetumer, S., Seay, K., Vahia, I., Young, I., Lebowitz, B., Pies, R., Reynolds, C., Simon, N., & Shear, M. K. (2014). Bereavement: Course consequences and care. *Current Psychiatry Reports*, 16, 482–492.

[CrossRef PubMed](#)