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COMPLICATED GRIEF

I have heard the term "pathological grief". What is it? Do different types exist and, if so, how would you define them?

A most difficult, yet important task for the helper is to be able to differentiate normal grief from so-called "pathological grief." The use of the terms "pathological" or "abnormal" are confusing terms. The reason for the confusion is that what is normal behavior in times of grief is often contrary to what is generally thought to be normal, healthy, adjustive behavior. So, what would normally seem pathological or abnormal is perfectly normal in grief.

Historically, attempts have been made to define those characteristics that are common to normal grief as opposed to characteristics that are common to pathological grief. We are now aware that this descriptive approach is insufficient as a means of differential classification. Distinguishing normal grief from pathological grief is primarily related to the intensity of a response or the duration of a response rather than to the presence or absence of a specific characteristic of mourning. So many individual differences and cultural variations exist in mourning process that to clearly define what is normal and what is not is all but impossible.

My personal bias is to suggest that the terms pathological, abnormal, unresolved, and atypical not be used at all. My rationale for the abolishment of these terms is that I frequently discover that caregivers are sometimes quick to use these terms out of a lack of understanding for the mourner's experience—the result being that distance is created in the helping relationship. The reasoning sometimes is as follows: "Well, the person is having a pathological response so there really isn't anything I can do for them." In other words, framing a mourner's response as abnormal or pathological appears to result in some helpers abandoning the very persons who are most in need of help.

The term I prefer to see used is "complicated grief." This may seem to be purely a semantic distinction. However, I have found that in making this distinction the helper is able to perceive that *just because the response is complicated does not mean that with appropriate counsel it cannot become uncomplicated.* A more hopeful, life-enhancing approach is taken when the helper has a belief that he or she has the knowledge and tools to uncomplicate the mourning process.

Multiple reasons exist for which a person's experience with grief might become complicated. Two primary reasons are outlined.

1. **The social learning that occurs within one's family and/or culture.**

As discussed earlier in this text, "being strong" in one's grief is often seen as being courageous. To deny and repress pain, to control tears, and to suffer in silence may be modeled as admirable behavior. However, when the mourner attempts to maintain these ideals, he or she typically denies the pain inherent in the experience and it becomes complicated.

2. **Lack of knowledge, or inaccurate knowledge about experiencing and reconciling the mourning process.**

Many people simply lack knowledge about the grief process itself. Few people will naturally experience grief smoothly and easily without first using more altered ways of coping with loss. This sets the mourner up for a complicated journey through grief from the very beginning. For those persons who have never had a previous experience with death, they have not had the opportunity to develop resources to cope.

The reader wanting more detailed information on the conditions that may predispose the mourner to complicated grief will find Lazare's[1] outline of both the psychological and social influences to be of help. Those factors that influence individual responses (see pages 25-32) also can impact on the potential of the complicated grief response.

Having acknowledged that no ideal system of classification for complicated grief has been given does not reduce the importance of attempting to develop some means of identifying when someone has strayed off course. A number of investigators have outlined their impressions of what is referred to in this text as complicated grief. What follows is a brief review of the existing literature. Differences of opinion on what constitutes disordered variants of grief reinforce the subjective nature of psychological diagnosis.

One of the first efforts to distinguish between normal and complicated mourning was Freud's[2] classic article on mourning and melancholia. His primary approach was descriptive in nature and subsequent studies have suggested that some of the characteristics Freud described as abnormal grief are actually observed in normal grief responses found in random populations. So while we might appreciate our friend Sigmund's efforts, our knowledge has advanced beyond this point.

Lindemann's[3] paradigm of abnormal grief focuses on distorted reactions and delayed reactions. He outlined the following criteria: overactivity without a sense of loss; the acquisition of symptoms of the last illness of the deceased, the development of recognized medical disease, alterations in relationships with friends and relatives, furious hostility toward specific persons such as doctors, schizophreniform behavior, lasting loss of patterns of social interaction, self-destructive behaviors, and agitated depressions. Again, we know that variants of some of these criteria can now be considered within the realm of normal grief.

Bowlby[4] acknowledged the difficulties inherent in the classification process and was in agreement with Lindemann that the two main influences of pathological responses are best described as delayed reactions (prolonged absence of conscious grieving) and distorted responses (chronic mourning). Siggins[5] defined a morbid grief reaction as a noticeable exaggeration of any of the responses typical to the grief process.

Welu[6] provided the following criteria for what he termed pathological bereavement: self destructive behavior, suicidal thoughts or feelings, physiological problems, social withdrawal, depressive states with obvious clinical symptoms, hospitalization for psychiatric symptoms, and the taking of psychotherapuetic

drugs. Once again, depending on the clinician with whom you talk, some of these criteria would be considered within the realm of normal grief. Obviously, differences of opinion would center on the matter of degree or exaggeration of these symptoms.

One other example that illustrates the subjective nature of some of the criteria that has evolved over this issue is provided by DeVaul and Zisook.[7] They outlined three guidelines for what they termed unresolved grief: Painful response when the deceased is mentioned, realization of grief by the individual, and unaccountable depression or the emergence of medical symptoms on the anniversary of the loss.

Since complicated grief is becoming more pervasive in our society, the need for more uniform ways of identifying the complicated grief experience becomes even more important. Once persons have been identified that need additional help we need to be willing to enter into the process of helping uncomplicate their experience.

CATAGORIES OF COMPLICATED GRIEF

The following classifications reflect a compilation of the most contemporary thinking about identifying complicated grief. These descriptions have been adapted from the work of several investigators [8-12] including my own clinical experience.

1. Absent Grief

In absent grief no apparent feelings of grief are expressed. The person may project a picture as if the death never occurred. While initial feelings of denial are a natural means of attempting to cope, prolonged denial indicates a complicated grief response that demands attention. Absent grief often appears to be influenced by what Lifton[13] has referred to as "psychic numbing"—the inability of the person to meaningfully incorporate the reality of the death into his or her symbolic framework. The incapacity to feel due to blocking can and does result in emotional and physical turmoil for the mourner.

2. Distorted Grief

In distorted grief a distortion occurs in one or more of the normal dimensions of grief. This distortion may prevent the grief

process from unfolding and the person often becomes fixated on the distorted dimension of the grief. For example, the person may keep self so angry that other feelings (loss, sadness, hurt) are not acknowledged and explored. Clinical experiences suggest that anger and guilt are the two dimensions that most frequently become distorted. In working to understand causes of this distorted response one often discovers factors related to the existence of long-term ambivalent or dependent relationships.

3. Converted Grief

In converted grief the person demonstrates behaviors and symptoms which result in personal distress; however, he or she is unable to relate their presence to the loss. A classic example of this is the person who has multiple physical complaints with no organic findings (somatization disorder). These persons need to protect themselves from the pain of the grief is often unconscious, and, therefore results in this conversion response. I have outlined elsewhere in this text (see pages 115-120) typical forms of what I have termed "grief avoidance response styles."

4. Chronic Grief

In chronic grief the person demonstrates a persistent pattern of intense grief that does not result in appropriate reconciliation. The continued foci are on the person who has died, over valuing objects that belonged to the deceased, and depressive brooding. Essentially, the mourner attempts to keep the person alive. Unfortunately, some people believe that if they really loved the person who died they must prolong their intense grief.

People around the mourner sometimes enable, maintain, or reinforce this presentation of chronic grief out of a lack of knowledge of how to facilitate movement toward reconciliation. While the mourner will be forever changed by the loss, the evolution of a chronic mourning pattern will result in an inability to continue living until one dies.

How do you go about assessing if a person is experiencing a complicated grief response?

I find that some people will seek help for what they typically identify as "feeling stuck" or a recognition that grief is impacting

on their lives in ways that prevent them from living as fully as they would like. The task of the helper at that point becomes one of being capable of assessing the potential complicators. In addition, in any initial assessment the potential of complicated grief should always be included.

Of course, knowledge of the four catagories of complicated grief previously outlined is essential. Beyond that I have made a practice of using Barton's[14] scheme for the assessment of complicated grief. As described below, his model is comprehensive and easily lends itself to an enhanced understanding of potential complicators. These criteria should only be considered a guide to help frame the helper's clinical knowledge.

1. Complicating Factors Related to the Death Itself

- Suddenness of death without adequate time for psychological preparation.
- Death considered exceptionally untimely, as in the death of a child or young adult.
- Mode of death considered incomprehensible, as in suicides.
- Ambiguity and unsureness about the death, with questioning of its actual occurrence, e.g., marked deterioration or mutilation of the dead person to the point that the feeling is that the person actually has not died.
- Absence or isolation from the occurrences surrounding the death resulting in inadequate sensory perceptions for the acknowledgment of its reality.
- A sense of having "participated" in the actual event causing the death accompanied by excessive guilt, e.g., the driver of an automobile involved in a wreck in which someone else is killed.

2. Complicating Factors Related to the Survivor's Psychological Traits

- Unresolved feelings and conflict related to earlier losses in the persons life.

- Tendencies toward depression or established difficulty in managing loss.

- Difficulties in expressing and managing feelings of sadness and anger.

- Extreme dependency on the reflected appraisals of others and the need for excessive approval by others, especially in the expression of feelings.

- A tendency toward assuming inappropriate levels of responsibility and the presence of excessive guilt over perceived failure related to the death.

- Excessive dependency on others to meet needs based on actual limited personal resources.

- A tendency to form markedly ambivalent relationships with others characterized by both loving and hating those persons.

- Survivor too young to conceptualize and integrate the finality of the loss.

- Limited options in terms of developing new life styles separate from those shared with the lost person.

- Failure to establish independent existence due to undermining of independence by others with whom the survivor relates—forced dependency.

3. Complicating Factors Related to the Survivor's Relationship With the Lost Person

- Extreme levels of identification with the lost person.

- The presence of intensely ambivalent feelings toward the deceased.

- Intensely close relationship with the lost person to the exclusion of any close relationship with others.

- Excessive and continued reliance on established life patterns with the pretense of a continued relationship with the dead person.

- The presence of unresolved conflict involving the lost person.

- Extreme dependency on the lost person for validation of self, identity, and meaning related activities—an inability to see oneself as a separate person.

- The deceased individual having been excessively dependent on the survivor.

- Excessive guilt related to the life events and death of the deceased accompanied by intense sense of personal responsibility.

- Excessive and prolonged survivor's guilt.

4. Complicating Factors Related to the Inability to Express Feelings Related to the Loss

- Inability of the survivor to be accepting of the high level of feelings surrounding the loss of the person. Suppression of the expression of feelings as an act of protectiveness toward others.

- Inability of other family members to legitimize the feelings related to grief.

- Failure of caregivers to legitimize the feelings surrounding the grief process.

- Other intense and extreme losses or compounded losses occurring at the same time.

- Interpersonal disruption in the individual's environment which disallows the grief process.

- Survivor unable to participate in the grief process during the established grief period due to his or her own physical incapacitation.

- Lack of access to usual rituals or belief systems employed in the management of loss and the grief process.

- Insistence by others that the survivors's grief be managed in a specific manner, i.e., intolerance.

- Dislocation of the person from the usual interpersonal context which is important and supportive in his or her expression of feelings.

- Dislocation from the usual sociocultural and religious context for the expression of grief.

- Excessive use of drugs or alcohol to suppress feelings connected with grief.

- Conversion of the expression of grief feelings to unrecognized symbolic expressions (as in identification symptoms involving physical symptoms).

- Extreme interpersonal isolation with an inability to establish other supportive relationships after the death of a significant person.

- Concurrent development of physical illness in the survivor, thus causing difficulty with both feelings related to the loss of others and the self.

- "Religious conflict" which leads to suppression of feelings.

- The dead person having extracted a "promise" that the survivor will not be sad or grieve after his or her death.

- Excessive attachment and maintenance of close proximity to possessions of the deceased individual, allowing the survivor to maintain a sense that the deceased is still alive.

- Excessive and premature involvement in life activities to the point that the loss is not acknowledged (pp. 116-117).