

# What Makes Grief Complicated? A Review

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Grief is a common and natural reaction to loss, involving a preoccupation with thoughts of the deceased, emotional 'hollowness', and physical manifestations. Whilst, in most cases these subside over time, a sizable proportion of grieverers will experience a prolonged, maladaptive reaction, referred to as complicated grief. The onset of complicated grief is mediated by factors relating to death circumstances and coping styles, moderated by factors, such as individual's developmental period, the relationship with the deceased, and the presence of concurrent stressors. Historical theories of grief have been found outdated by the findings of contemporary theories, calling into question the efficacy of treatment methods derived from these theories. The COVID-19 pandemic presents a particularly daunting period, with diagnostic rates of complicated grief expected to rapidly rise. This highlights the need for the development of modern grief treatments and greater availability of death and grief education in a psychological context.

**Keywords:** *counselling, hypnotherapy, hypnosis*

## What Makes Grief Complicated? A Review of Current Understandings

In 2019 there were an estimated 55.4 million deaths worldwide (World Health Organization, 2020), leaving behind an average of 5 grieverers per individual (Anttonucci, et al., 2004), or about 277 million grieverers (accounting for approximately 3.63% of the worldwide population). This number, whilst disregarding those grieving a non-death related loss, serves to highlight the widespread prevalence of the grief experience. Almost everyone will experience some form of loss in their lifetime, so that the experience of grief can almost be considered universal. Grief is a term used to describe the emotional, cognitive, and behavioural responses to the loss (typically to death) of a loved one. Grieving individuals often report a preoccupation with thoughts of the deceased, and physical manifestation such as weakness, a lack of energy, and a sensation of physical and emotional 'hollowness.' Manifestations of grief vary greatly between individuals, cultures, and situations; however, individuals suffering from grief typically

present with feelings of sadness, guilt, numbness, and/or shock. Howie (2007), notes a list of the grieving styles commonly presented in clinical practice;

- Absent Grief- no outward displays of grief. This may be due to emotional inhibition, denial of feelings, or the absence of typical grief reactions.
- Delayed Grief- grief that takes place sometime after the loss. This delay may be caused by other emotions, or the well-being of others, taking precedence, or the consistent and purposeful distraction of self.
- Chronic Grief- grief that is maintained or fails to diminish over time. This chronic course may be a result of unresolved guilt, anger, and/or depressive preoccupations.
- Somatised Grief- grief which is accompanied by variety of psychosomatic symptoms, caused by the suppressing of grief emotions due to a lack of social support, leading to externalisation in the form of somatisation.
- Distorted Grief- a disproportionate grief reaction, involving extreme anger, anxiety, or guilt which hinders other elements of the grief experience, by overwhelming normative emotional reactions. Excessive anger may be displaced onto others, including the deceased, leading to a loss of social support. Disproportionate grief may also lead to excessive rationalisations, to pry meaning from the loss. The level of negative affect required for grief to be considered 'disproportionate' depends on the cultural norms of those experiencing it.

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Australian Counselling Research Journal ISSN1832-1135

- Unresolved grief- a delayed or prolonged grief reaction, associated with clinical symptomology such as depression and sleeplessness (Zisook, & DeVaul, 1983).
- Disenfranchised grief- grief that is unacknowledged or invalidated by social norms, and therefore cannot be openly acknowledged or socially supported (Doka, 1999).

## Historical Models of Grief

### Psychoanalytic

Freud describes grief as a state of melancholia, whereby the grieving individual is searching for an attachment that is no longer there. The purpose of grief, therefore, is to stimulate the detachment process of the griever from the deceased. Successful resolution of grief requires 'grief work,' the process of thinking about the deceased, events following and after death, and working towards detachment from the deceased. Grief work involves three elements: detachment from the deceased; readjustment to new life circumstances; and, building of new relationships. Freud (1961) describes grief work as an arduous process, whereby purposeful engagement by the griever is necessary to resolve grief. According to this theory, typical mourning periods are relatively short; however, refusal to complete grief work can complicate this process, leading to a prolonged or pathological reaction (Freud, 1961). This theory, however, is based on clinical work with depressed grieving populations, and may not be generalizable to other grieving populations (Buglass, 2010).

### Phase Theory of Grief

The Phase Theory of Grief, proposed by Lindemann (1944) describes grief as experienced by; (1) somatic disturbance, (2) preoccupation with thoughts/memories of the deceased, (3) guilt, (4) anger and/or hostility, and (5) mild functional impairment. Lindemann also mentions a less common sixth phase, where the bereaved takes on traits of the deceased. Included in this theory are identifiable parameters of normal vs pathological grief, differentiated by duration, intensity, and level of functional impairment. Based on the Freudian perspective, recovery is said to come about through three fundamental phases; (1) accepting the loss as a definitive fact, (2) adjusting to life without the deceased, and (3) forming new relationships.

### Attachment Theory

Attachment theory is based on the assumption that humans have an intrinsic, fundamental, and biologically driven, need to form strong bonds with others (Bowlby, 1973). The irreparable severing of these bonds, through death, is therefore associated with a biological disequilibrium brought about by a sudden change in environment. The theory emphasises this disequilibrium in terms separation anxiety and distress (Klass, 1988). This distress is presented through four interrelated, flexible phases: Shock, yearning and protest, despair, and recovery. This theory borrows from Freud and emphasises the need for grief work in order to relinquish bonds; however, unlike the psychoanalytic viewpoint, relinquishment is to change bonds, rearrange interpretations of the deceased, and consequently of the self (Bowlby, 1973). Bowlby's attachment styles have been related to bereavement reactions, whereby the attachment styles, in conjunction with specific attachment factors between the bereaved and the deceased, differently related to

experiences of grief, depression, or somatization. For example, avoidant attachment style was associated with higher levels of somatization during grief, while anxious-ambivalent style of attachment was associated with experiencing greater depressive symptoms (Wayment & Vierthaler, 2011).

### Kübler-Ross' Five Stages of Grief

One of the widest known models of grief is Kübler-Ross' five stages of grief. The stages were developed based on the experiences of the terminally ill coming to terms with their impending deaths. The five stages are as follows (Kübler-Ross, 1970):

1. denial: rejecting the reality of newly presented information (i.e., a patient diagnosed with a terminal illness may deny the diagnosis),
2. anger: often manifested as misguided outbursts of blame towards others out of frustration of perceived unfairness,
3. bargaining: verbal or internal negation often in a religious nature,
4. depression: immense sadness and fatigue, and
5. acceptance: recognising reality, preparing for death and reflecting on life.

Kübler-Ross' stages have since been adapted to describe grief reaction towards another's death, with the stages describing these emotions being experienced about others. Major criticisms of this theory are that the stages are rarely sequential, and the common misinterpretation of these stages to describe experiences of the bereaved may not be appropriate (Corr, 1993 as cited in Buglass, 2010).

## Contemporary Models of Grief

### Task-Based Model

Worden's (2008) Task-Based Model describes grieving as an active process requiring the griever to engage in four tasks: (1) accepting the reality of loss; (2) process grief-related pain; (3) adjust to the world without the deceased; and, (4) maintaining an enduring connection with the deceased. Included in this theory are a list of seven protective/risk factors to explain differentiation in individual reactions: (a) who the deceased was; (b) what relationship the griever had with the deceased; (c) how the person died; (d) historical antecedents; (e) griever personality traits; (f) social mediators; and, (g) concurrent stressors. Like grief work, Worden's tasks are to be purposefully engaged in, and failure to complete each task results in a worsened grief reaction.

### Dual Process Model of Coping with Bereavement

An adaptive grief theory, proposed by Stroebe and Schut (1999), is The Dual Process Model of Coping with Bereavement. The model identifies two stressors related to bereavement: loss-oriented (related to the coping of the experience of the loss); and, restoration-oriented (coping with the lifestyle changes that come about due to the loss). The central theme of this theory is the oscillation between confrontation of the loss (by attending to feelings regarding loss), and purposeful avoidance of thoughts related to the loss. This allows for the griever to both process feelings while allowing for the capacity to deal with associated life changes, which come about as a result of the loss. In contrast to the psychoanalytic 'grief work approach', whereby avoidance is seen as inherently harmful to the grieving process, Stroebe and Schut (2010) argue the need for taking 'time off' when it gets

too painful, and restoration-oriented tasks must be attended to, provided the avoidance is not extreme or persistent.

## Continuing Bonds

A current trend in the field of grief and psychology is the moving away from the belief that successful grieving requires 'letting go.' This movement, introduced by Klass, Silverman, and Nickman (1996), referred to as 'continuing bonds,' stipulates that, not only is the severing of bond unnecessary, but maintaining them after death is a healthy coping mechanism. At the core of the model is the idea of continuing bonds; bonds once held with the deceased are adjusted and redefined, with the bereaved carrying an internal representation of the deceased attachment figure. The theory was prompted by the observation that the establishment of ongoing bonds was normative and considered healthier across other, non-western, cultures (Klass et al., 1996). This theory is in major opposition to that of Freud (1961), who viewed the maintenance of bonds following death a maladaptive grief reaction, leading to a prolonged, chronic, course of grief. Provided that the theory is contradictory to historical models and treatment methods derived from them (aimed at reducing lingering bonds), a greater depth of research is required to support the notion. However, some research exists to suggest that continuing bonds may provide grievers with some measure of comfort (Foster, et al., 2011).

## Grief Comorbidities

Due to the distressing nature of grief, grievers are at a higher risk of developing co-morbid mental illnesses, such as depression, anxiety, and Post Traumatic Stress Disorder (PTSD) (Friedman, 2012; Shear & Skritskaya, 2012; Zakarian et al., 2019). Manifestations of grief are often confused with these disorders, as they can share clinical presentation features. However, while they can be experienced alongside grief, they are not a part of a normative grief reaction. Prolonged periods of sadness are common during mourning and they typically resolve without the need for treatment within 2 to 6 months (Friedman, 2012). Normative grief was differentiated in the DSM-IV from Major Depressive Disorder (MDD) by requiring a greater period of active symptomology and more substantial functional impairment in current grievers, to reduce overdiagnosis (Maj, 2012). The bereavement exclusion was, however, removed in the DSM-5, meaning bereaved individuals could be diagnosed with MDD after only 2 weeks of mild depressive symptoms. This change has been criticised for its lack of empirical support and potentially inciting an influx of MDD diagnoses (Friedman, 2012; Wakefield & First, 2012). Others, however, have supported the change, citing the removal of the bereavement exclusion allows for greater diagnostic accuracy through bypassing arbitrary time-frames. Additionally, no significant increase in the diagnosis of MDD during bereavement has been found following the removal of the exclusion (Iglewicz, et al., 2013). The exclusion was replaced, in the DSM-5, by notes in the diagnostic criteria which precautions practitioners to differentiate normative grief from MDD by observing symptomatology. The APA advises that while grief and MDD share features they can be differentiated by important aspects such as; the perseverance of self-esteem during grieving, while in MDD a diminishment in self-worth is common. Additionally, grievers often experience waves of pain, often associated with experiencing positive memories of the

deceased, while in MDD mood is often a persisting negative (American Psychiatric Association, 2013).

Another co-morbid condition of grief is anxiety, which, in cases of acute grief, typically subside after 6 to 8 months following bereavement (Shear & Skritskaya, 2012). The development of an anxiety disorder during bereavement is estimated between 10%-20% of bereaved people (Shear & Skritskaya, 2012), with the presence of anxiety disorders having the potential to distort and complicate grief reactions (Howie, 2007; Shear & Skritskaya, 2012). Grief reactions can also have similar characteristics to PTSD, most notably in the form of memory intrusions. Whilst easy to confuse, PTSD is defined by intrusive images of the traumatic incident, causing intensified arousal and anxiety but, in grief reactions, intrusive images of the deceased often trigger feelings of longing, sadness or depressive symptoms (Howie, 2007). PTSD can, of course, develop in conjunction with a grief reaction following a particularly traumatic (unexpected, or outside typical human experience) or violent loss, which may complicate the course of normal grief (Zakarian et al., 2019).

## Complicated grief

Complicated grief (CG) (otherwise referred to as prolonged grief, persistent bereavement, and pathological grief) is a popular term used to describe a maladaptation of the normative grief reaction, including;

*"Current experience (more than a year after a loss) of intense intrusive thoughts, pangs of severe emotion, distressing yearnings, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased, unusual sleep disturbances, and maladaptive levels of loss of interest in personal activities"* (Horowitz et al., 1997, p. 904).

CG has an estimated worldwide lifetime prevalence of 2.4%–4.8% (Fujisawa et al., 2010; Kersting et al., 2011), and approximately 10-25% among grievers (Mancini et al., 2012; Robbins-Welty et al., 2018; Newson et al., 2011). This proportion is thought to increase following the death of a spouse, child, or someone with which a person had a particularly close relationship (Neimeyer et al., 2012; Nader & Salloum, 2011; Newson et al., 2011), and/or following a sudden and/or unexpected death of a loved one (Wilson et al., 2020). In a population-based sample, prevalence rates of 3.7% of the general sample and 6.7% following a major bereavement, have been found. The study also identified the highest risk factors as being female gender, low income, older age, having lost a child or spouse, and cancer as the cause of death (Kersting et al., 2011). CG is differentiated from normal/acute grief by intensity, duration and symptomology above and beyond clinically and culturally expected norms (Strobe et al., 2013). From a descriptivist perspective the primary differentiation between normal (acute) grief and CG is pathological functioning. Whilst normal grief involves experiencing negative emotions, the process involves no dysfunction, whereas a primary characteristic of CG is the social/occupational impairment that it causes. As a result, is considered maladaptive and a form of mental disorder (Strobe et al., 2013).

Freud is the first credited to differentiate between grief and pathological grief (Granek, 2010) in his book *On Mourning and Melancholia* (Freud, 1914-1916). This differentiation, however, is difficult to distinguish from Major Depressive Disorder as his writings were derived from working with a subset of depressed grievers. Horowitz et al., (1993) introduced pathological grief as a



diagnostic modification to PTSD to be included in the DSM-IV. The proposed diagnosis stipulated that pathological grief is a result of an individual failing to incorporate the death of a loved one into their representational schema due to a pathological tendency to stifle negative emotions. This failure results in prolonged and intensified grief symptoms. The proposed diagnostic criteria of pathological grief is to be similar to the diagnosis of PTSD; however, the primary difference is that the triggering stressor is no longer required to be 'outside the range of usual human experience', as grief is an experience almost every person will face (Horowitz et al., 1993). The incorporation of pathological grief (later referred to as complicated grief in a follow-up article) to the DSM-IV was debated by the American Psychiatric Association (APA), and the diagnosis was rejected due to the lack of empirical evidence (Horowitz et al., 1997).

The term, complicated grief, is now widely used, and much research has been dedicated to it (Shear & Shair, 2005; Boelen et al., 2006; Fujisawa et al., 2010; Kersting et al., 2011; Dodd et al., 2016; Nakajima, 2018; Iglewicz et al., 2019), with adaptations of this disorder added to the 11th iteration of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11) and mentioned in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Persistent Complex Bereavement Disorder is found in the chapter "Conditions for Further Study" of the DSM-5. The condition is marked by persistent yearning/longing for the deceased, intense sorrow, and preoccupation with thoughts of the deceased, resulting in clinically significant distress or impairment in psychological functioning, for at least 12 months (6 in children). This is distinguished from normal grief by the presence of severe grief reactions that interfere with the individual's capacity to function in social, occupational and other important domains [see DSM-5 for full diagnostic criteria] (American Psychiatric Association, 2013). Coded as 6B42, 'Prolonged Grief Disorder' is classified as a stress-associated disorder in the ICD-11. The disorder is characterized by a persistent and pervasive grief response, including preoccupation with the deceased, intense negative affect and difficulty engaging in social or other activities, exceeding social, cultural or religious norms. The disturbance causing significant impairment in social, occupational or other important areas of functioning, for at least 6 months [see ICD-11 for full diagnostic criteria] (World Health Organization, 2020).

Complicated grief has been associated with neurological abnormalities in the reward system, and lower levels of serotonergic brain activity similar to depressive disorders (Neimeyer et al., 2012; Bui et al., 2012). This explains the high comorbidity rates between grief and depressive disorders, with similarities in diurnal cortisol profiles between the disorders, suggesting a shared pathophysiological underlying (Bui et al., 2012). The normal grieving process has been observed to activate brain regions such as the dorsal anterior cingulate cortex (ACC), insula, and periaqueductal gray (PAG), regions of which are commonly associated with experiences of pain. This reaction was not, however, noticeably different between 'normal' grievers and those with CG, suggesting that these areas may not play a role in the development of CG.

In a study of bereaved parents in China following the one-child policy, smaller left hippocampal volumes were identified in those grieving compared to the non-bereaved, a symptom that has been associated with those suffering from PTSD. Interestingly, when the group was subdivided from those with/without PTSD no differences were found in hippocampal volume,

suggesting that bereavement specifically, rather than PTSD, is related to smaller left hippocampal volumes (Neimeyer et al., 2012). Hippocampal volume is directly related to declarative memory, the ability to recall facts and events suggesting prolonged grief can lead to declines in short-delay retention, long-delay retention and discriminability (Pohlack et al., 2012).

Additionally, those with CG have been found to have significantly less gray and white matter than those with acute grief, who showed no differences between the non-bereaved, suggesting the heightened grief severity, rather than grief itself is associated with reduced brain volume. This is supported by the findings that greater cognitive difficulties, in the areas of processing speed and verbal fluency, have been observed to be in those with CG compared to acute grievers and the non-bereaved (O'Conner & McConnel, 2018; Bui, 2018).

## Grief Complications in Children/Adolescence

It is estimated that 5-10% of children and adolescents who experience the loss of a loved one will experience some form of psychiatric difficulty (Spuij et al., 2013). In younger children, the inability to understand death may lead to grief reactions of general distress, regression, and separation anxiety, while adolescents, who have a clear perception of death may present with existential crises, anxiety, isolation, and risky behaviour (Revet et al., 2018). These findings suggest that during childhood, developmental periods may be a key mediator in how grief reactions are manifested. In a misconstrued effort to reduce the suffering of children, caregivers may explain the events of loss vaguely, or using unclear metaphors. This can lead to misunderstanding regarding a loss's permanence, causing a multitude of complications (Howie, 2007). Children may also inconsistently present grief, with a short period of sadness intermittent with regular behaviour. This presentation can often be misunderstood by caregivers as healthy coping, further undermining children receiving the required support (Howie, 2007).

## Grief Complications of the Elderly

Research indicates that 20-30% of the elderly are likely to develop a mental health complication, such as depression, PTSD, or complicated grief disorder following the loss of a loved one (Robbins-Welty et al., 2018). This higher proportion of complications is likely due to the nature of the loss; as the elderly are more likely to experience the death of parents, siblings, and spouses, loss of which is considered to increase the risk of CG development (Robbins-Welty et al., 2018; Newson et al., 2011). Additionally, early signs of complicated grief, such as cognitive decline, social withdrawal, and negative affect, often go unnoticed, overlooked as age-related decline. Complicated grief in older adults has also been associated with higher mortality rates (Robbins-Welty et al., 2018). Older individuals presenting with complicated grief, may also have higher rates of developing comorbid disorders than the general population, with 17.2% developing an anxiety disorders and 17.2% for major depression (Newson et al., 2011).

## Death of a child

The death of a child is considered a highly challenging

situation, accounting for the highest prevalence of complicated grief reactions (Neimeyer et al., 2012; Nader & Salloum, 2011; Newson et al., 2011). This is due to several factors. Firstly, the death of a child is almost always considered traumatic (i.e., not anticipated); with accidental injuries leading to over half of all childhood deaths. Secondly, the bond between child and parent is particularly strong, so that separation leads to an equivalently strong grief reaction. Finally, the bond between child and parent is also integral to both parties' core identity, leading to a large secondary loss (i.e., the loss of role as a parent/caregiver). This secondary loss also extends to the loss of a parent's aspirations and hopes regarding the child's future (Christ et al., 2003). These factors combined may increase the risk of grieving maladaptations, with sense-making (i.e., difficulty making sense and processing the child's death) as the largest moderating factor of grief intensity for grieving parents (Keesee et al., 2008).

## Complicated Grief and COVID-19

Grief and mourning have been further complicated in recent times, as a direct result of the 2019 novel coronavirus (COVID-19) pandemic, since it is responsible for not only primary loss but a variety of secondary losses. Secondary losses include; loss of job, loss of economic stability, loss of certain individual freedoms, and loss of community (Diolaiuti et al., 2021). The pandemic has also led to the loss of certain rituals, important in the mourning process. Mourning rituals such as attending a funeral and/or wake are important buffers in the defence of pathological grief (Nakajima, 2018; Diolaiuti et al., 2021; Wallace et al., 2020), and can lead to increased feelings of control and mitigate negative emotions (Norton & Gino, 2014). Due to social distancing restrictions, attending funerals has been prohibited, and visiting the dying in hospital or residential care has been made difficult or impossible, stripping some of their chance to say last goodbyes. This can complicate the integration of loss into representational schema (Diolaiuti et al., 2021), leading to experiences of disenfranchised grief (Wallace et al., 2020).

Disenfranchised grief, otherwise known as hidden sorrow, refers to grief that is unacknowledged or invalidated by social norms, and therefore cannot be openly acknowledged or socially supported (Doka, 1999). For example, if the deceased had not followed proscribed Covid-19 quarantine laws, the emotional impact of the death may be invalidated by the wider community due to intertwined anger and/or blame. This can also be caused by the large numbers of deaths, with the bereaved struggling to disconnect the individual from the statistics and receiving less individualised support (Wallace et al., 2020). Geriater and Shear (2020), predicts that diagnostic rates of PGD will increase during the COVID-19 pandemic, especially in older adults who are partially susceptible to the virus. Due to this susceptibility, elderly grievers face greater social isolation, due to imposed distancing practices to reduce chances of infection. Additionally, newly imposed social distancing laws have caused a postponement or loss of mourning rituals, and loss of religious rituals due to the closure of places of worship, impacting all grievers ability to appropriately outlet feelings associated with the loss.

An important consideration is the emotional consequences COVID-19 has had on front line carers. Throughout this pandemic, many providers have been exposed to death, on unprecedented levels. To deal with the emotional strain many providers may rely on coping strategies such as

compartmentation, and avoidance through distraction, such as increased occupational/social engagement, and/or emotional numbing through the use of alcohol, tobacco products, or recreational narcotics (Wallace et al., 2020). These strategies have a high chance of leading to unresolved grief, a delayed or prolonged grief reaction, associated with clinical symptomologies such as depression and sleeplessness (Zisook, & DeVaul, 1983). Providers are also likely to experience disenfranchised grief, as professional and cultural norms indicated that health care providers' grieving or the loss of patient are viewed as unacceptable and unprofessional (Feldstein, 1995; Granek et al., 2012; Papadatou, & Bellali, 2002 as cited in Carton, & Hupcey, 2014).

Another important consideration is the effect that COVID-19 has on the grieving of adolescence. Due to the nature of the virus, the majority of deaths are those with pre-existing vulnerability or the elderly, with every COVID-19 death leaving behind an estimated average of 2 children and 4 grandchildren (Birkner & Soffer, 2020 as cited by Weinstock et al., 2021), meaning that a substantially disproportionate subset of grievers are adolescents. As previously mentioned, adolescents present grief through existential crises, anxiety, isolation, and risky behaviour (Revet et al., 2018). Unfortunately, the circumstances brought about because of COVID-19, such as a reduction in peer social support and breakdown of community, have a real possibility to exacerbate these maladaptive reactions (Weinstock et al., 2021). Weinstock et al. (2021) states that the current pandemic may be a catalyst for a decline in the mental health of the youth, calling professionals and community support services into action to prevent the development of secondary problems, such as anxiety, depression and substance abuse.

## Models of Complicated Grief

### Cognitive-Behavioural

Complicated grief from the cognitive-behavioural perspective is the result of three interrelated processes: (a) insignificant elaboration and integration of loss within autobiographical memory; (b) negative thinking; and, (c) anxious depressive avoidance behaviours (Boelen et al., 2013). 'Insignificant elaboration and integration' is described as the lack of integration regarding a loved one's death into autobiographic memory, resulting in memories being easily elicited and the loss being constantly viewed as new, shocking, and unbelievable. The process serves to prolong the grief process, increase instances of unwanted memory intrusion, and exacerbate negative affect. 'Negative thinking' is presented as rigid and negative global cognitions regarding the self and future, which may result in a sense of blighted future and reduced goal-seeking behaviour. Secondary to this process is the misinterpretation of normative grief reactions, such as vivid and unwanted memory intrusion, as signs of one's own insanity. 'Anxious and depressive avoidance' includes both physical and cognitive avoidance, whereby the grieving attempt to alter the duration, frequency, and form of negative thoughts, feelings, and memories, and a withdrawal from social, occupational, and recreational activities is typically viewed (Boelen et al., 2006- 2013).

Following the aforementioned model of complicated grief, cognitive-behavioural therapy (CBT) of complicated grief involves: the integration of loss with existing autobiographic schemas; identifying and modifying negative cognitive schemas;

and, replacing avoidance strategies with more helpful ones. This is achieved through psychotherapy and the setting of homework tasks. To assist with the integration of loss into existing knowledge, tasks such as imaginal exposure, retelling of the event, journal keeping, writing a letter to the deceased, or exposure to memory triggering stimulation are used. To reduce negative thinking, cognitive restructuring (the processes of identifying maladaptive cognitions, examining their validity, and reformulating those cognitions) is used. In the reduction of anxious and depressive avoidance, behavioural activation and/or response prevention is implemented (Strobe et al., 2013).

CBT has been proven to be an effective treatment method for grief disorders (Mancini et al., 2012). In randomized clinical trial CBT when combined with exposure therapy (PG-CBT) show significantly greater reductions in depression, negative appraisals, and functional impairments than CBT alone. Additionally, at a six month follow-up fewer participants in the exposure group were diagnosable with prolonged grief disorder than CBT alone group (14.8% vs 37.9%) (Bryant et al., 2014). Rosner et al. (2014) found similar results with PG-CBT showing significant symptom reduction over the control, waiting list group.

### Multidimensional Grief Theory

The Multidimensional Grief Theory was developed as a childhood grief theory. It postulates that complicated grief is a result of maladaptive reactions within three content domains: (1) separation distress; (2) existential/identity-related distress; and, (3) developmentally link manifestations of grief. The theory is based on the assumption that both positive and maladaptive adjustment can occur within each domain, mediated by a combination of causal risk factors (e.g., etiological risk factors, circumstances of death), causal consequences (e.g., functional impairment), key mediators and moderators (e.g., cultural background, developmental stage), and developmentally linked manifestations of grief (in younger children general distress, regression, and separation anxiety, in adolescents, existential crises, anxiety, isolation, and risky behaviour) (Kaplow et al., 2013). Within the domain of 'separation distress,' normative manifestations are seen as missing the deceased, heartache, and yearning/longing (within culturally accepted limits), whereas maladaptive manifestations include the aforementioned manifestations beyond culturally acceptable thresholds and include suicidal ideation and/or developmental slowing or regression. Normative manifestations in the domain of 'existential/identity-related distress' are the contention with disruption in sense of self, meaning, and purpose. Within this domain, maladaptive manifestations emerge as severe distress and loss of personal identity, the resignation of future aspirations, and a sense of 'blighted' future. In the final domain of 'Circumstance-Related Distress', normative reactions include acute sadness, anger, disgust and horror, whilst maladaptive reactions include persistent rage, guilt, shame, or 'psychic numbing' through behavioural and cognitive avoidance (Kaplow et al., 2013).

Treatment based on multidimensional grief theory is based on four primary assumptions: (1) adaptive and maladaptive reactions to grief are inherent in the bereavement process and may arise within each content domain; (2) normative and maladaptive reactions can co-occur within each domain; (3) the different dimensions of grief and their related manifestations call for different intervention methods; and, (4) the intervention aims to encourage adaptive grieving and reduce the frequency, intensity and duration of maladaptive manifestations (Kaplow et

al. 2019; Layne et al., 2017; Hill et al., 2019). Multidimensional grief theory has a heavy focus on socio-environmental contexts and assumes that grieving children rely heavily on their caretaking environment to facilitate the grieving process (Clark et al., 1994). Multidimensional grief therapy (MGT) is specially designed for bereaved children aged 6 to 17 (Kaplow et al., 2019). The treatment is divided into two phases. Phase 1 'Learning about Grief' includes psychoeducation, skill-building, and identification/regulation strategies. Phase 2 'Telling My Story' guides the children through telling their story through each content domain and encouraging adaptive grief responses (Hill et al., 2019). A pilot study of MGT revealed that completion of phase 1 resulted in significant reductions of maladaptive manifestations in all three content domains. Completion of phase 2 also presented significant reductions, apart from existential/identity distress, beyond phase 1; however, phase 2 resulted in a significant reduction of PTSD symptoms in those presenting (Hill et al., 2019).

### Attachment Theory

Shear et al. (2007) proposes that the death of a loved one results in a decisive mismatch between the unrevised mental representation of that person and a dramatic change in the ongoing relationship with that person. This mismatch results in: (a) an unrevised working model producing a continuing sense of the deceased; (b) stress-related to bereavement activating proximity seeking and a sense of yearning and thoughts/memories of the deceased; (c) a disruption in the function of the working model resulting in a loss of emotional and attentional regulation; and, (d) inhibition of world interest and goal-seeking due to strong activation of attachment. In summary, grief triggers a preoccupation with thoughts of the deceased, accompanied by yearning and longing, which results in a detachment in the interest of others and life occupations. This experience typically resolves as the permanence of the loss is integrated into long-term memory and, as such, thought of the deceased become no longer preoccupying. Through this model complicated grief is seen as a stress response syndrome, in which the death of an attachment figure has failed to be incorporated into their schema, resulting in a cyclical grief reaction (Shear et al., 2007). According to Shear et al. (2007) assimilation of knowledge of a person's death into the working model, schema requires significant time, with this time being reduced by the expectation of death, which suggests that sudden unexpected deaths take longer to incorporate and would be more likely to develop CG.

Complicated grief treatment (CGT) is heavily based on Strobe and Schut's Dual-process Model, but incorporates aspects from attachment theory, interpersonal psychotherapy and CBT (Wetherell, 2012; Shear, 2010; Igelwicz et al., 2019; Neimeyer, 2014). The treatment is focused on two key areas: restoration and loss. Restoration focuses on the restoring of self-functioning by generating enthusiasm and creating plans for the future. The Loss focal area helps clients to think about death in a way that does not trigger excessive negative emotions (Neimeyer et al., 2012). The treatment has seven core themes: (1) Providing information to help participants understand and accept grief; (2) managing emotional pain and monitoring symptoms; (3) thinking about the future; (4) reconnecting with others; (5) telling the story of death; (6) learning to live with reminders; and, (7) connecting with memories (Igelwicz et al., 2019). These themes are addressed during a treatment period of typically 16 sessions over four months, using techniques such as psychoeducation,



in-vivo and imaginal exposure, and working on self-care (Shear, 2010). CGT has proven more efficacious than common depression treatments (Igelwicz et al., 2019), and is superior to interpersonal psychotherapy, showing higher response rates and faster response time (Shear et al., 2005). A promising treatment method of CG is the use of pharmacotherapy in conjunction with psychotherapy. The use of antidepressant medication has been found to increase the likelihood of completing a full course of Complicated Grief Therapy (CGT) (91% CGT with antidepressants vs. 58% CGT alone) (Simon, et al., 2008). Mancini et al. (2012) suggest that the use of antidepressants may serve a benefit in the completion of a course of grief therapy as it may help patients tolerate emotional pain that grief psychotherapy arouses.

## Complicated grief in clinical practice

Gamino and Ritter (2009 as cited in Gamino & Ritter, 2012) identified four impediments of therapists working effectively with grief (1) unfinished business regarding the death of a loved one; (2) excessive death anxiety; (3) a lack of education leading to generalisations based on personal experience; and, (4) a lack of personal history of loss leading to unawareness of personal or individual grief reaction. Stephen (1981, as cited in Dodd et al., 2017) found that 90% of therapists report competency in providing grief counselling despite having received little, to no, specialist training in the area. Despite the commonality of grief in clinical practice, a study of US colleges found that only 20% offered courses in death education (Eckerd, 2009 as cited in Dodd et al., 2017). Rogalla-Hafley (2008) suggests that death education can serve to help manage personal death anxiety, increase empathy and provide a deeper understanding of the client's experience. Simply put, while many professionals report having the personal competency to work with grievers, many still lack the technical skills to adequately provide specialised grief therapy (Dodd et al., 2017). These findings and discoveries in the area of grief disorders, call to light the need for greater practitioner education, especially considering the removal of the bereavement exclusion from the DSM diagnosis of MDD.

## Conclusion

The subject of grief, especially complicated grief, has been subject to a great deal of research in recent years. This research has provided a framework for understanding and diagnosing maladaptive grief reactions. This is especially important due to the difficulty in differentiating acute/normative grief reactions from their maladaptive counterparts and comorbid mental illnesses. Historical frameworks of grief are now outdated, considering new advancements in the field, because they can lead to potentially harmful assumptions by mental health practitioners, impacting their ability to adequately provide support. A prime example is the concept of Freud's grief work, which is in opposition to newer theories, especially regarding the notion of continuing bonds. This contention calls to attention the need for greater research regarding the nature of grief disorders and treatment approaches. As it currently stands, the majority of Mental Health practitioners are underequipped to treat grief disorders, lacking the technical skills required to work with grieving populations, potentially due to lack of mandated and/or available specialist education courses. Furthermore, with the removal of the bereavement exclusion from the diagnosis of Major

Depressive Disorder, and the predicted influx of complicated grief due to COVID-19, education of mental health professionals in this area is of particular importance.

Suggestions for future research included investigating the current competency and level of training that mental health professionals possess in the diagnostic of grief disorders. Additionally, further research is required to effectively apply the continuing bonds theory to treatment methods, and subsequently, investigate its efficacy compared to historical approaches.

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