Australian Critical Care 28 (2015) 58–62

Contents lists available at ScienceDirect

Australian Critical Care

journal homepage: www.elsevier.com/locate/aucc

Research paper

What is "normal" in grief?

Brian J. Arizmendi MA,
Mary-Frances O'Connor PhD*

Department of Psychology, University of Arizona, 1503 E. University Boulevard, Room 430, Tucson, AZ 85721, United States

ARTICLE INFORMATION

Article history:
Received 18 August 2014
Received in revised form
24 December 2014
Accepted 26 January 2015

Keywords:
Grief
Bereavement
Complicated Grief
Grief treatment
Grief trajectories
Immune system
Widow

ABSTRACT

Research conducted over the past two decades has revealed that grief, a common phenomenon experienced by many people following the loss of a loved one, is rarely experienced as a steady progression from high acuity (intensity) to eventual resolution. Instead of this single "traditional" path, four distinct trajectories are supported by empirical data: resilience, chronic grief, depressed-improved, and chronic depression. Furthermore, a small subset of individuals never fully integrate the loss into their life, and continue to experience severe disruption in daily life many years after the loss event, a phenomenon known as Complicated Grief (CG). Continued empirical research will help further our understanding of the normative grief process and CG as a disorder. This information is crucial for informing clinicians of best practices when attending to those suffering from loss.

1. Overview

This review provides an overview of the empirical evidence for the trajectories of grief, including disordered patterns of grief, along with a discussion of the physiological impact of grief and recent research into types of grief treatment. This is in effort to provide consumers with a succinct update on our understanding of grief, and of pathological Complicated Grief (CG), which may assist professionals in navigating this phenomenon in healthcare settings.

2. What is "normal" in grief?

There is no clear "getting over" grief, just as we do not "get over" our graduation, the birth of our child, or our wedding. Of course, these examples are of commonly positive events, but the death of a loved one is also an event, and it continues to affect us for the rest of our lives. A loss of a loved one is generally experienced in waves of grief, felt deeply in our emotions, present in our thoughts and seen by others in our behaviour. Eventually, for most people those waves do even out into ripples. Nonetheless, it is expected for the bereaved and those surrounding them to wonder what is typical, or what can be expected in the wake of the death of a loved one. However, it is important that a "normal response" is not rigidly applied as rules to the bereaved.

When an individual experiences grief due to loss of a loved one, that person may experience an intense longing for some time after. One of the oldest models of the grief process is the best known, the five-stage model by Kübler-Ross.[1] Recent research supports the theory's notion that a grieving individual may show any array of symptoms including emotional numbness, yearning, anger, despair, and acceptance. However, bereaved individuals manifest various symptoms during the entire process of grief, and they are not experienced in a sequential order.[2]

Acuity typically subsides in typical grief as the bereaved individual comes to terms with the finality of the loss and integrates this acceptance into their life. This is thought to include the integration of the reality and permanence of the loss into the survivor's memory and mental schemata as he/she resumes relationships with living loved ones. The grieving process is traditionally thought to begin with a period of high or acute distress and progress towards a state of low distress over time. Thus the process has historically been viewed as a relatively linear "recovery" trajectory over time.

However, research indicates that the course of bereavement does not always map neatly onto the ostensibly "normal" trajectory described above.[3] In fact, less than half of individuals who are grieving will experience grief in this way.[4,5] Instead research has empirically shown four distinct trajectories: resilience, chronic grief, depressed improved, and chronic depression.[6]

* Corresponding author. Tel.: +1 520 621 2173; fax: +1 520 621 9306.
E-mail address: mfoconnor@email.arizona.edu (M.-F. O'Connor).

http://dx.doi.org/10.1016/j.aucc.2015.01.005
1036-7314/

3. Trajectories of grief

Some individuals, referred to in the literature as "resilient," express very little outward grief after a loss, and instead show a consistent low level of distress or absence of grief altogether. Although this behaviour was once thought to be maladaptive, or lead to later poor mental and physical health, it has been consistently seen in a significant percentage of those who have lost a loved one, and does not correlate with poorer outcome.[7] As we have learned more, this response pattern has instead been attributed to positive coping styles and healthy adjustment, including remembering the loved one fondly, and ability to experience and express positive emotion.[3,8,9] A prospective study of 205 older adults measuring symptoms of depression (as measured by the CES-D) and bereavement (as measured by the Bereavement Index) prior to, 6 moths post-, and 18 months post-loss indicated that resilience reported low scores on both measures at each time point.[9] Moreover, this group accounted for 45.9% of the entire sample and thus appears to be the most common pattern of coping. Resilience can manifest as an absence of grief symptoms, but may not always do so. Rather, the individual may experience pangs of emotional distress occasionally, but is still able to function at their normal level[7] indicating that both an absence of symptoms and/or low, non-impairing symptomatology comprise this group. Another pattern evidenced in the literature is a "chronic" grief pattern, in which bereaved individuals continue to experience significant emotional pangs related to the loss, and continued yearning for the deceased.[3] This pattern only occurs in a minority of bereaved individuals, and is predicted most consistently by a high pre-loss dependency on the spouse.[9] Evidence suggests that chronic grief tends to eventually resolve in successful loss integration by 4 years post-loss.[7]

Some individuals actually improve after the loss, known as a "distressed-improved" pattern.[3] These researchers found that about 10% of spousally bereaved study participants showed clinical distress prior to the loss, and as the name implies, a subsequent improvement in distress after the loss. For example, these individuals reported improved ability to gain comfort from positive memories of the deceased, found meaning in the loss, and showed increased perceived benefits from dealing with the loss from 6 to 18 months post-loss.[3] This finding supports the notion that, for some individuals, the loss of the spouse marks the end of a chronic stressor. For instance, those who were in a difficult relationship or whose loved one was in severe distress prior to death may experience some relief after the death. Similarly, those who have lost a chronically ill spouse may also experience some relief following a reduction in their caregiving duties.

The final empirically evidenced trajectory is considered continual "chronic depression." Similar to the depressed-improved trajectory, this trajectory is characterised by high pre-loss depression levels. However, instead of recovery after the loss, depression endures and may even intensify as a result of the loss. This depression appears to remain stable even four years after the loss and is likely more related to ongoing mood disturbance than it is with the relationship to the deceased.[7]

From the studies listed above, as well as others, it becomes clear that a handful of distinct patterns of grieving have been empirically derived from bereavement research. However, consideration of individual differences amongst those who have suffered loss is key, and given the high contextual and personal variability across different individuals, the boundaries distinguishing these patterns may not be clearly defined. Although it is impossible to account for all variability in individuals, one study employing more sophisticated statistical methods mapped trajectories of individuals prospectively, thus allowing for a true baseline of each participating individual's functioning prior to loss. The authors found that even in this large sample, patterns of grief were consistent with those previously described, thus adding considerable support for the resilient, depressed-improved, and chronic grief delineations.[10]

3.1. Disordered patterns of grief

While many of those who have lost a loved one proceed through a natural course of grief, about 7% of those who have experienced bereavement do not, and are instead affected by CG.[11] When considering the type of loss, the prevalence of CG jumps considerably, to 20.3% and 23.6% in spousal and child bereavement respectively.[11] The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) currently distinguishes "normative" grief from CG (termed Persistent Complex Bereavement Disorder) by severity and chronicity, suggesting that pathological grief can only be diagnosed after 12 months.[12] The DSM-5 currently includes provisional criteria for Persistent Complex Bereavement Disorder in the appendix labelled "Conditions for Further Study."

Persistent Complex Bereavement Disorder is characterised by intense sorrow, persistent yearning and longing for the deceased, resulting in significant functional impairment that lasts from 12 months to many years after the loss event. Other symptoms can include emotional numbness, anger, avoidance of reminders of the loss, a belief that life in meaningless, and even suicidal ideation. Diagnostically, most existing studies use the Inventory for Complicated Grief (the ICG) as the gold standard for discerning CG from non-CG. The syndrome described in the DSM-5 has considerable overlap with the ICG and empirical descriptions of the disorder. Since this is not yet a diagnostic category per se, clinicians are advised to use the ICG and assess for symptoms of CG as delineated in the DSM-5.

Taken together, this syndrome is seen as distinct from other diagnoses, including Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD).[13] MDD and CG differ in aetiology; whereas CG arises specifically as a result of a lost loved-one, MDD can arise from any variety of sources and may even surface for no identifiable reason. Those with CG also demonstrate a consistent yearning for the deceased, and show avoidance behaviour specifically related to the lost loved one, while MDD is marked by more global avoidance and does not typically involve yearning. CG also differs from PTSD symptomatology. Although both are related by a severely distressing identifiable event, those with CG do not experience flashbacks, nightmares, or vivid and intrusive recollections of the distressing event. Richard Bryant distills these differences into six distinct arguments for the case of CG as a unique disorder.[14] His arguments rest largely on the core aspects of CG, such as yearning for the deceased. These unique core aspects have implications for many other distinguishing characteristics of CG, including cross-cultural prevalence and resistance to tricyclic antidepressant medications. It is the case however that post-loss symptoms of CG do overlap with some symptoms of MDD and PTSD, and comorbidity of CG with MDD is not uncommon. Indeed, 50–70% of CG individuals also meet criteria for a Major Depressive Episode,[15,16] making diagnostic distinction difficult for a treating clinician.

Lotterman and colleagues offer one approach, suggesting that although grief levels may be indistinguishable between chronic depression and CG, examining pre-loss levels of MDD can indicate whether post-loss grief symptoms have been "layered on top of" pre-existing depression or have arisen solely from the loss event.[17] Those with pre-loss depression may be more at risk for developing CG, as they have shown predisposed vulnerability to anxiety and stress, and report lower self-esteem and instrumental support. Importantly, depression, anxiety, and posttraumatic stress are not uncommon in family members of individuals in intensive care units (ICUs; Anderson et al.[18]) Specifically 50 family members