Complicated Grief

Adverse circumstances, such as sudden and traumatic death, can complicate grief, affecting the bereaved person's grief trajectory. When working with bereaved clients, it is important to be able to assess who is in need of support and to work to an effective outcome.

Types of Sudden Death

The following types of sudden death may prove problematic in terms of disturbing normal grief reactions:

- natural disaster
- war and conflict
- terrorist attack
- road-traffic crash
- murder
- suicide
- industrial and domestic fatal accident
- fatal accident on holiday
- drug overdose
- operating-theatre death
- heart attack and stroke
- embolism and haemorrhage
- stillbirth, neonatal death and miscarriage
- infection, including sepsis.

In these situations, mutual support with others bereaved has been shown to be helpful (Ikeda and Garces-Ozanne, 2019; Wilson et al., 2022).

Factors That May Complicate Grief

A number of factors may complicate grief, including:

- stressful situation
- stressful environment
- restricted/prohibited visiting of the loved one (during life and/or death)
- limited funeral
- conflicts with religious/cultural practices
- social isolation and low social support.

In cases of violent death, having found, seen or identified the body may complicate grief. Other factors include the loss being sudden and unexpected, and there being issues related to notification of the death.

Other factors relate to the bereaved individual and to the nature of their relationship with the deceased (Burke and Neimeyer, 2013):

- being bereaved of the spouse or a child
- having high pre-death marital dependency
- being of a young age
- being female
- having an anxious/avoidant/insecure attachment style
- having had a problematic relationship with the deceased
- having experience of prior losses
- experiencing high neuroticism
- having a low level of education
- being on a low income
- experiencing a lack of family cohesion.

Typical Grief Reactions

In normal grief, it is usual to experience the following reactions (Stroebe, Schut and Stroebe, 2007):

- *affective:* depression, despair, dejection and distress; anxiety, fears and dreads; guilt, self-blame and self-accusation; anger, hostility and irritability; anhedonia

(loss of pleasure); loneliness; yearning, longing and pining; and shock and numbness

- *cognitive:* preoccupation with thoughts of the deceased and intrusive rumination; sense of presence of the deceased; suppression and denial; lowered self-esteem; self-reproach; helplessness and hopelessness; suicidal ideation; sense of unreality; and memory and concentration difficulties

- *behavioural:* agitation, tenseness and restlessness; fatigue and overactivity; searching; weeping, sobbing and crying; and social withdrawal

- *physiological–somatic:* loss of appetite; sleep disturbances; energy loss and exhaustion; physical complaints that may be similar to those of the deceased; immunological and endocrine changes; and susceptibility to illness, disease and mortality.

Complicated Grief Reactions

Prigerson (1995) describes an inventory of 'symptoms' – including disruptive and invasive thoughts, upsetting memories, disbelief, avoidance, longing, being angry, loss of trust, loss of empathy, somatic pain, and life feeling pointless – as prevalent in complicated grief.

Shear et al. (2011) see complicated grief as persistent intense symptoms of acute grief: the presence of thoughts, feelings or behaviours reflecting excessive or distracting concerns about the circumstances or consequences of the death.

Shear, Boelen and Neimeyer (2011) recognise that these symptoms and others (yearning, a wish to die, hallucinatory experiences and pangs of sadness) are within normal limits for six to 12 months – after which, they suggest prolonged grief.

While some see prolonged grief as a disorder, others regard it as normal grief complicated by events and circumstances.

When Not to Offer Bereavement Counselling

It has been demonstrated that at least 48% of bereaved people are sufficiently resilient that they will recover well without counselling support. Over one-third will have a normal recovery pattern, leaving perhaps 10–15% with chronic grief. Research indicates that this is the group that bereavement services should be working with (Bonanno, 2004, 2010; Bonanno, Boerner and Wortman, 2008; Ott, 2003; Silverman et al., 2000).

Thus, we need to take care that we work only with clients who will benefit from bereavement counselling. Indeed, the validity of the 'grief work' concept has long been questioned (Silver and Wortman, 1980). Wortman and Silver later (1989) challenged the commonly held belief that *not* doing grief work was indicative of a pathological condition. Various papers (Stroebe and Stroebe, 1991; Stroebe, 1993, 2011; Stroebe et al. 2002; Stroebe, Schut and Stroebe, 2005) assert that 'grief work' is not a universal construct).

Wilson (2017) identified a number of factors that are associated with resilience:

- having a secure attachment style
- being of adaptable personality
- abandoning conserved schemas constructing new schemas
- actively participating in change avoiding ruminative coping
- accepting painful emotions
- oscillating between loss and restoration.

Schut et al. (2001) found that routine referral to primary preventive grief intervention is highly unlikely to be effective. Intervention for those at risk of developing complications was modestly effective, but lasted only short-term. Grief therapy for people suffering from complicated grief was proven to be effective, also in the longer term.

Neimeyer (2000) went even further, arguing that grief intervention can actually cause deterioration in nearly 38% of grief-counselling clients.

Working with Complicated Grief

Having identified those who do need help, some of the most important work we do – especially in the early sessions – is to collaborate with the client in making sense of the death, at their own speed. Sometimes, this involves them taking responsibility for tasks between sessions.

Guidelines

Wilson (2017) shows that bereaved people can move forward if they are able to:

- accept the reality of the death, including being able to talk about it in detail
- acquire and practise coping strategies, including use of the Dual Process Model (Stroebe and Schut, 1999, 2010)

- accept that for a time, sadness will be 'as good as it gets'
- find meaning in a life without the deceased
- anticipate (eventually) a positive future without the loved one. This may include a continuing bond with the deceased.

Acceptance of the reality and being able to talk about the death in detail is difficult if there are gaps in your narrative experience. Likewise, making sense of the death can be hard if you have only part of the story. In addition, the restricted funerals that were a feature of the pandemic may have affected the early beginnings of continuing bond formation.

Pluralism

A pluralistic approach can be very helpful in working with complicated grief (Bohart and Tallman, 1999; Cooper and Macleod, 2011). The pluralistic practitioner:

- recognises and celebrates the client's ability to self-heal
- works in collaboration with the client
- acknowledges that there are two experts in the counselling room
- understands that different things work for different clients at different times.

Useful tips

Always bear in mind that your client's grief is unique, and there is no one-size-fits-all manual:

- Pay attention to the client's culture.
- Treat 'death-specific' textbooks (e.g. on bereavement by suicide, baby loss and sudden death) with caution.
- Don't make assumptions. The risk of this may be greater if you have experienced an (apparently) similar loss.
- Plan the counselling journey together, as far as is possible/humane.
- Work in a spirit of mutual curiosity.

A manualised protocol

Shear (2015) has developed a 16-session manualised protocol for working with complicated grief:

- Sessions 1 to 3 include telling the story, history-taking, daily grief-monitoring, psychoeducation (including the Dual Process Model), and the introduction of ongoing aspirational goals work.
- Sessions 4 to 9 include imaginal and situational revisiting procedures, work with memories and pictures, and tape recordings for clients to replay.
- Session 10 is a mid-course review.
- Sessions 11 to 16 include an imagined conversation with the deceased.

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