Chapter Two

The Complications of Grief
The Battle to Define Modern Mourning

Leeal Granek

Mourning Has Broken

In 2005, all the women died. At least that’s how it felt to me. My mother, to whom I was exceptionally close, died after living with metastatic breast cancer for 18 years. In the same year, I also lost an aunt, a close family friend, a woman who was my mother’s “chemo partner,” and a cherished professor. I was 25 years old.

These were my first experiences with grief, and they shocked me. One of the things that I found most distressing about grieving was how shameful it felt to express my sadness in public. I often had the sense that I was doing something wrong or taboo when I appeared (feeling rather) unhinged in public. Aries (1981) argued that dying and mourning have been constructed as scandalous in Western culture. We have, according to Aries, “eliminated [death’s] character of public ceremony, and made it a private act, and on the other hand, associated with this privatization of death was the second great milestone in the contemporary history of death: the rejection and elimination of mourning” (p. 575). This was true to my own experience. I often felt ashamed, embarrassed, and regretful for my sadness, and I was sorry for burdening others with my pain.

After the shock came the curiosity. As a grieving health psychologist, I began to notice how many inconsistencies there were between what I was experiencing and what I had learned to be true about bereavement. One example of this contradiction was the matter of the duration of grief. While I was in the “acute” phase of grieving, which lasted well over a year, I often thought my suffering would never end. I longed for the pain to abate and
would have done anything to make it stop. While this was happening, I was getting the message from those around me that it was “time to move on.” I did not know yet that bereavement was listed in the appendix of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) or that there was a category called complicated grief (CG) that was widely used by psychology and psychiatry professionals and would become a hotly contested psychological diagnosis in the years to come.

Several years later, I had become a scholar and “expert” on grief. I put expert in quotation marks because although I have intimately experienced grief, have devoted years to its study, have heard from thousands of mourners about their experiences, and have published in the field, I still know little about what the grief process is, does, and transforms in us. I am still not certain about what is normal or abnormal; indeed, it appears from my extensive research on the topic that all grief is complicated in some capacity.

In this chapter, I dive into this ambiguity and uncertainty about grief. I begin by examining grief in its social and historical context and continue by addressing the psychological imperative to gain control over mourning by trying to define the parameters around what is normal and abnormal in expressions of grief. In the second half of the chapter, I explore the implications of this pathologization and the contemporary attempts to manage grief with psychotherapy and pharmaceuticals. In the fourth and final section, I explore what the public seems to wants when it comes to grief and how community support may be a particularly powerful antidote to the pathologization narrative.

**Grief In Context: Modernism, the Individual, Death, and Grief**

The emergence of grief as a psychological, scientific object of study is an early 20th-century invention (Granek, 2010a). While most of my research has focused on the contributions of the psychological and psychiatric disciplines in constructing cultural expectations about what is deemed normal or abnormal with regard to acceptable mourning practices, it is paramount to understand that the psychologization and pathologization of grief are situated within several other cultural and historical movements that have been part of the shifting understanding of mourning. These contexts includes the rise of modernism, the focus on the psychological self as a site of meaning, and the subsequent fear of death and grief (Becker, 1973; Kellehear, 2007; Seale, 1998); the proliferating role of therapeutic experts in managing everyday life (Illouz, 2008); and an adherence to a progress narrative that emphasizes...
happiness, innovation, and a forward-moving mentality while denying sadness and mourning (Cable, 1998; Gorer, 1967). Contemporary culture does not like to look in the rearview mirror when it comes to pain, loss, or grief.

The main tenets of modernism are an emphasis on scientific rationality, reason, the self, observation, and a belief in continuous progress. Modern life emphasizes goal directedness, functionality, rationality, and efficiency in all areas of living (Gergen, 1991, 1992). Science values empirical evidence and believes only what it can see and prove (Bordo, 1987). As such, modernism has developed in tandem with a decline in religion and a belief in science instead of God (Bauman, 1992; Gorer, 1967). This “desacralisation of social life” has meant a focus on the self as a site for meaning and identity, and in this process, a revisioning of the way people conceive of and understand death and grief (Mellor & Shilling, 1993, p. 413). Mellor and Shilling (1993) noted that whereas death used to be a disruption to the social body, it has become instead a disruption to the dying individual and the bereaved family. Whereas it used to be the case that religion and traditional societies offered social processes around mourning that ascribed rituals and practices to deal with death, and subsequently grief, the modernist focus on the self has left people bereft of meaning, community, and structure with which to manage grief.

These massive changes happening around death, dying, and grieving in the 20th and 21st centuries represent shifts in ideology and culture that have left an open space for psychologists to step in and provide guidance amid this uncertainty and ambiguity surrounding mourning (Illouz, 2008). Seale (1998) suggested that psychology has replaced religious institutions in giving explanations and rituals for dealing with death and grief. When applied to grief, this paradigm assumes that

People need to recover from their state of intense emotionality and return to normal functioning and effectiveness as quickly and efficiently as possible. Modernist theories of grief and related therapeutic interventions encourage people who have experienced loss to respond in just this way. Grieving, a debilitating emotional response, is seen as a troublesome interference with daily routines, and should be ‘worked through’... Such grief work typically consists of a number of tasks that have to be confronted and systematically attended to before normality is reinstated. Reducing attention to the loss is critical, and good adjustment is often viewed as breaking of ties between the bereaved and the dead. (Stroebe, Gergen, Gergen, & Stroebe, 1992, p. 1206)
Grief is often considered a pathological condition that necessitates psychological intervention for people to heal as quickly as possible. Indeed, this view is so widely held that (as of this writing) grief is being considered for inclusion in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2010).

### The “Grief Police”: The Pathologization and Psychologization of Grief

The grief police emerged in my own life before my mother had even died. Although she had been sick for close to two decades, the last few months of her life were shocking. A new form of cancer had developed, and it was extremely aggressive. One Friday, we had spent the day shopping. It was a day spent in slow motion; we walked, ate, talked, and traveled more slowly than we had ever done because she was so ill. On Sunday, she slow danced with my father at a family friend’s wedding. On Tuesday, she started talking gibberish. (We would later find out that the tumors had spread to her brain, causing confusion and speech problems.) On Thursday, she was admitted to the hospital, and on the following Tuesday, she took her last breath.

Punctuated in between doctor’s appointments, worried conversations with family members and friends, scans and tests, phone calls to relatives overseas, and vigilantly sitting by my mother’s side, I had conversations about work, teaching, and taking time off. Many had chimed in and urged me not to give up my work *even as my mother was dying*. The pressure to maintain my normal routine while in the throes of terrible anticipatory grief was a form of grief policing by well-meaning and well-intentioned family and friends who were having a hard time coming to grips with my mother’s impending end. It was hard for all of us (Granek, 2010b). Policing affect, especially grief with its rogue and unpredictable nature, is one way to try to gain control over that which is essentially uncontrollable. The attempt to police grief or to get a harness around it is the core of the contemporary psychological imperative to normalize some expressions of grief while pathologizing others.

Grief has always been policed in one form or another (Holst-Warhaft, 2000; Walter, 2000). In every society, grieving has been regulated in terms of duration, modes of expression, and rituals and traditions around how to
mark and mourn a death (Gilbert, 2006). As with my own community and their concern about my returning to work, this policing is perceived to be in the service of care. In other words, the policing of grief is more complicated than it first appears because it is delivered with genuinely good intentions and in the service of what is perceived to be best for the mourner, making it particularly challenging to contest when it does not suit one’s needs. This has become even more salient in the modernist context, in which the individual is held responsible for their self-care and functioning. As noted in the introduction, the policing of contemporary grief has grown in tandem with the modernist rejection of religious authority and community in favor of a focus on the individual situated within a therapeutic culture that prizes rationality and autonomy. In this context, psychologists, psychiatrists and other mental health professionals reign as experts and have stepped in to provide the dictates around what constitutes normal mourning. Turning to psychological services to cope with grief is a prime example of how the scientific paradigm deals with grief. Walter (2005–2006) noted

The distinction between the normal and the pathological is the central intellectual device of psychiatric medicine, so once grief became medicalised and psychiatrized, it was inevitable either that all grief would be seen as mental illness, or that distinctions between normal and abnormal grief would be made and elaborated. Overwhelmingly, it is the latter that has occurred over the past forty years. (p. 73)

In other words, all grief has become potentially pathological in 21st-century North America. By virtue of its inclusion as a psychological object of study, what was once considered to be a natural reaction to death has fallen under the purview of psychology, psychiatry and other mental health professionals and has therefore become monitored, understood, and experienced in a way that previous generations could not have conceptualized (Granek, 2010a). As with other psychological diagnoses in recent years (for example, social anxiety disorder, see Lane, 2007; Scott, 2006), the specific criteria of what constitutes pathology are less important than the notion that one can evaluate oneself on a continuum of normality–abnormality at all. Regardless of how grief has become pathologized within the discipline, the very inclusion of it as a psychological–psychiatric subject has had a drastic effect on the way people understand their experience of bereavement (Granek, 2008, 2010; Granek & O’Rourke, 2012).
Pathological Grief, Traumatic Grief, and CG

What exactly is pathological grief? There are quite a few debates on the matter. (For recent reviews, see Lobb et al., 2010; Mancini, Griffin & Bonanno, 2012; Wittouck, Van Autreve, De Jaegere, Portzky & van Heeringen, 2011.) In a frame in which all grief is considered potentially pathological, some grief is described as excessive, a disease, out of the norm, and a mental disorder (Forstmeier & Maercker, 2007; Goodkin et al., 2005–2006; Hogan, Worden, & Schmidt, 2005–2006; Horowitz, 2005–2006; Prigerson et al., 2009; Prigerson & Jacobs, 2001; Shear & Frank, 2006; Shear et al., 2011).

Bereavement is listed in the DSM-IV text revision as a V code, which indicates that it is a disorder that needs further research and clinical attention (APA, 2000). The extreme end of pathologizing grief is the diagnosis of CG (sometimes referred as traumatic grief, prolonged grief, or pathological grief) (Stroebe & Schut, 2005–2006). CG (at the time of this writing), is a proposed diagnostic category for the DSM-V (Forstmeier & Maercker, 2007; Goodkin et al., 2005–2006; Horowitz, Siegel, Holen, & Bonanno, 1997; Prigerson et al., 1995; Prigerson, Shear, Bierhals, et al., 1997; Prigerson, Shear, Frank, et al., 1997; Shear et al., 2011). Although CG is not an official diagnosis, it is widely used by researchers and clinicians.

The determination of the prevalence of CG depends on the definition, for which there is currently no professional consensus. One study that used one set of criteria for CG found the prevalence rate of the pathology to be 41 percent in a sample of bereaved people (Horowitz et al., 1997), whereas another study that used a different set of CG criteria found that prevalence to be anywhere from 20 to 57 percent, depending on how much time had passed since the death of the loved one (Prigerson, Shear, Frank, et al., 1997). Another review indicated that approximately 40 percent of the bereaved met criteria for grief-related major depression a month after the loss and another 15 percent met the criteria after one year (Hensley, 2006a, 2006b). According to the DSM-IV, a diagnosis of major depressive disorder (MDD) can be given to a bereaved person two months after a loss (APA, 1994). In the new edition of the DSM-V, this bereavement exclusion will be removed and an MDD diagnosis can be given two weeks after a loss. Pathological grief has been identified as being inhibited (absent or minimal grief; Jacobs, 1999); delayed (characterized by late onset and severe intensity; Parkes, 1988); and prolonged, or chronic (Parkes & Weiss, 1983).
The leading proponents of including CG in the DSM-5 are Prigerson and her colleagues, the majority of whom are affiliated with the Department of Psychiatry at the Yale Medical School (Prigerson et al., 1995; Prigerson & Jacobs, 2001; Prigerson, Shear, Bierhals, et al., 1997; Prigerson, Shear, Frank, et al., 1997). In their view, the main diagnostic components of CG include the following: (A) “chronic yearning, pining and longing for the deceased”; (B) the presence of four out of eight symptoms such as “inability to trust others,” “uneasy about moving on,” “numbness/detachment,” “bleak future,” and “agitation”; (C) marked and persistent dysfunction in the social and occupational domain caused by grief symptoms; (D) a symptom disturbance of at least six months duration (Prigerson et al., 1995; Prigerson & Jacobs, 2001; Prigerson, Shear, Bierhals, et al., 1997; Prigerson, Shear, Frank, et al., 1997). In order for CG to be diagnosed, all criteria must be met. When challenged about how CG differs from normal grief, the authors wrote

The issue is not whether the symptoms themselves fit into seemingly pathological versus seemingly normal symptom clusters. What our results demonstrate is that the set of CG symptoms that we have identified, at persistent (beyond six months post-loss) and severe (marked intensity or frequency, such as several times daily) levels, are predictive of many negative outcomes and that is the basis for distinguishing them from normal grief symptoms. (Prigerson & Maciejewski, 2005–2006, p. 15)

Horowitz (1997) and his colleagues also proposed criteria for the DSM-5 and differentiated between three categories of symptoms, including (A) intrusion, such as unbidden memories, emotional spells, and strong yearnings for the deceased; (B) avoidance, such as avoiding places that are reminders of the deceased and emotional numbness toward others; and (C) failure to adapt symptoms, such as feeling lonely or empty and having trouble sleeping. The main differences between Horowitz et al. (1997) and Prigerson and Maciejewski (2005–2006) are the criteria for duration and the number of symptoms necessary for diagnosis. Although Prigerson stipulated that a diagnosis can be made six months post-loss, she also indicated that all four criteria categories must be met. Horowitz, on the other hand, proposed that diagnosis should be made 14 months after loss; he also proposed that fewer criteria had to be met in order to be diagnosed.

More recently, Shear and colleagues (2011) have come forth with a new set of criteria for CG. As with Prigerson, Shear suggests that there is
little difference between the symptoms of acute grief and CG but that it is
the duration and intensity of the symptoms that distinguish pathology. She
notes that grief becomes complicated when the symptoms of acute grief last
for longer than six months and therefore become persistent. According to
Shear (2011), CG includes (A) persistent, intense yearning or longing for the
person who has died; (B) frequent intense feelings of loneliness; (C) recur‑
rent thoughts that it is unfair, meaningless, or unbearable to have lived when
the loved one has died and; (D) preoccupying thoughts about the person
who has died. In addition, she included a range of other symptoms in which
two of the following criteria are necessary for diagnosis: rumination, disbelief
about the death, shock, feeling dazed, emotionally numb, anger, bitterness
about the death, difficulty trusting or caring about people, feeling envious
of others who haven’t experienced a loss, having intense physical responses
to memories of the deceased, changing behaviors as a result of the loss (that
is, refraining from going places or doing things that remind a person of the
loss), and hearing voices or having visions of the deceased among others
(Shear et al., 2011).

The theme in all of these understandings of CG is the trend toward
inclusiveness and pathologization, and labeling even the mildly impaired
patient as diseased. Most proponents of CG as a disease category concede
that there is a fuzzy line between normal grief and pathological grief but
argue that this is not significant in making a diagnosis of CG. Researchers
in the field claim that although normal grief and pathological grief look the
same, it is a matter of duration and intensity that marks the distinction between them,
and furthermore, that psychologists and psychiatrists should err on the side
of caution by overdiagnosing rather than missing a case.

One difficulty with this conclusion is that it is hard to determine what
is dysfunctional or complicated in relation to grieving. For some people,
taking a year off from work to grieve a major loss is normal and culturally
appropriate. For others, taking more than a few days off to grieve would
be considered dysfunctional and suggest a need for professional help. What
qualifies as disordered seems laden with value judgments, and although
some theorists have argued that these distinctions are made on the basis
of culture context (that is, Horwitz, 2002), I suggest that psychologists and
psychiatrists have an active role in constructing cultural expectations about
what is deemed normal or abnormal. In the case of grief, psychologists and
psychiatrists have determined what is supposedly too long, too short, too
intense, or too absent with regard to grief.
The Grief Industry:
The Impact of Pathologization and Grief Interventions

The pathologization of grief has had an effect on how mourning is understood and managed in day-to-day life. The vocabulary of grief has been thoroughly psychologized. Terms such as “coping,” “recovery,” “healing,” “denial,” and “grief work” or “grief process” are all constructions of psychology, psychiatry and the mental health professions, and today psychotherapy and medication are common ways in which grieving is dealt with. For example, the treatment of both large-scale grief (events such as 9/11, school shootings, other acts of terrorism) and small-scale grief (individual responses to death) has become the province of psychology and psychiatry (for examples of psychologists intervening and providing grief counseling, see Brown & Goodman, 2005; Metcalf, 2005; Rosenblatt, 2005; Welt Betensky, 2007). Groopman (2004) called this phenomenon “the grief industry” and stated that it is led by professionals who claim that all bereavement requires intervention in order to avoid CG reactions. Whether it is for individuals or groups experiencing loss, the idea is that grief counselors are needed to help initiate the so-called grief work that enables people to express their feelings and begin the process of healing.

Despite the fact that the evidence for grief counseling is questionable (Groopman, 2004; Jordan & Neimeyer, 2003; Neimeyer, 2000; Mancini et al., 2012; Schut, Stroebe, van den Bout, & Terheggen, 2001), research on grief, grieving, and bereavement counseling continues to proliferate.

Psychological Counseling

Depending on how CG is defined, as many as 80 percent of people who are bereaved require counseling (Genevro, Marshall, Miller, & Center for the Advancement of Health, 2004). Although there is little evidence that grief counseling helps people cope specifically with grief (Allumbaugh & Hoyt, 1999; Jordan & Neimeyer, 2003; Kato & Mann, 1999; Schut et al., 2001), this has not stopped the publication of numerous articles on the efficacy of interventions. Various bereaved populations have been targeted, including all people who have experienced a loss through death; those bereaved in specific groups, such as widows or bereaved parents, and those with CG (Genevro et al., 2004). The evidence for counseling those at risk for CG is inconsistent. Some research has shown that cognitive–behavioral therapy is moderately
The Complications of Grief

effective for certain symptoms of CG, such as intrusion (intrusive thoughts), avoidance, and failure to adapt; however, the researchers also noted that

The percentage of patients who experienced reliable change was highest for intrusion and failure to adapt, but a considerable number of patients in the control group [who received no treatment] also showed reliable changes and low to moderate effect sizes. This replicates previous findings of natural declines in bereavement-related symptoms. (Wagner, Knaevelsrud, & Maercker, 2006, p. 447)

Other studies have shown the potential, but minimal, benefits of using cognitive–behavioral therapy to treat CG (Ehlers, 2006; Matthews & Marwit, 2004). However, another study looking at interpersonal psychotherapy for treating depression-related bereavement showed that the intervention was no better than a placebo in treating traumatic grief (Hensley, 2006a).

Finally, Currier, Neimeyer, and Berman (2008) conducted a meta-analysis examining the efficacy of grief counseling. In this ambitious study, the authors examined 61 randomized outcome studies of bereavement interventions (that is, psychological counseling, professionally organized support groups, crisis intervention, writing therapy, and formal visiting service) that were reported in 64 academic articles. The authors concluded

Bereavement interventions have a small but statistically significant effect immediately following intervention but that therapeutic outcomes failed to differ reliably from zero to later follow up assessments ... On average recipients of bereavement interventions are not appreciably less distressed when compared to those who do not receive any formalized help. (p. 23)

Although it would seem from this evidence that overall the effectiveness of grief counseling is questionable, professionals working in the field have explained this by arguing that grief counseling may not work in the form in which it is delivered in research studies, and that the positive effects of grief counseling are most likely masked by poor methodology and a need for different design and implementation of treatment (Jordan & Neimeyer, 2003; Schut et al., 2001). Even more striking, Jordan and Neimeyer’s (2003) suggestion that psychologists focus their energies on those who are at risk for CG means that everyone who is bereaved comes under the purview of psychological research and intervention, because everyone who is grieving is potentially at risk for CG. This tautological logic stipulates that if the
interventions don’t work, more research is necessary to find a good treatment for grieving; if the treatments do work, then it is evidence of the necessity of psychological intervention to aid in the grieving process.

**Pharmaceutical Industry**

The development of psychiatric categorization in the *DSM* has had a powerful effect on the perception of mental disorders as medical problems to be solved. Moreover, the development of drugs to treat mental disorders further increased the perception that mental disorders are akin to diseases.

The data regarding the use of pharmaceutical drugs to treat mental disorders are staggering. In 2007, sales of Paxil, an antidepressant–anti-anxiety drug, exceeded 2.7 billion dollars worldwide. In 2005, eight out of the 20 of the most prescribed medications (for all medical conditions, not just mental disorders) in the United States were antidepressants or anti-anxiety medications, with Paxil topping the list (RX list, 2007). In 2006, 227 million antidepressant prescriptions were written in the United States. (Barber, 2008). Estimates of the efficacy of antidepressants and anti-anxiety drugs are controversial and range from 15 percent to 45 percent in treating symptoms of depression and anxiety (Barber, 2008; Breggin, 1991, 1998, 2001; Glenmullen, 2000; Healy, 1997, 2003; Solomon, 2002; Stoppard, 2000). Despite the controversy over the efficacy of these drugs, and despite the clear evidence that placebos are often as effective as antidepressants, the drugs are still widely used and are the most common treatment for disorders like depression and anxiety (Barber, 2008; Healy, 2003).

The treatment of grief has been no exception to this trend. The number of people who are given pharmaceuticals to treat their grief is difficult to measure. Even though complicated, pathological, prolonged, or traumatic grief are not official disorders, some psychiatrists have explicitly prescribed medications to treat grief and, as with counseling, have had questionable results. Although these psychiatrists have focused specifically on grief treatment, countless other bereaved people have been prescribed antidepressants and anti-anxiety medications to treat MDD. The diagnostic system is decontextual, making it impossible to determine why people are depressed and prescribed antidepressants (Horwitz & Wakefield, 2007). It is highly plausible that many of the millions of patients put on antidepressants could have been suffering from context-specific depression that may have had to do with a loss.
The Complications of Grief

For example, Wakefield, Schmitz, First, and Horwitz (2007) looked at a U.S. comorbidity survey of 8,098 people ages 15 to 54 years. Of those who were diagnosed and treated for MDD, 90 percent attributed their depression to either a bereavement-related loss or another type of loss, such as losing a job or a relationship. The authors used these data to advocate for more stringent criteria for MDD that take into account the social context of why people are depressed before making a diagnosis, and their research is relevant to this argument. The authors found that those who were grieving looked almost identical in terms of symptom presentation (that is, appetite and weight problems, sleep problems, lack of energy, and so on) to those who were depressed for other reasons. The conflation of grief with MDD is a significant problem, as one is context-specific and should not be pathologized, whereas the other is a clinical diagnosis and is considered to be a pathology.

The conflation of grief and depression and the overuse of medications to treat grief make it significantly more likely that a grieving person will be given an antidepressant to deal with their sadness. The treatment of bereavement-related depression with medications and the new trials to test antidepressants for CG are the extreme result of the medicalization of grief (see Jacobs, Nelson, & Zisook, 1987; Pasternak, Reynolds, Schlernitzauer, & Hoch, 1991; Reynolds et al., 1999; Zisook & Shuchter, 2001; Zygmont et al., 1998).

The pharmaceutical industry—and the psychiatrists who are dependent on it for their funding—have a vested interest in turning grief into a pathological condition. Medicating people who are grieving not only puts them at serious physical risk, including increased suicidal thoughts (Barber, 2008; Healy, 2003), sexual dysfunction (Modell, Katholi, Modell, & DePalma, 1997; Montejo-Gonzalez et al., 1997; Patterson, 1993), medication dependence, and withdrawal symptoms (Frost & Lal, 1995; Giakas & Davis, 1997; Kent & Laidlaw, 1995; Keuthen et al., 1994; Lejoyeux & Ades, 1997; Pyke, 1995), but also affects their self-understanding and how they make sense of their grieving experience.

The pathologization of grief does not represent merely a diagnosis, it is a constructed narrative in which people learn how to understand themselves, and in the process, experience their grief in a new way. The pathologization narrative is a prime example of a shift from understanding grief within a religious, existential, and communal frame to understanding it within a psychological, individual, and private one.
The People Have Spoken: The Impact on the Public

In a critical reflection on the grief literature in psychology, Breen and O’Conner (2007) concluded, “there is a plethora of research on grief, including the descriptions of ‘symptoms’, ‘risk’ factors, and outcomes, without significant attendance to the context of the bereavement itself on the resulting grief experience” (p. 209). Kellehear (2007) wrote, “notwithstanding the genuine value of psychological grief theories there are several rather startling features of them that make those theories appear socially irrelevant, medically abnormal, and publicly bizarre” (p. 75). He goes on to state,

The main contemporary response to grief—however defined—is to view this as a mental health problem requiring individual therapeutic intervention. Grief is a problem of the emotions. Little academic or professional attention and energy has been spent understanding grief as a relationship and social context matter that requires a relationship and social context response. (p. 75)

Indeed, as grief has steadily slipped into the net of the psychological domain, it has also simultaneously moved out of the public communities that once housed its rituals and traditions. When examined in the context of the public’s experiences of grief, these psychological theories do appear to be highly disconnected from what people yearn for when it comes to dealing with their grief.

This conclusion came to me with jarring force as a result of an informal survey I conducted with the writer Meghan O’Rourke for the online magazine Slate.com (Granek & O’Rourke, 2011; O’Rourke & Granek, 2011). Within a week of mounting a survey asking about people’s experiences of grief, we had received nearly 8,000 responses; what respondents had to say was surprising, touching, and fascinating. There were three major themes that arose repeatedly in this survey.

The first was that there was a tremendous variation in people’s lived experiences of grief that significantly challenges contemporary psychological definitions of what grief should look and feel like, and more important, how long it should last. For example, 60 percent of our respondents (4,629 of n = 7,715) had dreams of the deceased, and 20 percent reported imagining they

---

1 The sample size refers to the total number of people who answered the specific question I am reporting the data on. Some participants skipped some of the questions. For each of the findings I report on in this chapter, I provide the total n who answered the question.
The Complications of Grief

had seen the deceased alive: “symptoms” that some health care professionals consider an indicator of CG (Shear et al., 2011). See Table 2-1 for a list of grief symptoms reported by our participants in the context of CG criteria.

In terms of duration, 27 percent of our respondents (n = 7,081) reported that they never went back to feeling like themselves after their loss, and another 27 percent said they felt normal only one to two years after the loss. Whereas complicated, pathological, or prolonged grief can be diagnosed six months after a loss, our respondents reported that recovering from the death of a loved one can take a year or several years, and 27 percent indicated that it may never happen at all. Indeed, a mere 11 percent of our sample reported feeling normal or symptom free again six months post loss.

Table 2-1: Results of Slate.com Survey of Grief Symptoms (N = 7,715)

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sorrow</td>
<td>81&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Overwhelming sadness</td>
<td>72&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Yearning or nostalgia</td>
<td>72&lt;sup&gt;b,c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Trouble sleeping or insomnia</td>
<td>57&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Trouble concentrating</td>
<td>63</td>
</tr>
<tr>
<td>Dreams of the deceased</td>
<td>60</td>
</tr>
<tr>
<td>Longing</td>
<td>57&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Frequent crying</td>
<td>56</td>
</tr>
<tr>
<td>Guilt</td>
<td>55&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Loneliness</td>
<td>55&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Anger</td>
<td>49&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Disbelief about the loss</td>
<td>49&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Anxiety</td>
<td>48&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Anguish</td>
<td>46</td>
</tr>
<tr>
<td>Overeating or trouble eating</td>
<td>40</td>
</tr>
<tr>
<td>Self-pity</td>
<td>37</td>
</tr>
<tr>
<td>Sense of disorganization</td>
<td>39&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Feeling run down or prone to illness</td>
<td>35</td>
</tr>
<tr>
<td>Forgetfulness</td>
<td>32</td>
</tr>
<tr>
<td>Physical pain or physical tension</td>
<td>30</td>
</tr>
</tbody>
</table>
The second major finding from our survey addressed what I have been suggesting throughout this chapter: that the process of psychologizing grief has inadvertently created a kind of public culture around mourning in which grievers feel embarrassed, uncomfortable, and unsure about whether their grief is normal or not. For example, our survey found that 40 percent of respondents ($n = 7,616$) said they felt pressured to “get over it,” “move on with their grief,” or “stop talking about it” some of the time. More distressing, 23 percent of respondents ($n = 7,616$) said they felt pressured to move on about their grief most or all of the time.

Finally, and perhaps most important, people seemed most of all to want a community in which to grieve but often felt alone with their mourning. Thirty percent of our sample ($n = 7,563$) reported being strongly encouraged to seek professional help by their families and friends, and 35 percent ($n = 7,683$) turned to a therapist or another professional to deal with their grief.

Note: The $a,b,c$ indicates which of these response options are considered criteria for complicated grief according to three theorists.

- Prigerson’s criteria must be met six months postbereavement.
- Horowitz’s criteria must be met 14 months postbereavement.
- Shear’s criteria must be met six months postbereavement.
The Complications of Grief

Grief. Interestingly, half the sample (n = 7,283) reported a desire for more social support and more public and collective ritual around grief and loss.

The grief literature has yielded similar findings regarding the benefits of social support. Social support refers to emotional, economic, and practical help or information that family members, friends, neighbors, and coworkers provide to those in need (House & Kahn, 1985). Diamond, Lund, and Caserta (1987) conducted a longitudinal study with bereaved spouses and found that the size and quality of one’s social network was associated with lower depression and higher levels of coping and life satisfaction. Goldberg, Comstock, and Harlow (1988) found that larger social networks, particularly friends who the bereaved contacted frequently, were associated with a reduced risk of emotional distress. Research in the field has reported the importance of social support in reducing the intensity of grief and helping the bereaved cope with their loss (Saranson, Saranson, & Gurung, 1997). The value of emotional and practical support from close family, friends, and work colleagues has also been stressed by the bereaved as particularly important to them. They cite comfort, practical help, and physical and social stimulation as being pivotal to their coping with grief (Cohen, 1988; Dyregrov, 2003–2004; Johnson, 1991; Sherkat & Reed, 1992; Thuen, 1997).

Community is therefore a particularly critical resource for the bereaved. The evidence for the effectiveness of the community in providing social support for grievers seems more convincing and more robustly indicated than the evidence for the effectiveness of grief counseling and medications. In agreement with the need for more communal support rather than psychological intervention, Kellehear (2007) argued that we must return to an organized community of compassion to support the bereaved. Judging from the evidence on social support and grief outcomes, this seems like an excellent direction to pursue.

Mourning Madness? A Conclusion of Sorts

The loss of protocol around how to grieve and how to help or support a mourner has left those grieving bereft not only of their loved ones, but also of any community in which to understand, mediate, and express their sadness. This is situated within a larger modernist cultural framework that fears and denies death, and believes that one should be perpetually happy and upbeat. Moreover, mental health professionals are not solely responsible for the disappearance of traditional grief practices in North America, and as
Stories of Complicated Grief

outlined in the introduction, have replaced religious authority to become the regulators of grief and loss. In many ways, these professions have filled the need of the listener and the supporter for the bereaved, and one could claim that this has aided sufferers from falling into deeper, more incapacitating depressions. Illouz (2008) noted that psychological ideas become particularly popular during times of upheaval and uncertainty.

What has made psychologists the arbitrators and guides of the soul in so many institutional manifestations is that they have performed massive "cultural work," a vague term that includes such diverse phenomena as the collapse of traditional social roles and role uncertainty, the demise of established patterns of life, the multiplication of values, and the intensification of social anxiety and fear, all of which can explain why individuals search for ways to explain the behavior of others and shape their own behavior. (p. 57)

Grief is a good example of this cultural work. The mental health sciences have been successful in drawing this area of human life into their purview because they provide a framework for how to manage grief in an era of uncertainty, anxiety, and fear around dying and mourning. In this sense, the pathologization of grief can be considered a positive outcome, for it has provided a feeling of orderliness around an area of life that is filled with chaos and insecurity for a lot of people.

At the same time, research has suggested that the boundary around pathological grief is ambiguous and therefore inclusive of almost anyone who is grieving. There is very little qualitative difference between what is deemed normal versus pathological grief, and it seems from the literature that the diagnosis of CG is arbitrary and based on the clinician’s or researcher’s determination of what she or he defines as normal. This ultimately suggest that the particulars of what defines pathology are less relevant than the idea itself that grief can be evaluated on a normal–abnormal continuum. The introduction of grief as psychological object has a symbolic value whereby one does not need to be diagnosed to be affected by the diagnostic classification of mental disorder. The self-consciousness around grief is one example of this. In addition to the sorrow and depression that often accompany bereavement, contemporary mourners are also faced with a distinctively modern anxiety about whether they are doing their grief work properly and whether they are on track with their progress. This new self-consciousness often comes
The Complications of Grief

with a sense of shame and embarrassment about mourning that has become part of the experience of the modern griever.

References


The Complications of Grief


The Complications of Grief


The Complications of Grief


