GRIEF COUNSELING and GRIEF THERAPY
A Handbook for the Mental Health Practitioner
FIFTH EDITION

J. WILLIAM WORDEN, PhD, ABPP

Fourth Edition Named a 2013 Doody's Core Title!

Praise for the Fourth Edition:

"In the fields of death education, research and counseling/psychology, surely Bill Worden is a giant... ALL of us, personally and professionally, are indebted to [him]. From his work we may be just a bit wiser, a bit healthier, a bit more competent, and a lot more in touch with meaning for the sake of all who mourn."

—Illness, Crisis, & Loss

"If you knew Worden's work and his writings previously, you'll find an enhanced book with a much broader and challenging perspective than his previous editions. If you are not familiar with Bill Worden, then it is time to begin."

—Ben Wolfe, MEd, LICSW, Fellow in Thanatology, Program Manager/Grief Counselor, St. Mary's Medical Center's Grief Support Center, Duluth, MN

Encompassing new content on the treatment of grief, loss, and bereavement, the updated and revised fifth edition of this gold-standard text continues to deliver the most up-to-date research and practical information for upper-level students and practitioners alike. The fifth edition includes updates to the author's Tasks and Mediators of Mourning, new case studies, and valuable Instructor Resources. The text highlights recent initiatives to extend care to the bereaved and fosters the knowledge and skills required for effective intervention and even preventive treatment. Also addressed is the impact of social media and online resources for “cyber mourning,” changes in the DSM-5 as they influence bereavement work, alternate models of mourning, and new findings on the varied qualities of grief.

The fifth edition continues to present a well-organized, concise format that is easy to read and provides critical information for master's level mental health courses in grief counseling and grief therapy as well as for new and seasoned practitioners alike.

New to the Fifth Edition:
• Refinements to the author's Tasks of Mourning
• New considerations regarding Mediators of Mourning on social variables
• The impact of social media and online resources on “cyber mourning”
• Complicated spiritual grief after mass shootings and other catastrophes
• Changes in the DSM-5 as they influence bereavement work
• Cross-cultural and multifaceted counseling for specialized grief, including grandparent's grief, prolonged grief disorder, and HIV/AIDS-related bereavement
• Updated information on grief and depression
• New case studies and updated references
• Includes reflection and discussion questions in each chapter
• Updated and revised information on grief counseling training
• Accompanying instructor packet with a manual, PowerPoint deck, and test bank
J. William Worden, PhD, ABPP, is a Fellow of the American Psychological Association and holds academic appointments at the Harvard Medical School and at the Rosemead Graduate School of Psychology in California. He is also coprincipal investigator of the Harvard Child Bereavement Study, based at the Massachusetts General Hospital. A recipient of five major National Institutes of Health grants, his research and clinical work over 40 years has centered on issues of life-threatening illness and life-threatening behavior.

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Dr. Worden has lectured and written on topics related to terminal illness, cancer care, and bereavement. He is the author of Personal Death Awareness and Children & Grief: When a Parent Dies, and is coauthor of Helping Cancer Patients Cope. His book Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner, now in its fifth edition, has been translated into 14 foreign languages and is widely used around the world as the standard reference on the subject. Dr. Worden’s clinical practice is in Laguna Niguel, California.
GRIEF COUNSELING AND GRIEF THERAPY
A Handbook for the Mental Health Practitioner

FIFTH EDITION

J. William Worden, PhD, ABPP

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In Remembrance of my Brother
Dr. Jack D. Worden
1940–2016
Happiness has gone out of our lives;  
Grief has taken the place of our dances  

Lamentations 5

You will weep, lament and be sorrowful, but  
Your sorrow will turn into joy.  

John 17

Weeping may endure for a night; but joy cometh in the morning.  

Psalm 30

Grieving allows us to heal, to remember with love rather than pain.  
It is a sorting process.  
One by one you let go of things that are gone and you mourn for them.  
One by one you take hold of the things that have become a part of who you are and build again.  

—Rachel Naomi Remen
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The idea for this book came out of a series of workshops that I presented at the University of Chicago for mental health professionals who spent 2 days of continuing education time exploring their own loss history as well as learning a model—the task model—for understanding grief, bereavement, and the process of mourning. These workshops began in 1976; they were offered twice a year for groups of 100 and were oversubscribed each year. Over time we offered such workshops in other parts of the United States. The first edition of the book was published in 1982 and contained much of the material presented at these grief workshops.

The title of the book came out of a lecture that I presented at the University of Florida, Gainesville. I was invited to present the annual Arthur G. Peterson lecture for a large group of mental health professionals. I titled my lecture “Grief Counseling & Grief Therapy.” This was the first time that I had made such a distinction, but it made sense to me and its usefulness has persisted over the years. Grief counseling refers to the interventions counselors make with people recent to a death loss to help facilitate them with the various tasks of mourning. These are people with no apparent bereavement complications. Grief therapy, on the other hand, refers to those techniques and interventions that a professional makes with persons experiencing one of the complications to the mourning process that keeps grief from progressing to an adequate adaptation for the mourner. Often there are conflicts of separation with the deceased that need to be addressed. This requires more skill, understanding, and training than doing grief counseling, which can often be facilitated by a skilled friend or family member.

Do we really need grief counselors? I had asked this question in the first edition of this book 35 years ago and said that I don’t believe...
that we need to establish a new profession of grief counselors. I still believe this. D. M. Reilly (1978), a social worker, says, “We do not necessarily need a whole new profession of . . . bereavement counselors. We do need more thought, sensitivity, and activity concerning this issue on the part of the existing professional groups, that is, clergy, funeral directors, family therapists, nurses, social workers, and physicians” (p. 49). To this, Lloyd (1992) adds, “Skills in working with grief and loss remain core essential tools for professionals who are not necessarily specialist counselors” (p. 151). I agree with this. What I want to do in this book is address those of you in these traditional professions who are already in a position to extend care to the bereaved and have the knowledge and skills required to do effective intervention and, in some cases, preventive mental health work.

In this fifth edition of Grief Counseling and Grief Therapy, new information is presented throughout the book. Previous information is updated when possible. The world has changed since 1982 when the first edition of this book was published. There are more traumatic events, drills for school shootings, and faraway events that may cause a child’s current trauma. There is also the emergence of social media and online resources, all easily accessible by smartphones at any time. Bereavement research and services have tried to keep up with these changes. In the following pages I have tried to present what is current for your consideration so that you, as a mental health professional, can be most effective in your interventions with bereaved children, adults, and families.

Special acknowledgments are due to the many people who have assisted me with this project. Three of my close friends and colleagues who are familiar with earlier editions of this book made specific suggestions that they felt would strengthen a fifth edition and bring it up-to-date. These colleagues who have encouraged me and given me specific suggestions are (a) Bill Hoy, clinical professor of medical humanities at Baylor University; (b) Mark de St. Aubin, from the College of Social Work at the University of Utah; and (c) Michele Post, a therapist from One Legacy in Los Angeles. I have incorporated most of their suggestions in the book.

Keeping up with current literature on this subject is an enormous task. I have over 5,000 annotated references in my database that was started at Harvard back in the 1970s. Those most current research assistants helping me were Alexes Flates and Haleigh Barnes, both of whom have now completed their doctoral training in clinical psychology and are working in the field. Making this assistance possible was help from
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REFERENCES


As an aid for using the fifth edition of *Grief Counseling and Grief Therapy* in class, qualified instructors can access the book’s ancillary materials (Instructor’s Manual, test bank, and PowerPoints) by emailing textbook@springerpub.com.
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Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner, Fifth Edition
INTRODUCTION

Over the 35 years since the first edition of this book was written, there have been a number of new concepts introduced into the field of grief, loss, and bereavement. Before we get into the content of this current edition, I would like to highlight some that I believe are worth noting. Many of these appeared during the past 20 years, and some of these I discuss in more detail in the book. Although tempted to put these into the top 10 in order of importance, I will merely list them. They are all important.

SOCIAL MEDIA AND ONLINE RESOURCES

One emerging trend is the use of social media and other online resources to help people who are grieving. These cyber mourning resources can be used (a) as ways to remember the deceased, (b) as ways to conduct intervention for the bereaved, and (c) as a way to do further research on bereavement and the mourning process (Stroebe, van der Houwen, & Schut, 2008). Let me outline several ways that social media and online resources are currently being used.

1. *Online memorials.* Families, friends, and others can go online and post thoughts about the deceased and send condolences to the family and friends of the deceased. These memorial pages are often set up by the funeral director who served the family or by non–funeral-related groups such as Open to Hope (www.opentohope.com) or nonprofit organizations such as Heal.
Grief (www.healgrief.org) where individuals can light online memorial candles or post eulogies, memorial art, or photo projects. There are also Facebook Memorial pages that can be used to announce the death or funeral service, post memories, and celebrate the life of the deceased. For some reason, these pages may attract strangers who did not know the deceased but will follow the entries and sometimes post messages (De Groot, 2014).

2. Internet-based intervention. Websites have been set up to offer online treatment for people suffering from various types of losses and diagnoses. Such interventions are conducted by a therapist. These include such conditions as posttraumatic stress disorder (PTSD), depression, and prolonged grief disorder. They can also assist people who are experiencing disenfranchised grief from losses that are difficult to talk about, such as a loss during pregnancy or LGBT partner loss. Anonymity that can promote self-disclosure seems to be one of the key attractions for this type of therapy, but this can be fraught with danger. If the patient becomes suicidal or homicidal, it is important that the therapist be able to contact the patient directly and provide direct resources. This type of treatment is not suitable for all patients, and a careful online or telephone-based diagnosis must be made before treatment begins.

3. Internet bereavement support groups. These can be found online, and are set up to address special types of losses such as suicide deaths (Feigelman, Gorman, Beal, & Jordan, 2008), while others are established to help those with a general variety of bereavement losses (M. Post, “Grief in the Digital Age” seminar, November 2, 2016). These groups are led, or at least monitored, by professionals who are able to admit or reject people from participation (Paulus & Varga, 2015). Outcome measures can be used pre- and postgroup to measure change due to participation in the group (van der Houwen, Schut, van den Bout, Stroebe, & Stroebe, 2010).

4. Peer-support web pages. Such self-help pages are set up after natural disasters (floods, hurricanes, earthquakes), mass shootings, and other catastrophes, allowing those interacting with the site to express feelings and questions, and to generally feel a part of a community grappling with these events (Miller, 2015). These sites offer no personalized professional feedback. However, they can be particularly effective for helping the person who cannot find help elsewhere (Aho, Paavilainen, & Kaunonen, 2012).
5. **Psychoeducational purposes.** Persons who need information about grief and loss and to *normalize* what they are experiencing can use such pages to obtain information about the grief process (Dominick et al., 2009). These are generally not interactional pages but are pages set up to give information on a topic. There are, however, some sites that allow the reader to ask a question about a particular topic that may or may not be answered by another person reading that particular page.

6. **Communicating with the deceased.** Some sites and some Facebook pages are set up in the name of the deceased. Mourners may use these pages to regularly write to the deceased, often in a letter format, expressing their thoughts, feelings, and questions. Those who have studied this phenomenon find that such communications with the deceased are primarily used for the purpose of *meaning making* and second for providing a *continuing bond* with the deceased (Bell, Bailey, & Kennedy, 2015; De Groot, 2012; Irwin, 2015).

For more information on Internet resources for cyber mourning, I would refer you to the book *Dying, Death, and Grief in an Online Universe*, edited by Sofka, Cupit, and Gilbert, and published by Springer Publishing in 2012.

**WHAT IS THE NATURE OF COMPLICATED Bereavement?**

For years, most of those working with complicated mourning and grief therapy have used terms like *chronic grief*, *delayed grief*, and *absent grief* to delineate the diagnosis of those with complicated bereavement or complicated mourning. In fact, some of these concepts were defined by consensus when Beverly Raphael and Warwick Middleton (Middleton, Moylan, Raphael, Burnett, & Martinek, 1993) conducted a survey to determine which terms were the most frequently used by leading therapists in the field. Although there was a surprising degree of consensus, the problem is that complicated grief is a Z code in the *Diagnostic and Statistical Manual of Mental Disorders*, and Z code diagnoses do not qualify for third-party payment through insurance carriers. Another problem has been the lack of precise definitions of these terms, which makes rigorous research of them difficult. The easiest solution has been to conduct research using well-defined pathological entities like depression, anxiety, and somatization, for which there are good standardized measures. Although these clinical entities may be part of the mourner’s experience, they clearly are not measures of grief. There were a few...
measures of grief like the Texas Revised Grief Inventory (Faschingbauer, DeVaul, & Zisook, 2001) and the Hogan Grief Reaction Checklist (2001), but most were normed on a clinical population.

Beginning with the work of Holly Prigerson, Kathryn Shear, and Mardi Horowitz in the 1990s, there has been a 20-year-plus attempt to come up with a diagnosis of complicated grief that would be acceptable to go into the DSM-5, which was released in 2013. Such a diagnosis would make insurance money available for the treatment of patients with this diagnosis and would make research funds available for further investigation on this clinical entity. Details on this diagnosis, its development, and its current status can be found in Chapter 5.

**DISENFRANCHISED GRIEF**

This term, coined by Ken Doka and further developed by Attig (2004), has been an important addition to the field. Although Doka’s first volume came out in 1989, he updated the concept in a second volume that came out in 2002 (Doka, 1989, 2002). Disenfranchised grief refers to losses in the mourner’s life of relationships that are not socially sanctioned. A classic example would be the death of someone with whom the mourner is having an affair. If this affair is not widely known, the mourner will not be invited to participate in the funeral rituals and may not receive the social support that many people find helpful after a death. Alternate lifestyles may not be socially sanctioned, and the friend or lover may be ostracized by the family of the deceased. There are numerous other examples of disenfranchised grief, and there are suggestions in this book for re-enfranchising some of these losses to aid the mourner in adapting to the loss.

Aaron Lazare (1979, 1989), an early colleague at Massachusetts General Hospital, talked about two kinds of loss that are directly related to this concept of disenfranchised grief. *Socially negated losses* are those losses that society treats as nonlosses. An example of this would be pregnancy loss, either spontaneous or induced. The second kind of loss related to disenfranchised grief would be *socially unspeakable losses*. These are specific losses about which the mourner has a difficult time talking. Common examples would be death by suicide and death by AIDS. Both of these losses carry some stigma in the broader society. One intervention that can be helpful to those experiencing these types of losses is assisting them in talking about them and exploring their thoughts and feelings about the death. Re-enfranchising suggestions for these types of losses can be found in Chapter 7 of this volume.
CONTINUING BONDS

Attachments to the deceased that are maintained rather than relinquished have been called continuing bonds. This is not an entirely new concept. Shuchter and Zisook (1988) noted that widows in their seminal conjugal bereavement studies in San Diego maintained a sense of their loved ones’ presence for several years after the death. In the Harvard Child Bereavement Study, Silverman, Nickman, and Worden (1992) observed ongoing connections with the deceased parent among a large number of these bereaved school-age children. For most it was a positive experience; for some it was not. The book by Klass, Silverman, and Nickman titled Continuing Bonds: New Understandings of Grief (1996) pulled together information from our study and several others to promote the notion that some people stay connected with the deceased rather than emotionally withdrawing, as was the notion previously promoted by Freud (1917/1957).

This new concept was not embraced by all and questions soon arose as to whether continuing bonds can be adaptive for some and maladaptive for others. Are continuing bonds actually associated with a healthy ongoing life? A lot of this controversy is based on the lack of good research evidence for the efficacy of continuing bonds. As more research is done, some of these questions will be resolved. Essentially, the questions center around four main issues: (a) What types of bonds are the most helpful in the adaptation to loss? These would include objects from the deceased (linking and transitional objects, keepsakes), a sense of the deceased’s presence, talking to the deceased, introjecting the deceased’s beliefs and values, taking on characteristics of the deceased, and the like (Field & Filanosky, 2010). (b) For whom are continuing bonds helpful, and for whom are they not? This necessitates the identification of subgroups of mourners; the concept should not be applied to everyone. One promising approach to this is to look at the mourner’s attachment style in relationship to the deceased (Field, Gao, & Paderna, 2005). In the case of anxious attachments that can lead to chronic grief, holding onto the deceased may not be adaptive. Some mourners need to relinquish and move on (Stroebe & Schut, 2005). (c) In what time frame are continuing bonds the most adaptive and when are they less adaptive—closer to the loss, farther from the loss? (Field, Gao, & Paderna, 2005). (d) What is the impact of religious and cultural differences on maintaining healthy bonds? This would include beliefs and rituals that promote a connection and memorialization of the deceased cross-culturally in various societies (Suhail, Jamil, Ovebode, & Ajmal, 2011; Yu et al., 2016). More on bonds can be found in Chapter 2.
MEANING MAKING

Meaning reconstruction and meaning making, concepts introduced and promoted by psychologist Robert Neimeyer, have been an important emphasis in the field over the past 20 years. He sees meaning reconstruction as the central process faced by bereaved individuals. This reconstruction is primarily accomplished through the use of narratives or life stories. When unanticipated or incongruous events such as the death of a loved one occur, a person needs to redefine the self and relearn ways to engage with the world without the deceased. The person cannot return to a pre-loss level of functioning but learns how to develop a meaningful life without the deceased loved one (Neimeyer, 2001). This is central to my third task of mourning, in which the mourner must learn to adjust to a world without the deceased. Death can challenge one’s assumptions about the world (spiritual adjustments) and one’s personal identity (internal adjustments). Bereaved individuals have serious questions such as: “What will my life look like now?” “What did the deceased’s life mean?” “How can I feel safe in a world such as this?” and “Who am I now that this death has occurred?” (Neimeyer, Prigerson, & Davies, 2002).

I think it is important to note, however, that some deaths do not challenge personal meaning making in any fundamental way. Davis, Wortman, Lehman, and Silver (2000) conducted research on two different bereaved populations and found that 20% to 30% of the bereaved individuals appeared to function well without engaging in the process of meaning making. Of those who searched for meaning, fewer than half of the individuals found it even over a year after the death. Those who did find meaning, however, were better adjusted than those who searched and didn’t find it. But, interestingly, for some, the quest to understand continued even after meaning was found.

Neimeyer (2000), commenting on the Davis research, makes note that the majority in the studies were struggling with meaning making and these should be helped with this process. But, he cautions the counselor about initiating this process if it does not occur spontaneously. He concludes his comments with an important distinction: meaning making is a process, not an outcome or achievement. The meanings associated with death loss are constantly revised. We see this clearly in our work with bereaved children, who, as they age and pass through new developmental stages, ask: “What would my parent be like now?” and “What would our relationship be like now that I am graduating college, getting married, etc.?” (Worden, 1996a). More on meaning making as a task of mourning can be found in Chapter 2.
RESILIENCE

When Phyllis Silverman and I studied 125 parentally bereaved children over a 2-year period after the death, we noted that children fell into one of three groups. The first was the group of children (approximately 20%) who were not doing well during the 2 years after the death. Since our research grant came from the National Institute of Mental Health for a study intended to identify bereaved children at-risk and prevent problem outcomes, this group became a major focus of our study. Could we identify at-risk children early after the loss so that early intervention might be offered to prevent later negative sequelae from the death? However, we also noticed a second smaller group of children who seemed to be doing very well, and we identified them as resilient children. Their academic performance, social life, communication about the deceased, self-worth, sense of control, and healthy identification with the deceased parent were all on the high side. The third and largest group was the group making do during the first 2 years of bereavement (Silverman, 2000; Worden, 1996a).

Thanks to the work of George Bonanno (2004, 2009), we have begun to look at resilient bereaved individuals. These are people who adapt well to the loss and are not in need of either counseling or therapy. I think this focus is overdue.

In Arizona, Irwin Sandler, Sharlene Wolchik, and Tim Ayers (2008) have added to our thinking on resilience. Like me, they prefer the term adaptation to recovery. Those mourners who make a good or effective adaptation to the loss have made a resilient adaptation. Sandler’s group has identified both risk and protective factors in their study of parentally bereaved children and their families that lead to a good (resilient) or a less good adaptation to the loss. By focusing on positive as well as negative outcomes, a resilient approach goes beyond the narrower focus of pathological outcomes. It is interesting that the risk and protective factors found in Arizona families are similar to those Silverman and I found in the Boston study. Multiple factors at both the individual and social environmental levels are at work here, so Sandler’s group calls their theory a contextual framework on adaptation. Individuals are seen as nested within families, which are in turn nesting within communities and cultures. This fairly new research and thinking on resilience in bereavement holds promise for our understanding of grief and loss. More on this can be found in Chapter 3.
TRAUMA AND GRIEF

Like depression and grief, trauma and grief share many of the same behavioral features. A number of articles discuss how they are similar and how they are different. There are some, like Rando, Horowitz, and Figley, who would subsume all grief under trauma, but I find this a stretch. I prefer the model offered by Stroebe, Schut, and Finkenauer (2001), which makes the following three distinctions. The first is trauma without bereavement. Here the person experiences a traumatic event that gives rise to trauma symptoms leading to a diagnosis of PTSD or acute stress disorder, mostly depending on the time frame. Other symptoms of depression and anxiety may lead to a comorbid diagnosis. In this first distinction, the traumatic event has not led to any deaths and the person is dealing with one or more of the classic trauma symptoms (intrusion, avoidance, hyperarousal) without bereavement. Bereavement without trauma is the second distinction. Here the person has experienced the death of a loved one without experiencing trauma symptoms associated with the event. If there are complications after the loss, one of the complicated mourning categories would apply to this complication. The third category could be called traumatic bereavement. Here the person experiences a death and there is something about the death itself (often violent deaths) or something about the person’s experience of the death (often related to an insecure attachment or conflicted relationship with the deceased) that gives rise to symptoms associated with trauma.

Two questions emerge in any discussion of traumatic bereavement. First, which is the most important in defining traumatic bereavement—the circumstances of the death or the reaction of the mourner? Second, in the treatment of traumatic bereavement, which symptoms should be addressed first—the trauma symptoms or the grief symptoms? Traumatic stress interferes with grief over loss; grief interferes with trauma mastery (Rando, 2003). Many believe that the trauma symptoms must be dealt with first before the grief can be addressed.

There have always been people who have been exposed to violent deaths, but the number of violent events seems to have increased during the past 15 years. The recent rash of mass shootings and multiple terrorist activities around the world, including September 11, 2001, illustrate the pervasiveness of violence in our society. Such violent events will continue to expose more people to both trauma and bereavement. We need more research on grief and trauma, including research on which interventions are most effective (Rynearson, Schut, & Stroebe, 2013). We also need to educate the media that interventions done in the days following a school shooting are not grief counseling but rather crisis
intervention, and there are major differences between the two in goals and techniques. More on this can be found in Chapter 3.

SOME CONCLUDING THOUGHTS

Let me conclude this introduction with something that causes me concern: the failure of both clinicians and researchers to recognize the uniqueness of the grief experience. Even though the mourning tasks apply to all death losses, how a person approaches and adapts to these tasks can be quite varied. A one-size-fits-all approach to grief counseling or grief therapy is very limiting (Caserta, Lund, Ulz, & Tabler, 2016).

When I was a graduate student at Harvard, Professor Gordon Allport had a strong impact on my thinking. Allport (September 1957, lecture notes) would tell students, “Each man is like all other men; each man is like some other men; and each man is like no other man.” Allport was affirming his longtime professional interest in individual differences—an interest that led to his collaboration with Robert White on the longitudinal case studies of men called Lives in Progress (1952). These studies affirm both the similarity and uniqueness of each person.

If we were to translate Allport’s dictum into the field of bereavement, we would say, “Each person’s grief is like all other people’s grief; each person’s grief is like some other person’s grief; and each person’s grief is like no other person’s grief.” Over the last 35 years, we have tended to lose sight of the uniqueness of the grief experience in our clinical and research undertakings. I always liked Alan Wolfelt’s (2005) idea of companioning the bereaved individual. In this approach, the counselor comes alongside the mourner and they share their personal experiences in a way that can be helpful for both. I worry that in our rush to formulate a DSM diagnosis for complicated (traumatic, prolonged) grief, we may focus too much on “Each person’s grief is like some other person’s grief” and lose sight of the uniqueness of grief, the fact that each person’s grief is like no other person’s grief. I have affirmed in each edition of this book that every person’s experience of grief is unique to him or her, and people’s experiences shouldn’t be saddled with the term abnormal grief. I much prefer the term complicated mourning, which affirms some kind of difficulty in the mourning process that brings the person to the attention of the mental health worker.

Affirmation of the uniqueness of grief is not a new emphasis in the field of bereavement. Colin Parkes (2002) said, “From the start, Bowlby and I recognized that there was a great deal of individual variation in
the response to bereavement and that not everybody went through these phases in the same way or at the same speed” (p. 380).

An interesting affirmation of the uniqueness and subjective quality of grief comes from an fMRI study of grief by Gundel, O’Connor, Littrell, Fort, and Lane (2003). After investigating the grief experience in the brains of eight women, they concluded that grief is mediated by a distributed neural network that subserves a number of neural processes affecting various parts of the brain and its functions, including affect processing, mentalizing, memory retrieval, visual imagery, and autonomic regulation. This neural network may account for the unique, subjective quality of grief, and this finding provides new leads in our quest to understand the health consequences of grief and the neurobiology of attachment.

I believe that the mediators of mourning outlined in detail in Chapter 3 hold the key to understanding individual differences in the mourning experience—the adaptation to loss from death.

REFERENCES


