Chapter 20
Grief, Loss, and Stress

Everyone can master grief but he who has it

Shakespeare

Death is the unavoidable endpoint of a terminal life. Since death is inevitable, grief is not only predictable but also likely to occur repeatedly during the course of someone's life. Despite being ubiquitous, grief is also mercurial, and may evince its qualities uniquely and at various times. For example, grief may begin at the thought of someone's death, it may occur well after someone has died, or it may occur for losses other than the loss of life. According to Holmes and Rahe (1967), who developed the Life Stress Inventory, the death of a spouse is the highest weighted life change event (i.e., stressful event) that an individual can experience. The purpose of this chapter is to review the terms associated with grief, the classic stage-based theories related to grief, the construct of prolonged or complicated grief, stress-related symptoms and prolonged grief, and intervention considerations for grief and loss with adults and children.

Definition of Terms

There are generally accepted definitions and fundamental concepts associated with grief, bereavement, and mourning. Bereavement, is the "term used to denote the objective situation of having lost someone significant through death" (Stroebe, Hansson, Schut, & Stroebe, 2008 p. 4). Understandably, bereavement is associated with considerable distress and is influenced by social and cultural norms (Jeffreys, 2005). Grief is the term generally applied to the internal emotional or affective reaction to loss, most typically of a loved one through death, but it could be from other tangible, symbolic or psychosocial losses, or even threats of losses (DeSpelder & Strickland, 2005; Jeffreys, 2005; Stroebe, Hansson, Schut, & Stroebe, 2008). Grief

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is a complex process with myriad reactions (e.g., loneliness, anger, frustration) that is often classified in terms of stages and has been considered to be something to be worked through (Bonanno, 2001; Bowlby, 1980; Goodkin et al., 2001; Shuchter & Zisook, 1993). Mourning, which is often differentiated from grief, refers "to the public display of grief, the social expressions or acts expressive of grief that are shaped by the (often religious) beliefs and practices of a given society or cultural group" (Stroebe et al., 2008, p. 5). It is generally accepted, however, that grief and mourning may equally influence each other. Before exploring the relation between these constructs and stress, the prominent theories of grief will be reviewed briefly.

Grief Theories

There have been several notable theories to explore the grieving process. Erich Lindemann, one of the seminal figures in social psychiatry and community mental health, and Chief of Psychiatry at Massachusetts General Hospital in the 1940s did some of the earliest empirical work on the process of grieving. After a tragic fire at the Cocoanut Grove Night Club in Boston on November 28, 1942, in which 492 people died, Lindemann found that many of the 101 family members he worked with had similar reactions after the loss (Lindemann, 1944). These reactions included somatic distress, preoccupation with thoughts or images of the deceased, guilt regarding the circumstances responsible for the death, hostility, or anger, and decreased functioning that were not present before the event. In his article, he suggested that eight to ten sessions over a month and a half would help to mitigate the impact of the loss and asserted that the tasks of grief entailed: emancipation from bondage to the deceased; readjustment to the environment in which the deceased is missing; and formation of new relationships (Lindemann, 1944). Lindemann's work was very influential, but his setting a proposed time frame of 4–6 weeks as a marker to mitigate ensuing grief may have inadvertently created a "normative" time standard, and that those who took longer to recover from their grief reactions may have been considered maladjusted (Simos, 1979).

Elisabeth Kübler-Ross, a psychiatrist who was born in Zurich, Switzerland, and became a US citizen in 1961, published her seminal text *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families* in 1969, in which, based on interviews with more than 200 dying cancer patients and their families, she described her now classically regarded five stages of grief. The following stages of Denial and Isolation, Anger, Bargaining, Depression, and Acceptance, imply a framework or model, but were not necessarily intended to be a rigid series or uniform progression through bereavement. The first stage, denial was originally conceptualized by Kübler-Ross as a time when the person diagnosed would "doctor shop" to ensure that the terminal diagnosis was correct. Many counselors have misinterpreted this stage as "resistance" and something to be confronted and worked through (Walter & McCoyd, 2009). Kübler-Ross considered it, however, to a "healthy way of dealing with the uncomfortable and painful situation with which

these patients have to live for a long time" (1969, p. 39). Denial and isolation are thought to help us pace our feelings of grief and enable us to survive. Anger, which can be manifested at oneself or others (often caregivers), including doctors and sometimes God, is thought to provide a bridge or structure for underlying expression of pain and abandonment. Bargaining for those terminally ill seems intuitive (e.g., "If I pray more or make amends with others, maybe I will improve") to alleviate pain or emotional discomfort, whereas for those bereaved due to the loss, they may attempt to bargain or negotiate to mitigate the pain of the loss. Depression for those preparing to die may include withdrawing from others in an effort to conserve energy, reflect upon their lives, and explore spiritual meaning (Jeffreys, 2005). It is naturally associated with feelings of sadness, fear, uncertainty, regret, and a certain amount of acceptance. For those bereaving the loss, it may feel as if it will never remit, but the sadness and pain may be seen as an appropriate response. Acceptance, which should not be mistaken for happiness, is often when the pain for the person dying has subsided, his or her interests have diminished and he or she often prefers to be left alone (Kübler-Ross, 1969). For those bereaving, it is learning to live with the loss, having more good days than bad ones, listening to uncomfortable feelings, and eventually reaching out to others.

John Bowlby, a psychiatrist noted for his research on attachment and child development, studied children separated from their parents in World War II, widows, and a few widowers, to develop his four phases of grief. According to Bowlby (1980), the four phases of grief are: (1) numbness, which occurs immediately following a loss, is associated with feelings of shock and intense distress that may last up to a week and serve as a protective defense that allows the person to survive emotionally; (2) yearning and searching, which may last for months and sometimes years, involves a pining for the deceased, a longing for his or her return and is associated with anxiety, anger, confusion, weeping and guilt; (3) disorganization and despair is associated with less yearning as the loss becomes more "real", more apathy, and an attempt to reorganize the loss; and (4) reorganization, the final phase, occurs when the grieving person begins to accept a new condition of "normal". During this phase grief does not end, but thoughts of sadness and despair diminish and are replaced with positive memories of the deceased.

With the past 5 years, William Worden (2008), a psychologist who has been studying life-threatening illness and life-threatening behavior for more than 40 years, has developed a task-based grief theory, partly in response to the stage-based models presented above. According to Worden, four tasks of mourning, which are intended to help the bereaved come to a better understanding of his or her loss, are (1) accept the reality of the loss, (2) work through the pain (both physically and emotionally), (3) adjusting to the new environment in which the deceased is missing (i.e., accepting new identity as a widow or widower), and (4) emotionally relocate the deceased and move on (e.g., not to forget the relationship with the deceased, but letting go of attachments so new relationships can form). Worden does not necessarily believe that the tasks need to occur in this particular order, and he did not set a specific time for how long these tasks should take. However, they are usually experienced over months and years as compared to days or weeks.

Complicated Grief

As noted, grief in response to loss is a normal experience of emotional reactions couched in cultural norms that is often mitigated by social support and personal resources and most often does not require professional intervention (Kyrouz, Humphreys, & Loomis, 2002; Malkinson, Rubin, & Witztum, 2005). It is clear that people grieve in different ways, for various durations, and with painful and disruptive symptoms that range from depression to anger to limited functioning. About 80–90% of people are thought to cope with the grieving process in a normal, uncomplicated manner (Barry, Kasl, & Prigerson, 2001; Boelen, van den Bout, & de Keijser, 2003; Bonanno, 2004; Latham & Prigerson, 2004). According to Prigerson (2004), by 6 months post-loss most bereaved individuals attain some sense of acceptance, are able to work productively, feel increasingly optimistic about the future, find meaning and purpose in their lives, maintain supportive relationships, cultivate new relationships and find pleasure in their spare time. In addition, self-esteem and sense of accomplishment remain intact in those experiencing more normal grief reactions.

There are, however, a minority of individuals, with estimates ranging from 15 to 20% (Bonanno, Wortman, & Neese, 2004; Prigerson, Frank, et al., 1995), who do not experience what may be considered normal grief reactions. For these individuals, signs and symptoms consistent with major depressive disorder (MDD), PTSD, or suicidal thoughts and gestures occur that preclude the individual from functioning adequately and may last for a prolonged period of time (Howarth, 2011; Prigerson, Vanderwerker, & Maciejewski, 2008). Individuals bereaved through deaths that are violent, unexpected, or untimely are at a heightened risk for these experiences (Lichtenthal, Cruess, & Prigerson, 2004; Stroebe, Schut, & Stroebe, 2007). Many terms have been used to describe these atypical grief reactions, with the two most prevalent being complicated grief (CG) and prolonged grief (PG). Prigerson and colleagues (2008) have worked to clarify the terms and provide compelling rationale to use the term prolonged grief to denote the elevated symptoms associated with the challenging adjustment to loss. The authors are quick to note that the word prolonged is an encompassing term for the distress associated with the disorder and not simply to imply that duration is the sole indicator of the pathological nature of grief. Moreover, Prigerson et al. (2008) note that the term complicated grief may be readily confused with the term complicated bereavement, used in the *DSM-IV* to describe symptoms of major depression secondary to bereavement. Despite these efforts to refine these constructs, the current literature continues to use both terms, often interchangeably.

Currently, PG or CG is not considered a mental disorder, and the construct of bereavement, which is limited to a single paragraph in *DSM-IV,* is mostly used as a potential exclusion criterion for other disorders, such as MDD or an adjustment disorder (*DSM-IV-TR;* American Psychiatric Association, 2000) and is classified in *DSM-IV-TR* as a "V" code, or one of "additional conditions that may be a focus of clinical attention" (p. 739). Prigerson et al. (2008, 2009) note distinctive phenomenology, etiology, and course associated with PG that results in substantial distress and disability and warrants inclusion as a separate mental disorder.

In a field trial designed specifically to develop diagnostic criteria of PGD, Prigerson et al. (2009) propose the following: Criterion A: Bereavement following the loss of a significant other is the event; Criterion B: Separation Distress defined as yearning (e.g., craving, pining, or longing for the deceased; suffering (both emotional and physical) by not being able to be reunited with deceased) daily or to a disabling degree; Criterion C: Cognitive, emotional, and behavioral symptoms; specifically five or more of the following nine symptoms (1) confusion about one's life role or diminished sense of self (i.e., feeling as if a part of oneself has died); (2) trouble accepting the loss; (3) avoidance of reminders of the deceased, (4) difficulty trusting others; (5) feelings of bitterness or anger related to the loss; (6) difficulty in moving on with life (i.e., cultivating interests, making new friends); (7) emotional numbness; (8) a perception of life as empty or meaningless, and (9) feeling stunned, dazed, or shocked by the loss; Criterion D: Timing, proposed diagnosis not made until after 6 months have passed since the loss; Criterion E: Impairment, in the form of clinically significant distress in social, occupational, or even domestic functioning; Criterion F: Relation to other mental disorders, meaning that the disturbance is not better accounted for by substance use, a general medial condition or MDD, generalized anxiety disorder, or PTSD. For this last criterion, studies have shown that symptoms such as yearning, emptiness, bitterness, and disbelief about the death are indicators that separate PGD from MDD (Boelen, van den Bout, & de Keijser, 2003; Prigerson et al., 1996, 1997; Prigerson, Frank, et al., 1995; Prigerson, Maciejewski, et al., 1995). Moreover, in contrasting PGD from PTSD (Prigerson et al., 2000; Shear & Mulhare, 2008), distress for the former is triggered by the loss of a close attachment while in PTSD it is triggered by a real or perceived physical threat. The two differ in the primary emotion expressed, with fear, along with hyperarousal, being more prevalent in PTSD, while sadness is the primary emotion in PGD. The two also differ in the type of avoidance displayed, with trauma victims experiencing more of a phobic avoidance of reminders of events as a compensatory strategy to mitigate arousal, whereas with PGD, there is more of an avoidance of accepting the loss as real, avoidance of moving on with one's life, and general difficulty accepting the loss. Also, separation distress, with symptoms such as yearning for the deceased, is not seen in PTSD.

Confirmatory factor analytic procedures on 456 bereaved adults were conducted to assess whether normal grief, CG, as well as the revised criteria of CG that make up PGD, differed (Dillen, Fontaine, & Verhofstadt-Denève, 2008). The factor analytic procedures suggested that CG/PGD symptoms are by nature distinguishable from NG, except for "strong yearning" which loaded on both factors. The authors noted, however, the Dutch translation of yearning may have accounted for this effect, so they were reluctant to imply that "intense yearning" does not distinguish between NC and CG/PGD. Overall, the findings support the contention that CG/PGD is separate and distinct from normal grief reactions and warrants consideration as a DSM 5 diagnoses. A more recent confirmatory factor analysis on 292 elderly participants (mean age 70 years; SD = 3.47) noted, however, a large overlap between PGD and PTSD, especially the intrusive component of PTSD (O'Connor, Lasgaard, Shevlin, & Guldin, 2010). The authors noted, however, the nonclinical nature of their sample and the low frequencies

of CG (9%) and PTSD (6%). There was also an average of 13.5 months for the most significant losses chosen with a SD of 13.1 and a range from 0 to 63 years. Clearly, more empirical research is needed on this important topic.

At the time of the writing of this chapter, the DSM 5 is still in development, but the condition, persistent complex bereavement-related disorder is being recommended for further study. Therefore, since comments are still being received and considered for possible diagnostic criteria, it would be imprudent at this time to convey anything more than a cursory summary of the APA workgroups' current document (http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=577). The current working criteria proposed for this condition overlap in many ways with Prigerson and colleagues' (2008, 2009) proposed criteria for PGD presented previously, with both placing an emphasis on symptoms of yearning, sorrow, and preoccupation with the deceased. The current draft of the proposed DSM 5 criteria of persistent complex bereavement-related disorder also structure additional symptoms into the categories of reactive distress to the death (e.g., bitterness, avoidance, maladaptive appraisals) and social/identity disruption (e.g., trust issues, confusion, detachment). The current APA proposed criteria also are more definitive regarding the timing of the loss (the individual experienced the death of a close family member or friend at least 12 months ago; however, in the case of a bereaved child, this death may have occurred at least 6 months ago). Both PGD and the upcoming DSM 5 offer proposed criteria-related functional impairment. It also is worth noting that in addition to persistent complex bereavement-related disorder being recommended for further study, the proposed DSM 5 updated criteria for MDD, single episode, currently includes the stipulation that the normal and expected response to a significant loss such as bereavement may resemble the symptoms of a depressive episode.

Complicated/Prolonged Grief and Stress-Related Symptoms

In a sample of 76 participants from the Pittsburgh area, most of whom were women, those with syndromal levels of traumatic grief, as assessed by the Inventory of Complicated Grief (Prigerson, Maciejewski, et al., 1995), were approximately five times more likely to report suicidal ideation than were participants with non-syndromal levels of traumatic grief (Prigerson, Bridge, et al., 1999). Latham and Prigerson (2004) used the Inventory of Complicated Grief-Revised (Prigerson, Shear, et al., 1999; Prigerson & Jacobs, 2001) to assess a sample of 309 bereaved adults at baseline (6.2 months post-loss) and again at follow up (10.8 months post-loss). Their results, after controlling for demographic factors, indicated that CG was associated with a 6.6 times greater likelihood of "high suicidality" at baseline, and an 11.3 times greater risk of high suicidality at follow-up. In a sample of 129 children and adolescents (age range 7–18 years) whose parents died of a sudden natural death, accident, or suicide, a modified version of the Inventory of Complicated

Grief-Revised (ICG-R), CG was related to functional impairment, including suicidal ideation, after controlling for MDD, PTSD, and anxiety (Melhem, Moritz, Walker, Shear, & Brent, 2007). In a studying assessing suicidal behavior, as compared to suicidal ideation, in a sample of 149 patients who met criteria for CG, 65% reported suicidal ideation following the death of a loved one, and more than half of this group (38% of the entire study sample) engaged in self-destructive behavior, including 9% who made a suicide attempt and 29% who engaged in indirect suicidal behavior (Szanto et al., 2006)

It was noted in the introduction to this chapter that loss of a spouse or significant other has long been considered among the most stressful of all life events (Holmes & Rahe, 1967; Prigerson et al., 1997; Zisook, Shuchter, & Lyons, 1987). The inherent stress associated with significant other loss is associated with compromised immune functioning (Irwin, Daniels, Smith, Bloom, & Weiner, 1987), more physician visits (Mor, McHorney, & Sherwood, 1986), and increased use of alcohol and cigarettes (Clayton, 1990; Lund, Dimond, & Caserta, 1985). In a sample of 150 widows and widowers who did and did not meet criteria for traumatic grief, those who met the criteria were significantly more likely to have heart trouble (19.2%) and cancer (15.4%) than those who did not meet the criteria (19.2% vs. 5.2%, and 15.4% vs. 0%, respectively) between 6 and 25 months after their loss (Prigerson et al., 1997). In a study comparing psychological, endocrine, and immune functioning over a 6-month period between 14 healthy participants who experienced *unpredictable* acute emotional stress, like the sudden death of a loved one, and 14 controls who did not experience loss, those who experienced the loss showed more stress as assessed by self-report (Hamilton Rating Scales), adrenocorticotropin and plasma concentrations, and nonsuppression in response to dexamethasone 10 days after the loss when compared to the controls (Gerra et al., 2003). Moreover, 40 days after bereavement, the unpredictable loss cohort showed decreased natural killer cell activity and other alterations in immune parameters not observed in the control group.

The development of neuroimaging techniques, such as functional magnetic resonance imaging scan (fMRI) and PET, has allowed researchers to investigate functional correlates of how bereavement affects task-related brain activity (Gündel, O'Connor, Littrell, Fort, & Lane, 2003); O'Connor, 2005; Ochsner & Lieberman, 2001). While many brain areas are noted to be activated during bereavement neuroimaging studies, a grief-eliciting paradigm (consisting of showing participants pictures or the deceased with a caption or words), a few of the most salient areas of the brain activated are the posterior cingulate cortex, which is activated during autobiographical memories and emotionally salient stimuli (Maddock, Buonocore, Kile, & Garrett, 2003), the medial/superior frontal cortex, and the cerebellum (Gündel, O'Connor, Littrell, Fort, & Lane, 2003; O'Connor). A more recent study by O'Connor and colleagues (2008) comparing event-related fMRI to idiopathic grief-related stimuli in 23 bereaved women (11 of whom had CG) showed that only those with CG evinced reward-related activity in the nucleus accumbens. This suggests that reminders of the deceased still activated reward activity, which may interfere with adapting to the loss.

Grief and Traumatic Events

Disasters, which by nature are sudden and unexpected, can result in multiple deaths (including children), mutilated bodies, devastated surroundings, and social disarray. Moreover, for survivors who may have witnessed horrific events, experienced the loss of loved ones and possibly blame themselves for what occurred, the process of grief and bereavement may be even more profound (Bonanno et al., 2007; Kaltman & Bonanno, 2003; Parkes, 2008). As noted by Parkes, the psychological interventions required of bereaved individuals following disasters are essentially the same as other bereavements, but high levels of anxiety and fear, along with anger, guilt, and aggression, may require anxiety-management programs or anger-management skills to mitigate severe or disabling symptoms that persist for more than 1 month.

Following the 1995 Oklahoma City bombing, Pfefferbaum and colleagues (2001) reported a positive relation between self-reported posttraumatic stress symptoms and grief. In a convenience sample, 704 bereaved adults surveyed 2.5–3.5 years after the September 11, 2001, terrorist attacks on the World Trade Center, 43% screened positive for CG reactions on a nine-item survey (Neria et al., 2007). Moreover, close to 65% of participants who lost a child screened positive for CG, 36% with CG had probable depression, and 43% had probable PTSD. Also of interest, and consistent with other data presented in this volume (see Chap. 19 on Sleep and Stress), nearly half (47%) of those who watched the attacks live on television screened positive for CG. In a sample of 262 (199 women and 63 men) bereaved inhabitants affected by the 2004 tsunami in Southeast Asia, 84% were identified as being severely emotionally distressed on the Hopkins Symptoms Checklist-25, and 77% were identified as being depressed 1 year after the tragedy (Souza, Bernatsky, Reyes, & de Jong, 2007). In a 2009 study (Johannesson et al. 2009) conducted 14 months after the tsunami that included 187 bereaved relatives of tsunami victims, 40% of the relatives reported CG and suicidal ideation. In addition, being chased by the tsunami waves was associated with more distress in the bereaved relatives.

Intervention

As noted previously, most normally grieving individuals will not require formal grief therapy (Jordan & Neimeyer, 2003). Usually with the passage of time, support from others, making sense of the loss through talking or writing about it, and integrating it into a new reality, productive resolution will typically occur in a relative timely fashion. In other words, part of the intervention task is to help the grieving individual reconfigure his or her sense of identity and create new meanings and new assumptions (Jeffreys, 2005). Jeffreys suggests various ways to facilitate this post-loss reality including: keeping a record of positive experiences

that occur during the week, create a new hobby that is not dependent on another person, rehearse responses to people who are unaware of the loss, and utilize relaxation strategies. For caregivers, suggestions for dealing with grieving individuals include: don't be or look rushed, be comfortable with silence, remain nonjudgmental, be prepared to normalize the myriad emotions being displayed ranging from sadness, fear, confusion, helplessness, hopelessness, dread, anhedonia, and anger, help the person remain active, be sensitive to cultural norms, and be sensitive and aware of your own compassion fatigue when trying to assist others (Jeffreys; Love, 2007).

There are times, however, when grief does not remit and more formal therapeutic interventions are warranted for GC. Clearly the communication styles noted above will apply; however, there are also likely to be tailored procedures that incorporate more formal cognitive-behavioral techniques (e.g., counterfactual thinking, exposure techniques), family-focused therapy, and more evidence-based treatments (e.g., modified interpersonal therapy). From a constructionist therapy perspective, which is a postmodern approach that focuses on people's need to impose meaning on their life experiences or life stories (Neimeyer, 2009), resolution following death involves assimilating and accommodating the loss into a coherent and meaningful self-narrative and involves techniques such as narrative retelling (recounting the death under safe conditions), therapeutic writing, use of metaphor, evocative visualization (encouraging the person to "enter" and "experience" the scene at a visual and tactile level in order to foster meaning), and encountering the pro-symptom position (the proclivity to construct meaning that maintains the problem despite its distress) (Neimeyer, Burke, MacKay, & van Dyke Stringer, 2010; Neimeyer, van Dyke, & Pennebaker, 2008) .

Grief and Children: Developmental Stages and Intervention

Developmental Stages

Children of all ages grieve, but they are impacted by loss very differently than adults. It is relevant to note that while children are individually and uniquely impacted by the experience of death, they may react to death from a general developmental perspective. For example, children under the age of 5 years may view death as a "separation" that may be temporary and reversible and do not fathom that all functions of life have ceased (Dyregrov, 2008; Worden, 2008). Between the ages of 5–9 years, most children are gradually developing a sense of mortality. However, they may still not envision death as personal, meaning that they somehow believe they will be able to escape it (Worden). From the ages of around nine through adolescence, they begin to fully comprehend the finality of death, the existential aspects of death, including that they too will die someday.

Evidence of Grieving in Children and Adolescents

Fortunately, children tend to be highly resilient, but they may still experience signs and symptoms associated with death and the grieving process. The following are some of the common ways children may respond to a death (Dyer, 2002; Dyregrov, 2008):

- Sadness
- Shock, denial, and confusion
- Anger and fear
- Sleep difficulties
- School performance drop
- Physical complaints
- Guilt
- Regressed behavior (e.g., thumb-sucking, bedwetting)
- Anhedonia
- Repeated questions about the deceased
- Decreased appetite
- Vivid memories
- Acting out
- Isolation

Helping Children Understand Death

There are many ways to help children understand the impact of death, but one of the biggest challenges is communicating with a young child. First of all, recognize your own fear and discomfort in talking with children about death, spend time listening to them and giving them the opportunity to explore their curiosity. When talking with young children, they respond well to straightforward, brief, simple, and *concrete* explanations done in a timely manner (Dyregrov, 2008; Raveis, Siegel, & Karus; 1999; Worden, 2008). According to Grollman (1998), death may be made more understandable by explaining it in terms of the absence of normal life functions (e.g., when people die they do not think, breath, eat, or feel anymore; when dogs die they do not bark or dig anymore; dead flowers do not bloom anymore). Make sure a child not only listens but also hears what you say; therefore, repetition and having him or her paraphrase back what you say can be helpful. Some children, for example, confuse death with sleep, particularly when they may hear adults say things like "eternal rest" or "rest in peace." It is important, therefore, that they know that going to sleep does not mean that they may die. Additionally, religious statements, such as "this is God's will" or that the deceased is at peace because he or she "is with God now" may be unnerving to a young child. Young children may also be predisposed to feeling guilty and somehow believing that they caused the death of a loved one.

Even though for younger children the concept of death may not be fully developed, there is no reason to doubt that they may react strongly to loss. Therefore, depending on if the child is old enough to understand the concept of death, and more importantly if he or she wants to participate in the funeral, being included may help him or her accept the reality of the loss and say good-bye to the deceased. However, it is important that the child be prepared about what he or she will see and hear before, during, and after the service.

Overall, for children experiencing the various types of normal grief reactions associated with death, different approaches are likely to be helpful, and all are based on the premise of openness and honesty. For example, incorporating creative approaches, such as play, art, and dance may help to facilitate emotional expression.

Despite being highly resilient, there are instances, however, when a child may be particularly overwhelmed by a loss and may require more formal interventions. If, for example, the signs noted above show very little remittance after about three months, then it is an indication that the child is having problems that may respond to professional help (American Academy of Child and Adolescent Psychiatry, 2011; Dyer, 2002). Other possible warning signs that more professional help following a death may be warranted include (Dyer; Dyregrov, 2008; Worden, 2008):

- Repeated statements of wanting to join the deceased person
- Refusal to attend school
- Alcohol or drug use
- Recurrent, unexplainable temper tantrums
- Stealing, vandalism, or other illegal behavior
- Phobias or panic attacks
- Withdrawal from friends
- Excessive imitation of the deceased

Summary

Dealing with the grief and mourning associated with the death of a loved one is considered to be one of the most stressful situations we will encounter. Fortunately, the challenges of sadness and hurt usually remit within six months of the loss and we are able to return to our normal level of functioning. As this chapter noted, there are times, however, when the signs and symptoms of grief are more profound, do not remit, and may result in PGD. With approximately 2.4 million deaths per year in the USA in 2009 (Kochanek, Xu, Murphy, Mini o, & Kung, 2011), and with an estimated 4 survivors per death, and using the estimated 15–20% rate of PGD following deaths from natural causes (Bonanno, Wortman, & Neese, 2004), then there are more than one million cases of PGD in the USA alone.

This chapter has provided a general overview of the relation between grief, loss, and stress. Let us review the main points of the chapter.

1. We began with a diffe=rentiation between the terms bereavement, grief, and mourning.
2. The major theories of grief, including Lindemann's (1944), Kübler-Ross' (1969), Bowlby's (1980), and Worden's (2008) were reviewed.
3. The construct of complicated/prolonged grief was reviewed and the proposed criteria for a diagnosis were presented.
4. The general criteria for the proposed DSM V condition of persistent complex bereavement-related disorder were briefly reviewed.
5. Research results have shown how complicated/prolonged grief results in stress-related symptoms, including suicidal ideation and behavior (Melhem, Mortiz, Walker, Shear, & Brent, 2007), compromised immune function (Gerra et al., 2003), and alterations in brain activity (Gündel, O'Connor, Littrell, Fort, & Lane, 2003; O'Connor et al., 2008).
6. Data have also shown how traumatic events, including man-made and natural disasters, impact symptoms of CG reactions, such as increased symptoms of depression and probable PTSD (Neria et al., 2007; Souza, Benatsky, Reyes, & de Jong, 2007).
7. The chapter concluded with proposed intervention strategies for adults (Jeffreys, 2005; Love, 2007) and children (Dyer, 2002; Dyregrov, 2008) to mitigate the impact of loss.

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