Academic Article

# Breaking up is hard to do

## An exploration of attachment styles as a predisposition to complicated grief disorder following relationship loss

*By Kaylene Petersen*

*While the majority of people are able to navigate the loss of an intimate relationship in due course, for some, the grief that follows can involve incessant yearning, become debilitating and, in some cases, be life-threatening. Numerous studies have shown that attachment styles can be a predisposition to this complex and multifaceted reaction to loss*

**Introduction**

Grief is a normal reaction to loss of anything significant from our lives. It is an ongoing process that may appear to be never-ending, however, for most people grief does subside in time. Unfortunately, for a subset of individuals, grief can become a prolonged and permanent state of being. Pathological grief reactions, marked by functional impairment, persistent emotional pain and an increased incidence of morbidity and mortality are possible following any major loss. This reaction is known by various names, notably 'traumatic grief', 'complicated grief disorder (CGD)', 'prolonged grief disorder' and, most recently, after review by the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (2013), 'persistent complex bereavement disorder', where it is currently placed under a chapter for further study. Failure to agree on a name is due in part to a lack of consensus on when grief becomes pathological. The term CGD is used in this article due to its prevalence in academic literature.

The end of a romantic relationship can be a highly painful event that can lead to CGD. Studies have shown that the grief response to relationship dissolution can mirror that of death, although relationship loss is generally not validated in the way death is.

At the heart of attachment theory is separation and loss, making it a clear theoretical framework for studying grief reactions. Several empirically-supported studies have found complicated grief therapy – a specific therapy for complicated grief – to be most effective in treating CGD.

**The universality of loss**

Loss is an unavoidable part of life. From the moment we enter the world, loss is apparent. In fact, "we begin life with loss. We are cast from the womb without an apartment... a job or a car" (Viorst, 1986, p.9). As we grow, life by its very nature continues to serve us up loss – loss of a prized possession; a friend moves away; our youth passes us by; we change jobs; lovers come and go; our

health deteriorates; and, probably most devastating of all, a loved one dies. All of these unavoidable losses are part of the fabric of life. Sometimes subtle, sometimes painful, but irrefutably necessary for us to change and grow (Viorst, 1986).

Of all the losses an individual will experience throughout the lifespan, death of a loved one is regarded as the ultimate loss (Bozarth, 1982). However, according to Viorst, (1986): "When we think of loss we think of the loss, through death, of people we love. But loss is a far more encompassing theme in our life. For we lose not only through death, but also by leaving and being left, by changing and letting go and moving on" (p.2).

Literature, music, film and poetry are bursting with themes of romantic loss and yet the vast majority of studies on loss, grief and bereavement are examined within the context of death (Harvey, 1998). However, the reasons that individuals seek professional intervention for loss far surpass that of bereavement through death of a loved one.

In romantic relationships, we inevitably form an emotional connection with our partner. The end of a relationship can therefore represent a major loss in an individual's life and give rise to a grief response. The dissolution of an intimate relationship is often painful – it signals the end of what once held meaning and shared hopes and dreams. Relationship loss is thus multi-layered. We are not alone losing the person we love, we are losing all that they represented and all we hoped they would come to represent in the future.

Grief can be defined as "an abiding and pervasive sense of sadness that overwhelms us when we are separated from a person, place or object important to our emotional life" (Doyle, 1980, p.6). It is a natural reaction when someone we love leaves us and encompasses physical, behavioural, emotional, cognitive and social reactions (Prigerson & Jacobs, 2001).

*For most people, the painful journey to recovery following relationship loss is relatively short-lived*

The degree to which we are affected by a loss is largely dependent on the level of attachment we ascribe to the loss. How long grief lasts and the intensity to which it is felt is dependent on numerous factors. According to Zisook and Shear (2009), these can include "...the individual's pre-existing personality, attachment style, genetic make-up and unique vulnerabilities; age and health; spirituality and cultural identity; supports and resources; the number of losses; [and] the nature of the relationship" (p. 67).

Doka (1987) uses the term 'disenfranchised grief' to explain grief that is not generally acknowledged or socially sanctioned. Examples of this include miscarriage, suicide and relationship break-ups.

While relationship loss may be regarded as disenfranchised, for many it is a highly stressful event. The Holmes & Rahe Stress Scale (1967) of life events that can result in illness, places a spouse's death as the most stressful event. This is immediately followed by divorce and then marital separation.

Significantly, grief experienced after relationship loss can mirror the grief response to death, namely, intrusive thoughts, insomnia and depression (Prigerson & Jacobs, 2001). More serious complications that have been found to coincide with the end of a romantic relationship include immune dysfunction and stress-induced cardiomyopathy, also known as 'broken heart syndrome', which is a sudden and temporary weakening of the muscular part of the heart (Field, 2011).

In one study of those recently bereaved by relationship loss, it was found that the same areas of the brain were aroused when the subject was scolded on the arm with hot coffee as they were when shown a photograph of their former partner (Eisenberger, 2012). The results revealed that the brain does not differentiate between physical pain and the intense emotional pain that can follow a break-up. Further, it can be argued that for some individuals, separation from a loved one can prove far more disruptive and emotionally painful than a physical illness.

Given the ubiquitous nature of grief, key contributors in the field have long been interested in its process: Bowlby, Lindemann, Kübler-Ross, Worden and Rando are all names synonymous with grief theory. While each theorist has their own personal take on grief, they are united on two fronts: grief is a process that must be worked through in stages or cycles to reach a stage of acceptance or integration; and grief can go wrong.

**Complicated grief**

For most people, the painful journey to recovery following relationship loss is relatively short-lived. Having traversed the rocky road of heartbreak – a process that involves confronting feelings of shock, sadness, anger, anxiety, loneliness and fatigue (Worden, 2009) – they eventually find their footing again and their lives return to a place of normalcy, although they are often irrefutably changed by the experience.

However, "it is important to

acknowledge that satisfactory reorganisation of one's life following a major loss is not guaranteed" (Neimeyer, 2000, p.14). For some individuals, the end of a romantic relationship can result in a prolonged grief process that can severely impact on their quality of life.

To this end, it is possible for an individual to become 'stuck' in their grief. When this happens, grieving can be ignored completely, the grief process can become chronic and, in some cases, grief can be so intense that it is life-threatening. This is CGD and research suggests it occurs in approximately 15% of bereaved individuals (Horowitz et al., 1997; Prigerson et al., 1995). However, it is important to note that CGD is a "greatly under-recognised public health problem across the lifespan" (Shear, Ghesquieve & Katzke, 2013, p.232) as many people with prolonged grief symptoms do not seek out clinical help (Lichtenthal et al., 2011).

There are several grief processes that fall under the umbrella term of 'complicated mourning'. These include: absent grief, where grief symptoms are not existent or minimal following a loss; delayed grief, where the grief response may not be experienced until a much later time; conflicted or exaggerated grief reactions, where an individual feels overwhelmed by grief and may resort to maladaptive behaviour such as anger and hostility as coping mechanisms; and chronic grief, where grief is prolonged and unremitting (Worden, 2009).

CGD can be defined as "the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behaviour, or remains interminably in a state of grief without progression of the mourning process towards completion" (Horowitz, Wilner, Marmar & Krupnick, 1980, p.1157). Although CGD is typically associated with death, its symptoms are also experienced following relationship loss (Field et al., 2009).

*Another distinguishing feature of CGD is avoidance of specific stimuli related to the loss*

Although our experience of grief is unique, a normative grief response following a romantic break-up could involve initial disbelief, followed by a combination of painful emotions such as preoccupation with the person who has left and a reluctance to process and accept the loss for a period of up to six months (Shear & Mulhare, 2008).

According to Shear et al., (2011) for a person to be diagnosed with CGD they must experience their grief symptoms following a significant loss for more than six months. They must also exhibit separation distress through one of the following symptoms on a daily basis:

- Intense emotional pain and pangs of sorrow related to the loss of the relationship
- Consistent intrusive thoughts relating to the loss of the relationship
- Intense yearning for the lost person

Further, they must experience five or more of the following:

- Confusion about one's identity
- Difficulty accepting the loss
- Avoiders of reminders of the reality of the loss
- Bitterness or anger related to the loss
- Difficulty moving on with life
- Numbness
- Feeling that life is unfulfilling, empty and meaningless
- Feeling stunned, dazed or shocked by the loss

(Shear et al., 2011)

Put succinctly, "individuals suffering from complicated grief fail to experience reprieve from pain and longing. Caught in a loop of prolonged grief symptoms and complicating psychological and/or life problems, time seems to stand still" (Shear et al., 2007, p. 453).

Although CGD is widely treated as depression, they are two distinct disorders, although symptoms may overlap. Notably, with depression there is a general feeling of sadness and a lack of interest in all areas of life. A depressed person is also likely to ruminate and dwell on past failings. With CGD, the grief is almost entirely confined to the loss, characterised by pre-occupation, yearning and the belief that reunion with the ex-partner will bring about satisfaction (Shear, 2012). Similarly, while the onset of CGD and Post-Traumatic Stress Disorder (PTSD) occur after a traumatic event, CGD symptoms of emotional numbness, identity confusion, feeling 'adrift' and that life is meaningless are not evident in PTSD (Prigerson & Jacobs, 2001).

Another distinguishing feature of CGD is avoidance of specific stimuli related to the loss. In addition, the stress from CGD can "increase the likelihood of onset or worsening of other physical or mental disorders" (Shear et al., 2011, p. 103). Other studies have noted significant levels of sleep disturbance among those with CGD (Germain, Caroff & Buysse, 2005; Hardison, Neimeyer & Lichstein, 2005) and a correlation between CGD and a heightened risk of substance abuse, cardiac disease, cancer and suicide (Szanto, Shear & Houck, 2006).

According to Zisook and Shear (2009), once CGD takes hold, it tends to be chronic and persistent. CGD can be diagnosed using the Inventory of Complicated Grief (ICG) (Prigerson, et al., 1995). The ICG is comprised of 19 statements

with response options ranging from 'never' to 'always'. An individual scoring ≥30 six months after bereavement can be clinically diagnosed with CGD.

Possibly the most extensive study into risk factors of prolonged grief was by Burke and Neimeyer (2013) who examined peer-review literature over a 30-year period. Confirmed risk factors for CGD include being the spouse of the deceased, low levels of support, high neuroticism and insecure attachment styles.

That CGD can be linked to attachment disorders is not overly surprising. When we lose someone from our life whom we loved, feelings of abandonment we may have suppressed since childhood can suddenly resurface in a highly distressing way.

**Attachment styles and complicated grief disorder**

How we cope with the end of an intimate relationship depends on personal, social and psychological factors, such as our personality, stage of life, supports we have around us, our mental health and, crucially, our style of attachment (Wilson, 2014).

According to John Bowlby, the pioneer of attachment theory, attachment refers to the "lasting psychological connectedness between human beings" (1969, p.194) and it is this primitive instinct that forms the basis of his theory of attachment.

During periods of stress, particularly in the face of separation or fear, an individual's attachment style is usually activated to varying degrees (Schenck et al., 2015). For this reason, theorists and researchers have turned to attachment theory to examine why human beings develop close affectional bonds and, further, why when these bonds are broken, intense emotional reactions can ensue.

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As detailed by Fraley and Shaver (1999): "Whether an individual exhibits a healthy or problematic pattern of grief following separation depends on the way his or her attachment system has become organised over the course of development" (p. 740).

**Research into attachment styles and complicated grief disorder**

CGD appears to be linked with attachment disturbance and high levels of insecurity with the self and with an individual's relationships to others (Berger, Shuster & von Roenn, 2007). Given this, it is not a stretch to hypothesise that securely-attached individuals would cope better with loss than their insecurely-attached counterparts.

According to Stroebe et al., (2007) adults with secure attachment, who had their emotional and physical needs consistently met throughout development, are generally equipped with the characteristics needed to navigate stressful situations, such as relationship loss, confidently and independently with minimal guidance from others. Thus, a secure attachment can be viewed as a protective agent against psychopathology and also against adverse reactions to situations of trauma and stress. The securely-attached adult is able to recall a former lost partner and talk about them coherently without too much difficulty (Collins & Feeney, 2000).

By comparison, in cases where an attachment figure is not seen as a consistent and reliable source of support and security, an individual may develop an insecure style of attachment (Feeney, 1999). This may result in "a predictable sequenced response to separation" (Shear & Shair, 2005, p. 254). Adults who are insecurely attached can develop either a more anxious response to their relationships, such as uncertainty about a partner's responsiveness and availability to them, or an avoidant response, such as unease when in situations that requires relying on others (Brennan, Clark & Shaver, 1998).

Individuals categorised with insecure-anxious attachment tend to lack trust in themselves and this can be played out with intense anxiety, sorrow and yearning following the loss of a significant other. Given this, insecure-anxious individuals tend to be highly emotional, more likely to have difficulty processing and accepting loss and find it harder to move on and establish new meaning in life when confronted with it (Delespaux et al., 2013). Similarly, individuals who have experienced abuse in childhood, i.e. disorganised attachment, have been found to be more susceptible to acute grief reactions and CGD (Silverman et al., 2001).

These findings were reinforced in one of the largest studies to date into emotional and behavioural reactions to break-ups. The online study of 5,000 individuals found that individuals classified as securely-attached utilised social coping strategies, such as confiding in friends and family, and used these supports as 'safe havens' to help alleviate distress (Davis et al., 2003).

Conversely, respondents who

were categorised as possessing an insecure-anxious attachment style reported a preoccupation over the loss of their partner. This encompassed heightened levels of physical and emotional distress, increased efforts to resurrect the relationship and turning to dysfunctional coping strategies, such as excessive intake of alcohol or use of recreational drugs (Davis et al., 2003).

Insecure-avoidant responders were noted to react to romantic relationship dissolution with more avoidant-style coping strategies, for example, suppressing their feelings, shying away from support from others and avoiding new relationships (Davis et al., 2003).

One study that examined attachment style and individual reaction to divorce found that adults with insecure attachment styles exhibited heightened distress and decreased well-being when compared to securely-attached participants (Birnbaum, Orr, Mikulincer, & Florian, 1997). The study found that while insecure-avoidant individuals were of the opinion they could cope, they saw divorce as a threat and, as such, utilised ineffective coping strategies that impacted negatively on their well-being. The researchers stated that while insecure-avoidant individuals may be able to control their level of distress following relationship dissolution in short-term dating relationships, they may not fare so well in the case of long-term relationships, such as divorce. Thus, for some avoidant individuals, the longer the duration of the relationship – and the higher the degree of attachment – the more heightened the level of distress and the more acute the grief experience.

Delespaux et al., (2013) corroborated these findings, suggesting that avoidant-attached bereaved individuals are more inclined to avoid emotional upset and revert to defensive reactions in an attempt to play down the significance of the loss and avoid memories of the person no longer in their life. This avoiding grief may prove beneficial in the short term but can lead to what is known as 'prolonged absence of conscious grieving' (Bowlby, 1980) or, more commonly, 'absent grief'.

*Students rated factors including crying, preoccupation with thoughts over the loss, being stunned and not being able to accept the end of the relationship*

**The Break-up Distress Scale**

In a bid to differentiate between acute grief symptoms and depression following relationship loss in young adults, the Break-up Distress Scale (Field, et al., 2009) was adapted from the ICG. The scales' authors were keen to highlight that as grief is a distinct disorder to depression, a unique mode of measurement is needed to categorise individuals with pathological grief following a break-up. They conducted a study of 192 college students who had experienced a recent traumatic break-up. Students rated factors including crying, preoccupation with thoughts over the loss, being stunned and not being able to accept the end of the relationship. Students were then separated into 'high-distress' and 'low-distress' groups. The study found females to be more susceptible to break-up distress, and non-initiators of the break-up reported higher levels of distress, as did those whose break-up was sudden and unexpected. It also found that those students in the high-distress group reported more intrusive thoughts, an inability to control such thoughts, insomnia and anxiety, concluding that distress from a break-up may take on the form of CGD.

Thompson (1987) found the main suicide stressors in young adults included romantic break-up (26%); family disagreements (22%); and problems with the law (16%). In another study, individuals six to 12 months following a bereavement were assessed using the Yale Evaluation of Suicidality. The results found that 10.1% of those characterized as grieving normally were positive for suicidal ideation, compared to 57.1% of those in the CG category (Prigerson et al., 2009).

**Treatment for complicated grief disorder**

Encouraging and supporting recovery following a significant loss has long been considered a staple of psychotherapy and, consequently, clinicians have put forward various forms of treatment for bereavement and grief-related issues. Such treatments draw from a diverse range of therapeutic techniques, however, most of these interventions do not specifically target symptoms of CGD, focusing more generally on depression and/or distress (Wetherell, 2012).

Individual and group psychotherapy is the primary mode for grief work and, to date, cognitive behavioural therapy (CBT) approaches have not alone been most rigorously tested, but have also received the most validation (Mancini et al., 2012).

In general, CBT approaches focus on: elements of cognitive restructuring – noting the most problematic aspects related to the loss and re-examining and developing an understanding of them; and exposure – this may involve verbalizing the personal story of loss and then confronting areas or people associated with the loss (Mancini et al., 2012).

**Complicated grief therapy**

An emerging treatment in the field is Complicated Grief Therapy (CGT) – an attachment-based psychotherapy process that incorporates elements of CBT and interpersonal therapy (IPT) (Shear, Frank, Houck & Reynolds, 2005).

CGT incorporates exposure techniques and places emphasis on personal goals and relationships. That this treatment is steeped in attachment processes lends credence to the assumption that CGD is "fundamentally an attachment disorder" (Lobb, Kristjanson, Aoun, Monterosso, Halkett & Davies, 2010, p. 690).

From an attachment perspective, acute grief follows the loss of an attachment figure resulting in disruption to one's attachment system. When a successful mourning process occurs, individuals are able to navigate from acute grief to integrated grief, that is, the loss is acknowledged, trauma related to the loss is resolved and painful memories become more 'bittersweet' as life goals are recognised and readjusted.

In CGT this process is made possible through the dual process model (Stroebe & Schut, 1999) that states healing is the result of two distinct processes:

1) A loss-oriented approach, whereby the client is able to come to terms with the loss; and
2) A restoration-orientated process where the client is able to incorporate new meaning in their life without their former partner.

Generally, CBT techniques target the painful and intrusive memories that accompany the loss as well as any avoidance behaviour. IPT works to help the client reconnect with relationships and personal life goals and help them rediscover meaning in their life (Wetherell, 2012).

*Insecurely-attached individuals have been found to react in differential maladaptive ways to loss*

Several investigations have shown empirical support for CGT (Wetherell, 2012). In one study of 83 adult patients with CGD, the efficacy of CGT was compared with IPT (Shear, et al., 2005). Results found that 51% of participants in CGT versus 28% of participants using IPT noted a 20-point or higher reduction in scores on the ICG. Those participants in the CGT group also reported ICG score reductions faster than those in the IPT group (Shear, et al., 2005).

Another randomized clinical trial of 151 individuals with CGD who received either CGT or IPT found that those in the CGT group reported over two times the response rate (Shear, Wang, Skritskaya, Duan, Mauro, & Ghesquiere, 2014). Significantly, those in the CGT group also reported a significantly greater decline in their symptoms.

CGT is comprised of 16 sessions of 45 minutes to one hour in duration and is divided into three stages. Stage one, the introductory stage (incorporating sessions one through three); stage two, the intermediate stage (sessions four to nine); and the final stage, (sessions 10 to 16). A summary of the structure of CGT is seen in Table 1 (p21).

**Conclusion**

As loss is a consistent theme throughout the lifespan, few will escape unscathed by its painful consequences. While death of a loved one is generally considered the most traumatic loss we shall ever face, we will encounter many other losses throughout our lives that may trigger acute grief responses. Many of these disenfranchised losses can have a profound impact on an individual's psychological functioning and can be just as painful and traumatic as loss of a loved one through death. However, grief following these losses is generally less noticed and less acknowledged.

While most individuals will recover from relationship loss in time and integrate their separation into the unique fabric of their life, for some, this integration fails to occur and they find themselves trapped in a painful, seemingly never-ending loop of acute sadness.

CGD is a largely under-recognised pathological grief disorder that has a significant adverse impact on quality of life mental health and in some cases can be so painful that, tragically, suicide is viewed as the only solution.

As has been shown, one clear risk factor for CGD is an insecure attachment style, with insecure-anxious, insecure-avoidant and disorganised styles of attachment found to be differentially linked to CGD.

Insecurely-attached individuals have been found to react in differential maladaptive ways to loss. Insecure-anxious and disorganised attached individuals are more inclined to find the end of a relationship a highly distressing event.

Insecure-avoidant individuals often feel uncomfortable expressing their feelings and as such are more inclined to minimise or ignore confronting feelings of anxiety following relationship loss. This absence of grief can have detrimental effects in the long-term, particularly if maladaptive coping mechanisms are employed.

The ICG and Break-up Distress Scale are two tools that can assess

**Table 1: Summary of the structure of CGT**

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|---|---|
| **SESSION 1** | The client is welcomed to the process of CGT. A history of interpersonal relationships and other significant losses is taken. Focus is placed on the client's story of the loss, support networks and stressors. The therapist gives a handout that explains the process of CGT and activities (that help clients move towards aspirations) to be completed between sessions. The client is also asked to record upsetting moments and triggers in a grief diary. |
| **SESSION 2** | Information from the grief diary is discussed. A copy of the CGT handout is given to the client to pass on to a supportive person who is invited to attend the third session. |
| **SESSION 3** | A supportive person joins the client and therapist in session (or via phone). This is an orchestrated move as sufferers of CGD often feel a sense of disconnectedness to the world. The supportive person is asked to describe the client since the break-up. The model of CGD is then explained to the individual. The client is seen alone for the remaining 15 minutes for analysis of the grief diary. |
| **SESSION 4** | The client is introduced to 'imaginal revisiting', which involves asking the client to visualise and discuss the moment they realised they were separating for approximately five minutes into a tape recorder. Imaginal revisiting allows the client to come to terms with their loss by rationalising the loss and integrating logic with the emotional processes. Debriefing with the therapist follows about what emotions are brought to the surface. The client names a reward that they could give to themselves in the following week for the difficult task of listening to the tape recording once every day. The grief diary is consulted again and restoration-oriented work continues, whereby the client works towards a personal goal not connected to the loss. |
| **SESSION 5** | The therapist reviews the imaginal revisiting and grief diary and introduces daily 'situational revisiting' – a process whereby the client details places and/or people they have avoided since the break-up because they trigger painful memories. |
| **SESSIONS 6 TO 9** | The grief diary, situational and imaginal revisiting activities are discussed. The client is asked to talk of positive and negative memories and characteristics of their ex-partner. Clients often bring photos to these sessions. |
| **SESSION 10** | The therapist uses the ICG questionnaire, or similar, to note 'stuck' points. Client and therapist collaborate regarding the remainder of therapy, i.e. examine previous losses, engage in more IPT-orientated work. |
| **SESSIONS 11-16** | These final sessions are spent analysing the grief diary and examining situational revisiting exercises. At this juncture, imaginal revisiting is generally no longer required. Clients are asked to participate in 'imaginal conversation'. Here, the client imagines the break-up has just happened and speaks for both themselves and their former partner. The client can ask questions of their former partner and this can prove a moving and eye-opening experience for them. In final sessions, clients work towards termination of the therapy. |

the prevalence of CGD and, further, help produce effective clinical outcomes by attending specifically to those individuals presenting with acute grief who have insecure attachment styles.

To date, CGT has been shown to be the most effective treatment for individuals with CGD in several studies. The therapy, combining attachment processes and borrowing from CBT and IPT techniques, helps individuals integrate loss by allowing them to detach from the former partner and move towards the attainment of new positive life goals.

Evidence supporting a definitive relationship between insecure attachment and a predisposition to CGD does appear to exist, but the minutiae of the relationship requires further research. When counsellors have a thorough understanding of CGD and the treatment options available, the emotional and physical consequences that mar the lives of those with CGD following relationship loss – and indeed any loss – may one day be significantly reduced.

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