THE MANY FACES OF BEREAVEMENT

The Nature and Treatment of Natural, Traumatic, and Stigmatized Grief

Ginny Sprang, Ph.D. & John McNeil, D.S.W.

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Introduction

Death and dying have been a concern of mankind as long as humans have existed. Evidence of this concern is the increased value that has been placed on life as civilization has evolved and the multiple ways survivors have developed to deal with the loss of loved ones. Special attention has been given throughout history to the death of significant figures, but until the past two or three decades little attention has been given to the possibility that there may be variability in the manner in which individuals respond to the death of a loved one.

Within this more recent time span, there have been numerous attempts to achieve theoretical and conceptual clarity regarding the symptomatology, process, and duration of grief. Kübler-Ross (1969) described the process of bereavement in terms of stages of grief. Worden (1982) criticized this conceptualization, arguing that stages of grief may be taken too literally so that symptom deviation from this model runs the risk of being viewed as dysfunctional, when in fact the symptoms may be very adaptive. Worden contends further that the stages of grief as presented by Kübler-Ross (1969), Doyle (1980), and others imply passivity, thereby adding to feelings of helplessness and loss of control. To support his contentions, Worden developed the "Tasks of Mourning" as a way of empowering the mourner to take an active role in grief recovery.

Other researchers, such as Zisook and Devaul (1984), have developed psychometric measures of grief that include acute mourning and unresolved grief as separate but highly related concepts. These theoretical and conceptual ambiguities impede empirical development in the study of bereavement, as well as limiting the delivery of services to grieving individuals. In addition, representatives of special populations are espe-

cially impaired as uncertainty prevails regarding what responses can be expected and what factors influence the extent of the reaction.

These theoretical debates among traditional grief theorists are further complicated by the lack of conceptual clarity regarding the distinction between normal and pathological grieving in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association, 1994), which fails to take into account variables such as the mode of death. Historically, our understanding of grief has been seen as a reflection of the times, encompassing societal expectations and standards, community practices, and the normative factors relating to and causing death. With the industrialization of society, the variables contributing to how individuals die have changed, and thus, so has the process of grief. Today, with the increase in violent crime, advances in technology, and the transformation of values and standards, we see an increase in murder, drunk driving fatalities, community disasters, and the type of illnesses (e.g., AIDS) that threaten human life.

Just as the manner in which humans live and die has changed, so must our conceptualization of "normal" mourning behavior change as well. To apply traditional models of grief across all populations, irrespective of the manner of dying, is injudicious and limits the clinician's ability to appropriately assess and intervene. Though many theorists have noted the significance of the mode of death variable in determining grief outcomes, evaluation of this variable has historically been done in anecdotal form, and there is little empirical literature proposing typologies of grief based upon the nature of the death.

While it is the contention of this book that the mode of death is a significant and often overlooked variable in the conceptualization of grief, one cannot lose sight of the valuable contribution made by the traditional conceptualizations and operationalizations of bereavement and its elements. Therefore, this book will explore the development and specifications of traditional models of grief to underline the importance of what is known about the process of grief, considering variables such as relationship, age, and personal characteristics of the mourner, as well as providing a framework of symptomatology specific to nontraumatizing, nonstigmatizing deaths for the purposes of comparative and theoretical specification. It is proposed that what is known about the grief response following the death of a spouse, a child, or an aged parent has valuable implications for grief model development considering other modes of death such as murder, drunk driving, AIDS, critical incidents, and suicide, though these conceptualizations are insufficient in explaining or predicting outcomes with these other types of grief.

The book is organized into three sections. The first provides an over-

view of traditional models of grief. Sections II and III cover suggested typologies of grief specific to the mode of death for traumatized and stigmatized grief processes, respectively. Treatment implications for each of these three sections are presented as an outgrowth of this study. The treatment chapter in Section I provides a general summation of treatment strategies and considerations, as a resource to the therapist as well as a point of comparison for future discussions on intervention. The treatment approaches in Sections II and III are largely based upon the personal experience of the authors as well as on contributions from the literature.

It is hoped this book can be used as a clinician's resource for understanding and treating the many dimensions of grief experienced in society today. By further development and expansion of the current body of knowledge concerning the way individuals grieve, it is the authors' desire to point clinicians and researchers in the direction of intervention and policy development that may attenuate the negative effects of death and dying among the many misunderstood survivor-victims and "secret survivors" currently suffering in isolation.

I

DEATH BY NATURAL CAUSES

1

A Theoretical Overview of Traditional Models of Grief

The discussion of death is one of the most avoided topics of conversation in society. Despite a flood of material that has been produced concerning death and dying and the resulting effects on the survivors, there is still considerable ambiguity regarding the factors that impact the nature, course, and duration of the grief process.

The majority of the literature on the bereavement process concerns the psychophysiological reactions of the mourners following a death from natural causes, illness, or accidents. Traditionally, the process of grief has been understood relative to attributes such as: (a) relationship of the bereaved to the deceased; (b) age of the deceased; and (c) personal characteristics of the survivors. Historically, grief theorists have appeared to recognize the mode of death as an important consideration in the conceptualization of bereavement. However, their examination of the mode of death variable has been preliminary, at best. This book proposes that the mode of death is a significant but often overlooked dimension in the determination of grief responses. In addition, it explores the considerable variation relevant to the specific characteristics of the loss. The purpose of this exploration is twofold: (a) to explain the importance of the abovementioned variables on the nature and course of subsequent bereavement, and (b) to provide a framework of symptomatology espoused by traditional models of grief for the purposes of comparison with traumatic and stigmatized models of grief and to further delineate the specific theoretical tenets.

To adequately understand the impact of death on the survivors and the affective, behavioral, cognitive, and physiological manifestations associated with the death, the meaning of attachment must be explored.

Bowlby's (1973) attachment theory provides a conceptual framework for understanding this phenomenon. An individual's need for security precipitates the formation of strong emotional bonds and is indicative of the basic human tendency to survive. Bowlby's thesis that security and safety are primary motivators for the development of attachments is supported by the observation of similar behaviors in animals. In his writings, Bowlby describes young children and young animals who during the development process periodically leave their primary attachment figure to explore their environment, always returning for support and reassurance. The disappearance of the attachment figure induces intense anxiety and distress. Bowlby (1973) goes on to state:

> If it is the goal of attachment behavior to maintain an affectional bond, situations that endanger this bond give rise to certain very specific reactions. The greater the potential for loss, the more intense these reactions and the more varied. In such circumstances, all the most powerful forms of attachment behavior are activated—clinging, crying, and perhaps angry cohesion . . . when these actions are successful, the bond is restored. If the danger is not removed, withdrawal, apathy, and despair will then ensue. (p. 42)

Lorenz (1963) describes this grief-like response in the separation of the greylag goose from its mate in the following example:

> The first response to the disappearance of the partner consists of anxious attempts to find him again. The goose moves about restlessly by day and night, flying great distances and visiting places were the partner might be found, uttering all the time the penetrating trisyllabic long distance call. . . . The searching expeditions are extended farther and farther . . . and quite often the searcher itself gets lost. (p. 40)

All of the objective, observable characteristics of the anxiety manifestations in the separated child and in the greylag goose roughly parallel the human bereavement process. Bowlby (1973) suggests that there are significant biological forces that influence the response to separation and are expressed in an automatic, instinctive way with aggressive behavior. The responses of animals to separation demonstrate that biological processes may influence the loss of attachment response in humans, yet there are features of this response that are unique to humans. These reactions are conceptualized as the bereavement process.

DEFINING THE NOMENCLATURE

An essential element in understanding the various dimensions of the bereavement paradigm explored in the following chapters is an accordance of interpretation of the terminology used to describe the concepts.

The term *bereavement* is a model used to explain the emotional state that results from the loss of a loved one. The expression of suffering is defined within a cultural context and is influenced by a number of variables, which will be explored throughout this book.

Grief is an associated concept that generally refers to the emotional components of the bereavement process. The essence of the grief response is often multidimensional, reflecting not only the loss of a loved one, but also the loss of identity and purpose.

Mourning is the behavioral component of bereavement and is most influenced by sociocultural influence and expectation.

The *process of grief* is understood in terms of a progression through a series of tasks or stages. Ochberg (1988) describes these tasks as:

> the expression of affect, the understanding of the meaning of the lost person or object, the elucidation of ambivalence in the relationship, and the eventual freedom to attach trust and love to new significant others and, in appropriate ways, to new replacement objects. (p. 10)

Engle's (1961) thesis parallels the death of a loved one with the experience of being severely wounded or burned. He states that the grieving process represents the loss of well-being and requires a psychological healing similar to the physiological healing necessary to recover from a physical trauma. Engle believed the terms *healthy* and *pathological* or *abnormal* applied to various courses grief may take in the psychophysiological process. This approach is similar to the tenets of developmental theory, which claim that there are certain developmental tasks that must be completed as a child grows. If the child fails to complete a task on a certain level, adaptation is impaired when the child is trying to complete tasks at a higher level. Engle (1961) applies this theory to the grieving process when he postulates that the failure to complete grief tasks or stages can impair future growth, development, adaptation, and resolution.

Uncomplicated grief has been conceptualized by Zisook and Devaul (1984) as "a painful, but self-limited reaction to loss which more or less follows an overlapping sequence of phases with a brief period of shock

and denial, merging into a phase of dysphoria and ending in a sense of resolution" (p. 169). DSM-IV states:

> The bereaved individual typically regards the depressed mood as "normal," although he or she may seek professional help for relief of such associated symptoms as insomnia or anorexia. A diagnosis of major depressive disorder is generally not given unless the symptoms are still present two months after the loss. Certain symptoms are not characteristic of "normal" grief reaction: (1) guilt about things other than actions taken or not taken by the survivor at the time of death; (2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; (3) morbid preoccupation with worthlessness; (4) marked psychomotor retardation; (5) prolonged and marked functional impairment; and (6) hallucinatory experiences other than that he or she hears the voice of and transiently sees the image of the deceased (pp. 684–685).

Although there are factors other than the mode of death that are predictive of complicated versus uncomplicated grief, normative grief processes tend to be less complicated than traumatic or stigmatized bereavement episodes.

STAGES OF GRIEF

Kübler-Ross (1969), Doyle (1980), and Westberg (1971) have identified phases or stages of normal grief to explain the process of grief and to provide clinicians with a framework for identifying problems. It should be noted that a bereaved person may experience more than one stage at a time and does not necessarily experience symptomatology in the order presented here. Many of the stages outlined by these authors have commonalities. For purposes of this book, the following stages of grief will be offered as a comprehensive representation of the "stage models" of grief.

STAGE ONE: Attempts to Limit Awareness: Shock, Denial, and Isolation

Shock and denial protect the mourner from experiencing the total extent of the reality all at once. Denial is usually a temporary defense, eventually replaced with at least partial acceptance that a death has

occurred. Accompanying the denial and shock is social isolation as the mourner may engage in self-protective actions to ward off others who may trigger overwhelming emotional states.

Historically, the grief process was facilitated by supporting family members and friends, religious rituals, social traditions, and customs. Today, the bereaved person must often face the struggle with grief alone. Neighbors often do not know what to say and choose to avoid the mourner. Families may be separated geographically and may be present only for the funeral.

The isolation and withdrawal of social resources can be linked to the urbanization of society that has caused the destruction of many traditional communities and rituals associated with death and dying. In the absence of some of these supporting structures, some individuals may not effectively deal with the tasks of grieving. Therefore, adequate social resources are important to facilitate appropriate passage of the mourner from one stage of grief to another. Shock and denial are considered healthy responses after a death by natural causes as long as these reactions do not extend for more than a few days (Doyle, 1980; Kübler-Ross, 1969; Westberg, 1971). Gardiner and Pritchard (1977) cited six extreme examples that illustrate prolonged and extreme forms of denial. The individuals involved in their study exhibited manifestly psychotic, eccentric, and reclusive behavior (e. g., keeping the body of the deceased in the house for a number of days prior to notifying anyone of the death) in an attempt to deny the loss.

STAGE TWO: Awareness and Emotional Release

As the shock and denial begin to diminish, the mourner may experience the second stage of grief—emotional release. As the individual affectively acknowledges the death, feelings of anger, guilt, and resentment, along with physiological symptoms of distress, become evident. Anger generally results from the frustration over the loss of control or the inability to change the situation. Anger can be expressed toward medical personnel, the self, the deceased, or other family members.

Guilt is often a common theme at this point. The closer the bereaved's relationship with the deceased, the greater the possibility for feelings of guilt to surface. Family members may assume culpability for the death and may feel their actions may have in some way caused the death or failed to prevent it. Guilt is most evident in the responses of parents after the death of a child. Society's orientation to children is one of supporting them and helping them grow to their full potential. Parents have been entrusted with the task of providing life and protecting chil-

dren from harm. Latour (1983) postulates that parents can be extremely angry and guilt-ridden, perceiving the death as personal failure. Role theory can be utilized to explain this phenomenon. Davis (1986) states that "social identity is the sense of ourselves that we derive from the positions we occupy and the adequacy with which we and significant others judge our role in society" (p. 546). This theory implies that our sense of self-identity is damaged by a perceived failure to adequately fulfill the role expectation dictated by society.

Kübler-Ross (1969) describes the concept of bargaining, which often occurs at this time in response to the overwhelming feelings of anger and guilt. Bargaining is usually witnessed in the early phases of the grief response when the mourner has not come to terms with the finality of the death. The mourner may attempt to make a deal with God by promising change in beliefs or behavior if the death can be reversed.

The emotional responses experienced during this phase of the grieving process are necessary for healthy adaptation to the loss (Zisook & Devaul, 1984). Often, there are gender differences that impact the affective acknowledgment of the death. Rando (1984) states that society tends to discourage emotional responses, especially in men, though it is a normal and essential part of grieving for most individuals. Withholding emotional responses can be unhealthy and lead to abnormal grief reactions. Davidson (1979) cites many cases of physical symptomatology in bereaved individuals that could not be traced to organic etiology. He concludes that individuals who do not allow themselves to grieve may develop medical symptoms and a deterioration of physical health. He theorizes that pain can be a symbol for suppressed grief.

The most common symptoms of physical distress are appetite and sleep disturbances, headaches, nausea, and gastrointestinal difficulties. Anxiety disorder symptomatology may be present due to feelings of panic associated with overwhelming affect, leading mourners to believe they are going crazy. This panic state may be induced by the psychological disorientation and disorganization of the grief response, or the fear that the emotions or their intensity is abnormal.

STAGE THREE: Depression

Depression ensues when denial of the loss can no longer be maintained and attempts at bargaining have failed. Depression manifests when the mourner views the situation as hopeless. Discomfort at the affective acknowledgment of anger may cause grieving individuals to internalize the angry feelings, due to a need to regulate their affect and/or an absence of coping skills to deal with the anger and guilt. Depression

after a loss is a normal reaction, though a prolonged reaction (over two months) suggests a complication by a Major Depressive Episode in the DSM-IV (APA, 1994). However, what constitutes a prolonged duration is not clearly defined.

Wolfelt (1988) provides possible distinctions between depressive grief and other forms of depression. In a normative grief response, the individual is responsive to offerings of support and comfort, whereas depressives may be unwilling to accept support. The bereaved individual is openly angry and can relate symptoms of depression to a specific aspect of the loss (i.e., the inability to say goodbye) as opposed to the depressed individual who does not overtly display anger but is irritable and expresses generalized depression symptomatology. In normal grief, individuals are able at some point to experience moments of happiness, whereas a depressed individual is not.

There is also a distinction in the affective presentation of the individual: grieving individuals present as acutely sad and empty, whereas depressives project an ongoing sense of hopelessness and helplessness and display a chronic emptiness. There are also differences in the chronicity of physical symptoms of distress.

STAGE FOUR: Acceptance and Resolution

In the final stage the individual "comes to terms with reality." There is a reinvestment in social activities, and the individual is able to talk about the loss and remember the deceased without experiencing severe emotional upheaval. The mourner begins to feel hopeful for the future and becomes involved in new activities and relationships.

CRITICISMS OF THE STAGE MODELS OF GRIEF

The "stage models" of grief have been challenged by researchers who believe that the models may not address individual idiosyncrasies and other variables that may impact passage through the stages of grief. From a methodological standpoint, there are obvious limitations. The research on these stage models has relied on clinical observation of small, nonrepresentative samples (Bowman, 1980; Burgess, 1975; Doyle, 1980; Poussaint, 1984). Generally, comparison groups have not been included.

Although there is general agreement regarding the symptomatology of grief reactions across the models of grief espoused, the conceptualization of the process has been called into question. Worden (1982) criticized the stage models of grief, stating that individuals do not always progress

through the grieving process in an orderly fashion and may experience more than one stage at a time. He argues that clinicians and clients may take the "stages of grief" too literally and may inappropriately judge deviations from this model of grieving as dysfunctional.

The Tasks of Mourning

Worden (1982) addresses this issue by developing the "tasks of mourning," thereby supplementing previous descriptions of the grief process with specific mourning behavior. He believes that the stages of grief imply passivity, something that the individual must endure helplessly. Tasks, on the other hand, are more congruent with the concept of grief work by implying that the grieving individual has power over progression through the grieving process. They also imply that the grieving process can be influenced by intervention, thus providing hope to the mourner. This model has the most implication for intervention and does not vary greatly in its description of the symptomatology of grief.

Duration of the Grief Response

Another criticism of the stage models of grief is that they fail to provide a temporal framework for understanding the duration of the grief response (Silver & Wortman, 1980). Indeed, there have been conflicting data regarding the length of time necessary to successfully complete the process of grief. Davidson's (1979) survey of individuals who had *not* experienced the death of a significant other found that the majority of these respondents expected the grief response to be completed within two weeks. Bornstein and Clayton (1972) conducted multiple interviews between one and 13 months with 109 widows and widowers following the death of their spouse and concluded that only 17% of their sample were definitely or probably experiencing symptoms of grief at the final interview, and most were better within four to six months of the loss. Parkes and Weiss (1983) refute these findings, based on their longitudinal study of bereaved individuals who were interviewed two to four months following the loss. Over 40% of the sample were rated by trained interviewers as showing moderate to severe anxiety at that time.

The lack of empirical definity regarding the duration of the grief response is most likely based on the number of endogenous variables (i.e., personality) influencing the individual's response to loss. Factors such as the relationship between the bereaved and the deceased, the abruptness of the death, the mode of death, cultural influences, and other external factors must be explored further.

THE ANTICIPATORY GRIEF FACTOR

Certain types of death provide for the mourners a pre-death grief process, which may impact the nature, course, and duration of the bereavement process. Death of the elderly and deaths due to terminal illness may include an anticipatory or forewarning period in which the survivors may begin the process of grief prior to the loss of life. This phenomenon was first observed by Lindemann (1944) when he noticed the absence of overt symptoms of grief in survivors who reported to have experienced many of the stages of grief prior to the death of their loved ones. The "anticipatory grief" process has been examined by many researchers (Aldrich, 1963; Kübler-Ross, 1969) since Lindemann's observation in 1944. Although it is clinically important for practitioners who work with patients and families prior to an anticipated death to have a good understanding of the anticipatory grief process, empirical evidence of the impact of this process on post-death bereavement is equivocal in nature. Exactly how this anticipatory phase impacts the course of bereavement will be examined in the following chapters.

CONCLUSION

This section has focused on describing the most traditional understanding of the bereavement process, based upon Bowlby's theory of attachment and loss. It provides a framework of symptomatology that focuses on variables such as the relationship of the bereaved to the deceased, the age of the deceased, and personal characteristics of the survivors. Essential to successful completion of this task is the exploration of how these models were developed and their significance to current perceptions of normal mourning behavior. Specifically, the grief response following the death of an elderly person versus the grief response following the death of a child will be discussed in the following two chapters. It is hoped the foregoing review of traditional models of grief will serve as a point of comparison for the subsequent analysis of grief relative to the mode of death.