Grief

A suffering, a distress, a wretchedness, a pain, a burden, a wound. These were among the meanings associated with the word grief in its premodern French origin. The term also referred to wrongs and injuries that have been inflicted upon an individual by others, thereby providing the related word grievance. There are still other associations: greeffe, grefe, and gravis—all denoting a heaviness that weighs one down toward the earth, the very opposite of levity. People who experience grief today are likely to feel many or all of the emotions that were inherent in the earliest definitions of the term.

Grief experts have also identified other facets of the grief response, such as a yearning for the lost person or state of affairs, a need to think repeatedly about past events, a sense of guilt, or even thoughts of suicide. As Kenneth Doka notes, the grief experience can begin even before the loss occurs; another useful distinction can be made between the immediate response to loss and the grieving that sometimes continues long afterward or which does not come to the surface until some time has passed since the death or other loss.

It is now recognized that grief is more than sorrow and emotional turmoil. Five dimensions are receiving particular attention in the mental health community. First, stress reactions include changes in physiological function that can increase one’s vulnerability to illness and exacerbate preexisting physical problems. Secondly, perception and thought are also affected, with the increased possibility of making impulsive and potentially harmful decisions and becoming more at risk for accidents. Third, a spiritual crisis often occurs, in which the guiding assumptions and values are called into question. Fourth, family and communal response to loss, often neglected in the past, is a significant factor in grief and grief recovery. And lastly, although the pain of loss may be universal, cultural heritage and influences and current support systems have much influence on the way one expresses and copes with stress.
ACUTE

Grief is a type of stress reaction, a highly personal and subjective response to a real, perceived, or anticipated loss. Grief reactions may occur in any loss situation, whether the loss is physical or tangible—such as a death, significant injury, or loss of property—or symbolic and intangible, such as the loss of a dream. The intensity of grief depends on the meaning of that loss to the individual. Loss, however, does not inevitably create grief. Some individuals may be so disassociated from the lost object that they experience little or no grief or their response is characterized by intense denial.

Acute grief is different from bereavement or mourning. Bereavement is an objective state of loss: If one experiences a loss, one is bereaved. Bereavement refers to the fact of loss, while grief is the subjective response to that state of loss. Mourning has two interrelated meanings in the scholarly literature on the subject. On one hand, it describes the intrapsychic process whereby a grieving individual gradually adapts to the loss, a process that has also been referred to as "grieving" or "grief work." Grief can also denote a social process, the norms, behavior patterns, and rituals through which an individual is recognized as bereaved and socially expresses grief; for example, wearing black, sending flowers, and attending funerals. Acute grief has also been described as the initial, intense reactions to a loss, differentiating it from later, less intense expressions of grief. Such a distinction, given the discussion that follows, is not made here.

Paradigms on the Origin of Acute Grief

Acute grief was first described by Eric Lindemann, a psychiatrist who studied survivors of the 1942 Cocoanut Grove fire, a blaze that swept through a Boston nightclub, killing 492 people. Lindemann described grief as a syndrome that was "remarkably uniform" and included a common range of physical symptoms such as tightness of throat, shortness of breath, and other pain, along with a range of emotional responses (1944, p.145). Lindemann's research was based on a sample of primarily young survivors of sudden and traumatic loss.

This medical model of grief was continued most clearly in the work of George Engel. In 1961 Engel asked if grief was a disease. He believed it could be described as one having a clear onset in a circumstance of loss, a predictable course that includes an initial state of shock; a developing awareness of loss characterized by physical, affective, cognitive, psychological, and behavioral symptoms; and a prolonged period of gradual recovery that might be complicated by other variables. Engel notes that other disease processes also are influenced by psychological and social variables. Even the fact that grief is universal and does not often require treatment, Engel argues, is not unlike other diseases. Engel also notes that whether or not a disease requires medical treatment or is, in fact, recognized as a disease is a social definition. Epilepsy, alcoholism, and many forms of mental illness are now recognized as diseases but were not at other times in human history or in other cultures.

Another paradigm that attempts to offer insight to the nature of acute grief is the psychological trauma model. This model, based on the work of Sigmund Freud, views grief as a response to the psychological trauma brought on by the loss of a love object. According to this view, acute grief is a normal defense against the trauma of loss. To Freud, grief is a crisis, but one that will likely abate over time and that does not usually require psychiatric intervention.

Perhaps one of the more influential theories of grief is the attachment model developed by John Bowlby. This approach emphasizes that attachment or bonding is a functional survival mechanism, a needed instinct, found in many of the social...
animals. Given humans' prolonged periods of infancy and dependency, attachment is necessary for the survival of the species. When the object of that attachment is missing, certain behaviors are instinctual responses to that loss. These behaviors, including crying, clinging, and searching, were seen by Bowlby as biologically based responses that seek to restore the lost bond and maintain the detachment. When these bonds are permanently severed, as in death, these behaviors continue until the bond is divested of emotional meaning and significance. A secondary purpose of these behaviors is that by expressing distress, they engage the care, support, and protection of the larger social unit. This psychobiological model sees grief as a natural, instinctual response to a loss that continues until the bond is restored or the grieving person sheds the bond. These early approaches continue to influence understandings of acute grief, though more contemporary models emphasize that grief is a natural response to major transitions in life and that bonds between the grieving individual and the lost object continue, albeit in different forms, after the loss. In addition, approaches of the 1990s emphasize that a significant loss may shatter assumptions, causing grieving individuals to reconstruct their sense of self, spirituality, and relationship to others and the world. While this may be a painful process, it also may be a catalyst for growth.

**Manifestations of Acute Grief**

Individuals can experience acute grief in varied ways. Physical reactions are common. These include a range of physical responses such as headaches, other aches and pains, tightness, dizziness, exhaustion, menstrual irregularities, sexual impotence, breathlessness, tremors and shakes, and oversensitivity to noise.

Bereaved individuals, particularly widows, do have a higher rate of mortality in the first year of loss. The reasons for this may include the stress of bereavement, the change in lifestyle that accompanies a loss, and the fact that many chronic diseases have lifestyle factors that can be shared by both partners; hence both partners share similar stress and patterns making them prone to similar diseases. It is important that a physician monitor any physical responses to loss.

There are affective manifestations of grief as well. Individuals may experience a range of emotions such as anger, guilt, helplessness, sadness, shock, numbing, yearning, jealousy, and self-blame. Some bereaved experience a sense of relief or even a feeling of emancipation. This, however, can be followed by a sense of guilt. As in any emotional crisis, even contradictory feelings, such as sadness and relief, can occur simultaneously.

There can be cognitive manifestations of grief, including a sense of depersonalization in which nothing seems real, a sense of disbelief and confusion, or an inability to concentrate or focus. Bereaved individuals can be preoccupied with images or memories of the loss. These cognitive manifestations of acute grief can affect functioning at work, school, or home. Many persons also report experiences where they dream of the deceased or sense the person's presence.

Grief has spiritual manifestations as well. Individuals may struggle to find meaning and to reestablish a sense of identity and order in their world. They may be angry at God or struggle with their faith.

Behavioral manifestations of grief can also vary. These behavioral manifestations can include crying, withdrawal, avoiding or seeking reminders of the loss, searching, hyperactivity, and changes in relationships with others.

The reactions of persons to loss are highly individual and influenced by several factors, including the unique meaning of the loss, the strength and nature of the attachment, the circumstances surrounding the loss (such as the presence of other crises), reactions and experiences of earlier loss, the temperament and adaptive abilities of the individual, the presence and support of family and other informal and formal support systems, cultural and spiritual beliefs and practices, and general health and lifestyle practices of the grieving individuals.

**The Course of Acute Grief**

There have been a number of approaches to understanding the process or course of acute grief. Earlier approaches tended to see grief as proceeding in stages or phases. Researcher and theorist Colin Murray Parkes, for example, described four stages of grief: shock, angry pining, depression and despair, and detachment. Recent approaches have emphasized that grief does not follow a predictable and linear course, stressing instead that it often proceeds like a roller coaster, full of ups and downs. Some of these more intense periods are predictable, such as holidays, anniversaries, or other significant days; other times may have no recognizable trigger.

Approaches during the 1990s have emphasized that acute grief involves a series of tasks or processes. Psychologist William Worden describes four tasks pertaining to grief: recognizing the reality of the loss, dealing with expressed and latent feelings,
living in a world without the deceased, and relocating the deceased in one's life. Psychologist Therese A. Rando suggests that grieving individuals need to complete six "R" processes: recognize the loss, react to the separation, recollect and re-experience the deceased and the relationship, relinquish the old attachments to the deceased and the old world, readjust to the new world without forgetting the old, and reinvest. (While the language of both Worden and Rando is specific to death-related loss, their models can be adapted to other losses as well.) These and other similar models reaffirm the very individual nature of grief, acknowledging that these tasks or processes are not necessarily linear and that any given individual may have difficulty with one or more of the processes or tasks.

It is worth emphasizing that the course of acute grief is not linear. Nor is there any inherent timetable to grief. Acute grief reactions can persist for considerable time, gradually abating after the first few years. Research emphasizes that one does not simply "get over the loss." Rather, over time the pain lessens and grief becomes less disabling as individuals function at levels comparable to (and sometimes better than) pre-loss levels. Nevertheless, bonds and attachments to the lost object continue, and periods of intense grief can occur years after the loss. For example, the birth of a grandchild can trigger an experience of grief in a widow who wished to share this event with her deceased spouse.

**Help and Acute Grief**

Persons experiencing acute grief can help themselves in a number of ways. Since grief is a form of stress, the griever can benefit from various forms of stress management, especially adequate sleep and diet. Bibliotherapy (the use of self-help books) can often validate or normalize grief reactions, suggest methods of adaptation, and offer hope. Self-help and support groups can offer similar assistance as well as social support from others who have experienced loss and respite. Others may benefit from counselors, particularly if their health suffers or their grief becomes highly disabling, impairing functioning at work, school, or home, or if they harbor destructive thoughts toward themselves or others. Parkes particularly stresses the value of grief counseling when other support is not forthcoming. Pharmacological interventions also may be helpful, particularly when the grief is so disabling that it severely compromises the individual's health or ability to function. Such interventions should focus on particular conditions—anxiety or depression—that are triggered or aggravated by the bereavement. Psychotherapy should accompany pharmacological interventions.

Most individuals seem to ameliorate grief; gradually they find themselves able to remember the loss without the intense reactions experienced earlier. Nevertheless, anywhere from 20 to 33 percent seem to experience more complicated grief reactions.

*See also:* Disasters; Freud, Sigmund; Grief Counseling AND Therapy

**Bibliography**


The concept of anticipatory grief was first described by psychiatrist Eric Lindemann at the end of a presentation to the American Psychiatric Association in 1944. Lindemann defined anticipatory grief as a progression through the stages of grief, including "depression, heightened preoccupation with the departed, a review of all the forms of death which might befall him, and anticipation of the modes of readjustment which might be necessitated by it" (Lindemann 1944, p. 148). He cautioned that there are advantages and disadvantages to anticipatory grieving, with the disadvantages including the possibility that the griever might pull away from the dying person prematurely (a circumstance referred to as decathexis).

In the era of advanced medical technology, the phenomenon of anticipatory grief is particularly important. The experience of terminal illness has changed, and there is frequently an extended period between diagnosis and death. Because of medical advances, dying has become more of a gradual process; debilitation is extended and quality of life has been improved. There is a longer time during which families and the patient can experience anticipatory grief.

In a more current definition, psychologist Therese A. Rando defined anticipatory grief as "the phenomenon encompassing the processes of mourning, coping, interaction, planning, and psychosocial reorganization that are stimulated and begin in part in response to the awareness of the impending loss of a loved one" (Rando 1986, p. 24). According to Rebecca Ponder and Elizabeth Pomeroy, however, "persistent debate remains about whether anticipatory grief results in shorter and easier periods of grief when the actual death occurs or ... may have adverse effects" (Ponder and Pomeroy 1996, p. 4). Some argue that post-death grief may be intensified by anticipatory grieving as loved ones witness the debilitating aspects of the illness; in some cases, there may be the tendency toward premature detachment and abandonment of the patient as death approaches. Others find that anticipatory grief facilitates the leave-taking process as loved ones have time to complete the "unfinished business" of life and detach in a more orderly manner; in the presence of death, many people are able to rise above the past and make the amendments necessary for a peaceful dying. Despite these contradictory beliefs, the concept initially suggested by Lindemann has endured.

Rando expanded the initial concept of anticipatory grief in several significant ways. She viewed it as a multidimensional concept defined across two perspectives, three time foci, and three classes of influencing variables. In Rando's conceptualization, anticipatory grief is not confined to the experience of the caregiver or family alone: The dying patient also experiences this form of grief. In addition, she considered anticipatory grief to be a misnomer suggesting that one is grieving solely for anticipated losses. Rando asserted that there are three foci of losses that occur as part of the anticipated grief: past losses in terms of lost opportunities and past experiences that will not be repeated; present losses in terms of the progressive deterioration of the terminally ill person, the uncertainty, and the loss of control; and future losses that will ensue as a consequence of the death, such as economic uncertainty, loneliness, altered lifestyle, and the day-to-day moments in life that will no longer occur because of death. Variables influencing anticipatory grief, according to Rando, include psychological factors—the nature and meaning of the loss experienced; social factors—those dimensions within the family and socioeconomic characteristics that allow for certain comforts and discomforts during the illness period; and physiological factors—the griever's energy and overall health.

In addition, Rando disagreed with Lindemann regarding the eventuality of a major decathexis from the dying person. She not only did not see it as an automatic response but also redefined the pulling away in terms of decathexis from the hopes, dreams, and expectations of a long-term future with and for that person, not from the person. Rando contended that "the future can be grieved without relinquishing the present!" (Rando 1986, p. 13).

**Phases of Anticipatory Grief**

In a 1983 book called *The Anatomy of Bereavement*, Beverly Raphael discussed phases of anticipatory grief for both the dying person and those close to the person that parallel actual bereavement. Building on the work of Elisabeth Kübler-Ross, Raphael noted that for both the patient and caregiver(s) the first response to news of a fatal condition is shock, numbness, disbelief, and denial. In time, the news is faced, distressed feelings can no longer be fended off, and a period of fear, anxiety, and helplessness ensues. Bargaining and the anguish raised by the question "Why me?" mark this phase. Hope may fend off some of the anguish, but as the loss is acknowledged, the process of anticipatory grief may become pronounced. Anger, regret, resentment, a sense of failure, a feeling of being cheated, guilt, and depression are common responses. Some reach the calm and acceptance described by Kübler-Ross. The dying person may withdraw as the family/caregivers struggle with the opposing pulls to remain close to the dying person and to relinquish the bond to the person to mitigate the pain of the impending loss.
Both Raphael and Rando contended that anticipatory grief is a process—an experience that takes time to unfold and develop. During the process, the work is to slowly dispel the denial and to develop an awareness of what is happening. In this way, the griever(s) can begin to experience optimum amounts of anticipatory grief to reach a level of benefit.

For a terminal illness, researchers have repeatedly raised the question of whether there is an optimum length of time before the positive effects of anticipatory grief diminish. Rando, in a 1983 study, and C. M. Sanders, in a 1982 study, both found that there was an optimum length of time for anticipatory grief as it affected the survivor’s postdeath adjustment: six to eighteen months.

### The Impact of Special Situations

In several situations, the benefits and disadvantages of anticipatory grief can be questioned. One such situation is that of children facing the death of a parent. Given the child’s developmental level and the profound nature of the loss, the limited ability of children to understand death and its finality, and the reality that the dying parent is unable to attend to the needs of the child, the benefits of anticipatory grieving may be mitigated. In a 1999 study of parentally bereaved children conducted by Amy Saldinger and her colleagues, anticipated death was consistently associated with less adaptive outcomes and poorer mental health outcomes, using a variety of measures. According to Vanderlyn Pine and Carolyn Bauer, for parents who anticipate the loss of a child, “there is no way to know just how much anticipatory grief is too much. It does not appear that there is an optimum amount” (Pine and Bauer 1986, p. 86–87).

For those struggling with the varied losses imposed by Alzheimer’s disease, there is a differential benefit to anticipatory grieving, depending on the duration of the illness. In a 1994 article for the *Journal of Gerontological Social Work*, Rebecca Walker and her colleagues attributed this to a combination of variables: the social stigma related to the disease as an illness of the aged, and the loss of cognitive ability and self-sufficiency; the progressive nature of the disease and the associated incapacitation; the multiple losses that the care-giver has to face; and the eventuality that the care-giver may have to relinquish care of the patient to others. From their 1996 study, Ponder and Pomeroy reported that for those dealing with patients with dementia and Alzheimer’s disease, the benefits of anticipatory grief were limited, noting that this group of individuals is at high risk for complicated mourning.

Anticipatory grief in relation to AIDS is another area that shows differential benefit for the griever. Several variables, similar to those related to Alzheimer’s disease and dementia, are operative for those with HIV/AIDS. The duration of the illness and the stigmatization that accompanies it are prominent factors. The course of HIV/AIDS often extends beyond the eighteen months designated as a beneficial length of time for anticipatory grief for the caregiver. In addition the multiple losses and the alternating periods of relative good health and battles with opportunistic diseases potentially abort the process of anticipatory grief. As a further complicating factor in the anticipatory grief trajectory is the relationship between the caregiver and the patient, a relationship that may not be sanctioned by society (i.e., homosexual relationships). In his 1989 book, Kenneth J. Doka used the term “disenfranchised loss” to describe a loss that is not recognized or validated by others. For those caring for the AIDS patient, completing some of the tasks of anticipatory grieving may be compromised by the lack of an official, socially sanctioned connection to the dying patient.

For practitioners working with patients and caregivers, the challenge is to combine the various elements of anticipatory grief. Practitioners must recognize that anticipatory grieving does not necessarily involve a pulling away from the patient; that there are multiple losses that span a period of time; that the process of anticipatory grieving goes through stages; and that it is a time of working on and working through the “unfinished business” for both patient and caregiver. Practitioners must be attuned to the tendency for premature detachment and diminishing communication between patient and caregiver and encourage discussion of fear, loss, and anger. Ideally, according to Walker and her colleagues, a practitioner “can help the caregiver both hold on to hope while letting go of the patient, thereby completing the very complicated work of anticipatory grief” (Walker et al. 1996, p. 55).

### Bibliography


JOAN BEDER

**CHILD'S DEATH**

The death of a child, regardless of age, is one of the worst possible losses adults can experience. Grief over a child's death is particularly severe compared to the loss of a spouse, parent, or sibling. The parent-child bond is uniquely strong and enduring. Children are extensions of parents; they hold parents' dreams, aspirations, and hopes for the future and promise the continuity of parents' life after their death. They define parents' sense of self and give meaning and a sense of purpose to their lives.

When a child dies, parents feel mortally wounded; it is as though part of them is torn away by force. The family also loses its wholeness. A child's death is perceived as untimely at any age because parents are "supposed to" die before children. Moreover, miscarriage, stillbirth, and death in childhood and adolescence are often sudden and unexpected and in some cases violent, which traumatizes survivors.

The question of "why" haunts parents as they review the event to make sense of the death. Their sense of failure in protecting their child from harm evokes guilt feelings and diminishes their self-esteem. Out of their despair and urgent desire to be with the deceased child and to end their relentless pain, parents may entertain the thought of death. Parents' grief is not only their personal, intra-psychic experience but an interpersonal process. A child's death affects all family members including extended members as well as others outside the family and their relationships and, in turn, others' responses to parents' plight affect parents.

**Effects on Parents and the Spousal Relationship**

A child's death can have a serious impact on parents and the spousal relationship. If a child is a victim of a serious illness, parents' anguish starts long before the child's death. Parents experience enormous stress emotionally, physically, and financially. They are confronted with conflicting demands between their work and the care of the ill child in addition to meeting the daily needs of well siblings. Typically, mothers assume the major responsibility of caring for the ill child while fathers fulfill their duties as providers, some holding two or three jobs to meet financial obligations. It is not uncommon that the relationship between husband and wife becomes strained. A mother's increased involvement with a sick child, often at the hospital, and a father's inability to accompany his wife and take an active part in the ill child's care may lead to the father feeling frustrated, excluded, and isolated. Physical exhaustion and emotional strain may affect a couple's sex life. As children become critically ill, fathers tend to withdraw and become unavailable to their families because of their inability to cope with the emotional ordeal, which angers their wives. Increased outbursts of anger and arguments often become part of family life. Strains in relationships that developed while children were ill may not easily be lessened after children die.
A review of research indicates that, regardless of the cause of death, a substantial number of marital relationships become strained after children die. The marital strain appears attributable to differences in couples' grief and ways of coping, which result primarily from differences in gender roles and personality and the singular relationship each parent has had with the deceased child. Soon after the child's death, parents' grief is so intense that they tend to withdraw into their own private world and minimally relate to others. They hesitate to talk to their spouses about the loss for fear of stirring up their spouses' emotions. In general, mothers express grief more openly and show more intense reactions to their child's death than do fathers. Husbands tend to feel responsible for helping other family members, particularly their wives, cope with their grief while controlling their own, but feel helpless not knowing how to comfort their grief-stricken wives, who are incapacitated in their usual roles as wives and parents. Husbands' behavior, however, comes into conflict with their wives' desire for emotional sharing. Wives feel angry over what they perceive to be their husbands' unwillingness to share their grief, which they may see as an act of abandonment, compounding their sense of loss. It may take some time before wives realize that their spouses' behavior is their way of coping with their pain of grief.

Anger and rage, which are common in bereavement, are often displaced onto the nearest target: a person's spouse. Spouses are generally irritable toward each other over trivial matters and matters concerning the deceased child. Loss of sexual intimacy is common, and it may take even a year or two to restore a sexual relationship. Serious strain in marital relationships can lead to separation and divorce, especially if couples had marital problems prior to their child's death. In the majority of cases, however, the marital bond is strong enough to withstand this major ordeal and may even be strengthened.

Parents who are single as a result of divorce or the death of their spouses and unmarried parents are spared the kinds of problems that confront marital partners, but they grieve while carrying a myriad of responsibilities and demands placed on them without partners with whom to share the burden. If they lost their only child they are left alone without companionship and feel they are no longer needed. Their support system plays a particularly important role in coping with their experience of loss.

When adults who are responsible for managing and maintaining the household and promoting the welfare of the family are overwhelmed by their grief, unable to function adequately in their usual roles, and experiencing relational conflicts, their family naturally experiences varying degrees of disorganization and disequilibrium. Surviving children are a source of comfort, but their presence does not mitigate parents' distress. For the initial few weeks after the child's death, relatives, friends, and neighbors may offer not only emotional support but assistance with household chores and child care. When they leave to return to their own routines, parents are left alone to face the new reality of having to live with the void left by the deceased child. Much of the time parents feel like they are in a daze and later do not remember how they managed to get through those early days of bereavement.

Parents cope with their grief one day at a time with frequent setbacks. Coping involves a combination of action and cognitive activity for relieving stress and mastering stressful situations. There is no one right way to grieve or to cope. Parents usually adopt a combination of strategies. Seeking release of tension is a necessity for most parents, given the enormous emotional turmoil the loss engenders. Emotional tension, if kept inside, does not disappear and may surface in ways that are destructive to individuals and their relationships. Parents, especially mothers, may relieve their tension through talking about their loss and crying. Other strategies to which parents turn to relieve tension include engaging in physical activities, keeping themselves busy, and expressing their grief in writing, art, and other creative activities. Many find relief in having something definite to do,
which prevents them from becoming totally consumed by their grief and mired in depression. In general, coping strategies that direct parents' attention away from their tragedy appear essential and helpful during the initial weeks or months of acute grief. Total avoidance in facing the reality of loss and its pain, however, can complicate the grieving process. Parents also seek an understanding and validation of their experience through reading books about loss and learning about the experience of others in similar predicaments, which helps them diminish their sense of isolation and gain a perspective on their own experience.

Even though some parents may initially express anger toward God who they feel has betrayed them, for many, religious faith serves as a major source of comfort and strength and appears to lessen the intensity of grief. A number of parents participate in support groups, seek professional help, and/or make frequent visits to the cemetery in order to cope. Some parents become connected with other bereaved parents through the Internet. Parents' dominant coping strategies change in the course of their bereavement. Many parents transform their tragedy into something positive and find new meaning in life through their work, including work that changes the condition that contributed to their child's death, volunteer work to help others in need, and the establishment of scholarship funds in their child's name. Some parents whose child died due to murder or the negligence of others have transcended their tragedy through their courageous and generous acts of forgiveness.

**Effects on Siblings**

When a sibling is terminally ill, other children "live in houses of chronic sorrow" with "the signs of sorrow, illness, and death" everywhere, writes the researcher Myra Bluebond-Langner, who studied terminally ill children and their well siblings extensively (Bluebond-Langner 1995, p. 123). The signs are visible on parents' faces as well as the face of the ill child. The amount of parental attention well siblings receive diminishes; however, seeing the toll the illness takes on their parents, children try to be supportive toward them. Parents' relationship with each other is strained. Parents are irritable and their tempers are short and unpredictable. Family plans change frequently. Children can no longer engage in normal activities, such as having their friends over to play. Their relationships with the ill sibling also change. Mutual give-and-take no longer exists. Well siblings try to get close to the dying sibling, but their efforts are often rebuffed. Instead, children not only help care for the sick sibling but parent their grieving parents, and yet they are not always kept abreast of the ill sibling's condition. Often they feel alone, confused, ambivalent, and neglected, but cannot express their feelings to distressed parents. After their sibling dies, many of the same conditions continue in the family for a period of time.

When children lose a sibling, they cope with their own grief and many consequent changes at home over which they have little control. Parents' diminished ability to function in their usual roles means the loss of a normal family life and many deprivations for children. Death in the family usually brings support for parents, but children's grief and need for support are often overlooked, increasing their sense of isolation and neglect. When children are young, parents tend to assume that their children are too young to be affected by the family tragedy and fail to talk to them about the circumstances of their sibling's death or provide them with opportunities to ask questions. There is, however, ample clinical evidence to indicate that even very young children are affected by the death. When children are not well informed, they resort to their imagination, distort reality, and experience an unnecessary sense of culpability over the death, resulting in a variety of developmental problems.

Furthermore, children face changes in relationships with their parents and hierarchical order among siblings with new parental expectations thrust upon them. Because of the centrality of the deceased sibling in the family during illness and after death, it may appear to surviving children that the deceased child is more important to parents than they are, making them feel insignificant. However, out of their loyalty and concern for distressed parents, children often become protective toward them, hiding their emotional and even physical pain so as not to burden their parents. They often become vigilant over parents' comings and goings. At the same time, parents, who fear that a similar tragedy may strike them again, become overprotective toward their surviving children. Parental overprotectiveness may be seen in their reluctance to discipline children or to allow children to engage in normal growth experiences. In some cases, parents' unresolved grief and desire to keep deceased children alive may result in using surviving children or children born after the death as replacement children, who are expected to take over the identities of the deceased, denying them their own unique identities.

**The Process of Healing**

The impact of a child's death is pervasive and profound. The family and its members are irrevocably changed. Grandparents grieve for their grandchild whose life ended prematurely as well as their own loss, but often their grief is more focused on their adult child who has suffered a devastating loss. Other extended family members, friends, neighbors, co-workers, and sometimes even strangers are touched by the death directly or indirectly. Too frequently, what others say and do out of their own discomfort or lack of understanding about parental grief hurts and angers bereaved parents, creating a chasm between
them and the bereaved, and thus diminishing the support networks to which the bereaved normally turn. On the other hand, those who stand by them and offer support and assistance while their child is ill and in their mourning are gratefully remembered by the bereaved.

The process of mourning is agonizingly long. It may be many months before parents restore their sense of equilibrium and become actively involved in daily life. Parents’ willingness to openly share their grief with one another strengthens their relationship, and their ability to provide a secure and supportive environment for children facilitates the process of healing in the family. A child’s death compels family members to reexamine their assumptions about the world, renew or question their spiritual or religious beliefs, and search for meaning in life. Realizing the fragility of life, survivors may develop a deeper appreciation of life and change their life priorities. Moreover, they discover inner strengths and resources they never knew they had.

A bond between deceased children and surviving family members continues for the rest of their lives. So does the pain of loss, which parents feel acutely from time to time throughout their lives as special days approach; when something, perhaps a song, triggers thoughts of deceased children; and as deceased children miss each of the developmental milestones that they would have reached had they lived. As Robert Kastenbaum states, parents may not wish to relinquish their grief, for the pain is part of the precious memory that keeps a connection with the deceased. After a long and difficult journey, most parents learn to live with their pain of grief and move forward, finding once again some pleasure in life and hope for the future.

See also: Grief Counseling AND Therapy; Replacement Children

Bibliography


DISENFRANCHISED

The professor and writer Kenneth J. Doka introduced the concept of disenfranchised grief in his 1989 book, *Disenfranchised Grief: Recognizing Hidden Sorrow*. Doka defined disenfranchised grief as "grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, socially sanctioned or publicly mourned" (p. 4).

The concept of disenfranchisement integrates psychological, biological, and sociological perspectives on grief and loss. Previous research has emphasized the variety of reactions in the grieving experience. While an individual may have an intense and multifaceted reaction to loss, that loss and the attendant responses may be unacknowledged by family, friends, or the surrounding society. Although the individual grieves, others might not acknowledge his or her right to do so. Such persons are not offered the "rights" or the "grieving role" such as a claim to social sympathy and support, or such compensations as time off from work or diminution of social responsibilities.

In order to understand the social aspect of grief, it is important to remember that every society has norms that govern not only behavior but also affect and cognition. Every society has norms that frame grieving. These norms include expected behavior, in addition to feeling, thinking, and spiritual rules. Thus, when a loss occurs, these grieving rules include how one is to behave and how one is to feel and think. They govern what losses one grieves for, how one grieves for them, and how and to whom others respond with sympathy and support. These norms exist not only as folkways, or informally expected behavior, but also as "laws." More formal statements of these grieving rules can be illustrated by company policies that extend bereavement leave to certain individuals, or regulations and laws that define who has control of the deceased body or funeral rituals.

In the United States and many other societies, these grieving rules limit grief to the deaths of family members. When a family member dies, one is allowed and expected to grieve, often in a specified way. Yet human beings exist in intimate networks that include both relatives and friends. They harbor attachment to fellow humans, animals, and even places and things. Persons experience a wide range of losses—deaths, separations, divorces, and other changes or transitions. When death or any other separation severs these attachments, the individual grieves for such loss in many ways, many of which might clash with the culture's norms for grief. The person then experiences a loss, but others do not recognize his or her grief. That person has no socially accorded right to grieve that loss or to mourn it in that particular way. The psychologist Jeffrey Kauffman suggests that individuals internalize these grieving rules. Thus there can be an intrapsychic or self-disenfranchisement of grief whereby individuals believe that their grief is inappropriate, leading to feelings of guilt or shame.

The Disenfranchisement of Grief

There are a number of reasons that grief can be disenfranchised. In most Western societies, the family is the primary unit of social organization. Hence kin ties have clear acknowledgement in norms and laws. While most individuals actually live their lives in intimate networks or associations that include both kin and non-kin, only kin have legal standing in making funeral arrangements and are accorded recognition as "mourner."

Another principle of Western societies is rationality, which means that beyond the family, organizations such as businesses are expected to be organized along fair, functional, and rational lines. Grieving roles reflect such social norms. Extending grieving roles to non-death situations or to non-kin would create organizational burdens. Organizations would be forced to define "levels of friendship" or "types of loss." They might be required to broaden the concept of bereavement leave, at considerable cost. Acknowledging only the death of kin conforms to rationalist organizational imperatives. It recognizes the grief of kin when a family member dies. By limiting the acknowledgement of loss to family members, it avoids confusion and potential abuse,
Typologies of Disenfranchised Grief

What losses are disenfranchised? In *Disenfranchised Grief* Doka suggested three broad categories of loss and implied a fourth. These categories were developed inductively and clinically; certain types of cases suggested a series of broad categories.

*The relationship is not recognized.* Grief may be disenfranchised in those situations in which the relationship between the bereaved and deceased is based on recognizable kin ties. Here, the closeness of other non-kin relationships may simply not be understood or appreciated. The roles of lovers, friends, neighbors, foster parents, colleagues, inlaws, stepparents and stepchildren, caregivers, counselors, coworkers, and roommates (e.g., in nursing homes) may be close and long-standing, but even though these relationships are recognized, mourners may not have full opportunity to publicly grieve a loss. At most, they might be expected to support and assist family members.

Then there are relationships that may not be publicly recognized or socially sanctioned. For example, nontraditional relationships such as extramarital affairs, cohabitation, and homosexual relationships have tenuous public acceptance and limited legal standing, and they face negative sanction within the larger community.

*The loss is not acknowledged.* In other cases, the loss is not socially defined as significant. Individuals experience many losses—some death-related, such as perinatal loss, or other non-death-related losses such as divorce, incarceration, the loss of a job or material possessions, or significant change in personality or temperament that may be unacknowledged by others. Some losses may be intangible. For example, a teenager aspiring to a career in sports is cut from a team, or parents discover that a beloved child suffers from a disability or grave disease. Similarly, the loss of reputation because of scandal, gossip, or arrest can be devastating. Even transitions in life can have undercurrents of loss. Aging, for example, leads to constant developmental losses such as the loss of childhood or other losses associated with different points of life.

*The griever is excluded.* There are situations in which the characteristics of the bereaved in effect disenfranchise their grief. Here, the person is not socially defined as capable of grief, therefore, there is little or no social recognition of his or her sense of loss or need to mourn. Despite evidence to the contrary, both the old and the very young are typically perceived by others as having little comprehension of or reaction to the death of a significant other. Similarly, mentally disabled persons may also be disenfranchised in grief.

*Circumstances of the death.* The nature of the death may constrain the solicitation of the bereaved for support and limit the support extended by others. For example, many survivors of a suicide loss often feel a sense of stigma, believing that others may negatively judge the family because of the suicide. Similarly, the stigma of AIDS may lead survivors of an AIDS-related loss to be circumspect in sharing the loss with others.

*The ways an individual grieves.* The way in which an individual grieves also can contribute to disenfranchisement. Certain cultural modes of expressing grief such as stoicism or wailing may fall beyond the grieving rules of a given society, and thus contribute to disenfranchisement.

These examples and categories are not exhaustive, nor are they mutually exclusive. An individual's grief may be disenfranchised for a number of these reasons. And, of course, this particular taxonomy is attuned chiefly to contemporary Western culture.
Charles Corr offered another way to categorize disenfranchised grief. Corr approaches classification deductively, asking, "What is disenfranchised in grief?" He concludes that the state of bereavement, the experience of grief, and the process of mourning can all be disenfranchised.

The Special Problems of Disenfranchised Grief

Although each of the types of grief mentioned might create particular difficulties and different reactions, one can legitimately speak of the special problems shared by all disenfranchised grievers. The problem of disenfranchised grief can be expressed in a paradox. The very nature of disenfranchised grief creates additional problems for grief, while removing or minimizing sources of support.

Disenfranchising grief may aggravate the problem of bereavement in several ways. First, the situations mentioned tend to intensify emotional reactions. Many emotions are associated with normal grief. These emotional reactions can be complicated when grief is disenfranchised. Second, both ambivalent relationships and concurrent crises have been identified in the literature as conditions that complicate grief. These conditions can often exist in many types of disenfranchised grief.

Although grief is complicated, many of the factors that facilitate mourning are not present when grief is disenfranchised. In death-related losses, the bereaved may be excluded from an active role in caring for the dying. Funeral rituals, normally helpful in resolving grief, may not help here. In some cases the bereaved may be excluded from attending, while in other cases they may have no role in planning those rituals or even in deciding whether to have them. Or in cases of divorce, separation, or psychosocial death (a significant change in another individual or relationship), rituals may be lacking altogether. In addition, the very nature of the disenfranchised grief precludes social support. Often there is not a recognized role in which mourners can assert the right to mourn and thus receive such support. Grief may have to remain private.

The Treatment of Disenfranchised Grief

Disenfranchised grief is treated by counselors as any form of grief. The psychologists Robert Neimeyer and John Jordan suggest that the key to treating disenfranchised grief lies in analyzing what they call "empathic failure," the factors that limit support and thus generate disenfranchisement. Once the cause of empathic failure is analyzed, therapists can devise interventions that develop or compensate for the lack of support. These interventions can include individual or group counseling, support groups, expressive therapies, or the therapeutic use of ritual.

See also: Grief AND Mourning IN Cross-Cultural Perspective ; Grief Counseling AND Therapy ; Mourning

Bibliography


KENNETH J. DOKA

FAMILY

Grief is a natural reaction to loss and a deeply personal experience. Its experience and intensity vary among individuals due to a variety of factors including who the deceased person was, the nature of the relationship with the deceased, the circumstances of death, and concurrent stress. The process of working through grief over a significant loss takes much more
time than the public generally assumes. Often it takes many years to reach satisfactory resolution of the loss. Resolution, however, does not mean that an individual puts the experience of loss behind; it means that he or she has learned to live with the grief and is able to move on with life even though life has been irrevocably changed and the enduring sense of loss will remain. While the experience of grief is unique to each individual, grief is also an interpersonal process. People live in intricate networks of inter-dependent relationships inside and outside the family. Dying, death, and bereavement occur in this context. Individuals' distress over a loss is an inter-play of their response to the loss, others' reactions, current and intergenerational family history of loss, and relational changes accompanying the loss. Therefore, grief can best be understood within the context of the family and its social environment.

The family is a social system in which members are interdependent and interact with one another in organized, predictable, and repetitive patterns. It is not a collection of individuals in isolation, but consists of individuals and their relationships. Because of interdependence among members, one member's behavior or whatever happens to one member affects the entire family. The family makes continuous adjustments in response to internal and external demands and tries to maintain its equilibrium. The family, like individuals, develops over time. While every family experiences stresses as it moves through different phases of development, events that occur out of sync with normative development, such as the premature death of a member, disrupt the process and produce added stress.

Families may be conceptualized along three dimensions: cohesion, flexibility, and communication. Cohesion, emotional bonding among members, ranges from disengaged (very low) to enmeshed (very high), a moderate level of cohesion being optimal under normal circumstances. Moderately cohesive families are those with members who are able to be both independent from, and connected to, their families. In disengaged families, members are emotionally distant and unable to rely on one another for support or problem solving while in enmeshed families members are excessively close, demanding loyalty and lacking personal separateness. Flexibility refers to the family's ability to change structurally and functionally, its levels ranging from rigid (very low) to chaotic (very high). Moderately flexible families are able to make changes effectively while rigid and chaotic families lack an ability to change when necessary.

Central to family functioning is communication, verbal as well as nonverbal, by which members relate to one another. How members communicate is a good measure of the health of the family. Communication facilitates the family in making adjustments on the dimensions of cohesion and flexibility in order to maintain levels suitable to the situational demands and developmental needs of members and the family as a whole. Good communication is characterized by attentive and empathic listening, speaking for self, and an open expression of feelings about self and relationships.

In general, families with moderate levels of cohesion and flexibility supported by good communication make for optimal family functioning. Those families are able to cope more effectively with a family crisis. Too much or too little cohesion or flexibility tends to be dysfunctional. There is some research evidence to indicate that cohesive families deal with grief more effectively than those families characterized by conflict, low cohesiveness, low expressiveness, and poor organization.

When a family member has a serious illness, both the ill member and others in the family face the enormous challenge of living with the uncertainty of chronic illness from initial crisis through the terminal phase. They cope with an emotional roller coaster as they live with the uncertain trajectory of illness, the demands of illness and caregiving, exhaustion, financial burdens, and thoughts of their final separation. Family members lose their "normal" life and must learn to live with ambiguities over a long period of time, well members sometimes vacillating between a desire to be close to the ill member and a desire to escape from the unbearable situation.

An impending death is likely to intensify existing relational patterns in the family. When members communicate openly, they can share grief, set priorities, provide mutual support, resolve unfinished business, including old hurts, and grow closer together through their struggle. All members, regardless of age, can benefit from being part of this process. When communication is lacking, denial and avoidance create distance between the dying and the rest of the family as well as among well members, each feeling alone and isolated with issues unresolved when death occurs. Sudden death is likely to complicate survivors' grief, but death after a prolonged illness is also followed by difficult bereavement. Some of the factors that affect survivors' grief include: witnessing disfigurement and suffering of the ill member; ambivalence felt over the ill member's disease-related personality change; stresses of caregiving; and guilt over relief experienced after death.

The death of a family member disrupts individual and family equilibrium. It engenders emotional upheaval, often brings into question individual belief systems, interrupts the developmental process of individuals and the family, and changes the family and individual identity. It alters the family structure and relational patterns. Members try to restore a sense of equilibrium both in
The death of a member who performed a number of task-oriented roles can restrict members' ongoing development and compromises and flexible families may show some degree of change in residence may present adjustment difficulties if survivors are ill equipped to assume those roles. On the other hand, if the deceased member was dysfunctional and held a nonfunctional role to function in their usual roles as parents and/or spouses diminishes, which further affects the family structure and increases distress. Moreover, relational conflicts and past unresolved issues that have been dormant may resurface under the stress and complicate family relationships. The tasks of adapting to the new reality, integrating the experience of the death into ongoing life, and moving forward developmentally are achieved through two overlapping and interrelated processes, family mourning and family reorganization. How these two processes are handled depends on the level of family functioning prior to the death as well as family resources.

The Process of Mourning

The finality of death touches the core of human vulnerability. Adults are confronted by their own and children’s grief and daily demands of family life. For weeks, while they cope with their intense pain of grief and try to survive and restabilize the family, a discussion of the deceased may be kept to a minimum. Reacting to one another's attempt to manage intense grief, members frequently collaborate to protect severely distressed members, with spouses protecting their partners and children protecting their parents. In the case of a child's death, differences between spouses in their experience of grief and coping strategies often invite misunderstanding, leading to marital conflict and increased family difficulties. While adults are in distress, children must cope not only with their own grief over the death of their parent or sibling but the psychological absence of their surviving parent(s) who cannot adequately attend to their needs.

As adults gradually regain their equilibrium, members of a family whose functioning was optimal before the death are likely to restore communication and reestablish neglected relationships. Participating in rituals appropriate to the family's cultural tradition and mourning their loss in a supportive and cohesive family environment will not only promote the healthy resolution of grief but facilitate the reorganization of the family. Obstacles that block the mourning process vary, including unresolved losses in the current family or family of origin, disengaged or conflicted family relationships, unresolved conflict with the deceased, a desire to hide the nature of death which the bereaved deem undesirable, such as death due to suicide or AIDS (acquired immunodeficiency syndrome), and idealization of the deceased disallowing members to freely talk about the deceased. Excessive use of alcohol or other substances to numb the pain of grief also interferes with communication and jeopardizes health and family relationships. A desire to avoid what is painful is a natural human inclination; paradoxically, healing comes through facing the challenge of giving the pain of grief the time and space that it requires. Even though there is no one way to cope with a major loss suitable for all, avoiding, inhibiting, or prohibiting talking about what everyone has in mind as though nothing has occurred hampers the mourning process. When members are deprived of opportunities to openly communicate and explore their own and the family's loss, the loss is compounded, resulting in a sense of isolation.

Through the process of mourning, the emotional center of the family gradually shifts from the deceased to the survivors and their future even though the deceased will continue to be psychologically present and serve as a source of support for members' ongoing development. Family members will establish their new sense of identity as widows, widowers, bereaved parents, fatherless or motherless children, children who have lost a sibling, and so forth. The change in identity also means a status change in social networks, requiring adjustments. When mourning is bypassed, the deceased individual remains as a "ghost" in the family, interfering with children's development as well as adults' developmental tasks, such as marriage, remarriage, or parenting, and places family members at risk for a host of physical and psychosocial problems. Those problems may not become evident until years later and may appear totally unrelated to the experience of loss.

The Process of Reorganization

A member's death changes the family's hierarchical structure, leaving a void and requiring not only an adjustment in relationships but an assumption of new roles and a reallocation of roles by surviving members. New employment and/or a change in residence may become necessary for some families. Emotional upheaval may precipitate some others to make drastic changes in their lives soon after the death, such as selling a home and/or business and moving to a new neighborhood. Decisions made under duress, however, may be regretted later on. Waiting a year or two, when possible, before making major decisions helps avoid additional disruption in the family. Under the stress of bereavement, even normally moderately cohesive and flexible families may show some degree of enmeshment and rigidity, which, if continued for an extended period of time, can restrict members' ongoing development and compromises children's development toward increased independence and separation from the family.

The death of a member who performed a number of task-oriented roles presents adjustment difficulties if survivors are ill equipped to assume those roles. On the other hand, if the deceased member was dysfunctional and held a nonfunctional role
in the family, adjustment may be minimally stressful. Rigid families with limited communication tend to allocate roles according to age and sex-role stereotypes with little negotiation. In flexible families roles are assigned through negotiation and based on member interest and competency. The death of children who played expressive roles leaves enormous psychic pain but does not necessitate task reassignment. Expressive roles, however, are also vital to maintaining family stability and cannot be left vacant for a long time. An empty space created by a child's death may exacerbate family problems that the child's presence kept at a distance. The death of a child who served to hold the parents' marriage together, for instance, can threaten the marital bond in bereavement. Sometimes a parent's continued attachment to the deceased child makes the parent inaccessible to others and poses problems in reorganization. Some parents start volunteer work or a project in memory of their child, which not only fills the void but brings new meaning to their lives.

Children who lost a parent or a sibling also confront changes in relationships with their parents as well as their siblings. With the death of a parent, older children may assume new roles to fulfill those roles formerly performed by the deceased or to support a depressed parent. Danger lies in children not only helping with household responsibilities or care of young siblings but assuming adult roles inappropriate to their age. Clear delineation of children's roles and responsibilities helps to prevent children from compromising their own normal development and possibly creating conflicts with siblings.

Family Resources

Families and their members differ in economic, personal, and social resources available to them in the process of family mourning and reorganization. Reduced socio-economic status due to death or a family's low material resources can negatively affect adjustment in bereavement. On the other hand, personal resources including such individual characteristics as viewing life as a series of challenges and having pride, motivation, and a sense of control over life, help members make a better adjustment in bereavement.

Social support is a critical resource in coping with bereavement. The presence of others (kin, friends, neighbors, employers, coworkers, and even strangers in the community) who offer emotional and material support helps bereaved family members validate and mourn their immense loss and meet their daily needs when their ability to support themselves is seriously impaired. Those who are part of a cohesive cultural or religious group are likely to receive considerable support from others in the group. The types and amount of support the family needs differ depending on the family and the loss suffered, and family and individual needs change with time. Families isolated with minimal contact with others in the community and possessing limited resources are at risk for complications in bereavement. Families lacking social support due to stigma attached to their loved one's death as well as those whose needs are not adequately met through their usual sources of support may seek or augment support from outside the family. When the family faces serious difficulties in coping with the loss, assistance from professionals may be in order. Support groups designed to provide mutual support for those in a similar predicament are also found to be valuable sources of help for both bereaved children and adults. Often the most helpful emotional support comes from those who have experienced a similar loss.

Rebuilding

The process of integrating the experience of loss and rebuilding the family without the deceased is a gradual one, which can take months or years, depending on the circumstances. Adults who attend to their own grief and receive support from the extended family and community resources for reconstructing family life are in a better position to help children grieve and promote their healthy development. The effects of a member's death differ for each survivor and so do the ways of coping and the length of time it takes for members to resolve their grief and move on. The family mourning process, however, is a shared experience. Understanding and accepting the diversity in the family through mutual sharing facilitate the healing process. New rituals may be created for cultural and religious celebrations and for special occasions, such as birthdays and anniversaries, to mourn and commemorate the deceased member and affirm the bond to the deceased in the ongoing family life. Troubling images associated with the death may continue to intrude into consciousness from time to time. The loss with its painful emotional and practical implications is revisited and grieved anew many times as the family and each member's life unfolds developmentally. Through embracing the past and reaffirming the continuity of life, members once again engage in life with hope for the future.

See also: Communication WITH THE Dying; Dying, Process OF; Good Death, THE; Grief Counseling AND Therapy; Mourning

Bibliography
GENDER

It has been suggested that because of different socialization experiences, or perhaps even biological differences, men and women exhibit distinct patterns in the way they experience, express, and adapt to grief. In much popular commentary it is further suggested that the male role inhibits grieving because it places emphasis on the regulation of emotional expression and constrains the seeking of support from others. Women, on the other hand, are seen as more ready to accept help and express emotions, both of which are seen as facilitating grief. Louis LeGrand, for example, stated in 1986 that this gender difference "does not mean that men are not grieving; it does indicate that they may not accomplish the task as successfully as women" (LeGrand 1986, p. 31). Allen Wolfelt, in a 1990 article in Thanatos, stated his belief that men's grief is naturally more complicated because men cannot express emotion or seek help. Carol Staudacher in her book Men and Grief succinctly stated.
this bias toward emotive expressiveness: "Simply put, there is only one way to grieve. That way is to go through the core of grief. Only by expressing the emotional effects of your loved one's death is it possible for you to eventually resolve the loss" (Staudacher 1991, p. 3). Yet the idea that men grieve poorly is clearly disputed by the research in the field of thanatology (the study of death).

Research Perspectives

Researchers have studied both therapists’ attitudes toward gender differences as well as the grief patterns and outcomes of men and women. The results have been mixed.

Therapists’ views. In 1997 Judith Stillion and Eugene McDowell reported the results of their study of certified grief counselors’ and grief therapists’ perspectives on gender differences in grief. The researchers found that the people in their sample did believe that men and women express grief differently. Men were perceived as less likely to express strong emotions and more likely to use diversions such as work, play, sex, or alcohol. Therapists reported that men were more likely to respond cognitively and to use anger as a primary mode of emotional expression. Women were seen as more likely to express grief affectively (emotionally) and to seek support.

The counselors in the sample also found differences in the expectations of others and the support men and women received from others. Others expected men to get over their loss more quickly and be able to function more effectively. Women were seen as needing and receiving more emotional support, but others also saw them as being more of a social risk—that is, being likely to break down in normal social situations. The result was that these therapists reported that their women clients received more comfort-oriented support but fewer opportunities for normal social activity than their male counterparts.

Despite these differences in the expression of grief, and the support men and women were likely to receive, the counselors surveyed did not report differences in outcomes. In fact these therapists saw different risks for each gender. In their view, men were more at risk for certain types of complicated grief reactions, whereas women were more prone to depression or chronic mourning.

Gender-based studies of grief. The perspective of these therapists, explicitly or implicitly, is grounded in much of the research that does show a difference in the ways men and women grieve. In summarizing this research in 1999, Terry Martin and Kenneth J. Doka noted the following:

1. Research has shown that widows and widowers face different problems in grief. For example, many widows reported financial distress and noted the emotional support that had been provided by their spouse. Widowers were more likely to report disruptions of their familial and social networks. Widows were more likely to seek emotional support, whereas widowers found solace in exercise, work, religion, creative expression, or more destructively in alcohol.
2. Many of these same results are evident in the loss of a child. Mothers reported more emotional distress than fathers. Strategies in dealing with the loss differed by gender. Women tended to use more support-seeking and emotion-focused strategies, whereas men were more likely to intellectualize their grief and use more problem-focused strategies to adapt to the loss.
3. Studies of the loss of a parent also showed that middle-aged sons were less likely than daughters to experience intense grief, had fewer physical manifestations of grief, and were more likely to use cognitive and active approaches in adapting to loss.
4. Differences between genders seem less apparent in older age groups. This may reflect the idea that individuals become more androgynous as they age.
5. Differences in gender are also affected by other variables such as social class, generational differences, and cultural differences.
6. The research on differences in outcome is quite mixed. Some studies have shown men to have better outcomes, others show women to do better, and still other studies show no significant difference or mixed results in outcome (i.e., men do better on some measures, women on other measures).

This research does have implications for counselors. Whether one sees these differences as due to gender or as patterns influenced by gender (see below), it does suggest that different responses to loss can affect relationships within the family as that family experiences a loss. Counselors will do well then to assist individuals in identifying and discussing the ways they deal with loss and in helping families to address how these differences affect each other’s grief.

Beyond Gender: Patterns of Grief
Martin and Doka suggested that one look beyond gender to understand different patterns or styles of grief. Martin and Doka proposed that these patterns are related to gender but not determined by them. They suggested that gender, culture, and initial temperament all interact to produce a dominant pattern of grief. They viewed these patterns of grief as a continuum. Martin and Doka further acknowledged that patterns are likely to change throughout an individual's development, often moving more toward the center of the continuum as an individual moves to late adulthood. Based upon the underlying concept of emotion regulation, Martin and Doka proposed three basic patterns of grief: intuitive, instrumental, and dissonant.

**Intuitive pattern.** Intuitive grievers experience, express, and adapt to grief on a very affective level. Intuitive grievers are likely to report the experience of grief as waves of affect, or feeling. They are likely to strongly express these emotions as they grieve—shouting, crying, or displaying emotion in other ways. Intuitive grievers are also likely to be helped in ways that allow them to ventilate their emotions. Self-help and support groups, counseling, and other expressive opportunities that allow these grievers to ventilate feelings are likely to be helpful.

**Instrumental pattern.** Instrumental grievers are more likely to experience, express, and adapt to grief in more active and cognitive ways. Instrumental grievers will tend to experience grief as thoughts, such as a flooding of memories, or in physical or behavioral manifestations. They are likely to express grief in similar ways—doing something related to the loss, exercising, or talking about the loss. For example, in one case, a man whose daughter died in a car crash found great solace in repairing the fence his daughter had wrecked. "It was," he shared later, "the only part of the accident I could fix" (Martin and Doka 1999). Instrumental grievers are helped by strategies such as bibliotherapy (the use of self-help literature) and other interventions that make use of cognitive and active approaches.

**Dissonant pattern.** Dissonant grievers are those who experience grief in one pattern but who are inhibited from finding compatible ways to express or adapt to grief that are compatible with their experience. For example, a man might experience grief intuitively but feel constrained from expressing or adapting to grief in that way because he perceives it as inimical to his male role. Similarly, a woman might also experience grief in a more intuitive way but believe she has to repress that feeling in order to protect her family. Counseling with dissonant grievers involves helping to identify their inherent pattern, recognizing the barriers to effective expression and adaptation, and developing suitable intervention techniques.

**(Where men and women are found on this continuum.** Martin and Doka suggested that many men, at least in Western culture, are likely to be found on the instrumental end of this continuum whereas women are more likely to be found on the intuitive end. The researchers stressed, however, that while gender does influence the pattern of grief, that pattern is not determined by gender. Martin and Doka also noted that many individuals in the center of the continuum may show more blended patterns, using a range of emotional, behavioral, and cognitive strategies to adapt to loss.

**Culture and Gender**

It is critical to remember that any discussion of gender differences in grief, or even of patterns of grief that are influenced by gender, must take into account cultural differences. Culture influences grief in a number of ways. First, each culture has norms that govern the ways in which grief is appropriately expressed. In some cultures these norms can differ between genders. In a 1976 study, Paul Rosenblatt and his associates found that in the sixty societies they surveyed, thirty-two had no differences in the expectation of crying between men and women. In the remaining twenty-eight, women were allowed more emotional expressiveness. Second, each culture defines relationships in different ways, which influences the level of attachment. These relationship definitions may also differ by gender.

*See also:* Gender Discrimination After Death; Grief Counseling AND Therapy; Suicide Influences AND Factors: Gender

**Bibliography**


SUICIDE

The death of a loved one is almost always followed by a period of mourning and bereavement accompanied by many different feelings, including loss, grief, shock, denial, despair, depression, anxiety, helplessness, hopelessness, guilt, shame, relief, and anger. Physical symptoms are also common, among them fatigue, sleep and appetite disturbances, apathy, withdrawal, and agitation. Some scholars have contended that bereavement after a suicide is the most trying of all because of the suicide's presumed emotional suffering and the consequent voluntary decision to die. This factor, with its implication of rejection and desertion, has special impact on some survivors. Moreover, a suicide is often complicated by society's negative reactions toward both the decedent and the family, which make bereavement more difficult.

The variation in scholarly opinion on the nature and difficulties of bereavement reflects different methodological approaches in research in this area, such as the use of appropriate control groups for comparison, variability in kinship comparisons, time elapsed after death, and so on. Mark Cleiren, for example, found more differences between groups compared by kinship, such as parents versus spouses, siblings, or children, than between groups compared by mode of death, such as suicide versus accident, homicide, or natural causes. Nevertheless, many researchers report a greater risk of complicated bereavement after a suicide death than after other kinds of deaths, including less emotional support and more physical illness, depression, and anxiety. Other researchers have concluded that the feelings and reactions of survivors of suicide are really no different from the reactions that ensue from other modes of death and that the differences that do appear are more in intensity than in kind. The psychologist Sheila Clark has described the differences as “both minimal and mythical” and points to the relatively few quantitative differences when outcomes after different modes of death are compared. She argues the importance of dispelling the myth of this difference because she believes that it engenders the expectation of a more difficult bereavement.

The psychologist Albert Cain's early review of the literature, however, found that nearly all of the reports described more severe reactions to suicides, with greater severity of psychopathology and expression of vulnerability. A partial list included reality distortion, massive use of denial, confusion of memory, fantasy and misconception, guilt, a pervasive sense of complicity, rage, a disturbed self-concept, shame and worthlessness, intense frustration of needs, depression and self-destructiveness, incomplete mourning, and a gnawing belief that they might have played some role in precipitating the suicide or that they could have done something more to prevent it.

Survivors of a suicide are typically haunted by the question of “why” and are thus tormented by constant probing, rehearsing last contacts, reviewing all clues, and so on. Depression is probably the most common emotional syndrome of normal bereavement. It becomes pathological when the survivor grows progressively less able to function and continues to sink further into despair, apathy, and emptiness. Trouble in concentrating, inability to think clearly, negative self-preoccupation, and self-reproach may appear. It is important to distinguish between the sadness of normal grief and pathological depression. One helpful distinction is that the psychiatrically depressed person is more likely to be preoccupied with himself than with the loss of the deceased loved one.

The suicide survivor’s feelings of guilt and shame often go unrecognized to the extent that they surface in other emotional guises, such as self-blame, humiliation, failure, and embarrassment. Both guilt and shame refer to individual and social development in relation to oneself and others, and they indicate an awareness of what is deemed virtuous as well as what is deemed criminal and immoral. Shame and guilt have so many elements in common that distinguishing them is often difficult. An important element that helps in the differentiation is the direction of the attention: In shame, the attention is on some defect exposed in the self-image; in guilt, the focus is on the act or behavior and its consequences.

Anger may be more frequent and more intense for survivors of suicide. Many persons find anger difficult to deal with because of social and religious customs that make it unacceptable. The anger is directed in one or all directions—toward decedent, self, and others. The anger may be directed at the deceased because of strong feelings of desertion and abandonment; for his or her not having used or accepted available help, especially from the survivor; for having deprived the survivor of a shared future and forcing the discarding of cherished dreams; and for having left the survivor with a tangle of financial and legal problems. Sometimes the anger is experienced as a violation of trust, a dependency each had invested in the other that leaves the
The anger may appear directed against the health and mental health professions who have failed to prevent the suicide, or it may be directed at their social network if it has withdrawn and offered less support than is ordinarily offered for survivors of a death by accident or natural causes. The anger may be directed at a society that condemns suicide and offers less compassion and understanding because a taboo has been violated. David Lester remarks that official agencies in the community often function in such a way that it continually reminds the survivor that the death was not a natural one and creates "unpleasant experiences the bereaved are ill-equipped to handle." Anger with religion may occur when it fails to comfort or creates logistical problems during burial services. Anger at God may appear for his having "let" the suicide happen. Sometimes the anger may be directed at oneself for not having seen the "obvious" clues that the suicide was imminent or for not having prevented the death even though the signs were clear.

A suicide affects family members both individually and collectively. To the extent that suicide carries a stigma, many react to it with silence, secrecy, and even distortion (i.e., denial that death was a suicide). Kenneth Doka has called such deaths "disenfranchised" because their taboo status has resulted in social sanctions. As a result, there is reluctance to mourn openly or publicly. There may be scapegoating with accusations and blaming by other members of the family, fear of hereditary factors, anger at the medical and mental health professions, troublesome involvement of the police and insurance investigators, and possible intrusions by press and other media.

Bereavement for Children

The question of whether children can mourn depends on the definition of mourning. The ability to grieve develops as the child first comprehends the finality of death; the timing of this realization is a subject of debate among scholars. Some find it present in young infants, while others have concluded that it does not appear until adolescence. According to one researcher, Nancy Webb, young children can experience sadness, longing, detachment, and rage, but it cannot be considered mourning until the child is able to understand the finality of the loss and its significance. She argues that children of ages nine to eleven are just beginning to view the world logically and thus able to comprehend abstractions and hypotheses, with the full flowering of this ability developing during adolescence.

Karen Dunne-Maxim, Edward Dunne, and Marilyn Hauser feel that children react to suicide deaths with feelings very similar to those of adults but with very different behavior. The symptoms have been likened to those characteristic of post-traumatic stress after a disaster, with clinging and whining in small children, regression and collapse of some of the stages of development, and fears and anxieties about usually comfortable situations or people. Older children may become model children, fearful of any activity that might bring censure, possibly because of fears that they in some way have been responsible for the death. Some may try to become a parent to the remaining parent, trying to fill the gap and to assuage his or her grief.

Children, even when young, should be told the truth about the suicide. Experience has shown that the efforts to keep the nature of the death a secret usually fail and that the truth, when revealed, is harder to integrate and to accept. Children and young
adolescents can construct terrifying fantasies, such as unwarranted guilt for personally causing the death. The inevitable discovery increases the confusion if the secret emerges in childhood; if the revelation occurs in adulthood, the usual reaction is anger at the prolonged deception. The parent is most helpful when reassuring the child with words suitable to age and level of understanding, words that "normalize" the child's feelings of guilt, shame, anger, or sadness. If signs of emotional disturbance continue, however (i.e., truancy, fighting, exaggerated grief), intervention by a trained child therapist might be in order.

**Professional Caregivers As Survivors**

Research has shown that therapists whose patients commit suicide often experience the same feelings as family members: shock, numbness, denial, anxiety, shame, grief, guilt, depression, anger, and others. However, there are also feelings that are inherent to the role of therapist: failure, self-doubts about therapy skills, clinical judgment, professional competence, and fear of litigation and professional ostracism. Grief reactions were correlated with the length of time in therapy. The effects of such reactions often led to changes in professional practice, like limiting practice only to patients who were not suicidal, avoiding undertaking treatment of severely depressed patients, hyperalertness to a patient's suicidal ideas and/or self-destructive behavior, hospitalizing very low-risk patients, putting more inpatients on suicidal precaution, and canceling inpatient passes. For the therapist in training there is the additional stress that may stem from pressures of competition within the group, a feeling of being under constant observation and evaluation, and a desire to win approval from the faculty.

Research on clinician-survivors has been sparse, although it is not an isolated or rare event. Morton Kahne estimated that one out of every four psychiatrists will experience a suicide in his or her practice. Subsequent researchers have reported a frequency of patient suicides for therapists in private practice that ranges from 22 percent to 51 percent. Philip Kleespies found that one out of every nine psychology interns had to cope with a patient's suicide attempt. The older the psychiatrist and the greater the years of practice, the less the guilt and loss of self-esteem; for psychologists, there was no relationship between age or years of practice and intensity of reaction.

In-hospital suicide provokes the same feelings and reactions among the staff that have been reported for clinicians in private practice: shock, numbness, denial, guilt, insecurity, and so on. There is the added dimension of the impact on other patients, with anger frequently directed against the staff for not preventing the death and thus causing them to feel less secure and less protected against their impulses. Some showed a marked identification with the deceased and an assumption of inappropriate responsibility for the death.

**Grief Relief**

Grief, mourning, and bereavement are the natural consequences of the death of a loved one. The loss by suicide adds to the problems and difficulties experienced by the survivors in this process. The basic tasks in the relief of the grief that follows include accepting the reality and pain of the loss, adapting to a life in which the deceased is now missing, and relocating the deceased emotionally and moving on with life. The tasks also include detaching the hopes the survivor had of the loved one and developing a new and different relationship with the memories previously held about him or her.

For most survivors medical attention or psychological treatment is not required. Familial, social, and environmental support, along with personal coping mechanisms and passage of time, will bring about recovery. A small percentage of survivors may experience severe reactions that are crippling, persistent, and disruptive for both family and social relationships. When this occurs, professional treatment is in order. A larger percentage of survivors may experience continuing moderate difficulties in adapting to the loss. In such cases, help may be sought through family, friends, special groups (i.e., Compassionate Friends, Widow-to-Widow), peer and professional grief counselors, individual psychotherapy, group therapy, and suicide survivor groups. Individual psychotherapy with a mental health professional would probably include current information on suicide, descriptions of the grief process, efforts to normalize the emotional reactions, discussions of disappointing or irritating social reactions, a determination of the survivor's social network and other sources of support, and an attempt to understand the role of any psychiatric illness that afflicted the decedent. The therapist would especially be alert for any evidence of suicidal thoughts and actions by the survivor or anyone in the family.

A survivor may also find help in group therapy led by a mental health professional. In such groups the process occurs within the context of frank discussion of the emotional problems of each member, with the interaction between the members of the group led by the therapist. Other forms of group treatment have been devised especially for suicide survivors. One is a form of family treatment that consists of sending trained nonprofessional volunteers to a family's home after a suicide to provide counseling and support. Another community provided counseling services by telephone along with visits to the home. In still another
community a mental health professional accompanied the coroner’s deputy so that support could be offered in the initial shock phase of the survivors’ grief. Additional contacts occurred for a period afterward, depending on the needs of the survivors.

Probably the most common method for helping adult survivors of the suicide of a loved one is survivor groups in which all the members are survivors of a suicide. Models may be time-limited or continuous, open-ended or closed; they may be varied or limited in kinship, frequency and length of sessions, fees, and leadership (professional, trained survivor facilitators, or mixtures). The basic objective of the survivors’ group is to provide a compassionate forum for discussion of the suicide, its impact on the survivors’ lives, expression of emotions unique to suicide grief, negative affect, understanding of the grief process, exposure to alternative models of coping, and provision of mutual comfort and support.

Suicide survivor support groups are most often found among the services offered by local suicide prevention centers, crisis service centers, or community health centers. A directory of suicide survivor groups compiled by the American Foundation for Suicide Prevention listed and described 475 groups in the United States. The American Association of Suicidology and the World Health Organization have published manuals on how to initiate and conduct survivor support groups.

See also: Children AND Adolescents’ Understanding OF Death; Grief Counseling AND Therapy; Literature FOR Children; Mourning

Bibliography


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THEORIES

Theories of grief should deepen understanding of the phenomena and the manifestations of grief. A theory of grief should not merely describe but also explain. It should account for the decline in mental and/or physical health that often attends grief. Most importantly, a theory of grief should further the development of therapies to ameliorate or prevent complicated grief reactions.
Contemporary research on grief has grown out of psychoanalytic/attachment theories and stress/trauma theories. The classic psychoanalytic theory of grief focuses on the emotional reaction to loss (this incorporates a broader range of psychological reactions than depression alone), providing explanation of psychological symptoms of grief. By contrast, a tradition of research on the physical health effects of stress in general led to an extension of the application of stress theory to bereavement. This approach views bereavement as a form of stress that can lead to impairment of health.

_Bereavement_ denotes the situation of losing a loved one through death, while _grief_ is the emotional reaction to such a loss and typically involves psychological, physiological, social, and behavioral manifestations of distress. _Grieving_ signifies the attempt to come to terms with loss and adapt to it. _Grief work_ is the cognitive and/or emotional confrontation with loss, incorporating reflections on events surrounding the death. _Complicated grief_ is a deviation from typical grief and grieving, taking cultural factors, the extremity of the particular bereavement event, and the duration of the bereavement into account. Different types of complication have been identified, including an absence of usual symptoms (absent grief), delayed onset of symptoms (delayed grief), or an exaggerated, chronic, more intense, or prolonged emotional experience (chronic grief). There is lack of agreement about how _traumatic bereavement_ should be defined. It is useful to limit definition to those bereavements in which the death occurred in jarring, unnatural circumstances. _Mourning_ is the social expression of grief actions and grief rituals that reflect one's culture and/or social group.

**Psychoanalytic and Attachment Perspectives**

Theories falling within the psychoanalytic/attachment framework owe much to Sigmund Freud's paper "Mourning and Melancholia." This approach has remained influential throughout the twentieth century, most notably in the work of major researchers, including John Bowlby, Eric Lindemann, Colin Parkes, Beverley Raphael, and Selby Jacobs, all of whom have developed their own lines of reasoning. According to psychoanalytic theory, when a significant person dies, the bereaved person faces the struggle to sever the tie and detach the libidinal energy (love) invested in the deceased person. The major cause of pathological grief is ambivalence in the relationship with the deceased, which prevents the normal transference of libido from that person to a new object. The psychological function of grief is to free the individual of the tie to the deceased and allow him or her to achieve a gradual detachment by means of a process of grief work. Since Freud, the notion that one has to work through one's grief has been central in major theoretical formulations and in principles of counseling and therapy. However, it has also met with considerable criticism. Dissatisfaction with the "working through" notion has led to further specification of ideas about adaptive coping in contemporary research and theorizing.

Departing in certain important respects from the psychoanalytic tradition, Bowlby's attachment theory emphasized the biological (evolutionary) rather than the psychological function of grieving. He argued that the biological function of grief was to regain proximity to the attachment figure, separation from which had caused anxiety. The observation of grieflike reactions to separation from attachment figures in primates and humans tends to support Bowlby's thesis that these responses have biological roots. It is indeed plausible that an adverse reaction to separation would increase the survival chances of animals that live in herds because predators tend to attack animals that are separated from their herds. Obviously, regaining proximity is not possible in the case of permanent loss, and such a response is therefore dysfunctional. Bowlby also argued for an active working-through of a loss. Like Freud, Bowlby saw the direct cause of pathological grief in the relationship with the lost person. However, the more distant cause was said to be childhood experiences with attachment figures—whether the child had been securely or insecurely attached to the primary caregiver. Insecure attachment is assumed to result from parental rejection in childhood. These influences were assumed to have a lasting influence on later relationships. Unlike insecure individuals, secure individuals would be expected to display normal or healthy grieving, experiencing and expressing emotions to a moderate degree and being able to provide a coherent, balanced account of their loss-related experiences. Following this line of reasoning, there are effects of attachment orientation on ways of grieving.

The attachment theory has fostered much useful scholarship. John Archer has further examined the origin and adaptive significance of grief, deriving arguments from theoretical principles of modern evolutionary theory. He applied the principles of natural selection, reproductive value, and parental investment to grief, reasoning that these determine the strength of the relationship with the person who has died. This line of research provides predictions about patterns of grief toward different kin and at different ages for parent-offspring and offspring-parent grief.

By contrast, Simon Rubin has probed the relationship with the deceased person, specifically, a deceased child, in his two-track model of bereavement, in which intense preoccupation with the deceased sets the bereavement response in motion. Two tracks refer to related but not identical dimensions of loss: relationship and functioning. Track I describes the biopsychosocial reactions, or how people function in families and how this changes. Track II focuses on transformations in the attachment to the
deceased, suggesting a dynamic mechanism in attachment.

Stress Perspectives

Cognitive-stress and trauma theories have proved most fruitful in investigations of bereavement. Stress theories are applicable to a broad range of life events (i.e., loss of a job, relocation, divorce), while trauma theories pertain more specifically to shocking, out-of-the-ordinary events (i.e., victimization, war, traffic accidents, violent bereavements). A basic assumption is that stressful life events play an important role in causing the various somatic and psychiatric disorders.

Cognitive stress theory, which emerged from the broader field of the psychophysiology of stress, views bereavement as a source of serious stress that can endanger health and well-being. An individual's cognitive appraisal of the event (relating situational demands to available coping resources, like social support) determines the extent to which the bereavement is experienced as challenging or stressful. Cognitive-stress theory thus emphasizes the role of cognitive appraisal in adjustment to loss; it is a variable that is similar, though not identical, to subsequent "meaning-making" conceptualizations. Cognitive-stress theory provides a framework for a fine-grained analysis of the characteristics of the stressor (bereavement) itself, the coping process (styles, strategies such as confrontation versus avoidance and emotion versus problem-focused) and outcomes (well-being and mental and physical illness). It offers a theoretical explanation for the health consequences of bereavement and provides the theoretical basis for the so-called buffering model. According to this model, high levels of social support protect (buffer) the individual from the health risks of stress. Stress research has helped identify physiological mechanisms linking stress to various detriments to the immune, gastrointestinal, and cardiovascular systems.

A number of bereavement-specific stress-coping models have been developed that have (a) led to further specification of cognitive tasks and processes in coming to terms with bereavement, and/or (b) increased the emphasis on the impact of others on individual grief. These types of analysis form much of the basis of contemporary theorizing about bereavement. William Worden's, and Colin Parkes and Robert Weiss's task models were among the first to specify the prerequisites for coping with loss during bereavement. Worden's model represents coping with bereavement as an active, demanding process rather than an event to be passively experienced. He describes four tasks, which include accepting the reality of loss, experiencing the pain of grief, adjusting to an environment without the deceased, and relocating the deceased emotionally. Parkes and Weiss described three somewhat different tasks such as intellectual and emotional acceptance of a loss and forging a new identity.

Other investigators have focused on the way that the loss is appraised (e.g., whether these are guilt feelings or regrets and whether there is dwelling on or avoidance of grieving. Significant theoretical developments have emerged from this work. For example, George Bonanno identified so-called dissociation between psychological and physiological reactions during episodes of disclosing emotions after bereavement. He showed that some persons who did not disclose verbally, thus suggesting denial, showed evidence of grief in high physiological arousal. In the long term, this pattern of dissociation was associated with good adjustment. This appears to contradict the idea that grief work helps and that denial is dysfunctional.

Alicia Cook's and Kevin Oltjenbrun's model of incremental grief examines the impact of others on individual grief. This describes how lack of congruence in grieving among bereaved persons (particularly families) leads to secondary loss, changing the relationship between survivors, and precipitation of further loss (e.g., breakup). Further specification of interpersonal influences on cognitive processing is provided in social construction models. Basic to this approach is the understanding that griefing is a process of meaning reconstruction, which is frequently negotiated between grieving family members and/or becomes established within the cultural context. This type of approach includes Robert Neimeyer's meaning-reconstruction model. According to Neimeyer, meaning reconstruction, which entails an understanding of the significance of the loss, is the central process of grieving, evidenced in six "propositions." Each of these propositions describes a type of cognitive process that affects the way a bereaved person adjusts to loss. For example, one of the propositions focuses on the way in which identities are reconstructed in negotiation with others. This proposition is based on the understanding that individual adjustment is affected by the way that grieving is done within its social context. Tony Walter's new model of grief focuses on the social context in a slightly different manner. Walter explains how biographies about deceased persons are created as the bereaved talk to each other about their loss and negotiate meaning and reality as part of the process of grieving. When a durable biography has been derived, such as when the grieving family members come to agree on the interpretation of the death, then the bereaved can find a place for the deceased, move on, and stop grieving. There are good reasons to argue that these meaning-reconstruction models are complementary to the cognitive-stress approaches. Among the advantages of attempting integration of these perspectives is that combination would force understanding of grief within its personal, social, and cultural context.
Although trauma theories can be considered within a general stress framework, as noted above, they are more specifically directed toward understanding the impact of those events that are especially jarring and horrific. Trauma theory has emerged along three independent lines. Mardi Horowitz has analyzed phenomena in terms of “stress response syndromes”; the work of James Pennebaker has focused on disclosure in trauma management; and Ronnie Janoff-Bulman and Colin Parkes have both developed the conceptualization of “assumptive world views.” Common to these three perspectives is the notion that although the traumatic event itself has passed the person remains affected and still suffers psychologically and, perhaps, physically. The event needs to be assimilated, and/or inner representations accommodated, before the person can function normally again.

According to Horowitz, “Negative stress stems from experience of loss or injury, psychological or material, real or fantasized. If action cannot alter the situation, the inner models or schemata must be revised so that they conform to the new reality” (1979, p. 244). Control processes regulate the working-through process, which is often marked by a battle to fend off the intrusion of disturbing thoughts. Intrusion is the compulsive reexperiencing of feelings and ideas surrounding the event, including sleep and dream disturbance. Avoidance is the counterreaction, often involving amnesia, inability to visualize memories, and evidence of disavowal. Horowitz views the stress-response syndrome as a normal human reaction to traumatic events, one that can balloon into the more severe form of posttraumatic stress disorder.

Pennebaker has explored the role of emotional disclosure and sharing in assuaging the impact of traumatic experiences such as bereavement. The experimental research of Pennebaker and his colleagues showed that health benefits resulted from writing about traumatic events. Although these beneficial effects have been demonstrated for a wide range of traumatic experiences, the evidence is weaker in the case of normal bereavement. Pennebaker suggests that the benefit of written disclosure lies in helping the individual to organize the experience, to clarify his or her psychological state to others, and to translate emotional experience into the medium of language.

Like Pennebaker’s approach, Janoff-Bulman’s is most applicable to traumatic bereavements. She emphasized the role of meaning in recovery, describing the changes in assumptive worldviews that occur following traumas. Fundamental assumptions people hold about themselves and their relationship to the world can be shattered by the death of a loved one. People normally hold the view that they are worthy, that the world is benevolent, and that what happens to them makes sense. With these assumptions shattered, the bereaved person struggles to integrate the experience. The process of achieving this integration involves rebuilding the inner world, re-establishing meaning, adjusting old assumptions, and/or trying to accept new ones.

Parkes’s psychosocial transition model is comparable in many respects to the model of Janoff-Bulman’s because he also argues for a gradual changing of assumptions and one’s internal model of the world. He specifies components in the process of changing assumptions, including preoccupation with thoughts of the lost person, painful dwelling on the loss, and attempts to make sense of it, either by fitting the experience into existing assumptions or by modifying those assumptions.

Stephen Fleming and Paul Robinson have analyzed how the process of meaning-making can go wrong and how it is possible for clinicians to use principles of cognitive behavior therapy for complicated grief. A bereaved person’s distress may be perpetuated in a cognitive-affective loop, in which beliefs (e.g., about the bereaved’s own responsibility for an accident causing the death) play on the emotions, which in turn prevent reconstruction of beliefs. They also cover the issues of attachment to the deceased, traumatic grief complications, and the impact of counterfactual thinking (the generation of imagined alternatives to actual events) on grieving.

**Two Integrative Models**

George Bonanno’s and Stacey Kaltman's four-component model is an example of contemporary attempts to synthesize current research into an integrative model. These investigators describe several components as fundamental in the grieving process and suggest ways in which they may interact during bereavement: (1) context of loss, risk factors such as type of death, gender, and cultural setting; (2) the continuum of subjective meanings associated with loss, appraisals of everyday matters as well as existential meanings; (3) the changing representations of the loss relationship across time, including the persisting bond with the deceased; and (4) the role of coping and emotion-regulation processes that can relief or aggravate the stress of the loss. Emotion-regulation research has provided a theoretical framework to understand how adjustment in bereavement could be enhanced. The general theory suggests how the regulation or even dissociation of negative emotions and enhancement of positive emotions may foster adjustment to bereavement and, likewise, enable identification of spontaneous or automatic processes in grieving.
Margaret Stroebe and Henk Schut have attempted a different type of integration in their dual-process model of coping with bereavement. The dual processes refer to two different types of stressors: those associated with the lost person, so-called loss orientation, and restoration orientation, those associated with the secondary upheavals that are also consequences of bereavement. The focus of attachment theory on the nature of the lost relationship is consistent with loss orientation. Similarly, cognitive stress theory's identification of a range of substressors suggests the need to include the additional tasks of restoration orientation in the model, because these too are associated with distress and anxiety. For example, it may be necessary to acquire new skills (e.g., cooking or dealing with finances) that had been the domain of a deceased spouse. The model suggests that coping with the two types of stressors is a dynamic and fluctuating process, labeled "oscillation," that incorporates confrontation and avoidance of different components at different times, and includes both positive and negative reappraisals. For example, at any one moment a bereaved person may be dealing with new tasks (restoration-oriented) and feeling good about mastering these, only to be interrupted by a piece of music, perhaps, that is a reminder of the deceased (loss-oriented) and that brings on feelings of sadness. This perspective integrates the processes identified by Folkman and Nolen-Hoeksema, and is also consistent with Bonanno's emotion-regulation component.

Conclusions

Theorizing in the field of bereavement is still marked by a pluralism of approaches, but attempts at integration have begun. Investigators are also looking more to related bodies of research such as emotion theory to derive sound theoretical and empirical hypotheses. Further probing of the biological bases of grief and grieving is needed. Likewise, broadening of theoretical interest from the single stressor of bereavement to a general psychology of loss, focusing on diverse phenomena, could encourage the formation of general principles. Nevertheless, the understanding of grief has deepened significantly during the past few decades, in part because of the theoretical grounding of fine-grained empirical research on social and cognitive processing.

See also: Continuing Bonds ; Freud, Sigmund ; Grief AND Mourning IN Cross-Cultural Perspective ; Mourning

Bibliography


Traumatic grief is defined as profound emotional trauma and separation distress suffered after the death of a loved one. It includes yearning, searching for the deceased, and excessive loneliness resulting from the loss. Traumatic loss sometimes happens when a death is sudden, unexpected, preventable, or of a child. Traumatic loss shatters the bereaved person's worldview, leaving him or her feeling overwhelmed and helpless.

**Diagnostic Considerations**

There are four diagnostic criteria for traumatic grief: (1) Traumatic grief occurs after the death of a significant other and includes distress that intrudes into the victim's consciousness; (2) traumatic grief lasts at least two months; (3) traumatic grief symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning; and (4) traumatic grief includes eleven marked, persistent symptoms that include behaviors, thoughts, and emotions. These symptoms reflect the bereaved person's feelings of devastation as a result of the death. Behaviors include frequent efforts to avoid reminders of the deceased (e.g., thoughts, feelings, activities, people, and places); and displaying excessive irritability, bitterness, or anger related to the death. Thoughts include purposelessness or feelings of futility about the future; difficulty imagining a fulfilling life without the deceased person; difficulty acknowledging the death; and a shattered worldview. Emotions include a subjective sense of numbness, detachment, or absence of emotional responsiveness; being stunned, dazed, or shocked; a sense that life is empty or meaningless; and feeling that part of oneself has died. Traumatic grief does not refer to the cause of the disorder or aspects of the death, but rather to the bereaved person's actual experience.

Two related forms of grief are delayed grief and complicated grief. Delayed grief is not apparent initially, but appears within the first six months of bereavement. Delayed grief might be particularly difficult to diagnose. Complicated grief occurs at least fourteen months after the death. The scholars who constructed this definition avoided twelve months because anniversaries often cause intense turbulence in the bereaved individual. Complicated grief includes intruding thoughts or avoidance behavior that is severe enough to interfere with daily functioning. The intruding thoughts may include unbidden memories or fantasies about the lost relationship, strong spells of severe emotion related to the lost relationship, and distressingly strong yearnings for the deceased. The avoidance symptoms include feeling far too alone or personally empty; excessive avoidance of people, places, or activities that remind the bereaved of the deceased person; unusual levels of sleep disturbance; and loss of interest in work, social activities, care taking, or recreational activities. These symptoms last for at least one month.

There are several differences between traumatic grief and complicated grief. One difference is in the duration of symptoms. For traumatic grief, the duration is at least two months, with no specification about the time since the death. For complicated grief, the duration is only one month, and the grief occurs within fourteen months of the bereavement. Another difference is in sleep disturbance. Only complicated grief includes sleep difficulty, which may be a result of the person being overly aroused. A third difference is that traumatic grief includes symptoms that reflect the devastation in the bereaved person's life caused by the death. There are no closely related symptoms in complicated grief.

Although they are related, traumatic grief is distinct from depression, anxiety, separation anxiety disorders, and posttraumatic
stress disorder (PTSD)—anxiety that develops when a person has a traumatic experience. Traumatic grief occurs among a significant minority of bereaved individuals, and lasts several years.

Origins

Persons who develop traumatic grief might do so in two ways. One way involves death that is sudden and violent, as in natural disasters, accidents, and criminal violence. The bereaved person might develop problems feeling close to loved ones because of a pervasive change in his or her view of the world, even when he or she was not vulnerable in the first place. In this case, in addition to traumatic grief, the bereaved person might also develop PTSD, as well as other psychiatric disorders. A second way involves loss of a significant other for a person with a vulnerable attachment style. The vulnerability might be the result of inherited characteristics, early nurturing experience, or some combination of the two. The person who was already vulnerable might develop other psychological disorders as well as traumatic grief.

An example of traumatic grief could be a mother who lost a beloved son in the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City. This mother makes strong efforts to avoid going through her son's belongings, and has excessive anger and bitterness about the death. Cognitively, she has no purpose, and has difficulty imagining a fulfilling life without her son, or even acknowledging his death. Her worldview is shattered. Emotionally, she feels numb and shocked that part of her life has died. Overall, she feels that life is empty or meaningless. These symptoms last for several months.

Another example of traumatic grief could be a father whose daughter is killed in an automobile accident, and whose mother dies six months later. He does not grieve immediately after the death of his daughter because he concentrates on caring for his sick mother. When his mother dies, both deaths "hit" him. Now, he is in a state of disbelief. Indeed, his chief complaint is that he still cannot believe what had happened. He feels overwhelmed by the losses. He obsesses over the details of the daughter's accident, and can think of little else. He has frequent episodes of crying, provoked by any reminders of his daughter or mother. His work performance suffers, and his relationships with the rest of the family deteriorate. He feels useless to himself and others, at least partly because much of his life had been devoted to being a good father and son. He loses a sense of security, and no longer trusts the world he now views as unpredictable. These problems persist for the six months since his mother's death, and he dreads the anniversary of his daughter's death.

Clinical and Research Literature

Grief counseling has proliferated in the last decades of the twentieth century. Professionals provide conferences and workshops on grief. Institutions and communities provide programs for bereaved individuals conducted by grief therapists, or operated on a mutual support basis by lay leaders. Journals that publish research about grief include Death Studies, Omega: The Journal of Death and Dying, Journal of Loss and Trauma, and Suicide and Life-Threatening Behavior.

One thorough research project by Gabriel Silverman and colleagues that was published in Psychological Medicine looked at the quality of life among sixty-seven adults widowed four months earlier. Those with traumatic grief reported significantly impaired quality of life, more so than persons with major depression or PTSD. Another research project by Holly Prigerson and colleagues, published in the American Journal of Psychiatry, focused on a vitally important aspect of traumatic grief—suicidal ideas. Among seventy-six young adults who had a friend commit suicide, those with traumatic grief were five times more likely to consider suicide themselves compared to those who were depressed. Still other research has shown that violent deaths, more than anticipated deaths, lead to problems for bereaved persons. For example, reviewing a broad selection of different research projects on bereavement, George Bonanno and Stacey Kaltman in 1999 concluded that adults whose spouse died unexpectedly (i.e., from suicide, homicide, or an accident) experienced PTSD at a higher rate than those whose spouse died of natural causes (e.g., cancer, congestive heart failure). Apparently, violent deaths may not only lead to the development of trauma reactions, but they also tend to exacerbate the more general grief response. Traumatic grief is different from other disorders and from general grief.

One major research project on grief analyzed twenty-three separate studies of bereaved persons. In each project, some participants were randomly assigned to receive some form of psychosocial intervention (psychotherapy, counseling, or facilitated group support). Others were randomly assigned to a control condition. Overall, treatment helped: Those who received treatment recovered more than those in the (nontreated) control group. However, the difference was small, which suggests that most people were helped, but some were not helped.

One reason for this finding could be time. Those people whose loved one died some time ago recovered more than those whose loved one died recently. Another reason could be age; younger clients fared better than older ones in grief therapy. Still
a third reason could be the type of bereavement. Grief counseling for normal grievers had essentially no measurable positive effect, whereas grief counseling for traumatic grief was helpful. Apparently, grief therapy is particularly suitable for mourners experiencing protracted, traumatic, or complicated grief reactions. Conversely, grief therapy for normal bereavement is difficult to justify.

Theory

A useful theory to treating traumatic grief focuses on making meaning in the aftermath of bereavement. A counselor who uses this perspective might help a bereaved daughter to see that her father had lived a full life or accomplished his last major goal before he died. This daughter might find meaning in the fact that her father's life had some purpose, or had come full circle. This perspective to treating traumatic grief is different from a medical model, which might emphasize controlling the symptoms such as crying spells or depression. This approach is also different from the vague though well-intentioned assumption that sharing feelings in a supportive environment will promote recovery. Sharing feelings might help, but making meaning is an added step that involves reconstructing one's individual, personal understanding.

Supporting this view, one study found that for 70 to 85 percent of persons who experienced a sudden, potentially traumatizing bereavement, the search for meaning played a compelling role in their grief. A significant minority, however, apparently coped straightforwardly with their loss, without engaging in deep reflection about its significance. For those who seek meaning and find none, the loss can be excruciating. These people report suffering intensely on a variety of dimensions. Conversely, bereaved persons who find a measure of meaning in the loss fare better, rivaling the adjustment of those who never feel the need to undertake a quest for meaning in the first place. In addition, many of those who find answers as to why the loss occurred revisit these answers in the months that follow.

Related to this emphasis on meaning is the assumption that describing one's thoughts and emotions about the traumatic grief promotes cognitive restructuring. Sharing with others allows bereaved individuals to restructure the difficult aspects of the loss, to explore ways of viewing themselves, and to regulate their own distressing emotions and bodily reactions.

Suggestions for Fostering Recovery

Traumatic grief does not respond to psychotherapy that is focused on interpersonal adjustment such as how the person gets along with others, whether or not this therapy includes antidepressant medicine. However, therapy that is oriented toward helping bereaved persons develop insight about their own lives, or to change their thoughts and behaviors, can be effective for those suffering from traumatic grief. Successful therapy includes a genuine, empathic, and compassionate relationship with the therapist and education about the bereavement.

Specific therapy for traumatic grief would focus on separation and traumatic distress. Treatment would include educating bereaved individuals about this type of distress, and helping them cope with it. Treatment would also include working with the person to lessen the distress in the first place. In addition, therapy should help the bereaved person to adapt to the new status caused by the bereavement and to the new roles required by that status.

Further, therapy would recognize that a quest for meaning plays a prominent role in grieving, at least for those who are bereaved by the sudden death of a loved one. When a bereaved person is struggling for significance in the loss, a counselor should facilitate this process. Grief counselors should be cautious, however, about instigating a search for meaning in the minority of bereaved persons do not spontaneously undertake such a search. These individuals might be coping adaptively already. Further, making meaning is more an activity than an achievement. Early, provisional meanings of the death tend to be revisited as the reality of living with loss raises new questions and undermines old answers.

Simply disclosing oneself to others may or may not be helpful, depending in part on the receptivity of would-be listeners. Some potential listeners may be overwhelmed by repeated communication of intense negative states, such as sadness or distress. Talking to them about feelings may drive away people who might otherwise offer some interpersonal support. Therefore, bereaved individuals need to be selective in the persons with whom they share their thoughts and feelings.

A public ritual such as a funeral or memorial can offer powerful closure for traumatic grief. Other approaches include letter writing to the deceased person and/or empty chair work—going through an exercise in which one imagines the deceased person to be sitting beside him or her in an empty chair, talking to the person as if they were still alive. Several useful procedures revolve around the concept of forgiveness for both self and others.
**Bibliography**


LILLIAN M. RANGE

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**User Contributions:**

I have found relevance to my situation being a Zimbabwean. Grief appears to start before the actual loss of a beloved especially when one is terminally ill. The idea of nursing a father when you have been informed by the doctors that he has very little time to live because of the condition he is in. You begin to grieve and distances may also worsen the situation. You grieve together with the ill person especially if they are aware that they are soon going to die. My own father was diagnosed with liver cancer and was given little time to live. I was on leave in December 2011 for 20 days. I was the weak one. My father was stronger than me. He told me no one flies away to heaven so you do not need to grieve over me. During this time you make all efforts to fulfill the wishes of your beloved one even when the doctor is against certain actions. It is the only time you try to please your beloved one. You try to do the best so that you wont feel guilt later. People have a problem coping with reality and what is expected.

It is true and important to note that grief is subjective. The effects vary according to relationship and perception of the people around. In my situation I was grieving over my mother more that my dying father. The thought of who would be besides my mother when my father is gone preoccupied my thoughts all days and I still cannot visualise my mother living alone at the matrimonial home. The effects of grief bring a whole range of unanswered questions. Noone has a prescription to manage
Metagame Analysis: Death And Dying. This variant system increases a character’s chance of surviving in combat against monsters that deal out tremendous amounts of damage per attack, since any character brought to 0 hit points against such a creature has a chance of survival. It eliminates the fear that every high-level character has faced: taking damage from a creature's attack that knocks him down close to 0 hit points, knowing that a second attack is coming and it will probably send him well below -10 hit points. Dying: A dying character is unconscious and near death. Each round on his turn, a dying character must make a Fortitude save (DC 10, +1 per turn after the first) to become stable. If the character fails the save, he dies. Behind the Curtain: Death and Dying. This variant system increases a character's chance of surviving in combat against monsters that deal out tremendous amounts of damage per attack, since any character brought to 0 hit points against such a creature has a chance of survival. As an anthropologist, I study death and dying from a cross-cultural perspective, and I wanted to create a course that would allow students to interact with these topics firsthand. In 2016, I designed the "Anthropology of Death and Dying" for my students at Brandeis University in Waltham, Massachusetts. In the course’s first iteration this spring, students