CHAPTER ONE

1. INTRODUCTION AND ORIENTATION

1.1 BACKGROUND

The death related loss of a primary relationship renders the bereaved vulnerable to grief reactions that are multifaceted involving somatic, psychological and behavioural distress (Cook & Oltjenbruns, 1998; Frantz, Trolley & Farrell, 1998; Horowitz, Siegel, Holen, Bonanno, Milbrath & Stinson, 1997; Moselhy & El-Dosoky, 1997; Prigerson, Bierhals, Kasl, Reynolds III, Shear, Day, Beery, Newsom & Jacobs, 1997).

For some mourners the intensity of the distress lessens and the person may become present and future oriented thus enhancing the growth potential of grief. For instance, Parkes (1996) and Viederman (1995) note that through the experience of bereavement and grief people are provided with the opportunity to improve their self-perception and change their world-view in a positive direction. Similarly, Davis, Nolen-Hoeksema and Larson (1998) subscribe to the view that loss provides the impetus for people to review their personal goals and priorities. In this sense, loss is regarded as an opportunity for gaining insight into the self, the self in relationship with others and in the context of adversity.

Frantz et al. (1998) support the above findings and describe the positive outcomes of grief in terms of mourners expressing greater appreciation of the value of life, becoming more independent, self-reliant and confident, experiencing increased family closeness and relying on more adaptive coping strategies.

More abstractly, Chen (1997) construes the positive outcome of grief in terms of Jung's (1971) concept of transcendent function. According to this perspective, grieving is likened to an altered state of mind, such as dreaming and spontaneous fantasies, that render the unconscious more accessible. Stated differently, grief provides mourners' with the opportunity to transcend the conscious, physical and sensory dimensions of the self. This transcendence enables psychic energy of the unconscious to break through - a process that is enhanced by emotional distress and crises such as the death of a

significant other. Once the unconscious breaks through, previous conscious and sensory functions become ineffective to address the crisis. At that point, the unconscious becomes conscious and regulates adaptation to the crisis through the collapse of old values and the achievement of new insights (Jung, 1971). By implication, each person experiences bereavement and grief in a personal and unique manner. The growth enhancing potential of bereavement and grief facilitates the evaluation and redefinition of individual beliefs, values, ideologies and priorities.

Miller and Harvey (2001) also remind the psychology community that the discipline has extended its treatment goals from curing mental illness and strengthening individuals that were damaged by childhood conflicts and trauma to nurturing the best within each person. Bereavement and grief probably provide psychology with the opportunity to achieve its positive mission. Specifically, loss and death are certainties and realities of life and are inherently painful experiences. Paradoxically, bereavement and grief have the potential to weaken human strengths in the same way as these experiences have the potential to build human strengths. In this sense, hope and resilience can be born out of the pain of loss, as long as meaning can be made of the experience.

Miller and Harvey (2001) take cognisance of the possibility that there are instances when loss and bereavement are experienced as too devastating to be construed as having meaning and as growth enhancing. Notwithstanding these circumstances, the discipline of psychology assumes an important role in nurturing and understanding the pain within the bereaved. In more formal terms, these theorists advocate for the development of both positive psychology and psychology of loss. The interplay between the two suggests that loss or bereavement may further the aims of positive psychology. In other words, any endeavour to translate loss, bereavement and grief into experiences that have meaning and growth enhancing potential may advance the positive mission of psychology. Victor Frankl's (1959a) personal experiences as a Jewish prisoner in a Nazi concentration camp coupled with the war related loss of three important people in his life formed the basis of his subsequent theoretical work "Man's search for Meaning". This combination probably bears witness to the interface between positive psychology and loss psychology (Miller & Harvey, 2001).

Bearing the positive aspects of grief in mind, Frantz et al. (1998) concede that literature tend to focus more on variables that either impede or facilitate the grief process. Concomitantly, the positive dimensions of grief have been slighted. Moreover, because bereavement and grief are painful experiences, society tends to deny the importance of grief (Chen, 1997). By so doing, society fails to understand and appreciate the potential benefits that grief might hold for personal growth and self-transcendence.

Willmott (2000) conveys a similar theme when referring to sociological studies that portray death as inherently negative. Specifically, modernists construe mortality or narrative of mortality as contrary to the development of a sound and coherent sense of reality and self-identity. As such, death poses a threat to ontological security and has become a taboo topic or an existential issue that has to be treated with caution. This presentation of death undermines alternative interpretations that have potential in terms of motivating human behaviour. From this point of view, mortality challenges daily practices such as health habits that are taken for granted, thus heightening awareness of the meaning and value of life.

On the negative side, both early and contemporary grief researchers agree that a sizable minority of people fail to adjust to or grow from the experience of loss due to death (Kissane, Bloch, Dowe, Snyder, Onghena, McKenzie & Wallace, 1996-I; Lehman, Wortman & Williams, 1987; Maercker, Bonanno, Znoj & Horowitz, 1998; Reynolds III, Miller, Pasternak, Frank, Perel, Cornes, Houck, Mazumdar, Dew & Kupfer, 1999). Failure to adapt to the death of a significant other relates to reactions that fall outside normal grief both in severity and in duration. The latter manifest in the formation of symptoms in the somatic, intrapsychic and behavioural domains. This represents complicated grief or grief that has become complicated by somatic, intrapsychic or behavioural symptomatology (Cook & Oltjenbruns, 1998). Complicated grief has a disabling impact on the functional capacity of the person (Moselhy & El-Dosoky, 1997). From this perspective, grief may deplete individual physical, emotional and psychological resources to the extent that personal strengths no longer serve the purpose of enriching life.

1.2 STATEMENT OF PROBLEM

Available information on complicated grief derives largely from international literature (Cook & Oltjenbruns, 1998; Horowitz et al., 1997; Moselhy & El-Dosoky, 1997; Parkes, 1996; Prigerson, Frank, Kasl, Reynolds III, Anderson, Zubenko, Houck, George & Kupfer, 1995; Prigerson et al., 1997; Prigerson, Shear, Jacobs, Reynolds III, Maciejewski, Davidson, Rosenheck, Pilkonis, Wortman, Williams, Widiger, Frank, Kupfer & Zisook, 1999; Shapiro, 1996). This contrasts against the paucity of South African literature on complicated grief in general and on the contextual dimensions of complicated grief in particular. Supporting this statement is the observation that the larger South African Psychology community in particular, seems to have neglected the topic of complicated grief. Specifically, a review of articles in the South African Journal of Psychology from March, 1989 to March, 2001 revealed that there was no article devoted to grief or complicated grief.

Contributions from the South African academic community regarding complicated grief derive from the AIDS field. For instance, in reviewing literature on grief reactions of AIDS orphans, Siegal and Gorey (1994) found no published empirical studies and only one unpublished study addressing the subject. From this point of view, the mourning and grief problems of AIDS orphans have been neglected in the clinical literature. Having noted the gap in clinical and empirical studies in the South African literature, Wild (2001) made a significant contribution in identifying stressors that confront AIDS orphans. Specifically, Wild (2001) examined the psychosocial adjustment of children orphaned by AIDS and drew on clinical literature, which suggest that grieving may be particularly difficult for this population. Difficulties are ascribed to multiple material and psychosocial stressors that accompany the parental death. These stressors in turn, complicate the grieving process.

Crowley (1995) on the other hand, focused on the importance of supportive services for professionals and non-professionals rendering services to AIDS populations. Whilst not the main thrust of the study, Crowley (1995) nevertheless draws attention to the potential that the phenomenal rate of AIDS related deaths have for grief becoming complicated. In other words, Crowley (1995) expresses awareness of the possibility that large scale

delayed and complicated grief secondary to the AIDS pandemic may occur amongst the population in South Africa at large.

Feigenbaum (1993, p. 57) refers to "things" that hinder and prolong the resolution of grief for many years to the extent that personality and quality of life are diminished. However, the specifics of those "things" that retard the resolution of grief are not spelt out.

The South African Social Work discipline addresses bereavement, grief and mourning from different perspectives. For instance, Bopape, (1995) focuses on grief from a cultural point of view. Strydom and Fourie (1998) on the other hand, focus on the development of a counselling programme for bereaved parents. In a study examining parental mourning after the loss of a child, Strydom and Fourie (1999) acknowledge that various factors predispose the bereaved to complicated mourning. However, the predisposing factors identified were derived from a secondary and international source namely, Volkan and Zintl (1993).

Having identified gaps in the South African literature, it is also important to note that relative to studies examining the psychological consequences of violence and criminal victimization in South Africa (Dawes, Tredoux & Feinstein, 1989; Friedman, 1996; Gewer, 1994; Hamber & Lewis, 1997; Hertz, 1999; Van Niekerk, 1997; Voster, 1997; Williamson, 1998) little is known about factors leading to complicated grief in survivors of both natural and unnatural deaths.

Mindful of the paucity of local literature, complicated grief is poorly understood in the South African context. By the same token, the contextual complexities that contribute toward grief assuming pathological proportions have not been sufficiently explored in South Africa. This void in the South African psychological literature is probably consistent with Banyard and Miller's (1998) observation that for a long time, a critique of mainstream psychology was the neglect of the multiple ecological layers that determine behaviour. Furthermore, Morse and Field (1996) would probably consider complicated grief as an immature concept in the South African context. This means that the concept has not been developed enough.

1.3 PURPOSE OF STUDY

Stemming from the statement of problem, the purpose of this study is to examine, understand and describe how context influences grief in people who experienced the loss, due to death of a primary relationship. Consistent with attachment theory, primary relationships are characterized by personal interaction and the attachment is a source of emotional security. The loss of an attachment relationship triggers persistent grief (Weiss & Richards, 1997). For purposes of this study, primary relationships are represented by the death of a parent, sibling, child, grandparent, spouse and live-in or intimate partners. Both natural and unnatural deaths are focused on.

Exploring pathogenic contextual influences have potential in terms of facilitating the prediction and identification of bereaved people at risk of maladaptive grief reactions. In turn, this will serve a preventive purpose by means of early intervention. The latter has significant potential with regard to maintaining or promoting physical and mental health, functional capacity and ultimately quality of life in bereaved people.

1.4 RELEVANCE OF CONTEXT

Steinberg and Avenevoli (2000) noted that context plays a determining role in the development of emotional and behavioural disorders. Special reference is made to disorders that have strong environmental contributions rather than those that have significant genetic loadings such as autism and attention deficit disorders. The notion advanced is that contextual factors may serve two distinct roles in the development of psychological disturbances. Firstly, contextual factors may serve the purpose of precipitating or eliciting symptoms or symptom patterns. Secondly, contextual factors may play a role in terms of either maintaining or exacerbating or diminishing psychological disturbances. Against the background of these roles, context is considered to assume importance with regard to both the onset and course of behavioural, affective and cognitive symptoms. Applied to bereavement, it is possible to speculate that contextual factors such as violence and man-made or natural disasters may well play a role in causing unnatural and unanticipated deaths. On the other hand, contextual factors such as the availability and quality of formal or informal support have significant potential in terms of minimizing or exacerbating grief reactions. From this point of view,

context provides the reality within which events (bereavement) are experienced and behaviour (grief) is expressed.

With reference to the death of a significant other, earlier and contemporary theorists (Averill, 1968; Bonanno, 1999b; Rosenblatt, 1988) noted that bereavement and grief unfold in social contexts. This observation is still valid in that the death of a significant person has a disruptive impact on the social systems that comprise the world of the bereaved. Therefore, the social reality that the bereaved once knew is no longer as they knew it before the death. Characteristically, social contexts have the potential to engender stressors, strains and strengths – all of which affect the person's quality of life and subsequent well-being. Consequently, the individual's experience of bereavement and expression of grief may vary according to the social context in which it is embedded. From a process point of view, social contexts operate through various social relationships. Fife (1994) refers to the role of others in defining the loss, experiencing the loss and coming to terms with the loss. Recognizing the potential that social context has on bereavement and grief it remains important to understand the influence that social context has on adaptation to loss due to death. Hence, the extent to which context influences complicated grief is the focus of this study.

Mindful of the above notions coupled with the statement of problem and the purpose of the study, this investigation focuses on three dimensions of context namely, the socio-environmental context, the family context and the personal context or the relationship of the bereaved to the deceased. Briefly,

- The socio-environmental context will be described in terms of the living environment and the social community in which the death occurred. These contexts comprise two sides of the same coin. Hence the stance adopted is that the socio-environmental context, borne out in the living environment and community in which the death occurred, plays an important role in the interpretation of death and experience of complicated grief. Furthermore, it is noted that societal institutions such as economics, politics and societal attitudes, manifesting in medical community attitudes, comprise macro social systems in which communities, families and individuals experience bereavement and grief. Of importance is the understanding that, while the control of these macro societal institutions is beyond the individual,

these institutions find expression in living environments and communities in which individuals live. As such, bereaved and grieving people do not escape the influence or impact of these societal institutions, hence its inclusion in the study.

- Death constitutes a transition that is destabilising and the family context provides an understanding of how the experience of complicated grief is influenced by family dynamics and processes. By focusing on the structural and functional dynamics of the family a shift is made from the individual as locus of complicated grief towards the family as locus of pathology. As such, the family is considered to provide an important context in which complicated grief unfolds.
- The personal context represents the bereaved person's relationship to the deceased. Various theorists assert that the intensity of grief correlates positively with the intensity of the relationship between the bereaved and the deceased (Field, Nichols, Holen & Horowitz, 1999; Leick & Davidsen-Nielsen, 1991; Parkes, 1996). In broader terms, for most people the death of a significant other precipitates a crisis in that the bereaved have to confront reality without the deceased.

Each of these contexts will be discussed comprehensively in Chapter Three.

1.5 RESEARCH AIM AND METHODOLOGY

As described in the statement of problem (Section 1.2) the influence of context on grief in general and complicated grief in particular is not well documented in the South African literature. As such, little is known about the influence of context on complicated grief. This renders the study exploratory in nature, which in turn warrants the use of an exploratory research approach. Hence the aim of this study is to explore and understand the influence of context on complicated grief. To this end an exploratory research approach is employed.

1.6 OPERATIONALIZING COMPLICATED GRIEF

Conceptually, complicated grief will be described as a "failure to return to pre-loss levels of performance or states of emotional well-being" (Prigerson, et al., 1995, p. 23). Operationally, this study will consider grief to have become complicated if six months after the death, the bereaved present with symptoms of depression and complicated grief of at least two months duration.

Relying on depression as a means of operationalizing complicated grief is purposeful in that it derives from clinical observations and empirical findings of both early and contemporary bereavement researchers. Specifically, Worden (1982) indicates that grief looks very much like major depression and grieving may result in full-blown depression. Similarly, Jacobs (1993) draws attention to a high rate (62%) of severe depression following the loss of a significant other. A further 20% of bereaved people develop a full-blown mood disorder. Moreover, severe grief lasting two months or longer without treatment increases the risk of grief resulting in a psychological disorder.

Diagnostic Statistical Manual IV (DSM-IV) (American Psychiatric Association [APA], 1994) does not acknowledge complicated grief as an independent clinical entity. However, it does acknowledge that some grieving individuals present with symptoms characteristic of a major depressive episode and that the occurrence of depressive symptoms two-months post-bereavement warrants the diagnosis of a depressive disorder.

Furthermore, Prigerson et al. (1995) observed that every discussion of grief refers to depressive symptoms as predictive of maladjustment to widowhood. In fact, these researchers recognize that depression and grief symptoms are not mutually exclusive and that these two syndromes may occur concurrently. Symptoms such as yearning, searching and feeling stunned by the death were found to constitute complicated grief. Horowitz et al. (1997) extended the above notion and provide empirically generated criteria for the diagnosis of complicated grief disorder.

In terms of establishing the point at which grief results in functional impairment, Prigerson et al. (1995) and Horowitz et al. (1997) suggest that assessments be made as close to six months as possible. Weiss and Richards (1997) add that assessments made early in bereavement can predict the quality of recovery following the death of an attachment figure. Stemming from the above, there appears to be support for operationalizing complicated grief as stipulated.

1.7 CONTEXT OF STUDY

This study is conducted in Community Mental Health Clinics situated in Boksburg, Brakpan, Springs and Nigel. These clinics are ambulatory care settings and form part of Primary Health Care clinics. Clients are referred to these facilities by various sources including the legal system, medical practitioners, religious organizations, welfare systems and non-governmental organizations. The researcher is employed as a Clinical Psychologist and forms part of a mental health team. The selection of clients from the Boksburg, Brakpan, Nigel and Springs clinics relates to the fact that the researcher rotates through these clinics on a weekly basis. Formal consent to conduct research at these centres was first obtained from the Director, Department of Health, Eastern Gauteng Region. Written consent was also obtained from clients to participate in the study. All study material was gathered in offices at clinics where privacy is ensured.

1.8 STRUCTURE OF STUDY

Chapter One describes the background to, purpose, aim and context of the study

Chapter Two provides an exposition of basic concepts, including variants of and symptomatic manifestations of complicated grief.

Chapter Three provides a review of literature related to contextual influences on bereavement and grief.

Chapter Four provides a literature review related to theories of grief.

Chapter Five outlines the exploratory research approach adopted in the study.

Chapter Six provides an analysis of the research data.

Chapter Seven provides the interpretation of the analysed research data in relation to the literature and a critical evaluation of the study.

CHAPTER TWO

2. EXPOSITION OF BASIC CONCEPTS

2.1 INTRODUCTION

An exposition of basic concepts used in this study is important for various reasons. Specifically, Cook and Oltjenbruns (1998) point out that, the grief process is often not well understood by a large section of society. Consequently, many grieving individuals do not receive the quality and type of support that is most likely to help them.

Furthermore, earlier formulations of the concepts bereavement, grief and mourning derived largely from the psychoanalytic framework. As such, these concepts are often used interchangeably even though differences are identified (Cook & Oltjenbruns, 1998).

Rosenblatt (2000) additionally, purports that grief theories do not account for all that people might conceptualise as part of bereavement. In fact, theories of grief are selective in their focus. Yet, they are important in moulding the reader's understanding of bereavement or grief and there is an implicit or explicit expectation that theories define bereavement or grief. Rosenblatt (2000) reasons that defining grief is a self-defeating exercise. This attitude stems from the notion that there are many different kinds, forms and expressions of what might be considered as grief. As such, grief may well be regarded as fluid, changing, socially defined and comprising many transient elements. Moreover, grief may change in meaning and intensity and overlap with many other dimensions that might or might not be considered part of grief. Hence there is no essential grief. Instead, grief is as diverse as peoples' understanding of their realities and their experiences.

Mindful of these debates, coupled with the notion that complicated grief could, in terms of Morse and Field (1996) be considered as a relatively immature or insufficiently explored concept (Chapter One, 1.2) in the South African context, an exposition of features describing these basic concepts would assist in providing the reader with some clarity.

2.2 LOSS

The term loss is often used very broadly. For instance, Weenolsen (1988, p. 19) defines loss as "anything that destroys some aspect, microscopic or macroscopic, of life and self". Use of the term "anything" gives the impression that loss is an object. Martin and Doka (2000, p. 12) in contrast, refer to loss as "being deprived of or ceasing to have something that one formerly possessed or to which one was attached". In this sense, loss has connotations of being a subject. Rando (1993a) on the other hand, recognizes that normative developmental transitions embrace loss that differs in kind and in intensity. As such, loss constitutes an integral part of the human life cycle and is therefore inevitable.

In the context of death, loss occurs at multiple levels. At a primary level, biological death deprives the survivor of the physical presence of and interaction with the deceased on a permanent basis. Stemming from this primary loss are secondary losses such as the loss of a relationship, role loss and a sense of purpose that the specific role provided the survivor with. Symbolic losses are represented by the loss of dreams, hopes, aspirations and faith. Martin and Doka (2000) describe these losses as more abstract and more difficult to recognize. Weenolsen (1988, p. 482) adds that metaphorical losses are often conveyed in expressions such as "It feels like I have lost part of myself". Equally important is the loss of a sense of holism. The latter derives from having shared a life with the deceased. Death deprives the survivor of the opportunity to share past recollections. Likewise, the deceased may well have been a source of validation to the bereaved. Martin and Doka (2000) are of the opinion that adaptation to the death of a significant other can only be achieved if losses at all levels are identified, recognized and mourned.

2.3 BEREAVEMENT

Doka (1989a) and Marwit (1991) describe bereavement as an objective act of loss or as the objective reality of loss. More recent researchers refer to bereavement in terms of the state of having lost a significant other to death or as a state of being that arises after the death of a significant other (Cook & Oltjenbruns, 1998; Leming & Dickinson, 1998).

Martin and Doka (2000) focus on the meaning that death has for the survivor, thus drawing attention to an additional dimension of bereavement. The symbolic or meaning dimension of

bereavement leans toward a sociological perspective and serves the purpose of providing the survivor with a sense of continuity between the past and the present. Furthermore, understanding bereavement in symbolic terms appears to be congruent with understanding loss due to death in terms of multiple levels.

2.4 MOURNING

Mourning is regarded as a process of adaptation to the loss of the valued object (Parkes, 1996). Unravelling this process in psychoanalytic terms, Hagman (1995) identified three underlying mechanisms namely, identification, decathexis and recathexis. These mechanisms reflect a process whereby the bereaved waver between emotional involvement with the deceased, acknowledging the reality of the loss, disengaging from and re-engaging with the deceased. From this point of view, mechanisms underlying mourning serve the purpose of facilitating adaptation to the loss.

Rando (1993b, in Martin & Doka, 2000, p. 23) also takes the lead from psychoanalytic theory and defines mourning as a "psychological process that occurs as individuals experiencing loss reorient their relationship to the deceased, their own sense of self and their external world". In behavioural terms, Rando (1993b) describes three operations embedded in the reorientation process. The first occurs during the acute phase or shortly after bereavement and the bereaved concede that contact with the deceased can no longer be maintained. Secondly, there occurs a redefinition of the self and sense of identity after the loss and without the deceased. The third operation entails a redefinition of the world and adaptation to the many changes brought about by the loss.

Stemming from the above, Rando (1993b) provides a model of mourning that manifest in three phases, each of which has inherent operations as set out below.

The Avoidance Phase embraces:

- Recognizing, acknowledging and understanding the death.

The Confrontation Phase involves:

- Experiencing and expressing the psychological reactions to the loss and identifying and mourning losses secondary to the death;
- Recollecting and re-experiencing the lost relationship both cognitively and affectively;

- Relinquishing emotional attachments to the deceased and previous assumptions about the world.

The Accommodation Phase entails:

- Re-adjusting to the new world while holding on to memories of the old;
- Establishing new relationships and commitments.

As postulated by Rando (1993b) mourning is a long-term process which, if not accomplished increases the risk of physical and mental deterioration.

Based on the above, it is appropriate to concede that the psychoanalytic framework provided the field of bereavement with an early and useful beginning. However, a weakness inherent in this school of thought is that it disregards the socio-cultural context in which mourning and grief occurs.

Having said this, later theorists have noted that social customs and cultural norms are also relied on as expressions of mourning. For instance, Doka (1989b in Martin & Doka, 2000, p. 23) defines mourning as the "culturally patterned expressions or rituals that accompany loss and allow others to recognize that one has become bereaved". Similarly, Cook and Oltjenbruns (1998) advance the notion that mourning is socially expressed in socially prescribed behaviours. Put in another way, mourning is socially determined in that various socio-cultural norms and rituals prescribe the conduct of people after the death of a significant other. From this point of view, mourning may be construed as the objective dimension of bereavement.

Reconciling bereavement in terms of objective and subjective dimensions is open to various interpretations. One such interpretation is the possibility that the bereaved may show overt, culturally prescribed behaviours of mourning such as wearing black clothes. However, the person may not necessarily experience the subjective emotions of grief. This discrepancy could probably be explained in terms of failure to adhere to cultural dictates of mourning as most likely to meet with censure and criticism from significant support systems. However, the opposite scenario may also be sketched. For instance, Mishara (1995) maintains that in the event of stigmatised deaths such as suicide, cultural rituals and social support may be lacking while the bereaved experience the most devastating emotions of grief.

2.5 GRIEF

According to Parkes (1996) the psychoanalytic framework recognizes that mourning evokes a wide range of emotional, physical and behavioural reactions. These reactions are known as grief. Cook and Oltjenbruns (1998) also express the view that grief is an outcome of bereavement and involves a variety of reactions. Martin and Doka (2000, pp. 14-15) elaborate and define grief as the "psychic energy that results from tension created by the individual's strong desire to:

- Maintain his/her assumptive world as it was before the loss;
- Accommodate themselves to a newly emerging reality resulting from the loss and
- Incorporate this new reality into an emerging assumptive world".

Elements of this definition suggest that grief reactions arise from conflict between the previously known relational and assumptive worlds (past), the relational and assumptive worlds that will not be the same again (present) and the uncertainty of how these worlds will become (future). Furthermore, use of the term psychic energy implies that the emotional tension resulting from the loss generates energy that has to be expended. Grief thus represents biologically based reactions that serve the purpose of adapting to internal and external change that has been brought about by death (Martin & Doka, 2000). These authors further refer to grief reactions as manifesting in various personal and biological domains. Stated differently, the psychic energy generated by the loss is experienced and expressed in different areas including:

- Physical reactions include somatic symptoms and distress such as headaches, muscular aches, physical pain, fatigue, nausea, menstrual irregularities, noise intolerance, tension, appetite and sleep disturbance.
- Affective reactions may relate to sadness, anger, guilt, anxiety, fear, shame, relief, jealousy and hopelessness and powerlessness.
- Cognitive reactions may involve obsessive thinking, poor concentration, fantasizing, apathy, disorientation and confusion, preoccupation with the loss, ruminating about the circumstances of the death, experiencing a sense of the presence of the deceased and trying to make sense of the loss.
- Behavioural reactions may embrace crying, social withdrawal, increase in the use of substances such as alcohol, increase in illness behaviours, searching for the deceased, avoidance of reminders of the deceased, increase in physical activities, uncharacteristic

behaviour and maintaining a sense of connectedness by for instance, visitations to the cemetery. Martin and Doka (2000) point out that these external behaviours may be expressions of internal reactions. Moreover, some behaviour may have negative consequences as when accidents are caused by increased alcohol consumption.

- Spiritual reactions may include searching for meaning in death and changes in spiritual beliefs, behaviours and feelings. Martin and Doka (2000) are of the opinion that loss has the potential to create intense spiritual crises, thus challenging beliefs and values that have sustained the bereaved over many years, necessitating a re-evaluation of core beliefs.

The above reactions convey the multifaceted and complex nature of grief. Manifestations of these symptoms may be unique in constellation, duration and intensity for each individual. Acute reactions may occur during the early post-bereavement phase but diminish in intensity from about six months. However, special dates may precipitate acute reactions even after initial responses have subsided (Cook & Oltjenbruns, 1998).

With regard to understanding normal grief and recovery, The Harvard Bereavement Study (Weiss & Richards, 1997) assumed a leading role. This study postulates that in order for the bereaved to regain their full functioning, three tasks are to be accomplished namely:

- The loss must be assimilated cognitively. The latter is achieved by providing an acceptable account of how the loss occurred. In this way, the bereaved person's world continues to be meaningful and secure;
- The death must be assimilated emotionally such that memories surrounding the relationship and its loss are no longer associated with intolerable pain;
- The third task involves the reorganization of emotional life such that energy becomes available for the establishment of new attachment relationships and commitments.

A major contribution of the tasks of grief is the insight it provides in relation to facilitating the process of adaptation to the loss. Stated differently, the course of recovery and eventual outcome of grief can be predicted from the extent to which tasks of grief have been accomplished (Cook & Oltjenbruns, 1998).

2.5.1 PATTERNS OF GRIEF

Martin and Doka (2000) assert that individual response tendencies play a determining role in the domain in which grief reactions manifest. Specifically, response tendencies are shaped by cultural influences and personality styles. The latter predispose individuals to respond to loss and grief in selected ways. For purposes of this study reference will be made to two identified response patterns namely, intuitive and instrumental. These researchers concede that pure intuitive and pure instrumental patterns are rare. It is reportedly more common for these patterns to occur on a continuum.

According to Martin and Doka (2000) intuitive grievers tend to expend psychic energy generated by bereavement affectively. Characteristically, grief is experienced as emotions that are enduring, intense and wide in range including, pain, hopelessness, loneliness, sadness and helplessness. These feelings may be experienced directly as a result of personal grief or vicariously, as in sharing the emotions of others who are in similar situations.

The expression of grief by intuitive grievers may assume the form of crying, sobbing, anger, depressed mood, anxiety, and poor concentration. Sharing of emotions comprises an important strategy for adapting to the loss. By implication, intuitive grievers are less inclined to seek out and solve problems. Instead, they remain preoccupied with their internal emotional experiences. Responses in the cognitive and physical domains are secondary but not completely absent. Martin and Doka (2000) tend to associate intuitive grieving with females.

Martin and Doka (2000) describe instrumental grievers in terms of three interdependent features namely: primary emphasis is on cognition, moderated affect, and a greater tendency towards problem solving and activity. These features suggest that instrumental grievers are more inclined toward experiencing grief intellectually and cognitively. Emphasis is placed on controlling emotions hence the loss is perceived as a challenge rather than a threat. Affective responses such as sadness, anxiety and loneliness may be present but less intense and the instrumental griever has greater difficulty sharing these emotions. In this sense, it is easier to share problems subsequent to the loss than to disclose personal feelings related to the loss (Carroll & Shaefer, 1994).

With regard to the expression of grief, instrumental grievers characteristically expend their psychic energy contemplatively, planning and executing activities. When instrumental grievers do express emotions, it is invariably anger, particularly when adaptive strategies fail as when personal and environmental control is being threatened. Solving problems secondary to the death, provide an important outlet for the expression of grief and simultaneously serve the purpose of restoring normalcy for the instrumental griever. These researchers associate instrumental grief patterns with males and recognise the role of gender socialization stereotypes.

Martin and Doka (2000) added significant insights to the bereavement field especially in as far as understanding gender differences in the expression of grief.

2.6 COMPLICATED GRIEF

Various labels have been used to denote abnormal grief. The most noted labels include complicated, pathological, chronic, delayed or exaggerated grief (Cook & Oltjenbruns, 1998; Middleton, Burnett, Raphael & Martinek, 1996; Moselhy & El-Dosoky, 1997). For purposes of this study, reference will be made to the term complicated grief.

Prigerson et al. (1995, p. 23) define complicated grief as "the failure to return to pre-loss levels of performance or states of emotional well-being". Two issues unfold in this definition. Firstly, for grief to be regarded as complicated, symptoms of normal grief persist and remain unresolved. Secondly, the persistence and non-resolution of normal grief symptoms pave the way for long-term functional impairment, ultimately preventing the bereaved person from resuming his/her previous level of functioning. Against the background of these two dimensions, the assessment of complicated grief commences with an understanding of the extent to which normal grief reactions have been resolved. Indications of unresolved grief, particularly at a time beyond that which is regarded as adaptive, are suggestive of the bereaved being at risk of complicated grief manifesting in functional impairment.

In an earlier version Rando (1993a) construed complicated grief in terms of failure to accomplish one of two tasks of grief. On the one hand, the person may deny the implications of the loss and avoid experiencing the loss both cognitively and emotionally. On the other hand, the person may be unwilling to relinquish the deceased and thereby, fail to regard or

attend to changed circumstances. Against this background, Rando (1993a in Cook & Oltjenbruns, 1998, p. 125) defines complicated grief as "some compromise, distortion, or failure of one or more tasks of mourning, given the amount of time since the death". Implicit in this definition, is the notion that it is not the constellation of symptoms that set complicated grief apart from normal grief. Instead, the former differs from the latter with regard to the intensity and duration of symptomatology, especially since tasks of grief cannot be accomplished amidst unresolved normal grief reactions.

2.6.1 PATTERNS OF COMPLICATED GRIEF

Moselhy and El-Dosoky (1997) note that grief responses occur on a continuum. At the abnormal end of the continuum grief manifests in various patterns.

2.6.1.1 INHIBITED GRIEF

Cook and Oltjenbruns (1998) suggest that inhibited grief is reflected in a prolonged absence of acknowledgment of the emotional pain of grief. People experiencing inhibited grief are considered to place emphasis on self-control thus negating the pain of grief.

2.6.1.2 DELAYED GRIEF

Delayed grief occurs some time after the death has taken place. Characteristically, the person will experience a death without expressing any thoughts or emotions appropriate to the loss. However, a subsequent death triggers grief reactions of significant intensity. The intensity of reactions to the recent loss would have been more appropriate if it were experienced and expressed at the time of the initial loss (Oltjenbruns & Cook, 1998). Middleton et al. (1996) add that delayed grief is more likely to occur in situations where the survivor's life was also being threatened. Under these circumstances, physical survival takes precedence over grief.

2.6.1.3 CHRONIC GRIEF

Chronic grief manifests in prolonged and intense grief symptoms. Cook and Oltjenbruns (1998) refer to symptoms lasting for 1 to 3 years or even longer, depending on circumstances circumscribing the death. The intensity of grief symptoms is such that the person is unable to reach a stage of reorganizing his/her emotional and interpersonal life. Variations of chronic grief have been identified. For instance, Aiken (1985) refers to mummification, in which case the bereaved keep things just as they were before the death. Similarly, idealization of the

deceased occurs when only positive characteristics of the deceased are recalled or focused on. In this way, the deceased is kept alive while fellow living beings assume secondary importance (Cook & Oltjenbruns, 1998).

Furthermore, identification with the deceased occurs when the bereaved manifest symptoms similar to those experienced by the deceased prior to his/her death (Sheldon, 1998). The bereaved may also show behavioural characteristics similar to the deceased (Parkes, 1996). Over a short period of time, identification with the deceased need not necessarily be pathological. However, over protracted periods of time, identification interferes with the daily functioning of the bereaved (Cook & Oltjenbruns, 1998).

Having identified the above variants of complicated grief, Middleton et al. (1996) nevertheless question the validity of the atypical responses. Specifically, these variations were derived largely from clinical or at-risk populations. The prevalence of these variations of complicated grief in non-clinical populations has yet to be clarified. In an initial study, these researchers found empirical support for chronic grief. However, inhibited and delayed variants were poorly represented.

2.7 SYMPTOMATIC MANIFESTATIONS OF COMPLICATED GRIEF

2.7.1 COMPLICATED GRIEF AND DEPRESSION

Historically, depression has always been considered to constitute an aspect of grief and psychoanalytic theory provided the groundwork for the notion that grief ranges from normal to pathological. The latter was associated with syndromal depression while normal grief was regarded as different from depression by the absence of self-denigration. Specifically, Freud (1917/1957a) noted that depressed persons displayed symptoms similar to those prevalent in mourning. However, an important difference was that depressed persons exhibited a loss of self-esteem and described themselves in negative terms such as being inadequate and worthless.

While being a forerunner in differentiating between normal and syndromal depression, Bonanno and Kaltman (1999) nevertheless assert that Freud's (1917/1957a) primary interest was in the etiology of depression rather than grief.

In the not too distant past, the bereavement field has witnessed greater conceptual growth and pathological grief continued to be associated with depression. For instance, Clayton (1982) referred to the sequelae of loss primarily in terms of depression. This implied that depression was a major criterion of an abnormal response to loss. Similarly, Worden (1982) proposed that grief looks very much like depression and grieving may result in full-blown depression.

Equally important is the recognition that post-bereavement depressed mood may be associated with additional factors. Clarifying this point are Folkman, Chesney, Collette, Boccellari and Cook (1996) who found that post-bereavement depressed mood among gay caregivers was associated with factors such as the caregiver's own HIV positive status, longer relationship with the deceased, pre-loss stresses and pre-loss mechanisms used to cope with the stress of care giving.

Based on these findings, the trend seemed to have been to rely on depressive symptoms in order to establish whether or not grief has reached pathological proportions. In fact, Prigerson, et al. (1999) note that DSM-IV (APA, 1994) regards depressive symptoms as the only treatment worthy complication of bereavement.

2.7.2 COMPLICATED GRIEF AS AN INDEPENDENT DISORDER

In moving away from construing complicated grief in terms of depressive symptomatology, more recent researchers advocate for a criterion based description of complicated grief. Prigerson et al. (1995) assumed a leading role in this regard. These researchers postulate that describing complicated grief in terms of specific criteria has potential that relate to:

- Facilitating an investigation into the prevalence, risk factors and consequences of complicated grief;
- Providing valid criteria that establishes support for the differentiation between complicated grief and other bereavement related emotional disorders and
- Enhancing treatment planning.

Mindful of the need for valid criteria to assist in the diagnosis of complicated grief, various researchers embarked on providing scientific evidence for phenomenological differences between intense and prolonged grief and depression. For instance, Horowitz et al. (1997) empirically found that symptoms constituting complicated grief include the experience of

intrusive thoughts, pangs of severe emotions, distressing yearnings, feeling empty and alone, avoiding tasks reminiscent of the deceased, unusual sleep disturbance and maladaptive levels of loss of interest in personal activities. Based on these findings, complicated grief was considered to comprise fewer symptoms and that there was no significant overlap with symptoms of major depression.

Having said this, Horowitz et al. (1997) note that the diagnosis of complicated grief and major depression are not mutually exclusive. However, pre-loss factors such as social context and personality traits may well predispose the bereaved to a dual diagnosis of complicated grief and major depression.

In an independent study Prigerson et al. (1995) provided further evidence in support of the distinction between complicated grief and major depression. Specifically, symptoms constituting complicated grief were found to include searching and yearning for the deceased, preoccupation with thoughts of the deceased, disbelieve regarding the death, feeling stunned by the death and lack of acceptance of the death. Accompanying these symptoms is impairment in global functioning, mood, sleep and self-esteem. Additionally, a small proportion of subjects in the study also presented with symptoms of syndromal depression. Results thus endorsed the notion that complicated grief and depression may co-exist but are phenomenologically distinct disorders (Prigerson et al., 1995). In a replication study involving a non-clinical population, criteria defining the earlier identified symptom profile of complicated grief emerged yet again (Prigerson, Bierhals, Kasl, Reynolds III, Shear, Newsom & Jacobs, 1996).

Put together, there appears to be empirical evidence for complicated grief to be regarded as a disorder distinct from major depression. However, note is taken of the possibility that the two disorders can occur concurrently. This feature draws attention to pre-loss factors that predispose the bereaved to a dual diagnosis.

2.7.3 COMPLICATED GRIEF AND POSTTRAUMATIC STRESS DISORDER

War and combat situations provided tremendous impetus to the formulation of Posttraumatic Stress Disorder (PTSD) as a clinical diagnosis. However, there was not a concomitant interest in the association between combat related loss and the bereavement process in survivors of

such losses. This omission occurred despite the realization that PTSD and pathological grief share areas of overlap in their symptomatic expression (Bagge & Brandsma, 1994). Against this background, Van der Hart, Brown and Turco (1990) used the term traumatic grief to link the diagnostic concepts of PTSD and pathological grief. These researchers describe the overlap as ranging from symptoms of arousal and intrusive imagery to avoidance and defensive numbing. Hence the term traumatic grief is considered to extract symptoms from both PTSD and pathological grief, thus spanning a bridge between the two (Bagge & Brandsma, 1994).

While not using the term traumatic grief per se, a review of clinical records led Parkes (1996) to believe that PTSD is common following unexpected and horrific deaths. In a more concerted effort and based on scientifically developed criteria, Prigerson et al. (1999) concurred that complicated grief resembles a stress response. These researchers therefore also gravitated towards the term traumatic grief rather than complicated grief.

In the context of traumatic grief, use of the word trauma is very specific in that it refers to psychological distress associated with separation from the deceased. Stated differently, trauma related to grief is not necessarily linked with a death that was horrific, unanticipated or unnatural. On the contrary, Prigerson et al. (1999) stipulate that the trauma due to loss by death also relates to being deprived or dispossessed of the presence of the deceased. Substantiating the appropriateness of traumatic grief further, Prigerson et al. (1999) refer to the clustering of criteria into symptoms of separation distress and symptoms of trauma distress. These clusters are considered to resemble symptoms of PTSD. Accordingly, correlates of separation distress manifest in intrusive behaviour and pre-occupation with the deceased. Symptoms of trauma distress on the other hand, are represented by avoidance behaviours. The latter include avoiding reminders of the deceased, a sense of numbness and detachment resulting from the loss, feelings of purposelessness and futility about the future, difficulty with acknowledging the loss, anger over the death and a fragmented sense of trust and security (Prigerson et al., 1999).

Notwithstanding parallels between complicated grief or the newly coined term traumatic grief and PTSD, Prigerson et al. (1999) also identified differences between the two. Specifically, symptoms of separation distress (yearning and searching) are not listed in DSM-IV (APA,

1994) criteria for PTSD whereas in traumatic grief these symptoms assume importance. Furthermore, the PTSD avoidance and hypervigilant criteria play a less prominent role in traumatic grief than in PTSD. Moreover, for traumatic grief, it is the absence of the deceased that is the source of distress rather than fears of reliving or re-experiencing the trauma. Hypervigilance on the other hand, refers primarily to searching for cues of the deceased. Hence, PTSD and traumatic grief symptoms may overlap but distinctions between the two can be made.

With regard to predisposing factors, Prigerson et al. (1997) identified pathways that render the bereaved particularly vulnerable to traumatic grief. Assuming importance are childhood experiences such as abuse and neglect, the nature of early attachment relationships, personality factors such as impulse control and qualities of the lost relationship. These predisposing variables are well captured in Bowlby's (1969/1980a) attachment theory. The latter draws attention to disordered mourning having its roots in early attachment disturbances. With regard to qualities of the lost relationship, reference could also be made to psychoanalytic theory. The latter postulates that individuals engaged in relationships characterized by ambivalence, conflict and narcissism are prone to pathological grief (Freud, 1917/1957a).

2.7.4 COMPLICATED GRIEF AND ANXIETY

Parkes (1996) refers to anxiety as a common psychiatric problem in bereaved people. Supporting this observation is Jacobs (1993) who found that 44% of subjects showed evidence of generalized anxiety or panic disorders. Special reference is made to panic attacks being brought on by reminders of the death. Manifestations of panic attacks included choking sensations, breathlessness and physical expressions of fear. Equally important is social isolation and loneliness which seem to exacerbate the pain of grief. Parkes (1996) summarily describes features of anxiety in bereaved persons as separation anxiety. The latter has implications in terms of the bereaved striving either to control or to avoid the pangs of grief – albeit unsuccessfully.

2.7.5 COMPLICATED GRIEF AND PHYSICAL ILLNESS

Historically, Lindemann (1944a) was among the first bereavement researchers to observe an association between bereavement and physical illness. At that stage bereavement was cited

amongst the alleged psychogenic factors in psychosomatic, now termed psychophysiological, disorders. The latter refer to physical conditions that have a strong psychological basis. Essentially, the person presents with a pre-existing medical condition and psychological stress either exacerbates the condition, or delays recovery or interferes with the effectiveness of treatment. Examples of psychophysiological conditions include coronary heart disease, hypertension, ulcers, headaches and asthma (Sue, Sue & Sue, 1994).

Based on the observed association between bereavement and physical illness, Parkes (1996) points out that bereaved people tend to consult medical practitioners more than they did before the loss. While reasons given for the consultations were attributed to physical complaints, underlying anxiety and tension could be detected. Furthermore, support was also found for the hypothesis that feelings of hopelessness or helplessness assume importance in the bereaved person's perceived physical illness.

With regard to physical conditions Stroebe, Stroebe and Hansson (1993) established that bereaved persons are at higher risk of mortality. This finding seemed particularly true for older widows, men being more vulnerable than women. Parkes (1996) and Rice (1998) refer to heart disease as contributing to the highest death rate amongst the bereaved. However, it is noted that mortality as a result of heart disease does not necessarily mean that the condition was caused by the bereavement. On the contrary, the possibility that bereavement may have exacerbated a pre-existing condition is considered. Alternatively, the heart condition would have occurred anyway. Additional causes of mortality in the bereaved also include cirrhosis of the liver, motor vehicle accidents, infectious diseases and suicides. Parkes (1996) notes that such deaths in the bereaved may also be associated with adverse health behaviours such as increased alcohol consumption, a lack of self-care, and lack of concentration when driving. Similarly, the role of clinical depression antecedent to bereavement may play an equally important role with regard to increasing the risk of mortality.

Rice (1998) further refers to early writings that implicated the immune system in the incidence of post-bereavement mortality. However, this notion was negated by the immune-suppression hypothesis, which favours the idea that bereavement may lead to a change in morbidity but not mortality. In clarifying this assertion, reference is made to two types of lymphocyte cells in the blood namely, B cells and T cells. The former present as anti-bodies and serve the purpose of

neutralizing antigens. These in turn, comprise proteins that are foreign to the body and are attached to harmful micro-organisms such as viruses, bacteria and toxic substances. T cells on the other hand, are also known as helper cells and assist B cells by helping to fight bacterial and viral infections. Rice (1998) describes B and T cells as multiplying rapidly and undergoing structural change when activated by antigens. However, under certain conditions the production of B and T cells may not be sufficient for the body to protect itself. When this happens, the body becomes more vulnerable if exposed to disease. An additional cell called the natural killer cell has a specialized function in that it recognizes and destroys tumour cells and virus infected cells (Rice, 1998).

Applied to bereavement, Parkes (1996) refers to the general expectation that people with AIDS would be more affected by bereavement, particularly since AIDS is a disease of the immune system. Supporting this notion are Kemeny and Dean (1995) who established that AIDS related bereavement was associated with more rapid loss of CD-4 cells and other immune system changes in bereaved HIV positive gay men. Similarly, Rice (1998) notes that cell activity in the blood is markedly suppressed following the loss of someone important.

Notwithstanding evidence supporting the link between the immune response system and morbidity, Rice (1998) and Parkes (1996) draw attention to the complexity of the field. Specifically, bereavement occurs against the background of multiple contextual and life style variables. The latter may impact on the immune response system thus blurring cause-and-effect relationships. Until greater control is exercised over extraneous variables and specific pathways of operation are identified, the association between bereavement and the immune response needs to be interpreted with caution.

Evidence supporting the association between bereavement and physical health outcomes was derived largely from conjugal bereavement studies, involving older subjects. In overcoming this selection bias, as well as extending available knowledge Prigerson et al. (1997) studied an independent, unrelated community-based sample. This study sought to understand why some bereaved persons and not others, are at risk of physical and psychological morbidity. Findings revealed that bereaved subjects reflecting high traumatic grief scores were at heightened risk of poor health outcomes. These researchers concluded that it is not the bereavement per se that

threatens individual health but psychological sequelae, such as symptoms of traumatic grief that mediates health outcomes.

2.8 SUMMARY

The exposition of complicated grief, its variants and symptomatic manifestations reflect the complexity of the bereavement field. Literature related to the field were initially dominated by knowledge arrived at either conceptually or from clinical observations. However, the empirical development of criteria has added scientific rigor to defining and describing complicated grief.

As a variant of complicated grief, chronic grief embraces different facets such as mummification, idealization of and identification with the deceased. The latter reflect situations whereby the bereaved acknowledge the reality of the loss but fail to attend to it. Such inattention is not likely to bring the person in contact with the health system. However, these facets of chronic grief are emotionally impoverishing and socially antithetical to the development of new relationships and commitments. In the final analysis previously established relationships, rather than the deceased person, are relinquished.

The symptomatic manifestations of complicated grief resemble physical and psychological illness. As such, the bereaved person will be involved with the health system. Unattended, the bereaved person's symptoms increase the risk of functional impairment. On the other hand, careful reconstruction of the person's functional impairment facilitates the tracking of the person's distress to his/her to the loss. This in turn, makes it possible to reframe the functional impairment as atypical grief. Essentially, complicated grief manifests in a complex symptom profile and the process may not always reach a state of adequate recovery – a situation that draws attention not only to individual factors but also to contextual correlates.