

Public Attitudes about Normal and Pathological Grief

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Abstract

Determining public expectations of grief is an important contributor to the debate differentiating normal from pathological grief. An international sample of 348 participants was randomly allocated to 1 of 12 conditions comprising a bereavement vignette and self-report items measuring grief expectations and social distance. Participants expected grief to decrease steadily between 2 weeks and 6 months then stabilize; however, time did not affect social distance. Gender of the bereaved and circumstances of death did not influence expectations, but did interact to influence social distance. These factors must be accounted for in determining a deviation from the norm in diagnostic nosology.

Key words: grief, bereavement, prolonged grief, accidental death, complicated grief

Public Attitudes about Normal and Pathological Grief

There is a growing argument in the literature over whether to delineate “normal” (time-bound) expressions of grief from “pathological” (prolonged, distressing and disabling) expressions of grief. The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) removed bereavement as an exclusion criterion for both Major Depressive Disorder and Adjustment Disorder and included Persistent Complex Bereavement Disorder as a condition for further study (American Psychiatric Association [APA], 2013). Similarly, the forthcoming International Classification of Diseases (ICD-11) proposed the inclusion of Prolonged Grief Disorder as a new classification (Maercker et al., 2013; Prigerson et al., 2009).

Despite considerable variation in the experience of grief, many individuals will experience changes in the expression of emotion (e.g., sadness or anger), physical sensation (e.g., fatigue or pain), behavior (e.g., changes in sleep or eating patterns), and cognition (e.g., feelings of disbelief or confusion). Additionally, individuals are often forced to adapt to secondary losses such as financial losses, changes in domestic roles and responsibilities, and social isolation (Breen & O’Connor, 2011; Turvey, Stromquist, Kelly, Zwerling, & Merchant, 2002); which may subsequently affects an individual’s sense of identity and purpose in life (Wortmann & Park, 2008).

A number of factors shape the experience of grief (Lobb, Kristjanson, Aoun, Monterosso, Halkett, & Davies, 2010). An area that has received considerable attention in the literature is gender. Some studies have found evidence of poorer outcomes in men (Stroebe, Stroebe, & Schut, 2001), while other studies suggest higher levels of traumatic grief, depression and anxiety following bereavement in women (Chen, Bierhals, Prigerson, Kasl, Mazure, & Jacobs, 1999). Other studies indicate that men and women experience grief

similarly (Lawrence, Jeglic, Matthews, & Pepper, 2005-2006), but may exhibit different patterns of coping (Martin & Doka, 2010).

Another factor relates to the circumstances of the death. Some research suggests that people bereaved by traumatic deaths are at greater risk for developing pathological grief reactions than those bereaved by natural deaths. For example, Barry and colleagues (2002) showed that bereaved individuals' perceptions of death as violent and unexpected were related to higher rates of psychiatric disorders such as Major Depressive Disorder and Complicated Grief Disorder. Similarly, Wright and colleagues (2010) found that deaths in intensive care units were associated with increased risk of psychiatric disorders in caregivers as compared with deaths occurring at home. In contrast, another study in Pakistan found that violent deaths did not predict Complicated Grief Disorder (Prigerson et al., 2002). These inconclusive findings may be partially explained by the fact that, although some studies rely on the researcher's interpretations of what is considered a traumatic death, others depend on the bereaved person's evaluation of the death.

Another factor for which considerable evidence has been put forth is time since the death. Despite some consensus in the literature regarding the symptoms that constitute pathological grief, one major area of disagreement is how soon a diagnosis should be made. Some researchers propose longer time periods to avoid over-diagnosis, especially around the 12 month anniversary (Horowitz, Siegel, Holen, Bonanno, Millbrath, & Stinson, 1997). However research examining resolution of normal grief over time (i.e., Maciejewski, Zhang, Block, & Prigerson, 2007) and a study that compared acute grief (high severity of grief symptoms for only 6 months post loss), delayed (high grief after 6 months post loss), and chronic (high severity of grief before and after 6 months post loss through 12 months post loss) identified the presence of severe levels of grief symptoms for 6 months or more indicated a diagnosis of Prolonged Grief Disorder (Prigerson et al., 2009).

A mental disorder is defined as a pattern of functioning associated with distress, impairment or risk of an adverse reaction that is *not a culturally normative response to a life event* (APA, 2013, our emphasis). Notably, a specific example of an exclusion criterion for a mental disorder is “death of a loved one” (APA, 2013, p. 20). Although pathological grief must deviate from cultural norms to be considered disordered, there is little evidence documenting these norms. It is apparent that many of the factors that influence the trajectory of grief also influence normative beliefs and expectations that others have of bereaved people. For instance, men and women are accorded the same level of appropriateness when they exhibit similar grieving behavior (Versalle & McDowell, 2005); however, people are more willing to interact with bereaved women than men (as measured by preferred social distance; Kubitz, Thornton, & Robertson, 1989). This contradiction suggests that judgments of appropriateness of another person’s behavior and subsequent behavioral intentions towards that person might be influenced by different mechanisms. Research also indicates that people offer less social support are less willing to interact with the bereaved person when the relationship to the death is considered disenfranchised (Thornton, Robertson, & Mlecko, 1991), such as the death of one’s extra-marital partner or a traumatic death (Dyregrov, 2003-2004), such as a death resulting from a car crash. Finally, research suggests that members of the general public have clear expectations concerning the appropriate duration of grief, providing evidence that time is an important factor in shaping norms (Costa, Hall, & Stewart, 2007). Past research has indicated that the more pervasive public expectations of grief are, the more likely bereaved people are to internalize these beliefs and feel that they must act accordingly (Breen & O’Connor, 2010).

No research has yet explored public expectations of grief in relation to the criteria in the DSM-5 and proposed for ICD-11, despite the contribution of these norms to the debate of whether or not to include bereavement in diagnostic nosology. A limited number of studies

have found that public attitudes toward pathologizing grief are mixed. Although bereaved people in Johnson and colleagues' (2009) study felt that a diagnosis would validate their experiences, studies of non-bereaved people suggest that because grief results from a common life event it is not conceptualized in the same way as other mental disorders (Holzinger, Matschinger, Schomerus, Carta, & Angermeyer, 2011). Consequently, any discrepancies between public expectations and the proposed diagnostic criteria may influence the general acceptance of this proposed disorder.

The purpose of the present study was to investigate public expectations of grief following bereavement. To prevent an anchoring effect of responding to multiple conditions, participants read 1 of 12 versions of a vignette with the analyses exploring between-group differences. The research question considered whether gender, circumstances of the death, and time since death affect people's expectations of grief symptomatology and behavioral intentions towards a bereaved person. We predicted expected grief symptoms will be: less intense for men than women but with a desire for greater social distance from bereaved men than women; more intense with a desire for greater social distance when the death occurs under traumatic than non-traumatic circumstances; and less intense with a desire for less social distance from the bereaved person as time passes.

Method

The research question was addressed using a between-groups fully randomized 3 (Time: 2 weeks, 6 months, and 15 months) x 2 (Gender of the Bereaved Person) x 2 (Death: Traumatic or Non-Traumatic) factorial design.

Participants

Over a three-week period in July 2012, an international sample were recruited using convenience and snowball sampling through social networking sites, research websites, and community noticeboards, and the researchers' personal networks. An a priori power analysis

determined that to achieve adequate power (.80) to detect a medium effect ($f = .25$) at an alpha level of .05, 168 participants would be necessary. As such, the final sample of 348 participants (29 per condition) provided adequate power. The sample of 222 women and 126 men were aged between 18 and 80 years ($M = 35.61$, $SD = 14.73$). Most (54%) were Australian residents, one-third (34.5%) were New Zealand residents and the remainder were residents of the United Kingdom, United States of America, Canada, Finland, Norway, Indonesia, Turkey, Iran or an unspecified country. Most (65.5%) reported they were employed full or part-time, while the remainder identified as students, retired, unemployed or otherwise.

Measures

Twelve versions of a vignette were created to reflect a common bereavement and varied only by the time that had passed since the death, the gender of the bereaved person, and the circumstances of the death. The vignette was designed to contain sufficient information to elicit interest (Hughes & Huby, 2004), but to prevent priming, and provide no information on how well the bereaved person was coping. The circumstances of death were selected to reflect the then-proposed DSM-5 diagnostic criterion in which a car crash would be considered a traumatic death (involving suffering, gruesome injury or blame), and a stroke would not (APA, 2012). Similarly the time since death was manipulated in accordance with proposed criteria: 2 weeks reflecting baseline grief, 6 months reflecting the most recent consensus in the literature of a cut-off for pathological grief and 15 months to avoid the 12 month anniversary of the death. Given mixed findings in past research, gender was also manipulated to explore its effects. For example, one vignette version read: *Two weeks ago, Kate's husband died after a car crash. Kate lives in the suburbs with their two teenage sons and dog.*

The Prolonged Grief Disorder scale (PG-13; Prigerson et al., 2009) is 13-item measure of maladaptive grief symptoms (e.g., *How often do you think this person would be feeling bitter over the loss?*) with high internal consistency (Cronbach's alpha = .82) from a community sample of bereaved individuals in Connecticut (n = 317). We modified it from first to third person, omitted one item (whether six months has passed since the death), and changed responses options to 1 (*never*) to 5 (*always*), rather than 1 (*not at all*) to 5 (*several times a day*) to allow for more general judgments. Principal components analysis with a follow-up parallel analysis produced a one-component model accounting for 38.36% of the total variance. Cronbach's alpha of .87 indicated high internal consistency in the current sample.

The Social Distance scale (Link, Cullen, Frank, & Wozniak, 1987; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999) is 5 items on willingness to engage in different relationships answered on a 4-point scale from 1 (*definitely*) to 4 (*definitely not*). We modified one item changing the relationship from 'child' to 'relative' to increase relevance to participants of all ages. Inter-item reliability in this sample was acceptable (Cronbach's alpha = .76). We presented the items in random sequence.

Procedure

Ethics approval for this study was granted by the Curtin University Human Research Ethics Committee. The study was available internationally through an online participant information sheet and self-administration of the anonymous questionnaire hosted on Qualtrics®. Participants were randomly assigned to read 1 of 12 versions of the experimental vignette before being directed to a standard version of the questionnaire. Upon completion of the questionnaire, participants were debriefed and given the opportunity to enter a prize draw.

Results

As expected, there was a significant effect of time since death on expectations of grief, $F(2,336) = 20.21, p < .001, \omega^2 = 0.10$. Bonferonni post-hoc analyses revealed medium, significant differences between expectations of grief at 2 weeks and 6 months, $F(1,336) = 17.81, p < .001$, Cohen's $d = 0.45$; and 2 weeks and 15 months, $F(1,336) = 38.81, p < .001, d = 0.67$, but no significant difference between expectations of grief at 6 and 15 months. People expected grief symptoms to decrease in the first 6 months post-death then remain similar up to 15 months. Contrary to predictions, there was no significant effect of time since death on preferred social distance, $F(2,336) = 1.41, p = .245, \omega^2 < 0.01$, indicating that participants were equally willing to interact with the bereaved person no matter how much time had passed since the death. Table 1 highlights the differences in expectations and preferred social distance as the time since death increased. Notably, the median social distance rating did not exceed 2 (on the 4-point scale) for any time point, indicating that participants were moderately willing to engage in relationships with the bereaved person, irrespective of how much time had passed.

Contrary to predictions, there were no significant effects (interactions or main effects) of either gender of the bereaved, $F(1,336) = 0.03, p = .866, \omega^2 < 0.01$, or circumstances of the death on expectations of grief, $F(1,336) = 2.18, p = .141, \omega^2 = 0.01$, indicating that neither variable influenced norms of grief symptoms.

As the grey bars in Figure 1 illustrate, participants' desire for social distance was affected by a small, significant two-way interaction between gender of the bereaved and circumstances of the death, $F(1,336) = 8.05, p = .005, \omega^2 = 0.01$. Simple effects analyses using a Bonferonni-adjusted alpha level ($\alpha = .013$) revealed that the gender of the bereaved had a large, significant effect on preferred social distance when the death was caused by a stroke, $F(1,336) = 12.06, p = .001, d = 0.75$, but not when it was caused by a car crash, $F(1,336) = 0.31, p = .580, d = 0.12$. Furthermore, circumstances of the death had a medium,

significant effect on preferred social distance for the bereaved man, $F(1,336) = 9.62$, $p = .002$, $d = 0.67$; but not the bereaved woman, $F(1,336) = 0.83$, $p = .362$, $d = 0.20$. In summary, these results indicate that participants were less willing to interact with a man bereaved by stroke than a woman, and less willing to interact with a man bereaved by a death caused by stroke than car crash.

Discussion

These findings indicate that when people read about a death, they expected a finite period of grief, which is consistent with empirical data showing decreases in the frequency and intensity of grief expressed over time (Ott, Lueger, Kelber, & Prigerson, 2007; Prigerson et al., 2009), as well as research on public attitudes indicating strong expectations of change over time (Costa et al., 2007). Contrary to predictions, participants reported a similar level of willingness to interact with the bereaved person, irrespective of time since bereavement. Participants' willingness to interact was found to be moderate across all time periods. Numerous studies have used social distance scales to evaluate behavioral intentions in manipulated vignettes. Comparing the means found in past research by Link and colleagues (1999) to that of the present study, it is apparent that people in our study were more willing to interact with a bereaved person than people in Link et al.'s study were to interact with people diagnosed with Substance Dependence, Major Depressive Disorder, or Schizophrenia. This may indicate less stigma around bereavement than other existing disorders; however, further research is needed comparing these scenarios using the same vignette template and study sample to explore whether this finding can be generalized. It is worth noting that in the present study, participants were not given any information regarding how the bereaved person was coping, and this kind of information may have affected their ratings of social distance. For instance, if the vignette had indicated that the person was still experiencing intense grief at 15 months, ratings of social distance may have been different.

The effect of gender of the bereaved on expectations of grief did not depend on the circumstances of the death. Contrary to predictions, there were no discrepancies between expectations of men's and women's grief. This supports past research which suggests that men and women commonly experience the same level of grief but that they may utilize different means of coping (Martin & Doka, 2010). Although not gender dependent, some women may cope intuitively through expressive thought and emotion, while some men may exhibit an instrumental coping style through problem solving and directive activity. Also contrary to predictions, expectations of grief did not differ when the level of trauma surrounding the death changed. As indicated by Prigerson and colleagues (2002), violent deaths may not necessarily predispose bereaved persons to experiencing pathological grief reactions.

The effect of gender of the bereaved on behavioral intentions depended on the circumstances of the death, but in the opposite direction to that hypothesized. Participants preferred greater social distance from a man bereaved by a stroke than a woman, and the type of death was taken into account when evaluating the bereaved man (with greater social distance accorded to stroke than car crash) but not the bereaved woman. This effect supports research by Kubitz and colleagues (1989) who found that people were willing to interact with bereaved women, regardless of the circumstances of the death (anticipated or unanticipated), but not bereaved men. This interaction could be explained in one of two ways. Although statistics indicate that men are far more likely to die by cerebrovascular disease (such as stroke) than transport accidents (World Health Organization, 2012), research on availability heuristics suggests that people tend to overestimate the probability of highly publicized events (e.g., car crashes) and underestimate the probability of comparatively less publicized events (Pachur, Hertwig, & Steinmann, 2012). This availability heuristic might lead people to desire greater social distance under less familiar circumstances (e.g., stroke), as there are

fewer norms to guide appropriate interaction with a person bereaved by this type of death (Dyregrov, 2003-2004). Based on the varied effects observed for circumstances of death, a second possibility is that the participants did not judge one of these deaths as less traumatic than the other. The categorization of stroke and car crash were based on a high-risk indicator included in the initial proposed criterion for the DSM-5 (APA, 2012), rather than on evidence exploring how people typically perceive these two causes of death. Strokes are sudden and often unexpected, particularly for younger and middle age adults, which mean many deaths from stroke might be experienced as traumatic. Future research should include pre-experiment pilot testing for alternative non-traumatic causes of death or post-experiment manipulation checks to examine public perceptions of what constitutes a traumatic death, and whether or not this is perceived to put bereaved individuals at greater risk for pathological grief.

Our results have a number of practical implications. Although time since death did not affect the participants' preferences for social distance, the bereaved person's gender and the circumstances of the death did play a role. These results suggest that bereaved men will be offered less social support than bereaved women, particularly when the death is due to a stroke. Due to pervasive expectations in this study concerning the appropriate duration of grief, it is expected that bereaved people may internalize these norms, shaping their perceptions of how 'well' they are coping and their overall experience of grief (Breen & O'Connor, 2010). Interventions should focus on correcting erroneous assumptions in the general public and highlighting the variability in the experience of grief, as reported by people who have actually been bereaved (Costa et al., 2007).

The main clinical implication of these results concerns the degree of alignment between public attitudes (reflecting current cultural norms) and diagnostic criteria for pathological forms of bereavement in the DSM-5 and proposed for the ICD-11. The

participants in this study expected grief to decrease over time. Further research is needed to determine whether there is an exact point in time that the general public differentiates normal from pathological grief, in order to confirm the relevance of the duration criteria of 6 and 12 months for the ICD-11 and DSM-5 respectively (APA, 2013; Prigerson et al., 2009).

Normative beliefs in this study also indicated that neither gender of the bereaved person nor trauma of the death were expected to alter the trajectory of grief. Given that a pattern of functioning must transcend cultural norms to be labeled a mental disorder, consideration must be made of the norms found in studies such as this. Stronger evidence for this effect might come from studies using actual cases of bereaved people who present with distress and impairment. The hypothetical vignettes in the present study were brief, low impact portrayals and therefore a study that examines examples of true characterizations might provide different results.

This study is the first to investigate the perceived appropriateness, according to cultural norms, of the DSM-5 and proposed ICD-11 diagnostic criteria. The reliance on convenience sampling limits the generalizability of the results. The response format of the PG-13 was adapted to gather data on public perceptions of the grief of others. It is worth noting that the adapted version showed high internal consistency reliability and retained the same factor structure as the original PG-13. With so little research exploring social norms, expectations and opinions concerning grief following bereavement, this study provides many avenues for further research. Although preferred social distance often predicts real-world behavior (Jorm & Oh, 2009), in using fictional vignettes, it is not possible to conclude that participants will actually respond according to their stated intentions. Further research might explore the possible influences of confounding influences such as social desirability on these behavioral intentions to better predict real-world behaviors. Furthermore, research indicates that personal experience of, and contact with people who are bereaved, may enhance an

individual's ability to understand grief and offer realistic expectations of the bereaved person (Costa et al., 2007; Jorm & Oh, 2009). Further investigation into the influence of personal experience on the effects observed in this study would be beneficial. Finally, although time since death, gender of the bereaved and circumstances of the death all had some effect on participants' attitudes, future research may benefit from priming participants to think about specific elements of the vignette to increase the size of the observed effects.

In conclusion, the general public holds expectations around the appropriate duration of grief and alters their behavioral intentions depending on the gender of the bereaved person and the circumstances of the death. Although many people believe that certain manifestations of grief could be considered disordered according to clinical definitions, their conceptualizations suggest a preference not to make this diagnosis prematurely and to factor in the distress and impairment required for the diagnosis of a mental disorder. It is important to focus on further defining public opinions towards pathologizing grief, exploring the influence of knowledge and personal experience, and the subsequent effects of these norms on bereaved people. Identifying these norms could inform the proposals to include pathological forms of grief in DSM and ICD nosology, both classification systems that depend on an understanding of deviations from the norm.

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Table 1

Expectations of Grief and Social Distance

Expectations of Grief	<i>M</i> [95% CI]	SD	Median	IQR
Time (<i>N</i> =116)				
Two weeks	3.80 [3.71, 3.90]	0.51	3.75	0.67
Six months	3.50 [3.40, 3.60]	0.56		
15 months	3.35 [3.25, 3.46]	0.57		
Gender (<i>N</i> =174)				
Man	3.55 [3.47, 3.64]	0.57		
Woman	3.54 [3.46, 3.63]	0.58		
Circumstances (<i>N</i> =174)				
Car crash	3.59 [3.51, 3.68]	0.56		
Stroke	3.51 [3.42, 3.59]	0.59		
Social Distance	<i>M</i> [95% CI]	SD	Median	IQR
Time (<i>N</i> =116)				
Two weeks	2.12 [1.97, 2.28]	0.84	2.00	1.40
Six months	2.04 [1.89, 2.18]	0.81	1.90	1.40
15 months	1.95 [1.81, 2.09]	0.77	2.00	1.40

Note. Medians and inter-quartile ranges (IQR) are provided as measures of central tendency and dispersion for non-normally distributed variables. Main effects of gender and circumstances of death for social distance scale are not reported due to the confounding interaction effect.

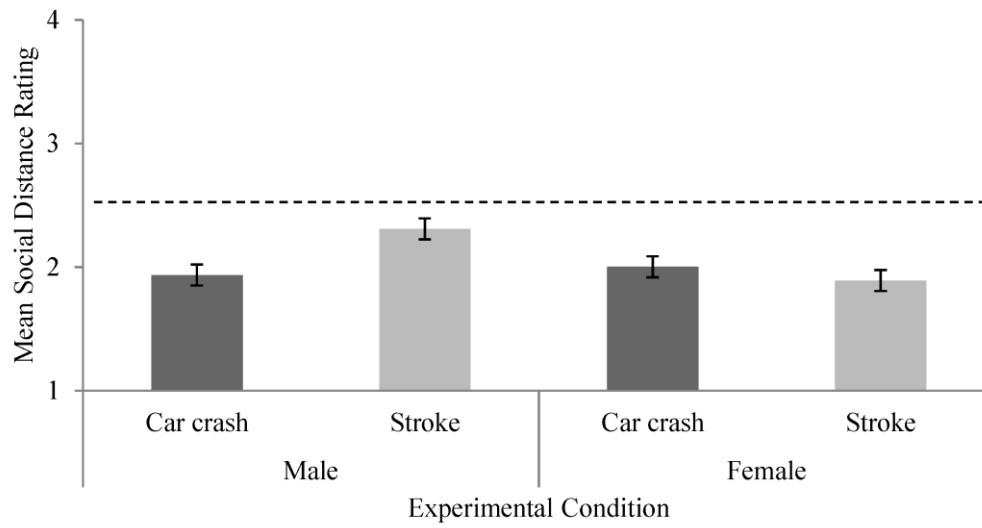


Figure 1. Means and standard error of the means depicting the interaction between gender of the bereaved and circumstances of the death on preferred social distance.