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Social support following bereavement: The role of beliefs, expectations, and support intentions

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Keywords: bereavement; community norms; grief; public perceptions; social support

Abstract

Social support is one of the strongest determinants of bereavement outcomes, yet little is understood about the community's recognition of grief and intentions to provide social support to grieving persons. A total of 476 adults responded to an online vignette and questionnaire measuring grief norms and supportive intentions. Respondent gender, age, and bereavement status all had some association with expectations of grief, intentions to support, perceived helpfulness of support attempts, and opinions toward the diagnostic classification of grief. Given that most bereavement support is informal, this study informs the development of community capacity to provide constructive, timely bereavement support.

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Introduction

Bereavement is a universal experience that will inevitably affect all people at some point during their lifetime. While the support of death, dying, and bereavement has increasingly been managed within formal medical settings, focus has shifted to building individual and group capacity to provide bereavement support through compassionate communities (Aoun, Breen, O'Connor, Rumbold, & Nordstrom, 2012; Kellehear 2013, Paul & Sallnow, 2014, Rumbold & Aoun, 2014). New public health models recognize that the majority of bereaved persons do not require specialized bereavement services (Aoun et al., 2015), but do benefit from informal opportunities to express their feelings and have their grief responded to in a nonjudgmental and empathic way (Breen et al., 2017). This bereavement care framework has the potential to reduce entrenched stigma around death and dying and empower individuals and their broader social networks to take collective responsibility for mental health and well-being (Paul & Sallnow, 2014).

Although social support is consistently reported to be one of the most significant predictors of psychological outcomes following bereavement (Burke & Neimeyer, 2013), studies have found that bereaved persons often do not receive sufficient or timely informal support to moderate their grief experience (e.g., Breen & O'Connor, 2011). To be of benefit, a need for support must be recognized accurately, the potential supporter must be capable of providing the support, and the supportive action must be perceived as helpful by its receiver (Kaunonen, Tarkka, Paunonen, & Laippala, 1999; Rando, 1993). Despite acknowledging the central role of informal supporters in bereavement care, thanatological research has placed far greater focus on how social support is received, than on predictors of supportive behaviors (Bath, 2009).

Recognizing that a minority of individuals are at high risk for developing grief complications (Aoun et al., 2015; Kersting, Brähler, Glaesmer, & Wagner, 2011), a dominant

argument in the grief literature is whether “pathological” responses to bereavement can be differentiated from what might be considered a “normal” or “typical” grief reaction (Doering & Eisma, 2016). The introduction of persistent complex bereavement disorder (PCBD) in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) did not escape criticism in professional or public domains. While one side of the argument promotes improved recognition of and treatment for at-risk individuals (Prigerson et al., 2009), the other takes the stance of the “sceptical public,” focused on safeguarding a natural phenomenon against pathologization and overdiagnosis (Iglewicz, Seay, Vigeant, Jouhal, & Zisook, 2013; Thieleman & Cacciato, 2013). Although the final criterion for PCBD in the DSM-5 specifies that the expression of grief must be “out of proportion to or inconsistent with cultural, religious, or age-appropriate norms” (APA, 2013, p. 790), empirical evidence for, or public endorsement of, these norms is limited. In studies of health professionals, only 43.1% endorsed a grief-related classification in diagnostic nosology, despite 73.1% having witnessed client presentations that would meet diagnostic criteria (Ogden & Simmonds, 2014). In general, community samples’ endorsement has been greater, ranging from 51% (Rüsch, Evans-Lacko, & Thornicroft, 2012) to 75% (Breen, Penman, Prigerson, & Hewitt, 2015); however, some still remain less likely to recommend professional support for bereavement-related distress than other mental health issues (Holzinger, Matschinger, Schomerus, Carta, & Angermeyer, 2011). Whereas in bereaved samples, 96.3% expect relief from a diagnosis and 98.5% would be receptive to receiving treatment for their grief (Johnson et al., 2009), others still propose that an understanding of the phenomenon is more important than any diagnostic label (Ghesquiere, 2013).

Discourses of grief play a pivotal role in societal conceptualizations of what it means to experience loss and grieve in a “typical” or “atypical” manner (Harris, 2009). The most

prominent discourse of grief is constructed on the assumption that grief is a finite, short-term experience that must be worked through in a predictable pattern across a series of quasi-linear stages, eventually culminating in detachment from the deceased (Breen & O'Connor, 2007). These ideas have been subject to robust theoretical and empirical challenges, suggesting that stage-based models perpetuate unrealistic expectations and a sense of inadequacy in those who fail to detach, move on, and “resolve” their grief (Hall, 2014). However, within informal social networks and some health and social care settings, these myths and assumptions have become “truths” that prescribe who should grieve, when they should grieve, how they should grieve, where the grief should occur, for how long they should continue grieving, and finally, for whom should they grieve (Doka, 1989, 2002). Through these implicit rules, a dichotomy is created where a loss is either appraised as enfranchised (legitimizing displays of emotion and with the offer of social support) or disenfranchised (where others will not recognize or validate the loss, and support will not be offered; Doka, 2002). How these rules will apply to any given person depend on a complex interplay of factors relating to the deceased (and their manner of death), the bereaved, and the potential supporter (Logan et al., 2017).

Two decades ago, Calhoun and Allen (1991) produced a literature review of 17 studies which identified three participant-related factors (age, gender, bereavement experience) and four decedent-related factors (age, gender, cause of death, family composition) that determined social reactions to suicide bereavement. Logan et al. (2017) conducted a systematic review of the entire bereavement literature and identified 42 studies yielding six participant-related factors (gender, bereavement experience, normative beliefs, current bereavement status, age, and familiarity with cause of death), five decedent-related factors (cause of death, anticipation of death, gender, age, and motive for suicidal death), and five bereaved-related factors (gender, time since death, relationship to the deceased, perception of coping, and perceived social support). This review highlighted significant methodological

flaws and omissions in this research base, including inconsistent outcome measures with poor or no psychometric properties, little to no control of extraneous variables, nonrepresentative samples, and low power to detect possible relationships.

Three key factors that emerged from Logan et al.'s (2017) review as warranting further investigation included the participants' own experience of bereavement (bereavement status), the anticipation of the death, and the level of social support the bereaved is perceived to already have. In terms of bereavement status, although some studies found greater empathy for and acceptance of bereaved individuals when the supporter had experienced a bereavement themselves (Blair, 2003; Egnato, Sirianni, Ortega, & Stefanone, 2014; Villa, 2010), other studies noted no relationship between bereavement experience and expectations of the other's grief or intentions to provide support (Bath, 2009, Catlin, 1993, Thompson & Range, 1990, Wagner & Calhoun, 1991). However, these studies focused on the event of bereavement and overlooked the subjective impact of bereavement. In terms of anticipation of death, although some study participants have rated anticipated deaths as being easier to resolve than unanticipated (Costa, Hall, & Stewart, 2007, Kubitz, Thornton, & Robertson, 1989), others have noted no difference in evaluations of the bereaved, prediction of bereavement outcomes, or supportive offerings (Range & Thompson, 1987, Range, Walston, & Pollard, 1992; Thompson & Range, 1990). Finally, perceptions of social support has only been investigated in two studies, demonstrating perceptions of better coping and less need for support when the bereaved person appeared to have a reasonable level of support (Costa et al., 2007; Villa, 2010). Further investigation is needed, controlling for extraneous variables, to verify the relative contribution of all three of these factors. Following a call to action for more rigorous, methodologically sound exploration of these influences (Logan et al., 2017), this study was devised to examine some of these less well understood factors that may affect community recognition of grief and intentions to support grieving persons.

Evidently, there are a broad range of factors that may either hinder or facilitate the provision of social support to grieving persons, but the evidence so far is poor in quality and limited in scope (Logan et al., 2017). Given the increasing emphasis on social support as a protective factor against complications of bereavement, an understanding of the mechanisms underlying when and how potential supporters respond to bereavement is of critical importance. The present study investigated whether bereavement status, anticipation of the death, and level of social support affect expectations of grief symptomatology and intentions to provide social support to grieving persons. Further, it explored relationships between bereavement status and beliefs about the helpfulness of support-intended statements and endorsement of a grief-related diagnostic classification. We predicted participants would rate grief more intensely and be more likely to provide support when they had a personal bereavement history and when the bereavement was characterized by both an unanticipated death and little available social support. We also hypothesized an association between bereavement status and helpfulness of support-intended statements and endorsement of a grief-related diagnostic classification; however, the literature did not provide sufficient evidence to support a directional prediction.

Methods

The role of bereavement status, anticipation of the death, and level of social support on expectations of grief symptomatology and intentions to provide social support to grieving persons were addressed using a between-groups 3 (bereavement experience: “none,” “yes but not significantly impacted,” “yes and significantly impacted”) x 2 (anticipation of the death: “prolonged/ expected,” “sudden/unexpected”) x 2 (social support: “little,” “a lot”) factorial design with the latter two conditions fully randomized. Beliefs about the helpfulness of support-intended statements and opinions about a grief-related diagnostic classification were addressed using simple between-groups designs. Members of the general Australian public

were recruited using convenience and purposive sampling through radio advertising, e-mail lists, community noticeboards, online noticeboards, and discussion forums. An *a priori* power analysis (Faul, Erdfelder, Lang, & Buchner, 2007) determined that 318 participants were needed to detect a small ($f = 0.10$) to moderate ($f = 0.25$) effect at an alpha level of 0.05. As such, the final sample of 476 provided adequate power. Data were collected through an anonymous questionnaire hosted on Qualtrics®. Participants were randomly assigned to read one of four versions of a vignette before responding to the questionnaire.

Measures

Vignette. Vignettes are commonly used in social and attitudinal research to elicit a response that best approximates how that individual might respond in real life (Hughes & Huby, 2004). For this study, four versions of a vignette were developed to reflect a hypothetical bereavement scenario, varying only by the described anticipation of the death and level of social support. Vignettes were kept gender-neutral and only varied by the two manipulated factors, designed to provoke interest but minimized superfluous details that might distract participants. An example vignette read: “A.L’s spouse died unexpectedly after a sudden illness. A.L lives alone and appears to have little support from family or friends.” To increase the validity of responses to these vignettes, participants were exposed to a postmanipulation check in the form of two questions that tested recognition of specific details in the vignette.

Expectations of grief and intentions to support. The first two scales assessed participants’ expectations of grief and intentions to provide support to the person in the vignette. Participants’ expectations of the severity and intensity of the target figure’s grief was measured using the 12-item expectations of grief symptomatology scale previously published by Penman, Breen, Hewitt, and Prigerson (2014) as a modified version of Prigerson and Maciejewski’s (2009) prolonged grief disorder scale. This revised scale asks

participants to rate a series of grief symptoms (e.g., How often do you think this person would be avoiding reminders that the person lost is gone?) on a five-point Likert scale from 1 (*never*) to 5 (*always*), with higher scores indicating an expectation of more intense grief. This scale demonstrated unidimensionality and acceptable internal consistency in the present sample ($\alpha = 0.87$) as in the past studies ($\alpha = 0.87$; Penman et al., 2014). Intentions to provide social support was measured using the four-item intentions subscale of the theory of planned behaviour for social support of grieving persons scale (Bath, 2009). This scale explores general intentions to support grieving persons, so the wording was modified to make judgments specific to the person in the vignette. Responses to items were measured on a seven-point Likert scale from 1 (*strongly disagree*) to 7 (*strongly agree*), with higher overall scores reflecting a greater intention to provide social support. This scale demonstrated unidimensionality and acceptable internal consistency reliability in the present study ($\alpha = 0.90$) as in the past studies ($\alpha = 0.71$; Bath, 2009). A single item from the same scale was used to examine past behaviors of providing social support to grieving persons from 1 (*none of the possible times*) to 7 (*all of the possible times*).

Perceived helpfulness of support attempts. Helpfulness of support attempts was assessed using the 64-item support-intended statements scale (Rack, Burleson, Bodie, Holmstrom, & Servaty-Seib, 2008). Responses to items were measured on a five-point Likert scale from 1 (*very harmful*) to 5 (*very helpful*) with a midpoint of 3 (*neither*); higher scores indicated a greater perceived helpfulness rating. This scale was theoretically devised and comprises 16 conceptually independent subscales with Cronbach's alphas ranging from $\alpha = 0.60$ – 0.92 (Rack et al., 2008). However, no published studies known to these authors have examined the higher order factor structure of these 16 subscales. In the present study, principal component analysis with a follow-up parallel analysis indicated a two-component model with eight subscales loading on each component. This two-component solution

accounted for 51.5% of the total variance. The first factor comprised offers presence/being there, expresses willingness to listen/provide opportunities to express feelings, expresses care and concern, includes in social activities, compliments the deceased, offer contact with similar others, discusses memories of the deceased, and provides tangible support. This factor appeared to represent efforts by the participants to support through closely connecting with the bereaved and tuning into the unique emotional experience (thus named *Support through Approach*). The second factor comprised compliments the living, discusses being reunited, highlights the positive, provide a religious perspective, identifies with the other's feelings, provides a philosophical perspective, gives advice, and minimizes feelings/force cheerfulness. This factor appeared to represent efforts by the participants to support through offering distal suggestions and seeking sameness without emotionally connecting to the individual's unique experience (thus named *Support through Avoidance*). The internal consistencies of *Support through Approach* ($\alpha = 0.83$) and *Support through Avoidance* ($\alpha = 0.85$) were both adequate.

Endorsement of a grief-related classification in diagnostic nosology. These opinions were measured using a two-item scale modified from Breen et al. (2015). The first item asked participants to rate the extent to which they agreed with a grief-related classification for individuals showing a complex set of symptoms indicating difficult adjustment to a death. Responses to items were measured on a five-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*), with a midpoint of 3 (*unsure*); with higher scores reflecting greater agreement. A follow-up open-ended question then asked participants to explain how they believed a diagnosis might affect an individual's experience of grief.

Demographics. Bereavement status was assessed using a single item which asked participants whether they had experienced bereavement and, if so, whether it had or continues to have a significant impact on their life. Recognizing grief as a lifelong experience for some,

focus was placed on the subjective impact of the loss rather than how recently it occurred. To ensure group equivalence for this bereavement status condition, a range of other demographic variables were measured and analyzed. The questionnaire included demographic questions relating to age, gender, country of birth, religion, highest level of completed education, occupational status, profession, professional exposure to/training in grief, and social desirability. Social desirability was measured using a 10-item version of the Crowne–Marlowe social desirability scale (Strahan & Gerbasi, 1972). This scale is commonly used alongside other self-report measures to control for tendencies to respond in what is perceived to be a socially desirable way (i.e., to prevent faking “bad” or “good”; Crowne & Marlowe, 1960). Responses to items are measured on a forced-choice *yes/no* scale (with five items keyed true and five false). Higher summed scores indicate more socially desirable responding. Although this scale demonstrated adequate internal consistency in the past research ($\alpha = 0.84$; Fischer & Fick, 1993), in the present sample, internal consistency was moderate ($\alpha = 0.63$).

Analysis

Possible group nonequivalence was assessed by exploring whether the conditions differed in their demographic characteristics. Variables which correlated significantly with the dependent variable were treated as bona fide covariates and included as control variables in subsequent analyses. The only exception is gender, which correlated with some dependent variables, so was included as an additional independent variable to analyze rather than simply control for, its impact. Generalized linear mixed models (GLMMs) were run using the Statistical Package for the Social Sciences (SPSS v20). To optimize the likelihood of convergence, separate GLMM analyses were run for each of the four dependent variables: expectations of grief symptomatology, intentions to provide social support, beliefs about social support, and endorsement of a grief-related diagnostic classification. As these variables

are conceptually independent, statistical significance was evaluated at the conventional per test alpha level of 0.05 and effect sizes were interpreted using Cohen's (1988) conventions.

The single open-ended question was analyzed using content analysis (Hsieh & Shannon, 2005). Analysis focused on identifying the range of effects (both positive and negative) that the participants believed a bereavement-related classification might have on the experience of grieving. Two researchers conducted an independent, blind open coding of 10% ($n = 43$) of the responses according to general effect with any disagreement resolved before the remaining responses were coded by the first author. All responses were open coded before concepts were refined, collapsed, renamed, and categorized to represent the final 6 positive and 10 negative effects.

Results

Demographics

The sample comprised 476 Australian adults (394 women, 82 men) aged between 18 and 93 years ($M = 39.76$, $SD = 15.64$). The majority of the sample (69.1%) was born in Australia. Approximately half (53.4%) of the participants had no religious affiliation, with the remainder identifying as Christian (37.0%), Buddhist (3.2%), Hindu (1.5%), Islamic (0.4%), and other (4.6%). The sample was predominately well educated with 70.4% having completed a tertiary qualification, 13.7% high school, 10.3% vocational education/training, and 5.7% not completed high school. Just under half (46.2%) reported working full-time, 31.9% part-time, 13.4% away from work, and 8.4% were unemployed.

In terms of bereavement status, 261 (54.8%) participants identified as having experienced a death that *did have* a significant impact on their life. The greatest proportion of bereavements were parents ($n = 80$), followed by extended family members ($n = 74$), friends ($n = 35$), spouses/partners ($n = 25$), children ($n = 15$), siblings ($n = 13$), and other ($n = 19$), which comprised in-law relatives, step-parents, perinatal deaths, ex-spouses/partners, children

of friends, friends of parents/partners, and work clients. Time since death ranged from less than 1 month to 62.75 years ($M = 7.62$, $SD = 9.14$). In contrast, 149 participants (31.3%) reported having experienced bereavement(s) that *did not have* a significant impact on their life, and 66 (13.9%) had not experienced the death of someone close to them. These two categories were collapsed for analysis. A total of 175 participants (36.8%) identified as having a professional role with some exposure to, or training in, grief following bereavement.

Expectations of grief and intentions to support

There were no significant three- or two-way interactions involving bereavement experience, anticipation of death, and level of social support on either the expectations of grief symptomatology or intentions to support scale, permitting evaluation of each main effect independently of the others. In total, 136 participants (28.6%) incorrectly answered one or more of the questions in the postmanipulation check. Further analysis revealed that the binary postmanipulation check variable only moderated one effect within the expectations of grief symptomatology scale and is described in detail below. Before analysis, all potential covariates were examined for their effects on the expectations of grief symptomatology and intentions to support scales. Only participant age was correlated and so was included as a control variable in both analyses.

For expectations of grief symptomatology, neither support level ($F[1, 460] = 1.54$, $p = 0.216$) nor anticipation of the death ($F[1, 460] = 2.34$, $p = 0.127$) directly affected participants' ratings of the anticipated intensity of the grief reaction. There was a significant small two-way postmanipulation check x anticipation of death interaction on expectations of grief symptomatology ($F[1, 444] = 9.41$, $p = 0.002$, $\eta^2 = 0.020$), indicating that the relationship between anticipation of death and the expectations of grief symptomatology scale varied as a function of whether the participant passed or failed the manipulation check. For participants who failed, there was no significant difference in the expected severity of

grief between the “anticipated” ($M = 3.70$, SE = 0.068) and “unanticipated” ($M = 3.45$, SE = 0.128) groups, $F(1, 444) = 2.99$, $p = 0.082$). In contrast, participants who passed the manipulation check rated the “anticipated” death ($M = 3.41$, SE = 0.086) as lower in grief intensity than the “unanticipated” death ($M = 3.70$, SE = 0.050), representing a small effect, $F(1, 444) = 8.44$, $p = 0.004$, $\eta^2 = 0.019$. Both participant gender and bereavement status had small, significant effects on expectations of grief symptomatology. Female participants ($M = 3.75$, SE = 0.028) expected a more intense grief reaction than males ($M = 3.43$, SE = 0.077), $F(1, 460) = 15.31$, $p < 0.001$, $\eta^2 = 0.032$. Participants impacted by bereavement ($M = 3.72$, SE = 0.066) also expected a more intense grief reaction than those not impacted ($M = 3.47$, SE = 0.049), $F(1, 460) = 9.62$, $p = 0.002$, $\eta^2 = 0.020$.

For intentions to support, support level ($F[1, 460] = 0.33$, $p = 0.568$), anticipation of death ($F[1, 460] = 0.19$, $p = 0.662$), and bereavement status ($F[1, 460] = 0.02$, $p = 0.886$) did not significantly affect participants’ ratings of how likely they would be to offer the target figure support following the death. However, again participant gender had a small, significant effect. Female participants ($M = 6.25$, SE = 0.050) indicated greater intentions to support than males ($M = 5.72$, SE = 0.146), $F(1, 460) = 11.99$, $p = 0.001$, $\eta^2 = 0.025$. Past behaviors providing social support was significantly correlated with future intentions to support, $r_s [N = 476] = 0.368$, $p < 0.001$; however, the relationship was not particularly strong with the two variables only sharing 13.5% of variance.

Perceived helpfulness of support attempts

For *Support through Approach* statements, participant gender had a small, significant effect, $F(1, 472) = 6.90$, $p = 0.009$, $\eta^2 = 0.014$. Female participants ($M = 0.07$, SE = 0.047) rated *Support through Approach* statements as significantly more helpful than male participants ($M = -0.30$, SE = 0.131). For *Support through Avoidance* statements, there was a significant bereavement status x participant gender interaction, $F(1, 455) = 4.97$, $p = 0.026$.

For male participants, there was no significant difference in ratings of helpfulness between those impacted by bereavement ($M = 0.99$, SE = 0.203) and those not impacted ($M = 0.68$, SE = 0.170), $F(1,455) = 1.68$, $p = 0.195$. For female participants, compared with those not impacted by bereavement ($M = 0.71$, SE = 0.118), those impacted ($M = 0.46$, SE = 0.117) rated Support through Avoidance statements as significantly less helpful, representing a small effect, $F(1, 455) = 7.78$, $p = 0.005$, $\eta^2 = 0.017$.

Endorsement of a grief-related classification in diagnostic nosology

In total, 188 participants (39.5%) disagreed/strongly disagreed with the concept of a grief-related diagnostic classification, 169 (35.5%) agreed/strongly agreed, and 119 (25.0%) were undecided. There was no significant main effect for bereavement status on endorsement of a grief-related classification, $F(1, 471) = 1.71$, $p = 0.192$. Participant age had a small, significant effect with younger participants more likely to endorse the classification than older participants, $F(1, 471) = 8.57$, $p = 0.004$, $\eta^2 = 0.018$. A total of 425 participants further qualified their response to this item by explaining how they believed a diagnosis might affect the experience of grieving. Of these 425, only 6 (1%) participants proposed that a diagnosis would have no effect whatsoever. Responses of all others are summarized in Tables 1 and 2 with effects quantified to illustrate the extent to which participants shared views about the potential impacts of a diagnosis. The majority of participants mentioned more than one effect and many mentioned both positive and negative consequences.

The written responses of participants indicated six positive effects of a diagnostic classification. Participants acknowledged that a formal diagnosis might improve access to and quality of professional support, with a shift from traditional depression-focused therapies to more specialized interventions that target the grief itself. Similarly, it was proposed that formal recognition would increase validation, legitimization, and normalization of each individual's unique grieving patterns. Some participants noted that a diagnosis might

promote coping by providing some context and meaning to the experience of grief which could facilitate the active expression of feeling. Others suggested that a diagnosis might facilitate the provision of special entitlements (e.g., extended bereavement leave) and social support which may reduce isolation and create space for mourning. Finally, participants highlighted the power of a diagnosis to accurately demarcate low-risk individuals experiencing “typical” grief from higher risk individuals exhibiting “atypical” symptoms over an extended period of time, facilitating decisions about who will benefit most from specialized bereavement support.

Paradoxically, many of the aforementioned positive effects were also interpreted as potential negative effects by participants. Participants argued that a diagnosis invalidates a natural phenomenon and suggests abnormality without reason, potentially risking the invitation of label-induced stigma associated with other mental health diagnoses. Some proposed that diagnosis encourages a reductionist approach which simplifies understanding of an individual’s grief while ignoring the nuances that make it unique. Although some suggested that a diagnosis might promote coping, others stated that a diagnosis might escalate distress, encourage a self-fulfilling prophecy, or even suppress the grief due to connotations associated with the diagnostic label. Participants reported that a diagnosis represents the pathologization and medicalization of grief rather than the acceptance and integration of a natural consequence of loss. It was argued that diagnosing symptoms may impose unrealistic expectations and regulations on mourning, introduce intervention where it is not necessary, or reduce the likelihood that an individual will seek help for their experience.

Discussion

The aim of this study was to explore some of the key mechanisms motivating participants’ expectations of grief, intentions to provide social support, beliefs about the helpfulness of support-intended statements, and opinions on a diagnostic classification for

grief. For the majority of bereaved individuals who do not require specialized complicated grief interventions, the study's findings highlight that characteristics of the responder (gender, age, bereavement status) may have a more profound impact on community recognition of grief than characteristics of the bereaved or decedent (support level, anticipation of death). Social support is strongly correlated with bereavement outcomes (Burke & Neimeyer, 2013); yet, as these findings suggest, the assumption that the general public is universally prepared, capable, and willing to provide such support is not well evidenced. Recognizing that few protective factors in bereavement can be modified to the extent that social support can (Bath, 2009), these findings support a growing initiative to realign public expectations of grief and improve community capacity to provide timely and appropriate bereavement care (Aoun et al., 2015).

For the small proportion of bereaved individuals who are at high risk for developing complications of bereavement (Aoun et al., 2015; Kersting et al., 2011), a slight majority of participants in this study would not support a diagnostic classification. This finding is similar to figures in a health professional sample (Ogden & Simmonds, 2014) but is considerably lower than in general community samples (Breen et al., 2015, Rüsch et al., 2012) and bereaved populations (Johnson et al., 2009). The one-quarter of participants who were undecided may indicate a perception of not being able to hold an informed opinion or indeed conceptualize the consequences of such a decision. This hypothesis is supported by findings that many people fail to access bereavement support services due to low awareness that what they are experiencing might be pathological (Lichtenthal et al., 2011). In line with Breen et al. (2015), responses in this study highlighted mixed perceptions about the potential effects of a grief-related diagnosis on the experience of grievers. Those favoring a diagnosis tended to focus on recognizing the small proportion of individuals whose grief is intense and persistent, validating the complexity of their experience, and providing them with informal supports and

specialized formal interventions to hold their grief. In contrast, those more cautious about applying a diagnosis warned against reducing a natural phenomenon to a single label and viewing it through a medical lens, suggesting that formal and informal supports are still possible without classifying the experience. Further research is needed to identify the relative impact of these beliefs on bereaved people and how this may influence their receptivity to receiving support, both formal and informal.

Contrary to predictions, participants' bereavement status held no relationship with intentions to support the bereaved or endorsement of a grief-related diagnostic classification but did impact expectations of grief symptomatology. This finding suggests that experiencing a significant bereavement may not be as clearly associated with particular responses to another person's grief as once thought. Identifying spaces where one can develop a sense of common understanding and similarity to others is often reported by bereaved persons to be a significant therapeutic process following bereavement, and indeed forms the basis for the effectiveness of many bereavement support groups (Umphrey & Cacciato, 2011). It is plausible that personal bereavement experience may facilitate more realistic expectations of another person's grieving but may inhibit closer empathic attunement, possibly due to fears of becoming engulfed by the other person's grief. This hypothesis is supported by Logan et al.'s (2017) finding that, although potential supporters with a bereavement experience may indicate greater empathy for and acceptance of bereaved persons, they may be no more prepared to offer support than someone not personally impacted by bereavement. Similarly, they may be no more informed in their opinion of whether or not a grief-related diagnostic classification would have merit, particularly when they are encouraged to think outside their own bereavement to how it would affect bereaved persons more generally. This finding has significance, given the only two existing studies using bereaved samples both asked

respondents whether a diagnosis would have been helpful to *them* specifically (Ghesquiere, 2013, Johnson et al., 2009).

Against predictions, neither the described level of social support nor anticipation of the death affected expectations of grief symptomatology or intentions to provide support. These findings refute previous conclusions that anticipated deaths are perceived to be quicker to resolve than unanticipated deaths (Costa et al., 2007; Kubitz et al., 1989) and may require less support (Villa, 2010) but confirms other research where participants have perceived that anticipated deaths might be equally challenging, dependent on the strength of the attachment bond (Range & Thompson 1987; Range et al., 1992; Thompson & Range, 1990). These findings are supported by empirical evidence that circumstances of the death have less impact on the manifestation of grief as time progresses (Feigelman, Jordan, & Gorman, 2009), and quantity of support does not always correspond to quality of support when it comes to informal bereavement care (Breen & O'Connor, 2011).

In line with the past studies (for a full review, see Logan et al., 2017), participant gender was significant, with women expecting more intense levels of grief of the target figure and being more willing to offer support than men. Women were also more likely than men to endorse *Support through Approach* statements as helpful and, if affected by bereavement, were more likely to rate *Support through Avoidance* statements as less helpful (where no difference existed in men). This finding contributes to contemporary theory that although a person's gender does not *predict* their grief reaction, it may influence their bereavement experience depending on their grieving style (intuitive versus instrumental; Doka & Martin, 2010). In line with this, these findings suggest that men may recognize and respond differently than women to the grief of others based on their own natural grieving style and whether they have been socialized in early years to experience grief and loss in a certain way. Similarly, participant age impacted opinions toward a grief-related diagnostic classification,

with older participants being less likely to endorse the proposed diagnosis than younger participants. Higher levels of mental health-related stigma have been found to correlate with age (Jorm & Oh, 2009); thus, the older adults in this study may have been more cautious in classifying grief that persists beyond “the norm,” with a broader understanding of the potential impacts such a label might have.

The emergence of age, gender (and bereavement status in interaction) as significant variables in this study indicates that the general public predominately recognize and respond to grief according to personal frame of reference. This finding is noteworthy, given such factors are amendable to change through community education and support. Empirical evidence dictates that it is not financially viable or effective to invest in a one-size-fits-all approach to the delivery of bereavement care (Aoun et al., 2015), but rather the majority of grieving individuals can benefit from the knowledge, insight, and resources that exist within their own communities (Rumbold & Aoun, 2014). However, as this study and others have found, the general public may not be as prepared, capable, or willing to assume responsibility for supporting grieving family, friends, colleagues, and neighbors as health and social care professionals might hope or expect. As identified by Kaunonen et al. (1999) and Rando (1993), the existence of social networks alone is not sufficient, but rather these networks must be able to recognize a need and offer an intervention which is perceived as helpful by its receiver, to affect the trajectory of grief. Recognizing such deficits, there is growing advocacy for stronger partnerships between formal bereavement services and communities to upskill the general public and develop more appropriate, targeted grief support from the ground up (Paul & Sallnow, 2014). Research findings such as these provide valuable insight into how grief is currently conceptualized and responded to in contemporary society, and how compassionate communities might be realized, particularly beyond palliative and end-of-life domains.

Empirical evidence suggests that behavioral intentions are usually fairly predictive of real-world behaviors (Jorm & Oh, 2009). The vignettes in this study were hypothetical and contained very little information; however, it is possible that participants may have responded differently if they had better identified with or known the person in the vignette. Vignettes are limited in their capacity to capture full individual realities and elicit valid responses (dependent on the validity of the vignettes themselves); however, this method is still recognized as the best approximation of real-life responding (Hughes & Huby, 2004). This study is the first to include a measure of social desirability which, contrary to expectation, did not significantly influence any of the results. Despite social desirability having low impact in online surveys (Duffy, Smith, Terhanian, & Bremer, 2005), future research should seek to rule out such influence using the full version of this scale, particularly given the less than adequate internal consistency of the short form used in the present study. Due to the study's focus on community norms, the representativeness of the sample is also worth mention. In line with the previous studies (Logan et al., 2017), the present sample predominately comprised well-educated women which may have skewed the findings somewhat. However, data in this study relating to mean age, country of birth, and religious affiliation/denomination closely approximated recent census data (Australian Bureau of Statistics, 2016), permitting some generalization. Just over one-third of participants identified as having a professional role with some exposure to, or training in, grief following bereavement. Although this figure is noteworthy and we might expect different grieving norms in this third of our sample, professional exposure/training did not emerge as a significant covariate for any of the outcome measures. This result may be due to the limited quality and outdated nature of grief education to which many professionals are exposed (Breen, Fernandez, O'Connor, & Pember, 2013; O'Connor & Breen, 2014). Future studies

could investigate how quality of education might affect recognition of grief and intentions to support grieving persons.

This study is the first to examine some of the less well-understood factors that may affect community recognition of grief, intentions to support grieving persons, and endorsement of a grief-related classification using robust research methods with strict control of extraneous variables. A particular strength of this study was its exploration of bereavement status as a nonbinary concept, permitting participants to self-define according to their bereavement experience and whether *they* believed it had significantly impacted on their life. Recognizing that the experience of bereavement may not, in itself, correlate with distress or an altered perception of grief, it is anticipated that this study may have more accurately captured the true relationship between bereavement status and grieving norms than past research.

Conclusion

Community expectations of grief, intentions to provide social support, and beliefs about the support and classification needs of grieving persons are dependent on a range of respondent characteristics including age, gender, and bereavement status. This study highlights the need to expand research beyond the experiences of the bereaved, to understand the motivations of the providers of social support. In order for communities to be compassionate in the wake of bereavement, there is a need for awareness-raising initiatives, distribution of resources to inform the public of current theories of grief, and clear and open communication between specialized bereavement services and communities so that each is informed of the unique role of the other. The findings offer insight into the direction of such strategies, for example, focusing on potential responders who hold less realistic expectations of bereaved persons or who may be less willing to offer support when it is needed. Although a minority of bereaved persons will have many of their support needs met through formal

bereavement services, for both these individuals and others, there is a need to deepen investment in the natural supporters of grief through improving perceptions of and attitudes toward death, dying, and bereavement and harnessing the informal resources inherent in communities. If community members are to assume the greatest bereavement support role and should “pathological” grief shift into mainstream diagnostic nosology, further research will be needed to inform efforts to enhance treatment receptivity for those at greatest risk for complications of bereavement and facilitate constructive, timely social support for those who are not.

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Table 1

Positive Effects of a Bereavement-Related Diagnosis on the Grief Experience

Effect	<i>n</i>	Exemplar Response
Improves access to and quality of professional support	94	<p>“Not having grief recognised in the DSM will not change its existence, only its possible treatment and understanding” – 60</p> <p>“Having a classification of grief in the DSM may result in easier access to and more tailored support for people suffering from grief” – 162</p>
Validates, legitimises, and normalises	94	<p>“If the grief issue were unusually prolonged, it might be comforting to know that it was a mental health issue, which they could get help for, rather than feeling like they’re losing their mind” – 167</p> <p>“It may allow the person going through grief some sort of social legitimacy that their feelings are reasonable, especially if they are feeling pressured to ‘get over it’ or ‘move on’” – 250</p>
Promotes coping	33	<p>“A grief-related classification would help an individual dealing with loss make sense of their emotions and give reason to them. By better understanding their emotional response, I believe that they would be in a better position to move through the grieving process and begin to feel better” – 215</p> <p>“Sometimes giving someone a medical name for symptoms and letting them know it is something that people get diagnosed with can help them accept their feelings and try to find a positive resolution” – 298</p>
Reduces isolation and increases support	22	“It might make people more aware that grief is a real issue for people and that, by bringing awareness to it, they can offer support to the person” – 18

“It may open the doors to more support and recognition which, given society’s inherent inability to confront and recognise grief, is useful” – 194

Facilitates entitlements	14	“If an individual was having difficulty in receiving adequate support from their workplace, having a classified mental disorder would allow them to justify taking as much time off as they needed to deal with their grief” – 3 “I think other people, in particular the workplace, may be more sympathetic” – 81
Delineates ‘atypical’ from ‘typical’ grief	9	“It may help to recognise negative signs of grief, for example when it lasts an extended period of time or the person is having thoughts of harming themselves or others” – 243 “There is a need to develop more effective ways of reaching and assisting individuals experiencing prolonged complex grief that is clearly outside of the normal range....In this way, complex bereavement could be distinguished from ‘typical’ bereavement in the same way that low mood is currently distinguished from depressive disorders, or stress from anxiety disorders” – 280

Note. Some participants noted more than one effect.

Table 2

Negative Effects of a Bereavement-Related Diagnosis on the Grief Experience

Effect	<i>n</i>	Exemplar Response
Invalidates and suggests abnormality	145	<p>“I think it may send the message that the grieving process is not a normal or acceptable part of life and could even be considered a weakness. Individuals may begin to question their grief and think that it may not be okay to feel the way they do which, in turn, could perpetuate the negative feelings” – 15</p> <p>“Labelling the grief as a ‘problem’ could ingrain a problem or make the person think they are a problem” – 112</p>
Invites label-induced stigma	87	<p>“Because mental illness continues to carry an amount of stigma, grieving people might feel even more unusual from what they used to feel (prior to the death) and even more distant from others around them and broader society” – 148</p> <p>“It could box them in so that their future decisions and life experiences are framed by this classification that they were given 10 or 20 years ago when they were having trouble coping with the loss of a loved one” – 96</p>
Promotes a one-size-fits-all approach	68	<p>“We are so keen on classifying everything instead of allowing people to be who they are. Grief is personal, individual, and takes time. Classification does not assist in any of this” – 43</p> <p>“You can’t quantify an individual experience. By trying to contextualise or classify an individual experience, I think you demean it in some way by assuming it’s the same” – 105</p>
Escalates distress	59	<p>“It could be detrimental to the person and only intensify the bereavement process by adding another step” – 227</p> <p>“I think if someone is classified as having a mental health disorder in times of grieving, this may make them feel worse</p>

		and less able to cope and might drive them to further, darker places” – 302
Pathologises and medicalises	58	<p>“I think pathologising grief and the experience of grief is unhelpful because it is yet another way in which we are trying to sanitise death out of our lives” – 26</p> <p>“I worry something like this may lead to over-diagnosis/over-classification of something which isn’t necessarily pathological or chronic. I worry also that diagnostic criteria for how a person deals with grief may emphasise what is ‘normal’ and what is ‘abnormal’ in a way that is not helpful or accurate” – 364</p>
Encourages a self-fulfilling prophecy	53	<p>“Some people can become very involved with their mental health issue and almost wear it as a badge of honour, causing them to remain stuck in their ways” – 233</p> <p>“It would allow them to accept the way that they are feeling as something that is not able to be controlled or changed” – 434</p>
Imposes expectations and regulations	27	<p>“We live in a culture of grief aversiveness, whereby deep sorrow is too confronting for most people and therefore we are hasty in encouraging people to move on from these feelings before they are ready to or have had a forum in which to experience and understand their feelings” – 235</p> <p>“I think that imposing boundaries on a very personal issue like grief/death is detrimental to the person and the wider community. It suggests that a person’s pain is understood and measurable. I contend that the death of a person you love is a process that you go through, and it is not up to mental health professionals to place artificial constructs on grief.” – 258</p>
May result in suppression or	22	“Grief would become something that no-one would want to display or share for fear of being labelled mentally ill/abnormal/incompetent” – 32

internalisation of grief		"I believe it might make people believe that it was not normal to experience grieving. They may feel that they should not talk about it too much to other people" – 134
Risks unnecessary intervention	13	<p>"Pharmaceutical companies could get in on the act and prescribe drugs which exacerbate the 'problem' and delay true healing" – 112</p> <p>"To medicalise it creates the risk of labelling a normal reaction as 'disordered' and suggesting interventions where none are required" – 300</p>
Reduces help-seeking	7	<p>"To classify it as a mental disorder would mean that people with complex grief might feel that only a mental health professional can help them and discourage the natural support network, who might then consider it 'best left to the professionals'" – 137</p> <p>"For some people, they may be confronted by the fact that they have been classified as suffering from a mental disorder and may pull back from support - in denial that they need it" – 162</p>

Note. Some participants noted more than one effect.