On September 11, 2001, Kate was working in New York City when she received a call from her elderly father’s nursing home upstate and learned that her father had only hours to live. Her efforts to leave the city were slowed by the chaos of that tragic day, and her father died before she arrived at the nursing home. She thinks of her grief over missing her chance to say good-bye to him as selfish and insignificant compared with the losses others suffered that day.

On the afternoon of September 11, 2001, 16-year-old Dan was killed in Ohio as he was walking home from school. He was run down by a drunk driver who, despite a history of drunk driving, claimed he had been drinking that afternoon in response to the day’s events. Dan’s family believes that Dan’s death has gone unnoticed.

A Manhattan psychotherapist observes that the initial increases in compassion and existential consciousness he saw in his clients soon after 9/11 have

Authors’ Note: Additional material related to this chapter, including suggestions for clinical, public policy, and educational interventions as well as directions for research, can be found online at http://equinox.unr.edu/homepage/cimurray/.
shifted to narcissistic, angry preoccupations. Meanwhile, the mass media continue to present heroic images of New Yorkers, not the detached people he sees in his neighborhood (Alper, 2002).

Months after the 9/11 terrorist attacks, Ricardo, who lives in Nevada, learns that his firefighter uncle has died 2,000 miles away while responding to an act of environmental terrorism in which a luxury car dealership was bombed. Everyone talks of his uncle as a young hero, and of the family's patriotism. Then the family is left to grieve alone, as the rest of the nation moves on. Two years later, Ricardo’s neighbor dies in the war in Iraq; Ricardo notices that there are similarities in how people respond to the neighbor’s family and how they responded to his family when his uncle died.

Despite terrorism and war, dying and grief have changed little since the previous edition of *Families and Change* was published. Most adults in industrialized countries still die from degenerative illnesses, and most young people die from sudden or violent causes. Death still “poses the most painful adaptational challenges for families” (Walsh & McGoldrick, 1991, p. 25). Changes in the cultural paradigm from narcissistic materialism to compassion and from a sense of security to vulnerability seem limited in scope, reflecting most Americans’ experience with single acute tragic events rather than with recurring large public tragedies. The mass media speedily convey the details of wartime danger, natural disasters, high-profile accidents, and purposive public acts of violence and provide marathon coverage of events through technologically enhanced reporting (Blondheim & Liebes, 2002). We live in an environment where death is invisible and denied, yet we have become desensitized to it. These inconsistencies appear in the extent to which families are personally affected by death—whether they define loss as happening to “one of us” or to “one of them.” In this chapter, we address enduring processes related to death in the family as well as some changes that have occurred since the terrorist attacks of September 11, 2001.

Annually, there are more than 2.9 million deaths in the United States, affecting 8 to 10 million surviving immediate family members, including 2 million children and adolescents (Hoyert, Arias, Smith, Murphy, & Kochanek, 2001). Death is a crisis that *all* families encounter, and it is recognized as the most stressful life event families face, although most do not need counseling to cope (Parkes, 2001). Research that examines loss as a family system phenomenon has only recently gained visibility (e.g., Shapiro, 1994; Walsh & McGoldrick, 1991), with increased attention paralleling movement into midlife of “baby boomers.”
Etiology of “Invisible Death” and Its Consequences

At least from the Middle Ages through the 17th century, death was viewed as natural and inevitable (Ariès, 1974). A movement to deny the realities of death occurred during the 18th and 19th centuries, and by the 20th century a lack of firsthand familiarity with death in Western culture fostered an era in which death became sequestered, privatized, and invisible. Factors contributing to this lack of familiarity with death included increased life expectancy, changes in leading causes of death from communicable diseases to chronic and degenerative diseases (although there is currently some concern about increases in communicable diseases such as West Nile virus, meningitis, and drug-resistant tuberculosis, and about the use of smallpox as a bioweapon), redistribution of death from the young to the old, decreased mortality rates, and increased duration of chronic illnesses (Miller, Engelberg, & Broad, 2001; U.S. Bureau of the Census, 1975). In industrialized Western nations, geographic mobility and social reorganization of families also resulted in reduced intergenerational contact and thus fewer opportunities for younger family members to participate in death-related experiences (Rando, 1993). In addition, the development of life-extending medical technologies has had several effects on Americans’ experiences with death: (a) It has moved most dying from people’s homes to institutions (National Center for Health Statistics, 2001), (b) it has resulted in care dominated by efforts to delay death by all means available, (c) it has led us to question our assumptions about what constitutes life and death, and (d) it has confronted families with decisions about whether to prolong the process of dying or terminate the lives of loved ones.

Although Western families are distanced from the intimacies of death, they are bombarded by public presentations of death through the news and entertainment media (Dolan, 2003; Murray & Gilbert, 1997). These frequent, sensationalized, violent portrayals of death as unnatural contribute to desensitization, repression, and personal traumatization of bereaved individuals (Alper, 2002; Rando, 1993). Media-orchestrated emotional invigilation in reporting on the deaths of famous individuals and mass tragedies leave consumers with illusions of intimacy and grieving (Walter, Littlewood, & Pickering, 1995). Individuals who did not personally know the deceased can go through rituals of mourning and “virtually” attend the funeral through television or the Internet, without feeling the depth of pain and depression of actual grief. Viewers may confuse their emotional responses (i.e., “virtual grief”) with the actual grief experienced by the deceased person’s loved ones.
Recovery from virtual grief is quick, so individuals who have experienced only virtual grief may be insensitive regarding the amount of time that others need to “return to normal” when actual grief occurs.

The changes described above have increased the stress that families experience when coping with death. Westerners generally do not view dying and bereavement as normal life-span experiences; rather, they compartmentalize death, frequently excluding children from family death-related experiences (Hurd, 1999). Families’ adaptation to losses through death has been hampered by the lack of cultural supports that could assist family systems in “integrating the fact of death with ongoing life” (Walsh & McGoldrick, 1991, p. 2) and the lack of instrumental social supports to help them manage disruptions in their daily lives, such as assistance with child care, housework, and finances (Shapiro, 2001). For many Americans, a minimum of rituals exist surrounding death, the roles of chronically ill or bereaved individuals are not clearly defined, and geographic distance hinders the completion of “unfinished business” (Harvey, 2000; Shapiro, 1994).

Although death and grieving are normal, survivors can experience physical, psychological, and social consequences that can be viewed either as stressor experiences (Burnell & Burnell, 1989) or as part of the coping process (Hall & Irwin, 2001). Bereavement can result in negative consequences for physical health (Prigerson et al., 1997), including physical illness, aggravation of existing medical conditions, increased use of medical facilities, and the presence of new symptoms and complaints (Burnell & Burnell, 1989). During anticipatory bereavement and the months following a loss through death, physiological changes in survivors are indicative of acute heightened arousal (i.e., increased levels of cortisol and catecholamines, change in immune system competence, and sleep complaints); however, changes in neuroendocrine function, immune system competence and sleep may endure for years in survivors (Goodkin et al., 2001; Hall & Irwin, 2001). Intrusive thoughts and avoidance behaviors are correlated with sleep disturbances, which appear to intensify the effects of grief, resulting in decreased numbers and functioning of natural killer cells (Ironson et al., 1997). Bereavement also appears to be related to increased adrenocortical activity, long-lasting brain changes, and possible long-term changes in gene expression (Biondi & Picardi, 1996). It should be noted, however, that Rosenblatt (2000) found sparse reference to any personal health problems in the narratives of bereaved parents regarding their children’s deaths or dying.

Epidemiological studies cannot assess a direct causal relationship between bereavement and physical ailments, but researchers have found bereavement to be an antecedent of disease (Goodkin et al., 2001; Hall & Irwin, 2001). Risk factors for increased morbidity and mortality during bereavement...
include self-damaging or neglectful behaviors, additional stress symptoms, elevated physiological arousal, and depression. Physiological resilience appears to be related to coping strategies, social support networks, and healthy sleep profile.

The consequences of bereavement for mental health also are difficult to measure (Attig, 2001). Characteristics typically associated with grief are ones that would evoke concern in other circumstances. High rates of depression, insomnia, suicide, and anorexia may exist in conjunction with consumption of drugs, alcohol, and tobacco (Stroebe, 2000). Individuals with personality disorders are more likely to exhibit complications (Rando, 1993). Lack of differentiation among grief, depression, and somatization (Wayment & Vierthaler, 2002), as well as researchers’ failure to examine traumatic or complicated grief reactions separately from “normal” grief, hinder determination of mental health consequences (Wortman & Silver, 2001).

Research has suggested that bereaved individuals identify bereavement as a social stressor, reporting lack of role clarity and support (Rando, 1993; Rosenblatt, 2000). The changes in social status, conflicts in identity, disputes over inheritance, and loss of roles, income, or retirement funds that may result when a family member dies can contribute to social isolation. Changes in family communication patterns and relationships with people outside the family are common.

Paradoxically, a body of literature is currently emerging that emphasizes growth as an outcome of loss. Posttraumatic growth is both a process and an outcome in which, following trauma, growth occurs beyond the individual’s previous level of functioning (Schaefer & Moos, 2001; Tedeschi, Park, & Calhoun, 1998). Growth outcomes may occur in the individual’s perception of self (e.g., as survivor rather than victim, or as self-reliant yet with heightened vulnerability), interpersonal relationships (e.g., increased ability to be compassionate or intimate, to self-disclose important information, and to express emotions), and philosophy of life (e.g., reorganization of priorities, greater appreciation of life, grappling with the meaning and purpose of life, spiritual change, and sense of wisdom). In contrast, terror management theory (Pyszcznski, Solomon, & Greenberg, 2003) suggests that what appears to be posttraumatic growth is actually cognitive coping, which protects or distances the individual from traumatic events and buffers his or her fear of death.

Theories of Grieving

Theories of grieving have moved beyond bereaved individuals to the interpersonal study of the group or societal influences and impacts of grief. They
include developmental stage and process-based theories focused on individuals’ experiences as family members as well as theories based on the family system.

Individual-Based Theories

Scholars have proposed theories of grieving that focus on developmental stages or trajectories for the dying (e.g., Kübler-Ross, 1969; Pattison, 1977) and for survivors (e.g., Rando, 1988; Worden, 1991) derived from the works of Freud (1917/1957) and Bowlby (1980). Such theories differ in the numbers of stages they describe, but they all assume that grieving consists of three basic phases: (a) a period of shock, denial, and disorganization; (b) a period of extremes including intense separation pain, volatile emotions, and active grief work; and (c) a period of resolution, acceptance, and (for the bereaved) withdrawal of energy from the deceased and reinvestment. Critics of developmental theories question the definition of “normal” grief and these theories’ assumptions about how people “should” respond, including the following: (a) Intense emotional distress or depression is inevitable; (b) failure to experience distress is indicative of pathology; (c) working through loss is important—intense distress will end with recovery; and (d) by working through loss, individuals can achieve a state of resolution, including intellectual acceptance (Wortman & Silver, 2001).

Stage theories have been criticized for being population specific and for representing progress toward adjustment as linear (Corr, 1993). Critics contend that progress is not always forward and that grief processes may have no definite ending (Rosenblatt, 2000; Wortman & Silver, 2001). They assert that the emphasis should not be on recovery or closure, but on continuing bonds, relearning relationships, and renegotiating the meaning of loss over time (Attig, 2001; Klass, 2001). Rather than dichotomizing relinquishing and retaining bonds, Boerner and Heckhausen (2003) suggest that transformation involves both disengagement from the deceased’s physical absence and connection with the deceased through mental representations.

Scholars have also argued that developmental theories view grief as passive, with few choices for griever (Attig, 2001). Critics of these theories contend that grieving is active, presenting bereaved individuals with challenges, choices, and opportunities. They question the necessity of “grief work”—traditionally accepted as an essential cognitive process of confronting loss (Bowlby, 1980; Freud, 1917/1957; Lindemann, 1944; Parkes, 2001). Margaret Stroebe and her colleagues suggest that grief work is not a universal concept and that the definitions and operationalizations of the concept that researchers have used have been problematic. They note that few studies have yielded substantial conclusions regarding the effectiveness of
grief work, and researchers have approached these studies with the aim of understanding the processes of grief rather than developing prescriptions for recovery (Stroebe et al., 2000).

Models based on varied tasks of grieving have begun to emerge in recent years. Worden (1991) has moved away from grief as illness to delineate a model based on the following tasks: (a) acknowledging the reality of loss, (b) working through emotional turmoil, (c) adjusting to the environment where the deceased is absent, and (d) loosening ties to the deceased. Horacek's (1995) heuristic model identifies tasks related to high-grief deaths and views grief responses as both reactive and proactive. Attig (2001) presents a model of grief as active in which the task of the bereaved person is to relearn the world in terms of physical surroundings, relationships, and who he or she is.

Among individual-centered process-based models is Rando's (1993) “6 R model,” which assumes the need to accommodate loss. The “6 R” processes are recognizing the loss, reacting to separation from the deceased, recollecting (and reexperiencing) the deceased and the relationship, relinquishing old attachments and the assumptive world, readjusting to move into a new world without forgetting the old, and reinvesting (p. 45). In contrast, the dual-process model of coping (M. S. Stroebe & Schut, 2001) suggests that active confrontation of loss is not necessary for a positive outcome; there may be circumstances when denial, avoidance of reminders, and repressive strategies are essential. The dual-process model concurs with the findings of social-functional research that minimizing expression of negative emotions and using laughter as a dissociation from distress may improve functioning (Bonanno, 2001). This model assumes that most individuals experience ongoing oscillation between loss orientation (coping with loss through grief work, dealing with denial, and avoiding changes) and restoration orientation (adjusting to various life changes triggered by death, changing routines, transitioning to a new equilibrium, avoiding or taking time off from grief). There is movement between coping with loss and moving forward, with the need for each orientation differing from individual to individual depending on such factors as type of loss, culture, and gender.

Family Theories of Coping With Death

Although scholars have focused on dying or bereaved individuals, death does not occur in isolation. An estimated 70% of deaths in the United States involve end-of-life decision making negotiated among family members, physicians, and (when competent) dying family members (American Psychological Association, 2000). Individual process models have not been broadened to aid in our understanding of families, except for psychoanalytic models, which
some have argued are suited for dealing with family bereavement because of their emphasis on ambivalent relationships (Blake-Mortimer, Koopman, Spiegel, Field, & Horowitz, 2003). Work on grief from a family perspective has typically utilized elements of systems theories, particularly through integrative approaches to complex issues. Refinement of systemic models recognizes that multiple griefs exist simultaneously for individuals, couples, families, and communities, and, although some thoughts and feelings are shared, others are not (Gilbert, 1996).

**Family Systems Theory**

Family systems theory focuses on dynamics and provides concepts that are useful for describing relationships (e.g., Jackson, 1965; Kantor & Lehr, 1975), offering a nonpathologizing conceptualization of grief as a natural process (Nadeau, 2001). The following premises of systems theory can be useful in examining families’ adaptations to dying and death:

1. A family reacts to loss as a system. Although we grieve as individuals, the family system has qualities beyond those of individual members (Jackson, 1965), and all members participate in mutually reinforcing interactions (Walsh & McGoldrick, 1991).

2. Actions and reactions of a family member affect others and their functioning. This interdependence exists because causality in systems is circular rather than linear (Shapiro, 2001).

3. Death disrupts a family system’s equilibrium, modifies the structure, and requires system reorganization in feedback processes, role distribution, and functions (Bowen, 1976; Jackson, 1965).

4. Death may produce emotional shock waves of serious life events that can occur anywhere in the extended family in years following a death (Bowen, 1976). Such waves exist in an environment of denied emotional dependence and may seem unrelated to the death. They may trigger additional stressor events and increasingly rigid strategies to maintain stability (Shapiro, 2001).

5. There is no single outcome from death of a member that characterizes all family systems. Various family characteristics, such as feedback processes (Jackson, 1965), patterns of relationship (Shapiro, 2001), family schema, and family paradigm (McCubbin, Thompson, Thompson, Elver, & McCubbin, 1998), influence the outcome.

Scholars have applied systems theory infrequently in examining death-related reorganization (Shapiro, 2001). Loss has traditionally been identified
as a historical, individual, or content issue and inappropriate for traditional family systems work (which focuses on process, homeostasis, differentiation of self from family, current interaction, and the present) (Nadeau, 2001; Walsh & McGoldrick, 1991). Recent versions of systems theory have focused on the balance of change and continuity as well as the negotiated inclusion of differences to balance self-assertion and cohesion. The application of family systems theory to the study of grief is now discussed in a framework that includes intergenerational and family life-cycle perspectives (Walsh & McGoldrick, 1991), focusing on change in structural factors such as boundaries, and family dynamics such as roles and rules, as well as meaning making and communication (Nadeau, 2001). In a recent examination of the relationship between individual grief and family system characteristics, Traylor, Hayslip, Kaminski, and York (2003) found that grief symptomatology at 4 to 5 weeks postloss did not predict any family system characteristics or grief symptomatology 6 months later. However, individuals’ perceptions of family system cohesion, family expressions of affect, and communication were predictors of later grief.

**Integrative Models**

Particularly useful models are those that simultaneously consider individual, family, and cultural dimensions. Rather than relying on traditional family systems, these models integrate family systems’ concepts with other perspectives. Rolland’s (1994) family systems–illness model examines the interface of individual, family, illness, and health care team. Rather than taking the ill individual in a family as the central unit of care, it focuses on the family or caregiving system as a resource that both is affected by and influences the course of illness. This model can be useful for understanding the experiences of the ill individual and family members during the terminal phase of chronic illness, in multiple contexts and across time.

Moos’s (1995) model of the interrelationship of processes involving grief tasks of individuals and those of their families highlights the interdependence of family processes and individual perceptions. This model addresses relationships between individual and family grief symptoms, the influence of each family member on a family system’s coping strategies and grief reactions, and the mediating roles of family history, cultural constraints, feedback, and nuclear family functioning. Shapiro (1994, 2001) has applied a systemic developmental approach in examining grief as family process. This clinical model views grief as a developmental crisis influenced by family history, sociocultural context, and family and individual life-cycle stages. A crisis of identity and attachment, grief disrupts family equilibrium but makes possible the development of “growth-enhancing stability” (Shapiro, 1994, p. 17).
Popular interactionist approaches account for context by incorporating life-course, social constructionist, and systems concepts. These models recognize the unique interpretation of internal and external worlds of individuals and families dealing with loss (Harvey, Carlson, Huff, & Green, 2001; Nadeau, 2001; Neimeyer, 2002; Rosenblatt, 2000). They utilize narrative methods, focus on meaning making or account making, and recognize intimate losses as part of changing identity. Such models assume that the accuracy of the meaning given to any particular event is of limited importance, because it is meaning itself that influences family interactions. Interactionist counseling can help families not only to understand and manage grief symptomatology, but also to reconstruct meaningful narratives of self, family, and world.

Factors Related to Family Adaptation to Death

Characteristics of the Loss

Below, we discuss briefly a number of factors that have been identified as related to death itself and to how society’s interpretation of a loss influences family adaptation.

*Timing of illness or death.* When the duration of time before death is far longer or shorter than expected, or the sequence of death in a family differs from the expected order, problems may occur. Elderly individuals are assumed to experience “timely” deaths. Early parental loss, death of a young spouse, and death of a child or grandchild of any age are considered tragic and evoke searches for explanations (Murphy, Johnson, & Lohan, 2003).

*Nature of death.* Initial grief reaction to sudden or unexpected death may be more intense than reaction to death related to protracted illness (Bowlby, 1980), with survivors experiencing a shattered normal world and a series of concurrent stressors and secondary losses (Murray, 2001), with unfinished business more likely to remain (Lindemann, 1944). Factors existing along a continuum that can affect coping include (a) whether the loss was natural or human made; (b) degree of intentionality/premeditation; (c) degree of preventability; (d) amount of suffering, anxiety, or physical pain the deceased experienced while dying; (e) number of people killed or affected; (f) degree of expectedness (Doka, 1996, pp. 12–13); (g) senselessness; and (h) the survivor’s having witnessed the death or its aftermath or having found out
about the death through the media. Differences related to suddenness of death appear to be short-term when internal control beliefs and self-esteem are taken into consideration (W. Stroebe & Schut, 2001) and are lessened when families are present during emergency medical procedures, such as efforts to resuscitate (Kamienski, 2004).

According to the National Center for Health Statistics (2000), 80% of deaths to adolescents and young adults in the United States result from sudden violent accidents, homicide, and suicide. In a longitudinal study of parents surviving a child’s sudden death, Murphy, Johnson, Wu, Fan, and Lohan (2003) found that marital satisfaction decreased among the parents during the 5 years following the death; nearly 70% said that it took them 3 to 4 years to put their children’s deaths in perspective, and at 5 years post-death, 43% said they still had not found meaning in their children’s deaths.

Although popular works often discuss suicide of a loved one as the most difficult loss, there is little empirical evidence to support this contention (W. Stroebe & Schut, 2001). Homicide appears to be most directly related to posttraumatic stress disorder and grief marked by despair. In a mass trauma (a potentially life-threatening event experienced by a large number of people), adaptation appears to be influenced by whether it is a single event or recurring/ongoing, by emotional or geographic distance (with vicarious traumatization possible through viewing of media coverage, particularly for those who have experienced other, unrelated losses), by attribution of causality, and by the interaction of personal, community, and symbolic losses (Webb, 2004).

Death following protracted illness can also be stressful. In such cases, family members have experienced a series of stressors before the death, including increased time commitments for caring, financial strain as a result of cost of care and lost employment, emotional exhaustion, interruption of career and family routines, sense of social isolation, and lack of time for self or other family members (Rabow, Hauser, & Adams, 2004; Rolland, 1994). Although research findings on the existence, role, and multidimensionality of anticipatory grief have been inconsistent, protracted illness appears to be associated with trauma and secondary morbidity—that is, difficulties in physical, emotional, cognitive, and social functioning of those closely involved with the terminally ill person (Rando, 1993). Deaths following chronic illness may still be perceived as sudden or unexpected by surviving adults who are not yet “ready,” by children whose developmental stages inhibit their understanding that the death is inevitable, and following multiple cycles of relapse and improvement. Deaths from trauma and illness have much in common. Similar to families who have witnessed or experienced death through violence, families experiencing prolonged or complicated grief, multiple deaths
simultaneously, or a series of deaths in close proximity may display signs of posttraumatic stress disorder, with family caregivers experiencing secondary traumatic stress (Bucholz, 2002; Figley, 1999; Rando, 1993).

**Losses unacknowledged by society.** Recently, scholars have devoted increasing attention to disenfranchised grief—that is, grief that exists although society does not recognize the bereaved person’s right, need, or capacity to grieve (Doka, 2002). Examples include grief over the loss of unrecognized or unacknowledged family and other relationships (i.e., relationships not recognized as significant), such as the loss of a former spouse, lover, cohabitor, or extramarital lover; a foster child or foster parent; a stepparent or stepchild; a coworker; a partner in a gay or lesbian relationship; or a companion animal. In addition, deaths related to pregnancy (i.e., miscarriage, elective abortion, stillbirth, neonatal death) may result in disenfranchised grief. Professional caretakers and emergency first responders, especially those labeled as “heroes” or those who are competently focused on tasks of rescue and recovery, also may suffer unacknowledged grief when they lose those for whom they provide care. Bereaved grandparents, men in general (Gilbert, 1996), and families of deceased addicts may also experience disenfranchised grief. Many people see others, such as young children, older adults, and mentally disabled persons, as incapable of grief or without a need to grieve (Doka, 2002). Disenfranchisement also occurs when it is assumed that the circumstances of particular deaths do not warrant grief, and when bereaved persons are told that they are experiencing or expressing grief in inappropriate ways.

**Stigmatized losses.** People grieving various types of deaths have reported feeling as though their grief has been stigmatized (Walter, 2003). They feel that others are uncomfortable around them and so distance themselves, and they experience direct or indirect social pressure to become “invisible mourners” (Rosaldo, 1989). Disenfranchised grief often results from stigmatized losses, particularly when there is an assumption that the death was caused by the deceased’s disturbed or immoral behavior (Shapiro, 1994) or a fear of contagion, such as with AIDS- and cancer-related deaths (Doka, 2002). AIDS-related deaths have been stigmatized because of their concentration in the homosexual community and, more recently, in poor inner-city Latino and African American neighborhoods. Survivors of AIDS-related deaths may be experiencing multiple losses among family and friends, lack of legal standing in relation to their deceased loved ones, denial of death benefits, and isolation. In inner-city neighborhoods many of those infected with HIV are women, some with infected children, and many have already
lost companions, siblings, children, and friends. Although the disclosure of HIV-positive status may sometimes bring relationship partners closer together, mothers coping with HIV infection must also deal with finding caregivers for their children and negotiating safer-sex practices with partners reluctant to use condoms. Stigma also occurs in families that have lost members to suicide or homicide, resulting in altered identities, provoking feelings of anger and guilt, and leading to isolation, blame, and injustice—characteristics of revictimization (Bucholz, 2002). The resulting secrecy and blame can distort family communication, isolate family members, and diminish social support (Walsh & McGoldrick, 1991).

Factors Affecting Family Vulnerability

*Timing and concurrent stressors in the family life cycle.* Death-related loss involves many secondary losses, including personal, interpersonal, material, and symbolic losses. Families have more difficulty adapting to death if other stressors are present, as dealing with a loss does not abrogate other family needs (Murray, 2001). When normative events associated with family life cycle (e.g., new marriage, birth of child, an adolescent’s move toward increased independence) are concurrent with illness or death, they may pose incompatible tasks (Shapiro, 2001).

*Function and position of the deceased prior to death.* The centrality of the deceased’s role in the family and the degree of the family’s emotional dependence on that individual influence family adaptation (Shapiro, 2001). Shock waves rarely follow the deaths of well-liked people who played peripheral roles or of dysfunctional members unless dysfunction played a central role in maintaining family equilibrium (Bowen, 1976).

*Conflicted relationship with the deceased.* Complications in family adaptation can occur when intense and continuous ambivalence, estrangement, or conflict exists (Elison & McGonigle, 2003). High levels of grief and depression have been reported by those with anxious-ambivalent attachments; somatization is more common among those with avoidant attachment styles (Wayment & Vierthaler, 2002). Grief after the death of an abuser can result in ambivalence, rage, secrecy, sadness, and shame (Monahan, 2003). During illness, there may be time to repair relationships, but family members may hesitate, fearing that confrontation may increase risk of death. Surrogate end-of-life decision makers report greater ability to resolve family disagreements when they perceive a family as psychologically close or open to communication (Mick, Medvene, & Strunk, 2003).
Family Resources, Capabilities, and Strengths

Resources that assist families in meeting demands may be tangible (e.g., money or health) or intangible (e.g., friendship, self-esteem, role accumulation, or a sense of mastery) (McCubbin & McCubbin, 1989). The disruption a bereaved family experiences also is related to the family’s degree of openness (Mick et al., 2003) and is mediated by the intensity and chronicity of family stress. Adaptation is facilitated by members’ emotional regulation capacity, nonreactivity to emotional intensity in the system, cohesion and adaptability, and marital intimacy (Nadeau, 2001; Shapiro, 2001; Znoj & Keller, 2002). Research findings concerning the importance of open communication about loss are mixed. Pennebaker, Zech, and Rime (2001) suggest that confiding in others is related to health after a loss. Other scholars assert that the best predictor of emotional well-being is emotional regulation, not emotion-focused coping (Bonanno, 2001; Znoj & Keller, 2002).

Social support networks appear to simultaneously complicate and facilitate grieving. Supporters may listen, but they may also hold unrealistic expectations. The availability of formal or informal networks does not guarantee support, especially in a society that does not sanction the expression of emotions surrounding loss. Some bereaved family members turn to self-help groups composed of persons who have experienced similar types of losses—a practice that may be predictive of finding meaning in death during the years that follow (Murphy, Johnson, & Lohan, 2003). However, the rules of some family systems discourage members from sharing intimate information and feelings with persons outside the family. Religious beliefs also may simultaneously complicate and facilitate grieving. Belief in “God’s plan” can help a bereaved individual create meaning from loss, but it can also lead to anger toward God for unfairly allowing the death, which can isolate the individual from his or her spiritual roots.

Family Belief System, Definition, and Appraisal

*Family paradigm.* To understand fully how a family perceives a death or uses coping strategies following a death, one must determine the family’s worldview (Boss, 1999). A common paradigm is the “belief in a just world,” which posits that the self is worthy and the world is benevolent, just, and meaningful (Janoff-Bulman, 1992; Lerner, 1980). This paradigm values control and mastery and assumes fit between efforts and outcomes: One gets what one deserves. Such a view is functional only when something can be done to change a situation. Challenges to the “just world” assumption make the world seem less predictable and can lead to cognitive efforts to manage fear of death. Such efforts can lead to blaming chronically ill
persons for their conditions and lack of recovery, or to linking adolescent
deaths to drug use or reckless behavior as a way of affirming, “It can’t hap-
pen to my child.” In contrast, for those dealing with loss, understanding the
complexities, multiple levels of context, and short- or long-term effects of
the event will facilitate grief (Murray, 2001).

Death’s legacy. Family members share some beliefs that are unintentionally
but collectively constructed. Family history and experiences with death
provide a legacy (a way of looking at loss that has been received from
ancestors) that is related to how the family will adapt to subsequent loss
(McGoldrick, 1991). Particularly in relation to several traumatic untimely
deaths, a family may have a legacy of empowerment (family members see
themselves as survivors who can be hurt, but not defeated) or a legacy of
trauma (family member feel “cursed” and unable to rise above their
losses)—either of which can inhibit openness of the system. Families may
not recognize transgenerational anniversary patterns or concurrence of a
death with other life events, and members may lack emotional memory or
have discrepant memories regarding a death (Shapiro, 2001). Family
members may make unconscious efforts to block, promote, or shift beliefs
to maintain consistency with the legacy.

Family meaning making. Grief can be viewed as a process of meaning con-
struction that evolves throughout the life of the bereaved. Several factors
appear to influence families’ construction of the meaning of their losses,
including family schema, contact, cutoffs, interdependence, rituals, secrets,
coherence, paradigms, divergent beliefs, tolerance for differences, rules
about sharing, and situational and stressor appraisals (McCubbin et al.,
1998; Nadeau, 2001). Researchers are increasingly noting the importance
of making sense of the event, finding benefits from the experience, and
shaping one’s new identity to include the loss (Neimeyer, 2002). Violent
death that is irrational and meaningless may result in meaning making
expressed through activism or intense pursuit of numerous small actions.

Boundary Ambiguity

Boundary ambiguity is the confusion a family experiences when it is not
clear who is in and who is out of the system (Boss, 1999). Ambiguity rises
when (a) facts surrounding a death are unclear, (b) a person is missing but
it is unclear whether death has occurred, and (c) the family denies the loss.
Degree of boundary ambiguity may be more important for explaining
adaptation and coping than the presence of coping skills or resources. Both
denial and boundary ambiguity initially may be functional because they give
a shocked family time to first deny the loss and then reorganize itself before it accepts the fact that the loss is real. If a high degree of ambiguity exists over time, the family is at risk for maladaptation. However, reports that bonds continue to exist after death, and that conversations with the dead may be replacing rituals as the normative way of maintaining such bonds (Klass, 2001), may challenge the notion of boundary ambiguity, suggesting that individuals can recognize loss while holding psychological, emotional, and spiritual connections to deceased loved ones.

Factors of Diversity

Gender. Despite Western cultural expectations, most marital couples experience incongruent grieving, often with one adult whose grief could be called cognitive and solitary and the other whose grief is more social and emotional (Gilbert, 1996). Perhaps this incongruence can be understood as a family system–level manifestation of M. S. Stroebe and Schut’s (2001) dual-process model. A functional system would require loss orientation and restoration orientation.

Studies of incongruent grieving have suggested that women display an intuitive grieving style, with more sorrow, guilt, and depression than men (Doka & Martin, 2001). Men are socialized to manage instrumental tasks, such as those related to the funeral, burial, finances, and property. Women are more likely to take on caregiving roles, which require them to engage in both of the dual processes. However, men are more able to immerse themselves in work and thus block other intuitive tasks. Reasons for gender-related differences in grieving are not well understood, but they seem to be influenced by expectations and socialization. Research in this area has been hampered by reliance on studies completed during acute stages of grief and a lack of nonbereaved control groups. When bereaved persons who have suffered violent or traumatic losses are examined in longitudinal studies, few gender differences appear (Boelen & Van Den Bout, 2002–2003).

With gender controls, despite differences in social support, widowers have been found to experience greater depression and health consequences than widows (W. Stroebe & Schut, 2001). It has been thought that men have unrecognized problems because their socialization interferes with active grief processes (Doka & Martin, 2001). Men’s responses to grief typically include coping styles that mask fear and insecurity, including remaining silent; taking physical or legal action in order to express anger and exert control; immersion in work, domestic, recreational, or sexual activity; engaging in solitary or secret mourning; and exhibiting addictive behavior, such as alcoholism. Cook (1988) has identified a double bind that bereaved fathers experience: Societal expectations are that they will contain their emotions in order to protect and
Comfort their wives, but they cannot heal their own grief without sharing their feelings. Similarly, Doka and Martin (2001) have identified a third pattern of grief involving dissonance between the way an individual experiences grief and the way in which he or she expresses it. For example, some males may experience internal grief feelings but are constrained from expressing them. Much of the problem may not be in men's grieving, but in our understanding of the mourning process (Cook, 1988), which largely has been formulated through the study of women. As such, concepts of meaning making (Gilbert, 1996) and the dual-process model (M. S. Stroebe & Schut, 2001) may be more relevant than concepts of grief work for research with men.

Culture, religion, and ethnicity. Grief is a socially constructed, malleable phenomenon, and given current levels of immigration and contact among various cultural and ethnic groups, mourning patterns in the United States can be expected to change. In addition to commonalities, group differences in values and practices continue to exist and present a wide range of normal responses to death. General areas in which differences exist include the following: (a) extent of ritual attached to death (e.g., importance of attending funerals, degree to which funerals should be costly, and types of acceptable emotional displays); (b) need to see a dying relative; (c) openness and type of display of emotion; (d) emphasis on verbal expression of feelings and public versus private (i.e., solitary or family) expression of grief; (e) appropriate length of the mourning period; (f) importance of anniversary events; (g) roles of men and women; (h) role of family; (i) beliefs about what happens after death, particularly related to ideas of suffering, fate, and destiny; (j) value of autonomy/dependence in relation to bonds after death; (k) coping strategies; (l) social support for hospice patients; (m) whether certain deaths are stigmatized; (n) definition of when death actually occurs; (o) barriers to trusting professionals; and (p) interweaving of religious and political narratives (McGoldrick et al., 1991; Rosenblatt, 2001).

Specific Losses

Death of a Child

The death of one’s child is viewed as the most difficult loss, for it is contrary to expected developmental progression and thrusts one into a marginal social role that has unclear role expectations (Klass, 2001; Rubin & Malkinson, 2001). Deaths of offspring ranging from fetal loss to the loss of an adult child who may also be a grandparent or a caregiver to older parents can cause reactions similar to posttraumatic stress (Znoj & Keller, 2002). From an
Eriksonian perspective, young-adult parents grapple with death-related issues of identity as a parent and spousal intimacy, middle-aged parents deal with loss of generativity, and elderly parents deal with loss in terms of ego integrity versus despair. Attachment and psychoanalytic models appear to be inadequate to address the experiences of a parent who loses a child to death. Newer models focus on integrating the deceased child into the parent’s psychic and social worlds (Klass, 2001; Rubin & Malkinson, 2001).

Society expects spouses to provide support and comfort to each other during times of stress; however, this may not be possible for bereaved parents, who are both experiencing intense grief as individuals, with unique timetables, and may not be “in sync” (Rando, 1993). Sexual expression between bereaved spouses can serve as a reminder of the child and elicit additional distress (Rosenblatt, 2000). However, previous reports of high divorce rates among bereaved parents appear to be erroneous; the research on which they were based has been shown to lack longitudinal value and to confuse marital distress and divorce (Schwab, 1998).

Death of a Sibling

Most research on sibling death is recent, focused on children and adolescents. Prior work on sibling loss generally was confined to clinical studies; recent work differentiates between normal and complicated sibling grief patterns (Silverman, Baker, Cait, & Boerner, 2003). Even in the same family, sibling grief reactions are not uniform or the same as those of parents; rather, they can be understood best in relation to individual characteristics (e.g., sex, developmental stage, relationship to the deceased sibling). Scholars have not found behavioral or at-risk differences in school-age children who have experienced parental death or sibling death, but they have found gender differences, with boys more affected by loss of a parent and girls more affected by death of a sibling, especially a sister (Worden, Davies, & McCown, 1999).

Initial negative outcomes and grief reactions of siblings include drop in school performance, anger, sense that parents are unreachable, survivor guilt, and guilt stemming from sibling rivalry (even when survivor siblings recognize the irrationality of their beliefs) (Rando, 1988; Schaefer & Moos, 2001). Parents report more frequent and negative symptoms in adolescents than in younger children, with mothers and fathers reporting different problem behaviors (Lohan & Murphy, 2002). Although siblings report more family conflict than do parents, siblings rarely direct their anger toward parents, who they perceive to be vulnerable and hence in need of protection from additional pain. Long-term changes appear to be positive, especially in terms of maturity, which adolescents relate to appreciation
for life, coping successfully, and negotiating role changes. Adults who lost siblings in childhood have reported that these losses fostered greater insights into life and death (Schaefer & Moos, 2001).

Deceased siblings still play an identity function for triangulated survivors who may feel a need to fulfill roles the deceased children played for parents or to act in an opposite manner in an attempt to show that they are different (Bank & Kahn, 1975). In later adulthood, sibling death is the most frequent death of close family members, yet researchers have largely overlooked this form of loss. Surviving siblings appear to experience functioning and cognitive states similar to those of surviving spouses (Moss, Moss, & Hansson, 2001).

Unfortunately, research on sibling grief to date has consisted primarily of cross-sectional investigations that rely on retrospective data, data no more than 2 years beyond the loss, and longitudinal data treated as cross-sectional due to small sample sizes. Research is needed to determine how siblings’ grief may change over time, particularly in the context of stigmatized losses such as AIDS-related deaths.

Death of a Parent

Death of a parent can occur during childhood or adulthood. Children’s reactions to parental death vary and are influenced by emotional and cognitive development, closeness to the deceased parent, and responses to interactions with the surviving parent (Rando, 1988). A recent research trend has been to identify grief responses and perceptions of social support among children who have lost parents (Rask, Kaunonen, & Paunonen-Limonen, 2002). Adolescents grieving the death of a parent appear to have a heightened interpersonal sensitivity, characterized by uneasiness and negative expectations regarding personal exchanges (Servaty-Sieb & Hayslip, 2003). Comparisons of retrospective data from adults who experienced a parent’s death during adolescence with data from adults who experienced parental divorce suggest that both groups received comfort-intended communication, but bereaved adolescents were more accepting of comments that highlighted the lost parent’s positive attributes (Marwit & Carusa, 1998). Adolescents tend to flee grieving peers, thus family support may be especially important and instrumental in preventing maladaptive behavior (Balk, 2001; Silverman et al., 2003). Although many adolescents live in single-parent, divorced, or blended families, researchers have largely ignored the topic of parental death in those contexts or have focused on surviving parents’ grief and adjustment (Scott, 2000).

Death of a parent is the most common form of family loss in middle age. Adult response to this loss is influenced by the meaning of the relationship, the roles the parent played at the time of death, anticipation,
disenfranchisement, circumstances of the death, the impact of the death on the surviving adult child, and maintenance of the parent-child bond while letting go (Moss et al., 2001; Rando, 1988). Adults whose parents experienced protracted illness or lived in nursing homes prior to death exhibit multidimensional responses to their parents’ deaths, including sadness, grief, relief, persistence of memories about the parents, and a sense that the protection against death provided by the parents has vanished (Elison & McGonigle, 2003). Adults who are “orphaned” through parental death may find their identities as well as their remaining relationships affected.

Adults with mental disabilities who experience parental death have some aspects of grief in common with others, but they also have unique concerns. When individuals with psychiatric disabilities are faced in midlife with the death of a parent, they often have had no preparation for this event. They may suddenly find themselves faced with making funeral arrangements and somehow dealing with the financial repercussions of the death as well as possible residential relocation (Jones et al., 2003).

Death of a Spouse or Life Partner

Death of a spouse is the adulthood loss that scholars have studied most intensively, although they have paid less attention to spousal death in early or middle adulthood, including widowed parents with dependent children, and to death of any other life partner, such as one member of a committed homosexual couple. Loneliness and emotional adjustment are major concerns of a spouse who has lost a companion and source of emotional support, particularly in a long, interdependent relationship in which both members had a shared identity based on systems of roles and traditions (Moss et al., 2001). Conjugal bereavement can be especially difficult for individuals whose relationships assumed a sharp division of traditional sex roles, leaving them unprepared to assume the full range of tasks required to maintain a household. Death of one’s spouse brings up issues of self-definition and prompts the need to develop a new identity. Despite these problems, many bereaved spouses adjust very well (Schaefer & Moos, 2001). Some derive pleasure from their new independent lifestyle, feeling more competent than when they were wed.

Conclusion

Dealing with death is a process, not an event. It is an experience that all families will encounter. As Klass (1987) notes, “Bereavement is complex, for
it reaches to the heart of what it means to be human and what it means to have a relationship” (p. 31). Despite its importance in the experiences of individuals and families, death still appears to be a taboo subject in Western cultures. Research and theory have focused on the experiences of dying individuals and on dyadic relationships between bereaved and deceased. A contextualized multigenerational approach to family systems theory is well suited to addressing issues of loss and needs further application to research and clinical practice. Families’ adaptations to death vary; factors that influence the process include characteristics of the death, family vulnerability, history of past losses, incompatible life-cycle demands, resources, belief systems, and the sociocultural context in which a family lives.

Although loss is a normal experience, theorists and researchers have treated it as a problem. At this point, scholars need to increase their focus on processes and strengths associated with loss, such as processes of coping (rather than problems), and factors that facilitate growth from loss (rather than those that inhibit growth). Examination of posttraumatic growth is a first step, but this concept warrants application beyond individuals to entire families.

Suggested Internet Resources

Association for Death Education and Counseling (342 N. Main St., West Hartford, CT 06117): http://www.adec.org

Center for Loss and Life Transition (3725 Broken Bow Rd., Fort Collins, CO 80526): http://www.centerforloss.com

The Compassionate Friends (P.O. Box 3696, Oak Brook, IL 60522), a non-denominational support group for bereaved parents and siblings: http://www.compassionatefriends.org

The Dougy Center: The National Center for Grieving Children and Families (P.O. Box 86852, Portland, OR 97286): http://www.dougy.org

Grief in a Family Context (online course): http://www.indiana.edu/~famlygrf

GriefNet (online grief support): http://www.griefnet.org

Tragedy Assistance Program for Survivors (2001 S Street SW, Suite 300, Washington, DC 20009), offers support for all members of the armed services who have been affected by death: http://www.taps.org

References


