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THE IMPACT OF ETHNICITY ON GRIEF:
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THE IMPACT OF ETHNICITY ON GRIEF: IMPLICATIONS FOR BEREAVEMENT SUPPORT

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ABSTRACT

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The problem addressed in this thesis is the challenge of providing appropriate bereavement support, especially for members of ethnic groups whose norms for grieving may be significantly different from those of the dominant culture. This paper reviews and synthesizes literature from psychology and anthropology to identify factors which put ethnic group members at risk for complicated grief: lack of access to traditional mourning rituals, perceived lack of social support, and social and economic disadvantage. The grief work hypothesis, which dominates Western grief intervention strategies and prescribes cognitive grief work, fails to acknowledge somatization as a legitimate form of grief work. The conclusion reached is that there is a need for bereavement support programs targeted to specific ethnic groups in which the full range of possible reactions to grief can be affirmed.

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PREFACE

I am an Ele's Place volunteer. Ele's Place is a nonprofit community based organization that provides bereavement support for grieving children and their families following the loss to death of a family member or important friend. Ele's Place provides support from trained volunteers, peers, and professionals; Ele's Place does not provide therapy. When an individual appears to be suffering complicated or pathologic grief, a referral to a mental health professional is considered appropriate.

As a volunteer interested in learning more about grief, I became familiar with a range of popular and professional literature on the subject. I became intrigued with the frequency with which ethnicity appears on lists of factors that influence the course of grief and bereavement. Yet, almost universally lacking was much explanation of just what that influence might be. Thus emerged the subject of this thesis.

My initial expectation about the direction the topic would take was to identify examples of distinctive cultural norms and practices that may alter the course of bereavement. However, while the anthropological literature is fascinating in its description of exotic mourning rituals and bereavement practices (public displays), it rarely deals with the personal experience of grief

of individuals either in exotic cultures or in the U.S. A direction which seemed more fertile was to identify factors which are common across ethnic groups, factors that are related directly to the experience of ethnicity, and which influence the private, emotional reaction to a loss. Thus, factors such as perceived lack of social support and the stress of uprootedness, which are frequently experienced by members of ethnic groups and which have critical relevance as risk factors in complicated mourning, have become central in this work.

My early intention had been to focus on grief very narrowly, that is, as the reaction to the loss to death of a significant other. However, parallels between grief in response to the loss of a loved one and grief in response to other kinds of losses--divorce, illness, retirement--occupy a prominent place in current grief literature. Further, unresolved prior losses other than to death are of critical importance in cultural bereavement, a phenomenon frequent among ethnic minorities.

It is my hope that this thesis will be of practical value to individuals involved directly in bereavement support efforts as well as to a variety of health care professionals whose work brings them in contact with bereaved individuals of diverse ethnic backgrounds. Given the frequency with which somatization is the form into which the distress of grief becomes translated, the conclusions of this thesis have particular relevance for primary care physicians to whom somatizing individuals frequently appeal for help.

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INTRODUCTION

Almost uniformly, researchers and the public identify the death of a loved one, and the ensuing grief, as among the most potent stressors an individual may experience. Further, there is general agreement that high levels of stress are negatively correlated with both physical and mental health (Osterweis, Solomon and Green, 1984). By 1980 the interest in grief as a factor in overall health had risen to the point that, at the request of the Office of Prevention of the National Institute of Mental Health, the Institute of Medicine appointed a committee to study the factors that affect the bereavement process and its impact on general and mental health. Among the significant factors identified as influencing grief and mourning was the ethnic affiliation of the bereaved. Among the conclusions and recommendations of the report was the warning that "professionals should use great caution in interpreting the bereavement experience of refugees, immigrants, and traditionally oriented ethnic group members as deviant because of the possibility that the norms for these groups may differ from their own [the professionals'] and from those of the mainstream culture" (p. 210).

Unfortunately, the text offers no further illumination of just how it is that ethnicity impacts grief and the course of bereavement. The professional in

search of a body of literature which would offer insight into the potential impact of ethnicity will find the literature sparse indeed (Eisenbruch, 1984b).

Some writers suggest that it is the responsibility of grief specialists to acquaint themselves with the mourning observances in different cultures (Webb, 1993). According to Osterweis, Solomon and Green (1984), "Bereavement specialists...should be instructed in cultural differences in the bereavement process in an attempt to reduce the potential for cross-cultural miscommunication and iatrogenic effects" (p. 210). While instruction in cultural differences may be helpful in increasing sensitivity to cultural norms which may differ from the therapists', several authors (McGoldrick et al., 199l; Rosenblatt, 1988; Shapiro, 1994) warn that superficial treatment of ethnic minority beliefs, values, and behavioral norms may in fact create another problem--the stereotyping of individual members of ethnic groups. Stereotyping may result in expecting individuals to react and behave in predictable ways based on traditional, published norms for their group. Kalish and Reynolds (1976) assert, however, that there is as much intra-ethnic diversity in reaction to death and dying as there is inter-ethnic variability.

An understanding of the role of bereavement support programs demonstrates the importance of appreciating the potential impact of ethnicity on bereavement. Bereavement support programs do not offer psychotherapy; they offer support. Of particular significance to the bereavement support worker is the challenge of distinguishing between normal and pathologic grief,

since according to much of the bereavement support literature, when a bereaved individual is showing signs of pathologic grief, it is appropriate that a referral to a mental health professional be made (Schiff, 1986). The determination of when grief is pathologic, however, is not unequivocal. For members of the white, Anglo-Saxon, Protestant (WASP) dominant group in the U.S. the determination is complicated enough (Rynearson, 1990). For members of ethnic minority groups the determination is even more challenging (Eisenbruch, 1984b). Given that cultural influences shape the mode of expression of emotion, it is imperative that consideration be given to the possibility that a passionate, wailing expression of grief, while outside the norm for the WASP majority, may be entirely within the norm for an ethnic minority individual (e.g., Italian, Greek). Conversely, an individual's cultural norm may severely restrict the expression of sadness and discourage the articulation of anger, as is the case for Asians. Such individuals may internalize the expectation placed upon them by well-intentioned caregivers that they must "get in touch with and verbalize their pain" and in the process experience this contradictory expectation as an additional complication in their quest for resolution of their loss.

Not only is the determination of pathologic grief equivocal, the expediency of referral to mental health professionals is also debatable. Some writers caution that the referral of some grieving individuals to professional mental health practitioners may have negative rather than positive

consequences (McGoldrick et al., 1991; Qureshi, 1994). Traditional Asians, for instance, are concerned that to seek help from a mental health professional may negatively influence their chance of arranging marriage for their daughters, or will escalate the required dowry.

In addition to implications for bereavement support professionals and volunteers, issues of grief and its impact on health are significant to other health care workers. It is widely accepted that a high proportion of patient visits to primary care physicians in the U.S. are related to psychosocial distress translated into somatic complaints. It has been estimated that the proportion may be as high as 75% (Rasmussen and Avant, 1989). Burnell and Burnell (1989) suggest that circumstances which bring individuals to physicians' offices with multiple somatic complaints are more likely among members of the working class of certain ethnic groups in which somatization of grief is culturally approved. According to Kleinman (1982), extensive workups for such patients are generally unnecessary and sometimes even harmful. Many of these patients, perhaps even the majority (McGoldrick et al., 1991), strongly doubt the value of psychotherapy.

The challenge, then, is how to provide appropriate bereavement support to individuals whose mode of expression of grief may be quite different from that of the dominant culture. It is argued that the cognitive grief work which predominates in Western mental health therapeutic approaches fails to respond to the needs of individuals whose culturally-approved distress idiom is

somatization. Further, it is critical to devise strategies which will help to overcome the reticence of ethnic minorities to participate in mainstream social services programs.

Chapter One reviews the various theoretical models which have been formulated to describe the typical course of grief beginning with the psychoanalytic (Freud) and proceeding through attachment and loss (Bowlby and Parkes), psychosocial (Parkes), death and dying (Kubler-Ross), holistic (Schneider), and family systems (Rosenblatt, Shapiro, Walsh and McGoldrick). After describing what normal grief may look like, a consideration of pathologic grief is offered, including the factors which put an individual at risk for pathological grief. Among these factors are unresolved prior losses and the absence of social support, factors frequently present in ethnic individuals.

Chapter Two explores ethnicity, with particular attention to those dimensions of ethnicity which put individuals at risk for complicated bereavement. Lack of access to traditional mourning rituals, perceived lack of social support, and social and economic disadvantage weigh heavily in this picture. The concept of "cultural bereavement" is introduced, suggesting the prevalence of unresolved previous losses related to uprootedness among ethnic minorities.

Chapter Three looks at grief cross-culturally. The first question posed is the extent to which grief is universal. Evidence from both non-human primate research as well as cross-cultural studies is presented. An analysis of

the grief work hypothesis and its applicability to the grief experience of individuals other than white-Anglo-Saxon-Protestants (WASP) is presented. The assertion is made that somatization is a more pervasive distress idiom for ethnic minorities than the cognitive or psychologizing idiom which characterizes the grief models which dominate the literature. The percentage of primary physician encounters which result from somatic complaints is discussed, with the speculation that a high percentage of these complaints represent the somatization of unresolved grief. The importance of a comprehensive psychosocial history of patients presenting with somatic complaints is discussed. Especially significant for the ethnic minority patient is the involvement of the patient's family or some member of the ethnic community in the treatment plan.

Chapter Four considers bereavement support and specifically what bereaved individuals find helpful. Bereavement support groups are shown to be helpful in providing both emotional support and an opportunity to work through the role ambiguity which results from the loss of a significant other. The role of religion as a source of support is explored, finding that the participation in religious activities is of greater comfort than the content of the religious belief system. The importance of being supported by persons who have had comparable life experiences and who are of an individual's same ethnic group is discussed. Contrary to the widely held notion that ethnic group members take care of their own, in times of stress, physical and emotional

resources may be stretched to the point that necessary support may not be available. The design of ethnically specific bereavement support programs which may overcome the reticence of ethnic minorities to participate in mainstream social programs is discussed.

Finally, the summary and conclusions of this study are presented. Many ethnic minority individuals are believed to be at risk of persistent somatic illness resulting from a variety of unresolved grief issues. Referral of these individuals by primary care physicians to mental health professionals will in many cases not be as helpful as facilitating their access to community support networks. The myth of the availability of informal, effective social support among ethnic communities is challenged. Given the reticence of ethnic minorities to participate in mainstream social programs, the importance of designing and implementing ethnically targeted support groups is argued.

CHAPTER ONE
GRIEF THEORY

Terminology

The term grief as used in the death and dying (thanatology) literature refers to the reaction to the loss to death of a significant other or to the anticipation of one's own death or that of a loved one (Kubler-Ross, 1969; Wass et al., 1988). When used in this way, a distinction between grief, bereavement, and mourning is useful. According to Rosenblatt, Walsh, and Jackson (1976), grief is the sorrow, mental distress, emotional agitation, sadness, and suffering caused by a death; grief is distinctly personal and private. Bereavement refers to the period of time following a death during which grief is occurring. Mourning refers to the culturally prescribed behaviors that are customarily employed following a death; mourning is more public and social than is grief. These general distinctions between grief, bereavement, and mourning will be used in this thesis.

The distinction between grief and mourning is, of course, of only limited usefulness, as it has been well demonstrated that even the experience of emotion, for adults, is heavily influenced by culture (Stroebe and Stroebe, 1987; Eisenbruch, 1984a). This fact is one which makes the measurement of

grief so complex. However, the focus of this work is not on mourning rituals, as such, but on grief, as it is the personal, emotional response to loss which has the potential for directly impacting health. The influence of mourning practices on health is indirect, as the availability of and participation in traditional mourning rituals are among the important factors in individuals' personally coming to terms with loss.

A broader use of the term grief which gained popularity with the work of Parkes (1971) includes the reaction to any major change in one's life. His psychosocial transitions theory asserts that whenever a major change occurs in one's life space (people, places, or things), individuals must restructure their ways of looking at the world in which they live. In this view, a wide array of life changes--divorce, retirement, illness, becoming a parent--are among the events which may precipitate the reaction known generally as grief. According to Schneider (1984, 1994), any changes, even positive ones, involve loss. No matter what is ahead, something must be left behind. Grief is the reaction to the loss of whatever is left behind. This broader concept of the possible bases of grief is the one adopted in this thesis.

What Grief Looks Like

The typical reactions to the death of a loved one include a broad range of physical, emotional, behavioral, and cognitive manifestations (Worden, 1982). The physical symptoms may include tightness in the chest, hollowness

in the stomach, tightness in the throat, shortness of breath, muscle weakness, numbness, and lack of energy. Emotional responses may include sadness, anger, guilt, anxiety, loneliness, yearning, and a sense of helplessness. Among the behavioral changes which may occur are sleep disturbances, appetite disturbances, absent-mindedness, social withdrawal, searching for the lost one, and crying. Cognitive reactions may include disbelief, confusion, preoccupation with the loss event, sense of presence of the deceased, and hallucinations. No single grieving individual will necessarily experience all of these symptoms, but most experience many of them. For the purposes of this paper, it is sufficient to acknowledge that the distinctions between the four major groups of symptoms are fuzzy. That they all may occur in the course of a normal grieving process is the important point.

The literature generally agrees that not all losses are of the same significance to the bereaved and consequently there is wide variation in the intensity of grief experienced by individuals (Aiken, 1994; Osterweis, Solomon and Green, 1984; Rando, 1993; Wolfelt, 1992). Among the factors acknowledged to impact the intensity and the course of bereavement are: 1) the nature and quality of the lost relationship; 2) the characteristics of the death or loss; 3) the personal characteristics of the bereaved, including gender; 4) the available support system; and 5) ethnic/cultural/religious affiliation. Further discussion of these factors will be included in the section dealing with the distinctions between normal and pathologic grief.

Linear Models

Various models have been proposed to describe the course of grief and bereavement. Rather than representing rigidly different schools of thought, the models are overlapping. They differ in the emphasis placed on different dimensions of the reaction (Shapiro, 1994; Stroebe, Stroebe, and Hansson, 1993). The models range from the somewhat simplistic linear models through the complex family systems model.

An early linear model is Freud's, published in *Mourning and Melancholia* in 1917. According to Freud, grieving presents a dilemma because there is a need to acknowledge the absence of the love object in order to complete the grieving process, but "letting go" of the deceased involves considerable emotional pain. The predictable pattern is for the bereaved person to initially deny that the loss has occurred, become preoccupied with thoughts of the deceased, and lose interest in the outside world. However, over time, as memories are reviewed and grief work is done, the bereaved's bond with the deceased is weakened, and the bereaved regains emotional energy which is now available to invest in new relationships (Osterweis, Solomon and Green, 1984). In Freud's words:

> In what, now, does the work which mourning performs consist?...Reality testing has shown that the loved object no longer exists, and it proceeds to demand that all libido shall be withdrawn from its attachments to that object. This demand arouses understandable opposition...This opposition can be so intense that a turning away from reality takes place and a clinging to the object through the medium of a hallucinatory wishful psychosis. Normally, respect for reality gains the day. Nevertheless its orders cannot be obeyed at once. They are

> carried out bit by bit, at great expense of time and cathectic energy, and in the meantime the existence of the lost object is psychically prolonged. Each single one of the memories and expectations in which the libido is bound to the object is brought up and hypercathected...when the work of mourning is completed the ego becomes free and uninhibited again (p. 52).

Of significant influence on subsequent models of grief was Freud's belief that bereavement is concluded with the relinquishment of all ties to the lost object (Shapiro, 1994). Also significant is this first appearance of the concept "the work of mourning," which is referred to by other authors as "grief work" (Stroebe, 1992-93; Wortman and Silver, 1989).

Freud's psychoanalytical model has had enduring influence on much of the psychiatric and sociological literature dealing with grief and mourning written since that date (Gorer, 1965). Freud's distinction between normal grief (which he refers to as healthy mourning) and pathologic grief (which he calls melancholia) is that in mourning it feels like the external world is empty; in melancholia it feels like the internal world is empty. Freud's aim was to develop a hypothesis concerning the pathological condition of melancholia. He gave less attention to the "normal" emotions which he termed mourning. The attention given is interesting, however, in light of the current use of the term grief to describe the reaction to losses other than to death. Freud also recognized the experience of mourning in response to losses other than the death of a beloved. He said: "Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an idea, and so on" (p. 51).

Another influential model of grief is that described by Lindemann (1944). While frequently cited in the literature as a study of survivors of the Coconut Grove disaster (a fire in 1942 in a famous Boston restaurant in which many perished), Lindemann's study included patients in four groups: 1) psychoneurotic patients who lost a relative during the course of treatment; 2) relatives of patients who died in hospital; 3) relatives of members of the armed forces; and 4) bereaved disaster victims (of whom 13 were survivors of Coconut Grove). Lindemann identified five responses common to the entire group: 1) somatic distress, 2) preoccupation with the image of the deceased, 3) guilt, 4) hostile reactions, and 5) loss of patterns of conduct. His observation supported the earlier hypothesis of Freud--that being willing to feel the pain of the loss was necessary to eventual healing. In Lindemann's words:

> The duration of a grief reaction seems to depend upon the success with which a person does the grief work, namely emancipation from the bondage of the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships. One of the big obstacles to this work seems to be the fact that many patients try to avoid the intense distress connected with the grief experience and to avoid the expression of emotion necessary for it (p. 144).

In addition to affirming Freud's concept of grief work, an important legacy of Lindemann's work was the notion that grief is time-limited. He reported that in the majority of cases the acute manifestations of grief lasted approximately 5-6 weeks. This overly optimistic picture of the time-limitedness of grief has endured in much of the literature which attempts to assess the duration of

normal grief. Likewise, he contributed to the notion that there is a quite definite end-point to the process of grieving.

The attachment model emerged in the late 1960's. This model was reached independently by two separate researchers, Bowlby (1969) and Parkes (1972). Regarding their subsequent collaboration, Parkes says: "Our collaboration has been close since, and it is difficult to sort out who deserves credit or blame for many of the ideas that make up the overall theory" (Parkes, 1972, p.28). Their attachment theory maintains that during the course of normal development, individuals form distinctive bonds or attachments, first between child and parent; later between adults. They posit that when such bonds are threatened, powerful behaviors aimed at preserving the bonds are activated, such as clinging, crying, and angry protest. They argue that the severing of such a bond by physical absence/death evokes comparable behavior even though the behavior is aimed at reuniting when there is no possibility of success.

Based on available literature and on Bowlby's observations of young children's separation from parents, they maintained that successful bereavement involves passing through four major phases. The first phase is characterized by the stunned, numb reaction to the apparent absence and anger in protest of it. The second phase includes intense yearning and searching, evidence of the determination to find and reunite with the lost one. Eventually, behaviors aimed at reuniting with the absent loved one diminish and the third phase is

reached. This is characterized by withdrawal of energy and disinclination to look to the future. Finally, having given up hope of reattachment and having broken down that bond they are able to begin to establish new ties to others and to experience a gradual return of previous interests (Bowlby, 1980).

In a work published somewhat earlier, Engel (1961) described the stages of grief in a comparable way, identifying 1) an initial phase of shock and disbelief, in which the sufferer attempts to deny the loss and to insulate himself against the shock of the reality; 2) a stage of developing awareness of the loss, marked by the painful effects of sadness, guilt, shame, helplessness or hopelessness; 3) a stage characterized by a sense of loss and emptiness, including loss of interest in one's usual activities and associates; and 4) finally, a prolonged phase of restitution and recovery during which the work of mourning is carried on, the trauma of the loss is overcome, and a state of health and well-being re-established. Engel's work has been prominent in discussions of the extent to which even normal grief is a "disease" (Gorer, 1965).

The psychosocial model builds on concepts from both the psychoanalytical and the attachment models. This model emphasizes the process by which the bereaved creates a new identity. Parkes and Weiss (1983), in extensive work with widows and widowers in both England and Boston, concluded that grieving adults' initial denial of the reality of the death of their spouse, followed by the gradual acknowledgment of it, buys time for

the main task of adult grief--reconstructing their identity in a world in which the partner is not physically present.

Kubler-Ross's (1969) five stage model gained great popularity and did much to diminish the taboo of death as a topic of polite conversation. Her model is based on observations of and interviews with hundreds of patients coming to terms with their own impending deaths. Kubler-Ross identified different responses that individuals exhibit when they are faced with the tragic news of a terminal diagnosis. She grouped these types of reactions, defense mechanisms in psychiatric terms, into five categories which she termed "stages." The five stages she identified are: denial, anger, bargaining, depression, and acceptance. While her model became very popular and has had broad influence on conceptualizing the grieving process, a methodological weakness in the model is that it suggests that each individual griever progresses through those five stages. However, she did not conduct multiple, sequential interviews on single individuals progressing through those stages; rather, she devised the model based on single observations of multiple patients at various "stages" in their coming to terms with their terminal diagnoses. Thus, the conclusion that most individuals progress through those five stages in somewhat that order is not warranted by her work.

A notion closely related to that of the stages of grief is that of the tasks of grief. According to this model, there are tasks (which roughly correspond to the stages proposed by other authors) which must be completed before the

bereaved individual can fully recover from the loss. These tasks are: 1) to accept the reality of the loss; 2) to experience the pain of grief; 3) to adjust to an environment in which the deceased is missing; and, 4) to withdraw emotional energy and reinvest it elsewhere (Worden, 1982). This model contributes to the notion that there is a definite end point to the grieving

Criticism of Linear Models

It is agreed by most authors that both the stage and the task models are only to be used as guides, not as prescriptions, and that the grief experiences of individuals are distinctly their own (Aiken, 1994; Schneider, 1984, 1985; Stroebe and Stroebe, 1987; Wolfelt, 1992). Significantly, Kubler-Ross acknowledged that the stages which she described were not to be thought of as discrete or absolute. Speaking of her own model of grief associated with death and dying, she said: "We have discussed so far the different stages that people go through when they are faced with tragic news...These means will last for different periods of time and will replace each other or exist at times side by side" (p. 122). Parkes (1972) likewise described the tendency of individuals to oscillate back and forth between the phases: "Grief...involves a succession of clinical pictures which blend into and replace one another...each of these stages of grieving has its own characteristics and there are considerable differences from one person to another as regards both the duration and the form of each stage" (p. 7).

The usefulness of the conceptualization of the course of grief as occurring in stages, phases, or tasks is limited. While bereaved individuals may appreciate knowing that the symptoms they are experiencing are normal and that their reactions fit a model which describes the journey of many through their grief, they may be highly resentful of the implied suggestion that there is some particular way they should be feeling or some rate of progress which they are expected to achieve (Berardo, 1988). As a tool for use in the education and training of volunteers and professionals for working with the bereaved, the models do help in the organization of a vast amount of material into a somewhat coherent schema. They also provide an important frame of reference in distinguishing between normal and pathologic grief, since both intensity and duration of symptoms figure in that assessment. However, the danger is that the concepts will become prescriptive and the grief counselor may unconsciously be expecting some particular sequence of reactions (Stroebe and Stroebe, 1987).

Other criticisms of stage models of grief have been made. Corr (1993) points out, specifically with regard to the Kubler-Ross model, that it pays attention to only the intrapersonal aspects of the dying person and focuses totally on the dying process to the exclusion of other events which are occurring and other persons who are present in his/her world. Corr contends that a good model should provide an improved basis for understanding all of the dimensions and all of the individuals who are involved in coping with

dying, not just the dying person. He insists a helpful model should emphasize the shared aspects of coping with dying, thus providing guidance for family members and care providers in their optimal participation in the process. He further contends that a really good model would describe both that which is universal and that which is individual in the process. He is critical that stage models, because they are generalizations, risk stereotyping both individuals and the process of dying. Kastenbaum (1977) also suggests that the Kubler-Ross model, by limiting itself primarily to feelings and psychosocial reactions, attends mainly to selected aspects of the coping person's life and does not offer a holistic perspective.

Similar criticisms may be made of all the stage models of grief--that their single-dimensionality fails to account for the rich variety of possible responses to loss and does not suggest the wide range of behaviors which the helping person may be called on to validate. Another feature of the stage models which is subject to criticism is linearity, suggesting a beginning point and a definite end point to the grieving process. Recently writers have emphasized that one never fully recovers from a loss; rather, that the process of redefining one's relationship with the deceased (Moss and Moss, 1984-85; Myerhof, 1978) and of reformulating one's view of the world never ends (Parkes, 1993; Schneider, 1994). Myerhoff (1978) suggests that for the elderly, recovery from grief involves integrating memories and values of the deceased into current life, not replacement. Likewise Moss and Moss

(1984-85), based on work with widows and widowers, speculate that in healthy bereavement, themes of the marital tie continue throughout widowhood. In contrast with Freud, who held that holding on to the tie with the deceased is pathologic, this view emphasizes the potential for enhancing the widow(er)'s identity and well-being by maintaining the tie.

Non-Linear Models

A model which progresses beyond linearity and single-dimensionality is the holistic model proposed by Schneider (1984, 1994). According to his model, life includes a continuing series of changes and losses to which the individual is constantly in the process of adapting. He emphasizes the potential for growth which loss provides, including optimally the power of grief to transform one's life view. According to Schneider, from this transformed perspective, rather than viewing loss as limiting, an individual may see it as an opportunity. In Schneider's words: "Transforming loss allows us to discover new ways to relate, understand, create and commit ourselves to an ongoing process of renewal and discovery" (1994, p. 23).

Schneider's model is non-linear, suggesting that grieving is an ongoing process without a definite end point, and emphasizing that a new loss may occur at any point in the process of adjusting to earlier losses. A new loss, however, demands one's attention with more immediacy that an older loss which one has integrated to some extent. Schneider sees the process of

grieving with respect to a particular loss to include: coping with an awareness of the loss; gaining a perspective of what is lost and what remains; integrating the loss, that is, remembering restoring and recreating; reformulating, that is, exploring what is now possible; and finally, transforming, that is, recognizing forces beyond the individual ego. He emphasizes that throughout the process there is continuing vacillation between limiting awareness of losses and being aware of them. Coping strategies include fight (holding on to whatever connects us to our old world, our social part, energy using) and flight (letting go, our solitary part, energy conserving).

Schneider's model, in addition to being non-linear, is multi-dimensional. Each of the phases (awareness, perspective, integrating, reformulating, transcending) is experienced in several ways--behavioral, cognitive, emotional, physical and spiritual. He emphasizes that the key role helpers can play in facilitating progress along a transformative path is to validate the unique experience of the bereaved at any point along the way on any of these dimensions.

While Schneider's holistic model allows for a richer description of the experience of the bereaved, it still focuses on the experience of the individual griever. Some writers emphasize that grief is a family process which is best understood in the context of family systems theory (Rosenblatt, 1988; Shapiro, 1994; Walsh and McGoldrick, 1991). The family systems approach meets an important criticism of Corr discussed earlier, acknowledging that more than a

single individual is at the center of the grief event. Family systems theory emphasizes that family rules and patterns shape a loss experience and that a significant loss is played out in a system of family relationships (Rosenblatt, 1988). The death of a 50 year old man may mean the loss of a spouse, father, son, brother, etc. Each of the bereaved experiences the loss individually, but also as a part of a family system. The individual family members may not experience their grief in the same way but how each experiences their grief impacts how each of the others experiences theirs.

Walsh and McGoldrick (1991) assert that the emotional impact of the loss of a family member can reverberate through a family system for generations. Shapiro (1994) argues for a transformation of attachment to, instead of detachment from, the deceased family member in sustaining and enhancing family development. While a family systems approach does not lend itself to a handy four word or four stage description of the course of bereavement, it does provide a schema within which to consider ethnicity as a factor influencing the course of bereavement, given the extent to which family and ethnic affiliation are intertwined. This topic will be explored more fully in Chapter Two.

Pathological Grief

Among the elusive concepts in grief and bereavement is that of pathological grief. Some of the popular literature suggests that the distinction

between normal and pathological grief is rather straightforward. For example, Schiff (1986) says: "Sometimes a facilitator will be faced with a situation where he sees quite clearly that individual counseling is necessary" (p. 240). Yet she gives no guidelines for what that situation might look like.

Difficulties in distinguishing between normal and pathological grief stem from both the idiosyncratic nature of normal grief and the lack of objective criteria for what constitutes pathological grief. Neither duration nor intensity of grief reaction, by themselves, signal pathological grieving; rather, it is the interplay of quality and quantity of reactions over time that suggest pathology (Osterweis, Solomon, and Green, 1884). Schneider (1980) suggests that there should be no drastic obstruction to the conduct of daily life after an average time of six months after the loss. Worden (1982) emphasizes progress, suggesting that grief is pathological when the individual is overwhelmed and remains in the state of grief without progressing in the grieving process toward completion. Parkes and Weiss (1983) describe pathological grief as the bereaved becoming stuck in the grieving process. According to Parkes and Weiss, grieving becomes pathological when the inability or unwillingness to work through grief seems preferable to the absolute hopelessness anticipated should they relinquish the lost relationship.

Rynearson (1990b) suggests three general syndromes of pathological grief: 1) dependent; 2) unexpected loss; and 3) conflicted. The first, the dependent grief syndrome, occurs in response to an over-reliant attachment in

which one's image of self is dependent upon the availability of another, who is now absent and will not return. This absence deprives the bereaved of the continuing interchange with his partner which had been necessary in maintaining his image of self as whole and acceptable. A pathologic shift in self-image occurs, with the bereaved's sense of self now seen as weak and incompetent.

The second, the unexpected loss grief syndrome, occurs when the circumstances of the death itself are sudden and/or unnatural and therefore traumatic. The event of the death may have been so horrendous as to preclude the bereaved's ability to assimilate and accommodate. When this occurs, due to close identification with the lost person, the image of the bereaved himself/herself is perceived as fragmented or annihilated. This syndrome is characterized by the posttraumatic stress syndrome of hyperactivity; recurrent intrusive recollections of the death event alternating with compensatory psychic numbing; and the loss of sense of control over one's destiny.

The third, the conflicted grief syndrome, occurs following the death of an ambivalently valued figure. The ambivalent investment in the lost person is now internalized within the bereaved himself or herself, a self now experienced as guilty and defective. A formulation which is common to all three syndromes is, according to Rynearson: "...an enduring emotion that draws one toward something or someone who is missing, whose absence is accompanied by a dysfunctional revision of assumptions of self and future" (1990b, p.300).

Rynearson's description of pathologic grief syndromes is intrapsychic and does little to help the bereavement support worker identify behaviors which suggest the need for professional help.

The concept "return of ordinary function" is used by Weiss (1988) to signal a healthy grieving process. If after a reasonable period of time (his work suggests that two years for widows is not unusual) there is not progress toward return of ordinary function, pathological grief may exist. He suggests five indicators which may be representative of ordinary function: 1) ability to give energy to daily life, demonstrating a willingness to invest in the present; 2) psychological well-being as evidenced by relative freedom from the distress of disturbing thoughts and feelings; 3) ability to experience pleasure when hoped-for or desirable events occur; 4) hopefulness regarding the future; being able to care about plans; and, 5) ability to function with reasonable adequacy in social roles as spouse, parent, and member of the community.

Weiss emphasizes that there is no universally accepted set of criteria for ordinary levels of effective functioning. He asserts, however, that constructing a framework of recovery is useful in sorting out the various aspects of personal and social functioning, and makes it possible to identify areas in which recovery may be incomplete.

Risk Factors Which Predispose to Pathological Grief

Various formulations have been suggested to predict which bereaved individuals may be at high risk for pathological grief. Rando (1993) identifies seven factors which increase the risk of grief becoming complicated: 1) a sudden, unexpected death, especially if it is traumatic, violent or mutilating; 2) death from an overly lengthy illness; 3) death of a child; 4) the bereaved's perception of the death as preventable; 5) a relationship of the bereaved with the deceased which was ambivalent or overly dependent; 6) unaccommodated prior losses; and 7) the bereaved's perceived lack of social support. Given the scope of this thesis, attention will be focused on unaccommodated prior losses and perceived lack of social support.

According to Rando (1992-93), contemporary sociocultural and technological trends are increasing the risk that recovery from grief will be complicated. Among the factors she cites are increased urbanization, industrialization, technicalization, secularization, deritualization, and social and geographic mobility. The consequences of these trends include the loss of the traditional sources of comfort which are present in some form or other in all cultures everywhere-- religious beliefs, family, and close friends. She suggests, further, that there is an exclusivity in some American families which fosters unusually intense emotional involvement as compared to other societies and which results in an overidentification and overdependence among family members. Then, when separated, for example as a result of geographic

mobility, a bereavement episode leaves them especially vulnerable.

The following case example, "A Pathological Grief Reaction with a Positive Outcome," appears in a current text book on bereavement (Aiken, 1994). It illustrates the confusion which is perpetuated about what constitutes normal v. pathological grief.

> Nadine, a 66-year-old former high school teacher, lived with Charles, age 67, her husband of 40 years (also a retired teacher). The couple had been nearly inseparable since they met--they even taught at the same schools during most of their teaching careers. They lived in a semirural community where they had worked and had raised their children, all of whom married and moved to a large metropolitan area about 100 miles away. For years they had planned their retirement and had hoped to travel around the country visiting friends. A week before their fortieth anniversary, Charles had a heart attack and, after five days in the intensive care unit, had a second heart attack and died
>
> Nadine took Charles's death quite hard. Even though she had a great deal of emotional support from her many friends and her children, she had great difficulty adjusting. Elaine, one of her daughters, came and stayed a few days and encouraged her to come to the city for a while. Nadine declined the persistent invitation even though she had little to do at home. Friends called on her frequently, but she seemed almost to resent their presence. In the months following the funeral, Nadine's reclusive behavior persisted. Several well-wishers reported to Elaine that her mother was not doing well and was not even leaving the house to go shopping. They reported that Nadine sat alone in the darkened house--not answering the phone and showing reluctance to come to the door. She had lost interest in activities she had once enjoyed.
>
> Greatly worried about her mother's welfare, Elaine organized a campaign to get her mother out of the house and back to doing the things she had formerly enjoyed. Each of Nadine's children and their families took turns visiting and taking her places until she finally began to show interest in living again. In time, Nadine agreed to come to each of their homes for visits. This proved a therapeutic step since Nadine had always been fond of children and took pleasure in the time spent with her eight grandchildren--she actually extended the visits longer than she had planned (p. 336).

The information provided in this example is insufficient to render a diagnosis of pathological grief. Critically, the time dimension is not clear. "Months" may suggest four, or may suggest twenty-four. If four, then the reticence to engage socially is not unusual. If twenty-four, the feature of pathologic grief which Parkes and Weiss (1983) describe as stuck would appear more likely. Also not clear is the extent to which Nadine's children visited her in those early months. It is not unusual for bereaved individuals to prefer the support of immediate family, as Rando has suggested (above). If her children, even at a distance of 100 miles, failed to visit her during those months after the funeral, Nadine may well have felt abandoned by those most important to her. Another feature of pathological grief which it is not apparent in Nadine's case the dysfunctional revision of assumptions of self and future which Rynearson (1990b) describes. This is not to say that it may not be present; only that the information provided is insufficient to make that assessment. Given Rynearson's (1990a) caution that the stamp of pathological be reserved for the "rare and rigorous circumstances of the disease" (p. 294), it is not clear that Nadine qualifies.

Summary of Chapter One

The linear models of grief, which have dominated the psychology literature since Freud, fail to account for the wide range of reactions to a loss which individuals may exhibit. Further, the linear models perpetuate some

misconceptions about healthy grieving, including that there is a distinct end point which is accomplished by severing all ties with the deceased. These misconceptions contribute to the difficulty of distinguishing between normal and pathological grief. The holistic models, while non-linear and multi-dimensional, still place a single individual at the center of the grief event, a feature which limits consideration of the broad range of interconnected reactions to the loss occurring throughout the individual's family. Family systems theory provides a perspective which acknowledges that most deaths leave several bereaved individuals, whose strategies for coping with the loss impact each other. This perspective is important in understanding some of the special challenges of ethnic bereaved which will be explored in later chapters.

CHAPTER TWO
ETHNICITY AND GRIEF

The Scope of the Problem: Ethnic Population Trends

Contrary to the melting pot theory, which anticipated that the U.S. would eventually become a society in which the several ethnic groups who emigrated here would intermarry and result in a single, homogenous culture, it has become increasingly evident that such is not the future of the U.S. Nor is it apparently the future condition of humanity, at least not in the foreseeable future (Sokolovsky, 1990b). Scholars note that pluralistic societies are on the rise throughout the world (Cool, 1987). Thus, people within any given society must increasingly interact socially and politically with individuals who represent different ways of living and thinking.

According to the U.S. Census in 1990, one in four American residents were members of ethnic minorities, that is nearly 62 million people. In 1980 that ratio had been one in five. This increase in racial composition changed to a greater degree between 1980 and 1990 than during any other decade in this century (Irish, Lundquist, and Nelson, 1993). Within large ethnic groups, several differing cultures are represented. The Asian group, numbering 7.3 million in 1990, consists of Chinese, Filipino, Japanese, Vietnamese, East Indian, Korean, and Laotian-Hmong and show an increase of 108 percent since

1980. Hispanics, numbering 22.4 million in 1990, consist of Mexican, Puerto Ricans, and Cubans, as well as immigrants from Central and South America. As a group their numbers have increased 53 percent since 1980. African Americans, numbering 30 million in 1990, increased 13 percent over 1980 figures.

Michigan's population profile reflects comparable ethnic minority trends (Michigan Dept. of Public Health, 1988). In 1980 the non-White population constituted 14 percent of the total in Michigan. By 1985 that percentage had grown to 15 percent, a number which does not take into account the significant disproportionate undercounting of minority group members which is an acknowledged feature of census data. In addition to the large numbers of Asian, Hispanic, and African Americans represented in the population, a significant ethnic population in Michigan are Arab Americans, who numbered 70,000 in 1980. Of these, 75 percent live in the Detroit area. They are a culturally diverse group, with representatives identifying themselves as Lebanese, Assyrian, Syrian, and Iraquis.

Clarification of Terms

The reader will note that the census data presented above uses interchangeably the terms racial and ethnic. This usage reflects the way in which the terms have been utilized by the authors cited. Ethnic groups have been as broadly defined as "social groups that are distinguished on the basis of

race, religion, or national origin" (Markides and Mindel, 1987, p. 13). However, this definition is very misleading. Consider that both a black Kenyan international student and a black Detroit factory worker would be categorized by the same racial distinction, yet culturally are worlds apart. Correspondingly, an upper-class Boston Irishman and a migrant Hispanic may both be Catholic, yet their cultural heritage is significantly different. And regarding national origin, immigrants from South Africa might include either socially advantaged white Afrikaners or severely disadvantaged blacks.

While such a broad definition of the term ethnic blurs significant dimensions of ethnicity which are the focus of this paper, to point out that the terms are sometimes used imprecisely provides a perspective from which to appreciate the difficulties in constructing accurate demographic data upon which to base decisions regarding health and social programs which are sensitive to specific ethnic groups. Not only do inaccurate numeric profiles result, but such imprecise usage effectively perpetuates the commonly held belief that race and culture are somehow synonymous. Regarding enumeration difficulties, often the category "non-White" is offered as a catchall for all non-caucasian racial groups (Markides and Mindel, 1987). In this usage, non-White may be assumed to refer to Black, but not all non-Whites are Black. As noted in the Michigan population profile above, non-White includes, in addition to Black, large numbers of Asians, Hispanics, and Arabs. The large ethnic group referred to collectively as Hispanics includes individuals of

Mexican, Cuban, Puerto Rican, Central and South American ancestry. To lump them with each other suggests cultural homogeneity, a very misleading suggestion. To include them with Blacks in a count of non-Whites further limits what can be inferred from such an enumeration. This practice is not unusual, however, in studies by governmental entities collecting demographic and socioeconomic data.

Enumeration Difficulties

Very different enumerations result depending on the method used to identify ethnicity. The Mexican-American group provides an example. The various possibilities for how to identify persons of Mexican ethnicity include: 1) persons born in Mexico or of Mexican parentage; 2) use of Spanish as the household language; 3) Spanish surname; and 4) the respondent's identification of him or herself by origin (Harwood, 1981). Each method contains its own difficulty. The first tends to underenumerate, as it excludes persons whose grandparents, great-grandparents, etc. came to the U.S. The second method tends to overenumerate, as it includes immigrants and descendants of other Spanish-speaking groups (e.g., Puerto Ricans, Cubans). The third method mixes under- and over-enumeration potential. It eliminates from the count persons of Mexican ancestry who have married and relinquished their Hispanic surnames. In contrast, it includes, perhaps inappropriately, individuals who still carry Hispanic surnames but who trace their origins to regions of New

Mexico and Colorado previously part of New Spain and who do not identify with the Mexican-American community. Method four is subject to variability based on the subjective experience of the respondents, who one day may feel an affinity for their Mexican-American ancestry, while another day may strongly identify with the WASP culture to which they have become acculturated to some degree.

Operational Definition of Ethnicity

To develop a concept of ethnicity which provides a framework for considering the influence of ethnicity on the course of grief and bereavement, it is necessary to reach beyond the dimensions of race, religion, and national origin. That is not to say these dimensions will be excluded; rather, that others will be identified from which ethnicity derives its potential to influence grief and bereavement. The notion of sense of identity is central to this potential. For the purposes of this thesis, an individual is *ethnic* to the degree to which they *emotionally identify with* a group who share race, religion, and/or national origin. Sokolovsky (1990b) describes ethnicity as "social differentiation derived from cultural criteria such as a shared history, a common place of origin, language, dress, food preferences, and values that engender a sense of exclusiveness and self-awareness of membership in a distinct social group" (p. 201). In this sense, ethnicity fulfills a deep psychological need for identity and historical continuity.

The presence of a larger social context against which the ethnic differences stand in contrast is a dimension emphasized by Cool (1987). Stated another way, "To be an ethnic minority requires sociocultural contrast for its validation..." (Elsass, 1992, p.220). Further, ethnicity evokes deep feelings, with discussions about and/or between ethnic groups frequently becoming polarized. The "we" and "they" touches on something basic in the human psyche (McGoldrick, Pearce, and Giordano, 1982).

Disadvantaged Social Position

In addition to cultural distinctiveness, exclusivity, and emotional content, virtually all ethnic groups in the U.S. have been impacted by their immigration histories and the ongoing social, economic, and political forces which result from American class stratification (Sokolovsky, 1990b). Their immigration histories include both what they came to and what they left behind. Of particular significance in this regard is that most immigration to the U.S. has been in response to the U.S. need for labor and/or the promise of opportunity. Immigrants thus have long been a valuable commodity in the labor market, but have been destined to a bottom rung on the socioeconomic ladder (Worsley, 1984). Immigrants have traditionally been willing to take undesirable jobs which the longer-settled Americans (the now acculturated mostly Anglo-Saxons of previous generations) have been unwilling to perform. For example, the Chinese and the Irish came in the 1860's to build the

railroads, putting their lives at risk while dynamiting through entire mountains. The Mexicans came in the 1960's to work as farm laborers, earning a pittance for back-breaking, labor-intensive harvesting of crops.

For these immigrants, their lack of command of the spoken language, their inability to read, their lack of experience of the local social institutions, their distinctive style of clothing, and their unfamiliar customs alienated them socially from the mainstream culture. Many immigrants reacted to this social exclusion by emphasizing their ethnicity--living together in barrios, organizing recreational associations, and in some cases organizing trade unions and political parties (Worsley, 1984). What might be viewed as a healthy sense of tradition--attachment to the past as a value in itself--may also be viewed as a "nostalgic spiritual contrast to present disprivilege" (p. 249). While this retreat into an insulated haven of comfort and affirmation reduced the immediate pain of the situation, it served to delay the learning of language, social skills, and customs which were necessary if the disadvantaged position was to be overcome.

It is from this view of the immigrant as valued labor commodity but disvalued social entity that the category ethnic minority takes on particular meaning. Minority can be used to indicate power relationships within a society, not numerical magnitude. For the entire world, those of the white race constitute a distinct minority numerically; "people of color" are the vast majority (Irish, Lundquist, and Nelsen, 1993). However, in both the past and

the present, numerical minorities sometimes maintain power over nonwhite majorities, such as in South Africa, controlling the circumstances under which the latter live. In the U.S., white majorities have dominated and discriminated against nonwhite minorities.

Cultural Uprootedness

In addition to the disadvantaged social position to which ethnic minority members came and to which they continue to be relegated, what they left behind also has enormous significance. For some groups, the reason for emigration was to flee for their lives, as was the case for the Jews during World War II and for the Cambodians during the Pol Pot regime in the 1970's. The atrocities to which they were subjected prior to their flight resulted for many in severe stress reactions. Quite aside from the reaction to the atrocities, the loss of homeland was in itself monumental. Uprooting cannot be understood merely as physical relocation. According to Marris (1974) uprooting disrupts the continuity of an individual's concept of selfhood as well as the individual's "structure of meaning,"--how the individual organizes and understands one's environment. He likens the reaction to uprooting to the grief reaction more typically thought of as accompanying the bereavement which results from the loss to death of a significant other.

Eisenbruch (1984a) uses the term "cultural bereavement" to describe the phenomenon of grief reaction to the massive social loss caused by

uprooting. Marris (1980) asserts that the anxieties which accompany such losses center on the struggle to defend or recover meaningful patterns of relationship. According to Marris, the nature of grieving shows that meaning is a whole--the loss of any crucial relationship tends to undermine the sense of all relationships. The Psychosocial Transitions theory of Parkes (1971) supports this view. Parkes asserts that whenever a major change occurs in one's life space (people, places, or things), the individuals must restructure their ways of looking at the world in which they live. The significance of any particular change, according to Parkes, depends on its influence on our "assumptive world,"--our assumptive world being the total set of assumptions which we build up on the basis of past experience. Studies of adult refugee groups from eastern Europe, Taiwan, Latin America, and Cuba suggest that even after apparently successful early adjustment, there may be a high rate of subsequent physical and mental breakdown (Eisenbruch, 1984a and 1984b). He found that advancing age, personal bereavements, and the social isolation of immigrants may promote a renewed sense of exile and reactivate the trauma of the original uprooting.

In summary, the dimensions of ethnicity which have been identified as specifically salient to issues of grief and bereavement are: 1) emotional identification with a group who share race, religion, and/or nationality; 2) distinctive language, dress, and customs of that group which are in contrast to the dominant culture; 3) a disadvantaged social position within the larger

society; and 4) cultural uprootedness with potential for unresolved cultural bereavement. These dimensions, however, should not be thought of as existing uniformly among all individuals of all ethnic affiliations. The extent to which an ethnic group and/or individual members within that group have become acculturated to the dominant WASP culture is dependent upon a number of variables. These variables are the subject of the following section.

Assimilation Theory

Traditional assimilation theory views ethnicity and minority status as temporary. According to this view, while ethnic groups coming to the U.S. may enter at the bottom of society, they are able to gradually rise to the middle class, losing both their subordinate status and their cultural distinctiveness on the way (Markides and Mindel, 1987). This view predicts that within an immigrant family, younger generations born in the U.S. can be expected to replace the ethnic groups' traditional values and customs with the more modern, WASP social patterns of their peers.

Another theory, that of "cultural pluralism," suggests that differences between ethnic groups and the dominant culture tend to persist despite some assimilation by some members of their groups (Trela and Sokolovsky, 1979). Two models within this theory are "integrated pluralism" and "invidious pluralism." Integrated pluralism refers to the coexistence of distinct ethnic groups without patterns of subordination of any group by any other. This

model generally explains the persistence of cultural distinctiveness among European-origin White ethnic groups such as the Irish in Boston and the Polish in Detroit. In contrast, invidious pluralism focuses on the effects of subordination and discrimination of minority groups (Markides and Mindel, 1987). This model explains the situation of the Blacks in Detroit, the Mexicans in Los Angeles, and the Puerto Ricans in New York City.

In common usage, the distinction between "multi-ethnic" and "multi-cultural" is frequently blurred. Irish, Lundquist and Nelsen (1993) suggest that both terms refer to societies in which multiple cultural groups exist but with varying degrees of assimilation and subordination. According to their distinction, a multi-ethnic society consists of identifiable cultural groups that exist quite separately from and subordinate to a majority population. Such groups are not appreciably assimilated and do not receive equal respect from the majority, and thus lack equal access to opportunities within the society. In contrast, a multi-cultural society includes groups that are somewhat distinguishable in the sharing of some common customs and values, but who are able to share fully in the wider society's resources and opportunities. While the Irish, German, Italian, Polish, and others qualified as ethnic minorities early in their immigration history, this distinction no longer applies as they have made their way up the socioeconomic ladder and have become more or less fully acculturated. To varying degrees, however, they retain their cultural distinctiveness. In contrast, the ethnic groups who retain the distinction of

minority status in the sense of subordination are, significantly, non-White groups including Mexican, Asian, Black, and Native American (Markides and Mindel, 1987).

Speed of apparent acculturation is a multi-faceted phenomenon. Individuals and families who migrated alone have had a greater need to adapt to the new situation, and their cultural bereavement is more hidden. This is the case of the educated immigrants who came for professional positions in the U.S. While they have been apparently successful in the sense of learning the language of their new home and participating without discrimination in economic opportunities, their lack of access to others with whom they can speak their native language or share customs and rituals is especially problematic in the event of a new significant loss beyond their uprootedness.

The place of residence of the family also impacts the rate of acculturation. Large cities with large numbers of ethnic minorities are more likely to have ethnic neighborhoods which cushion against the stress of migration but which also tend to slow the rate of adaptation to the customs and values of the U.S. For families living in such neighborhoods, the choice for individual family members between upward mobility and ethnic loyalty can be a source of severe identity conflict (McGoldrick et al., 1991). The intensity of one's identification with an ethnic group is likely to be inversely correlated with education, income, and socioeconomic class (Markides and Mindel, 1987). As immigrants becomes more educated, receive a higher income, and

move upward socioeconomically, their identification with their ethnic heritage tends to weaken, at least in their day-to-day activities.

Ethnicity and Stress

Apparent acculturation may collapse under conditions of emotional distress, however, with a reversion to sense of ethnic identity surfacing. It is not unusual for a married couple to tolerate differences, perhaps even to find them endearing. Under stress, however, one's tolerance for difference diminishes (McGoldrick et al., 1991). Rosenblatt (1988) asserts that Americans frequently act as though ethnic differences don't extend beyond food preferences and holiday celebrations. For some married couples of different backgrounds, when a significant loss occurs may be the first time the differences in ethnicity become problematic as different norms for defining and dealing with the loss become evident. Unfortunately, at that time, individuals may lack the focus, energy, or flexibility to deal with their relationship. They may use their ethnic customs or religious values selectively to justify an emotional position within a family or against outsiders, or, couples may react to each other as though the other's behavior were a personal attack rather than a difference rooted in ethnicity.

Eisenbruch (1984b) suggests that there are parallels between the coping strategies in response to cultural uprootedness and pathological outcomes of bereavement due to death. He sees excessive clinging to the culture from

which one has been uprooted, with an inability to move on to form new attachments and learn new customs, as similar to the overidealization and overidentification with the deceased which can be seen in pathological grief. In contrast, the opposite reaction, with rapid and apparently smooth assimilation into the host society, may be seen as similar to the abrupt immersion in a new relationship and marriage which may occur after the loss of a spouse but prior to coming to terms with the multiple meanings of the lost relationship with the deceased.

The interplay among ethnic identity, religion, and family life are complex. The family may be thought of as the focus of ethnic identity because it is within this sphere that ethnic values and behaviors are perpetuated. But it is important to see family life and religion as distinct and separate aspects of ethnic identity. Poles, Italians, and Irish may all be Catholic, but the flavor of religious observances will differ significantly. Conversely, long after an individual member of those families may have rejected Catholicism intellectually, their identification with the family's ethnic heritage may be intense.

Summary of Chapter Two

Ethnic population trends suggest that the presence of diverse ethnic groups in the U.S. is on the rise. The reliable enumeration of these groups is a challenge which must be acknowledged in the design of social programs. The

dimensions of ethnicity which are identified as having particular relevance to grief and bereavement are: emotional identification with the minority group; customs which contrast with those of the larger society; a disadvantaged social position; and cultural uprootedness. Cultural bereavement, the grief reaction to the massive social loss which accompanies uprootedness, is among the factors predisposing ethnic group members to complicated grief when confronted with additional losses. Degrees of apparent acculturation are seen to collapse during times of emotional distress, with reversion to stronger identification with individuals' ethnic roots.

CHAPTER THREE
GRIEF: A CROSS-CULTURAL PERSPECTIVE

Is Grief Universal?

Grief theorists generally agree that grief is universal: that to make attachments, to have them disrupted by death or separation, and to experience distress as a result of that disruption is part of the human condition (Counts and Counts, 1991; Eisenbruch, 1984a; Schneider, 1984, 1994). Some insight into the extent to which the human species experiences grief universally can be gained by considering the relative contributions of biology and culture. Insight so gained can also help to assess the extent to which the response of an individual to distress has been conditioned by his/her cultural experience.

Biological Evidence

Some arguments have been made that grief has a biological basis. Darwin (1872/1965) compared in human infants and monkeys the facial muscles which were involved in expressions of apparent protest and pain. He also collected detailed information from colleagues who observed facial expressions associated with apparent emotional distress in indigenous peoples in Australia, India, and Africa. He found that the same sets of facial muscles are universally

used by human infants, monkeys, and adults in situations believed to be cause for grief, suggesting a biologic basis for grief.

Darwin was careful not to generalize from observations of blacks in America as he recognized the extent to which their reactions might be influenced by the responses they observed in the white world in which they were immersed. Darwin likewise believed that observing infants is more reliable than observing adults, noting that infants exhibit many emotions with extraordinary force, whereas in adults, some expressions no longer reflect the pure and simple source from which they spring in infancy.

Further support for a biologic basis for grief is found in the work of Averill (1968). Averill hypothesized that grief is a biological reaction, the evolutionary function of which is to ensure group cohesiveness in species where a social form of existence is necessary for survival. This cohesiveness is accomplished by making separation from the group, or from specific members of the group, an extremely stressful event both psychologically and physiologically. This stress is particularly pronounced when the separation breaks a dependent relationship such as parent/child, mated pair, or mutually supportive friendship.

Consistent with the work of Bowlby (1969) already discussed, Averill observed that attachment is a necessary predecessor to grief, and that the strength of that attachment is correlated with the intensity of grief. His work with monkeys separated from their mothers demonstrated that protest,

yearning, and searching behaviors are typically evoked in the absence of their mothers. When rhesus macaque monkeys are compared with bonnett macaque monkeys, it is noted that rhesus display more intense separation grief than do bonnetts. Averill argues that this difference exists because rhesus form close, one-to-one mother-infant attachments, while among the bonnetts, mothering is widely shared among the females of the clan.

Similarities in the physiological reactions of humans and those of non-human primates following the loss of a mate, parent, and offspring have been found by Zeller (1991). The depression of the immune systems of both humans and macaques as a result of prolonged corticol elevation follows separation from significant attachment figures. Interestingly, in examining both the physiology and behavior of humans and monkeys it has been found that there may be a lack of correlation between these two indicators of stress. In adult humans as well as both rhesus and squirrel monkeys, behavioral agitation can decrease but levels of pituitary adrenaline may still remain elevated. This lack of correlation between physiology and behavior has implications for deciding what outcomes should be used to indicate successful recovery from grief.

Significantly, many studies reported as "primate" research have been done on monkeys, acknowledged to be evolutionarily and genetically less proximate to humans than the higher primates--chimps, orangutans, and gorillas. This may suggest that the findings are not as generalizable to humans

as might be possible if the research were done on higher primates. However, the monkeys' shorter life-span makes them more desirable laboratory animals than are higher primates, whose life-span parallels that of humans. While studies of higher primates are less numerous, observations of chimps and gorillas strongly suggest grief reactions upon separation from their young comparable to those of human mothers. These observations provide even stronger support for a biologic basis for grief in humans than do monkey studies. A zoo chimp who consistently lost her infants because she had unsufficient milk was observed huddled in a corner for weeks after the death of her infants (Zeller, 1991). A zoo gorilla was observed to carry, pat, and gently encourage nursing in a stillborn infant for four days before she would allow the zookeepers to remove the partially decomposed corpse. Afterward, she became lethargic, just sitting with her head against the wall with a facial expression resembling a grieving human.

Cross-Cultural Evidence.

Moving on from the evidence which suggests a biologic basis for the universality of grief, the cross-cultural evidence for universality will be explored. A classic study which is central to the anthropology literature is the work of Rosenblatt, Walsh, and Jackson (1976). They studied grief and mourning in seventy-eight cultures which varied widely in complexity, degree of contact with Western civilization, and major religious systems. They studied

the ethnographic descriptions of those cultures which had been done by other anthropologists and evaluated the attributes which were of interest to them. Among the attributes studied was the frequency of crying by bereaved adults in each society. Each society was rated on a scale from one to five with one signifying crying absent to five signifying crying very frequent. Some societies were not ratable because of methodological problems. Of the sixty nine societies who could be rated reliably, sixty-seven were rated as at least four, that is, displaying frequent crying at death. Only were the Balinese rated as one, that is, crying absent. Significantly, the Javanese, who are geographically and culturally proximate to the Balinese, was the only other society not rated as displaying crying frequently. For them the rating for crying was two, that is "rarely present."

In a follow-up study conducted by an observer on site for twenty-four days to gain insight into the apparent lack of crying in Bali, two women and many children were observed to cry, but in each case the crying ended more abruptly than it typically would in the U.S. This phenomenon may be explained, at least in part, by the Balinese religious belief that encourages people to be calm and undisturbed. It is also consistent with the findings of others who suggest considerable differences between public and private expressions of feeling (Counts and Counts, 1991; Eisenbruch, 1984b). Three Balinese men were observed to smile or laugh during the telling of very sad events in their lives (one had lost three children to death). They explained that

if they did not laugh, they surely would cry. While such a strategy to avoid crying also occurs in the U.S., it appears to be a common pattern in Bali. Rosenblatt, Walsh and Jackson concluded that the experience of grief seems to be the universal cost of having enjoyed long-term contact and interdependence with other human beings. Further, they concluded that crying is the almost universal private reaction to the loss to death of someone important.

Another study which looks at crying behavior was done by Briggs (1970), who conducted a 17-month field study among a band of Utku. This band was composed of between 20 and 35 individuals who lived intermittently at the mouth of the Back River, northwest of Hudson Bay. Briggs lived as an adopted daughter, sharing an igloo with a family. She described the care with which children are taught to control the expression of all emotion, thus maintaining the absolute equanimity in the camp which is necessary for the survival of the whole under harsh and isolated conditions. She reported an example of a minute infraction: when a very ill adult man was leaving to be taken to hospital by government plane, perhaps to never return, "a tear had run down the nose of his fourteen-year-old son, and this incontinence was reported as amusing by the boy's older sister on her visits to the neighbors" (p. 258). Such behavior by the older sister would be considered insensitive, if not blatantly cruel, in mainstream U.S. culture. However, for the Utku this behavior is representative of the type of social sanction which molds their children into adults who are models of equanimity.

A study which looked at the extent to which the reaction to pain is culturally influenced was conducted by Zborowski (1969). He studied four groups of patients in a large Veterans Administration hospital in New York City during the years 1951 through 1954. The composition of the groups were of Jewish, Italian, Irish, and "Old American" origin. The term Old American was used by Zborowski to refer to patients of Anglo-Saxon origin, usually of Protestant religion, whose ancestors had lived in the U.S. for more than three generations. He considered this group to be the social group which represented the dominant cultural model in the U.S. The research techniques employed consisted of participant observation and both formal and informal interviews. Zborowski was interested in whether there were discernible differences between cultural groups in their reaction to pain, that is, in their behavioral and observable response to the stimuli.

One level of reaction to painful stimuli is heavily biologically determined and independent of human consciousness. For example, painful stimulation can provoke physiological manifestations such as changes in respiration, heartbeat, perspiration, or reflex muscular contraction in an experimental setting. In actual clinical settings, reflex reactions such as twitching or wincing are helpful in determining the presence of pain; but the specific qualities of the sensation--such as intensity, location, and duration--are greatly influenced by the patients' emotions and anxieties, which are reflected in their overall

behavior and in the ways they describe the experience. It is this pain experience which is subject to cultural influence.

The appropriate reaction to painful stimuli is learned from the norms of acceptable behavior in specific circumstances in the social group to which the individual belongs. For example, in the U.S., pain exclamations may be expected in the hospital during the repair of a football related injury, but might be considered out of place on the football field. Likewise, in some primitive tribes, men are expected to tolerate ritually inflicted pain in silence but are allowed to moan and groan when their pain is illness related (Bentsen, 1989). This is not to say, however, that all members of a given cultural group embrace universally all of the published norms. Anthropologists are increasingly aware of the extent to which our notions of group norms have been shaped by narratives provided by the powerful and the articulate within groups (Lewis-Fernandez and Kleinman, 1995). The experience of the less powerful, less visible members of a group may be quite different.

Zborowski found that both the ethnographic data gathered and the statistical measures employed showed significant differences among ethnic groups in how they reacted to pain. On measures of both emotionality and intensity, the Italian and Jewish groups were more emotional in describing their pain and "played it up." They most often described their pain as very severe, whereas the Old Americans and the Irish frequently differentiated between slight, moderate and severe pain. While Irish and Old American patients most

frequently indicated they prefer to hide their pain, the Jewish and Italian patients freely admitted they show their pain and they do it by crying, moaning, being demanding, and stating clearly that they could not tolerate pain. Interestingly, the Jewish patients seemed most future oriented about the course of their pain, being concerned with its implication for the future. In contrast, the Italian patients were very present-oriented, indicating more frequently than any other patients that their pain was present all of the time. Further, they seemed concerned almost exclusively with the pain dimension of their illness, rather than being concerned with the other symptoms of their illness.

The conclusions of Zborowski's study were affirmed subsequently by other social and medical scientists who investigated the role of ethnicity in influencing individuals' responses to pain and illness. Of particular relevance was a study which tested Old American, Irish, Jewish, and Italian housewives and found parallel differences in pain attitudes to those found by Zborowski (Sternbach and Tursky, 1965). This study was a laboratory one, comparing the women's response to electric shock. Sternbach and Tursky found, for example, that Italian women participants reacted expressively to the pain of the electric shocks while the Old American participants attempted to mask their discomfort.

One of the few empirical studies reported which attempted to look specifically at differences between how members of different ethnic groups grieve is that of Luborsky and Rubenstein (1990). They studied widowers of

three ethnic groups--Irish, Italian, and Jewish-- (culturally distinctive, though not disadvantaged) to find out how they had reorganized their lives two years after the deaths of their spouses. The study revealed that regardless of ethnic background, elderly widowers suffered some general features of widowerhood, most significantly a sense of isolation after the loss of their intimate confidant. For each there was only a slight decrease in the sense of attachment to their wives over time.

The distinctive ethnic heritage of the widowers was found to be the basis for involvement in current activities, both family and community. Ethnic identity can provide a sense of continuity through both identification with traditional values, sentiments, and practices, and as a guide as to what to do in times of stress. Such identification can provide a desired sense of rootedness in a time of turmoil. Unfortunately, revitalizing ethnic and family traditions in some cases also awakens past difficulties or brings into focus current tensions. For example, Luborsky's study described the case of Mr. McGraw, an Irishman and recovered alcoholic for years before his wife's death. He began drinking again after his wife's death, certainly a self-destructive behavior, but nonethelsss a way to rekindle a sense of earlier family life and Irish tradition. A more positive immersion in ethnic heritage was seen in the case of Mr. Stern. He and his wife had regularly attended synagogue and kept Sabbath observances at home. Subsequent to her death, traditional mourning customs provided a daily structure to his life as well as a vehicle through which to

honor her memory. Significantly, he reported these religious practices also provided an opportunity to meet other people who were also dealing with losses.

Mourning Rituals

A consideration of the variety of mourning rituals which have been observed by anthropologists can provide a context within which to consider the possible meanings of a range of behaviors subsequent to the death of a significant other. Van Gennep (1909/1960) surveyed funeral and bereavement practices across the world and noticed similarities in the structure of practices within most societies. He identified three basic aspects of the practice: rites of separation; a transition or liminal phase; and rites of incorporation. Among the rites of separation he observed were such practices as transporting the corpse, burning the deceased's house or possessions, and various rites of purification. He characterized the transition or liminal phase as a period during which both the mourners and the deceased comprise a special group, situated between the world of the living and the world of the dead. How soon living individuals leave that group depends on the closeness of their relationship with the dead person as well as how long the spirit of the deceased remains. During this liminal period, social life is suspended for all those affected by the death. The third part, the rites of incorporation, signal the end of the mourning period and include such practices as shared meals and ritually

prescribed intercourse of the surviving spouse with the partner(s) designated as appropriate by the group. Van Gennep described the rites of separation and those of incorporation as, while not uniform, not nearly as complex or diverse as the transition rites.

A death disrupts a community in several ways: 1) through the loss of one of its members, a loss that must be accommodated for the restoration of group functioning; 2) by altering the roles of the bereaved kin, roles that must now be redefined; and 3) by forcing the community to confront the existential reality of death, a reality which is addressed in symbolic rituals consistent with the belief system of the group (Counts and Counts, 1991). Bereavement rituals create avenues for the public articulation of deeply felt emotions such as sorrow and anger and provide community support for the expression of those emotions. They help in restoring the social order disrupted by the death (Shapiro, 1994).

The norm in the U.S. has been moving increasingly toward the dominant WASP model which minimizes expression of emotion and formal rituals for dealing with death (McGoldrick et al., 1991). Through public health regulations and employment leave practices, considerable social control is exercised over the funeral process. The funeral industry has commercialized and uniformalized the preparation of the body and has taken over the elaborate religious funeral rituals previously performed by the family or appropriate group members. The typical employment leave policy severely limits the performance of traditional bereavement practices. "Scientific management" and

prescribed personnel practices have limited the length of the period of mourning to three days for immediate family and do not formally acknowledge any mourning period for friends (Pratt, 1981). Thus, mourning has become increasingly private and the responsibility of immediate family.

The extent to which the Western world is a death-denying culture is portrayed in the work of both Gorer (1965) and Becker (1973). Both contend that the topic of death has replaced the topic of sex as the major taboo in polite conversation. Becker challenges Freud's theory of sexual repression as underlying all intrapsychic difficulties, suggesting that it is actually the repression of the notions of death and of one's own eventual annihilation which is the underlying problem.

In addition to the diminished funeral rituals, increasing disregard in the U.S. of a formal mourning period has meant that bereaved individuals get little support from society at large beyond the funeral itself. Furthermore, there is no culturally prescribed process for redefining the social roles of the bereaved. Parkes (1972) contends that the cultural evolution that has made marriage an integral part of our social organization has done little to ensure that the functions that it performs will be adequately carried out after its dissolution. He cites the custom of levirate marriage--automatic remarriage to the husband's eldest brother, once the custom among the Jews--as an example of a bereavement practice which, while it may not have solved the personal grief of the widow, it must have ensured that many of her essential needs were met and

protected her from the loneliness, poverty, rolelessness, and insecurity which are the lot of many modern widows.

The failure to carry out mourning rituals contributes to bereaved individuals' inability to come to terms with their losses (Walsh and McGoldrick, 1991). Because of the U.S. dominant culture's tendency to minimize the need for rituals, individuals may not have opportunities to feel supported in their own exploration of the personal meaning of losses. Lack of access to comforting, supportive ritual is potentially all the more problematic for ethnic group members whose ethnic identity is in transition as a result of uprootedness and/or partial acculturation to the WASP norms. The potential for pathological grief is great under these circumstances.

Key Factors in the Course of Bereavement

Key factors in variations in mourning rituals and bereavement practices which are of particular relevance in distinguishing between normal and pathological grief are: 1) the duration of the prescribed mourning period, and 2) the form of expression of emotion sanctioned. Both factors are dependent on belief systems about what happens to an individual after death as well as what is believed about the relationship between the expression of emotion and health of the bereaved individual as well as the entire group. The following examples, while admittedly sketchy and simplistic, illustrate these factors.

The duration of public mourning periods reported by anthropologists varies from the extremely short period which was typical of the Navajo to the extended period customary for the Hurons. The Navajo limited the mourning period to four days, during which expressions of grief and speaking of the deceased were allowed (Stroebe and Stroebe, 1987). Excessive show of emotion even during this period was discouraged. After the four day period it was expected that the bereaved return to their ordinary way of life, not grieving, not speaking of the deceased, and not referring in any way to their loss. Underlying this practice was the Navajo fear of the power of the spirit of the dead person and their belief that to continue to refer to the deceased would increase the potential that that spirit would harm the living.

In contrast, the Hurons believed that death occurred in stages including dying, just dead, and "dead and gone" (Ramsden, 1991). The just dead stage to the Hurons meant that the individual's body was partly dead, and through physical decomposition the individual continued to die. They believed the spirit of the just dead continued to stay in the village and to take part in the activities of the living. It was their practice, therefore, to place the just dead so the living would have easy access to them. This included, in some instances, keeping them in the hut with the living, where they would be periodically bathed, "fed," and visited. The final burial of the corpse did not occur until all the flesh had rotted away from the skeleton. Intense public mourning occurred at the time of this burial, in spite of the fact that the individual may have been

partly dead for as long as ten years.

An example which shows a contrast in the socially sanctioned expression of emotion is provided by the work of Wikan (1988) in two Muslim communities. She found that while the Muslim religious belief system frowns on excessive expression of grief (to do so would be behave as if one does not agree with God's will), the practice which accompanies this belief is culturally shaped very differently in Bali than in Cairo. A Muslim mother in Cairo who loses a child is expected to scream, yell, beat her breasts, and to be beyond herself for weeks. After that, to sit speechless and listless for three to seven months would not be considered unusual. In contrast, a Muslim mother in Bali with a comparable loss would cry softly for a while, but would strive to be composed, even laughing and joking cheerfully at times. Wikan's interpretation of this contrast is that Egyptians live in a world where to express one's unhappiness and anger is believed to be necessary for health and to attain one's social dues. The Balinese, in contrast, believe that to be sad is dangerous to your health. They believe that when you are sad, you are weak and vulnerable, have no energy, and cannot think and plan for your life.

These examples of the differences in the culturally sanctioned duration of the mourning period and expression of emotion underscore the limited usefulness of these factors in determining whether an individual's visible reaction to the loss of a significant other may be pathological.

The Grief Work Hypothesis

Among the critical debates/issues in the grief literature is the extent to which it is necessary to do grief work in order to be able to progress from the initial shock of a loss to eventual resolution (Stroebe, 1992-93; Stroebe, van den Bout, and Schut, 1994; Wortman and Silver, 1989). The grief work hypothesis asserts that time alone does not heal, but rather that the bereaved individual must actively and cognitively confront the loss (Lindemann, 1944; Osterweis, Solomon and Green, 1984; Worden, 1982). Proponents of the grief work hypothesis hold that it is necessary to consciously feel the pain of the loss and to articulate it in order to adjust to the loss of a loved one without lasting detriment to mental and/or physical health. The grief work considered therapeutic, according to this view, would include such cognitive experiences as reviewing the events proximate to and at the actual time of death, reviewing memories of the deceased, and of consciously working toward detachment from the deceased. This view of the necessity of grief work has long been a central construct in both bereavement research and clinical intervention programming (Stroebe, van den Bout, and Schut, 1994). It has invaded both the popular literature and lay beliefs about recovery from grief.

In recent years there has been increasing clinical evidence and research suggesting that there are many individual and family pathways for coping with grief and that the exploration of distressing feelings is in some instances quite disruptive (Weiss, 1988). Though some grief therapists assume that the open

sharing of intense, emotional feelings is a necessary part of healthy bereavement, the first priority for a grieving family may well be reestablishing the stable family patterns that make day-to-day functioning possible (Shapiro, 1994). Furthermore, it is now accepted by some grief theorists that the absence of apparent distress post loss, previously thought to signal denial and pathology, may be attributable to adaptive coping strategies and/or philosophic life-views which permit relatively smooth accommodation to new realities (Janoff-Bulman, 1992).

Significantly, the insistence on cognitive grief work requires that the bereaved must be able to articulate verbally regarding the source of their pain. However, according to Lewis-Fernandez and Kleinman (1994), the great majority of the world's people, including many in North America, are limited in their capacity to differentiate between somatic and psychological experience, and thus to cognitively conceptualize and verbalize their pain. They warn of the possibility of iatrogenic harm if an expectation for cognitive grief work is imposed on an individual whose predominate cultural mode of dealing with pain is somatic. Schiff (1986), in contrast, suggests that the role of the bereavement support worker is to facilitate the bereaved individual's getting in touch with and verbalizing what they are feeling and to refer to a professional if the course of bereavement seems beyond the norm.

This interpretation of the role of the bereavement worker reflects two critical Western assumptions about the course of bereavement: 1) that it is

desirable/necessary for the bereaved to verbalize their feelings; and 2) referral for professional counseling is appropriate when reactions other than those expected in Western models occur. Schiff makes no mention of the possibility that cultural factors may be influencing the mode of expression of the pain of grief or that referral to a professional may be negatively perceived by individuals of some cultural traditions.

Western Notions of Mental Health

It is important to consider the grief work hypothesis in the Western cultural context in which it has evolved. Among the values which characterize Western culture are rationality (logic of the mind); individualism/egocentrism; independence/self-reliance; competition; future orientation; progress/change; and the verbalizing of feelings (McGoldrick et al., 1991). In contrast, non-Western cultures value more highly a "logic of the heart"; suppression of individuality; mutual dependence and collective responsibility; conformity and harmony; reverence for the past; emphasis on conservation over change; and the suppression of emotion. Western values predominate in both the theoretical constructs of mental health in the U.S. and in the therapeutic modes emphasized (Shapiro, 1994).

Furthermore, Shapiro points out that the grief work hypothesis was developed based on observations of clinical populations, that is, individuals who had identified themselves as needing professional help and who would

have been characterized as "stuck" in their grief based on such indicators as denial of reality and overidentification with the deceased. In contrast, the vast number of bereaved individuals (probably the majority) who are able to devise coping strategies which allow them to continue in a relatively healthy, functional manner and thus to not seek professional help are virtually unstudied. Thus, the grief work hypothesis does not reflect the various strategies employed by them to adjust to a reality in which the deceased is no longer physically present.

For Western-trained therapists, the healing process emphasizes the following concepts: individual growth and change achieved through individual efforts; goal setting and future accomplishments; verbal, intimate, self-disclosure of emotional states; and clear distinctions between physical symptoms and mental processes (McGoldrick et al., 1991). In contrast, many non-Western cultures believe that mental health is achieved through self-discipline, exercise of will power, and the avoidance of morbid thoughts. In such cultures, for example the Chinese, there may be considerable shame attached to being seen as mentally distressed. Disclosing mental distress to anyone outside the family results in a loss of social status.

Contributing to the taboo against expressing negative emotions is the predominance of Buddhism in many non-Western cultures. Buddhist philosophy sees suffering as a natural part of life and emphasizes that it is that attachment to things which causes sorrow (Obeyesekere, 1985). Meditation

and acceptance of reality is seen as the way to reach understanding and overcome suffering. Individuals well grounded in Buddhist tradition would accept the loss to death of a significant person as a natural reflection of the vicissitudes of life. While their external behavior might appear listless and apathetic, this would not be viewed negatively or given an illness construct, because it would be a response consistent with the existential reality as perceived by them. This life view is in marked contrast to the Western philosophic orientation which seeks to avoid suffering by control of the external world and which emphasizes attachment of individuals to each other.

Lewis-Fernandez and Kleinman (1994) assert that three culture-bound assumptions underlie concepts of mental health and illness in North America: 1) the egocentricity of the self; 2) mind-body dualism; and 3) science as immutable reality. Regarding the first assumption, an egocentric view of the self sees the individual as a totally self-contained entity, with a set of internal attributes that determine behavior. In contrast, most of the world holds a more sociocentric view (Schweder, 1991), seeing the self as developing and behaving within networks of social relationships that become the locus of self-worth, self-fulfillment, and self-control. For example, both Chinese and Hispanic societies are more sociocentric than is the U.S. In Chinese society, self-assertion is valued in relation to the extent to which it advances family rather than individual interests. In Hispanic culture, in situations which evoke strong emotion, the reaction may include an outburst for which the individual is

not considered the agent (Lewis-Fernandez and Kleinman, 1994). The behavior is interpreted as occurring beyond the self as agent. During episodes of acute bereavement, the reaction may take shape as an *ataques de nervios* (attacks of nerves). These attacks may be experienced as trembling, bouts of screaming, aggressive behavior, and hyperventilation. A common phrase reflecting the basis of the behavior is "eso no estaba en mi", which translates to "that [outburst] was not part of me" (p. 70).

The second assumption, mind-body dualism, evolved from Descartes' attempt to reconcile the scientific advances of the 17th century with the Catholic theology which was dominant at the time. Descartes constructed a paradigm which distinguished clearly between bodily, material, physical, mechanistic phenomena and the non-physical phenomena which are the purview of the mind or soul. This separation makes possible the explanation of experience as arising in either the mind or the body, of distress as being either distinctly emotional or distinctly physical. Contrary to this model, the great majority of the world's population experiences human suffering in an integrated, somatopsychological mode, as simultaneous mind and body distress (Kleinman, 1982). According to Lewis-Fernandez and Kleinman (1994), "the dualistic professional model systematically misinterprets the nondualistic cultural experience of patients as reflecting a lack of introspection or a so-called primitive cognitive style and forces a differentiation between psychological and somatic experience where none exists" (p. 67).

The third Western assumption, science as immutable reality, views culture as a set of beliefs superimposed upon a bedrock of scientific reality. As opposed to belief, which acquired the connotation of falsehood, science has been seen as synonymous with reality, the touchstone against which all false views are tested, rather than as an equally cultural enterprise. This view fails to recognize that the scientific view characteristic of Western thought is itself a belief system. This assumption leads to a discounting of the disease categories, illness experiences, and healing practices of people of non-Western cultures.

Fortunately, all three assumptions are coming under increasing challenge in the fields of cultural psychiatry and medical anthropology. However, an indication of the limited impact to date of cultural psychiatry on clinical psychiatry is the recent failure to culturally validate the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in spite of considerable evidence of the need and clear recommendations otherwise.

Somatization

The cross-cultural work of Kleinman and Good (1985) has demonstrated that there is a significant difference between Western and non-Western cultures in the extent to which distress is psychologized or somatized. Further, they contend that somatization is not unusual even in the U.S. They believe that a more somatizing expression of distress is associated with lower socioeconomic and educational levels, rural origins, and active and traditional religious

affiliation. They further contend that somatization was even more prevalent prior to the emergence of an increasingly psychological idiom of distress. They see the emergence of this trend toward psychologizing as related to the cultural transformation of modernism which emphasizes analysis and rationalization. They contend that affect as it is experienced among the middle class in the West is shaped as psychological experience and rationalized into discretely labeled emotions that prior to modernism would have been principally felt as bodily experiences.

Kleinman and Kleinman's model (1985) posits that prior to cognition, affective states are an essential psychobiological phenomenon with physiological correlates. It is at this level that response to stress is universal across the human species. However, it is culture which determines how an individual evaluates a stimulus; what is perceived as a stressor in one culture may not be so in another. Ever since Zborowski's 1969 study (previously discussed) of the effects of culture on how pain is reported, researchers have been interested in how cultural group affiliation affects how physical and psychological states are interpreted (Angel and Guarnaccia, 1989).

Beiser (1985) asserts that the dimension of sociocentrism versus egocentrism in a culture contributes to whether a somatizing or a psychologizing idiom predominates. According to him, egocentric societies tend to legitimize and permit the expression of affect. As societies become more egocentric, the expression of inner emotional life becomes part of the

expected behavior for a greater part of the total population. Beiser's view is supported by the work of Lock (1987) in Japan, a sociocentric society in which the direct expression of emotions is discouraged.

A somatic illness in modern Japan described by Lock (1987) is *moving day depression*. Moving day depression is a syndrome which afflicts Japanese women, frequently upon moving to a new place (almost always in connection with their husband's work) or upon being separated from their husbands whose work has taken them far away for an extended period of time. The syndrome includes numerous generalized complaints (headaches, fatigue, dizziness). Women who seem most susceptible to the syndrome are women who take particular pride in their housework and in the organization of their family life. They report feeling that their personalities have changed and that they will no longer be able to maintain their homes at the standard they consider acceptable.

The social context in which moving day depression occurs is the Japanese exploitation of individuals and families by the expectation that personal needs be subordinated to the demands of business and industry. When the stress which results to families and individuals who are physically separated by the demands of the husband's employment (or by the stress of being uprooted to follow him to a new place of employment) is translated into somatic expression, it can then be viewed as a physical problem, thus diverting attention from the larger social issues involved. It may be acceptable to talk about dizziness, palpitations, and tingling sensations, and thus gain the

sympathy of others. Yet it may be totally unacceptable to articulate or challenge the stress-producing situation in which the symptoms occur.

In contrast to Japanese sociocentrism and insistence on low affect, among the Kaluli, tropical forest people of Papua, New Guinea, expression of affect is encouraged (Schieffelin, 1983). A man's influence is related to his individual energy and assertiveness in supporting his friends and inspiring the cooperation of others. The dominant dimensions of their emotional life are anger and grief. Anger is both feared and admired, and is a societally valued affect aimed at influencing others by intimidation. The grief affect, expressed in wailing or sobbing, is a societally acceptable manner in which to attempt to evoke compassion and support. Generally, for the Kaluli, every reason to be angry or sad--any loss, injury, or disappointment--is interpreted in terms of reciprocity. The behaviors associated with anger project power--stamping of feet, yelling. Those associated with grief project vulnerability--wailing and weeping. They both provide access to the redress to which they are entitled within the cultural context of reciprocity.

Kaluli ceremonial life is passionate and expressive. Ceremonies are structured to purposely evoke intense feelings of loss anger, rage, and sadness. The images of lost loved ones and times past which are evoked by song become so poignant that many of the listeners are deeply moved to tears. Then they may become so angry at the anguish they have been made to feel, they may leap up, grab a torch from a bystander, and stamp it out on the back of a dancer.

This pattern is repeated throughout the night until dawn. Finally, the dancers pay compensation to those in the audience whom they caused to weep, and everyone returns home in a mood of exuberance. While acknowledging that it can be difficult to distinguish normal aches and pains from depressively induced somatization, Schieffelin concludes that depression/somatization is rare among the Kaluli, apparently related to the culturally successful response to loss provided by their special brand of reciprocity and expressiveness.

Cross-Cultural Assessment of Pathological Grief

Given the wide variety of culturally appropriate expressions of response to loss, how can a Western caregiver tell if an individual of another culture is experiencing pathological grief? There is not an easy answer. People in societies where death is considered to be the work of malevolent spirits do not consider it pathological to express rage in their grief (Counts and Counts, 1991). Instead, for them, grief work includes assessing guilt and exacting retribution. Reid's (1979) work with the Yolngu of Australia suggests that indicators of pathological grief among that group of indigenous peoples include conspicuous alterations in relationships to others, lasting loss of patterns of social interaction, behavior detrimental to the individual's or his/her dependents' social and economic welfare, and suicidal tendencies. But can an individual not fully acquainted with both the individual's pre-loss behavior and

the norms of the culture make this determination? Several authors suggest the answer is no.

Much of the psychology literature ignores the significance of cultural factors in an individual's response to grief. In 1990, an entire issue of *Psychiatric Annals* was devoted to the topic of pathologic grief. None of the six articles mentions ethnic or cultural considerations. Eisenbruch (1984b) attests to the absence of clinically-based, culturally-specific literature on pathological grief, and emphasizes the need for research to determine whether there are culturally-specific manifestations of, in his words, "bad grief." Though his 1984a and 1984b articles include no original research, consisting entirely of literature review and hypotheses derived from that review, they are the most current, most frequently referenced articles dealing with cross-cultural considerations in grief. He points out the difficulty in gaining access to bereaved members of communities who do not regard bereavement as something potentially requiring professional services, or who do not know where to get help. Even if the obstacles to access are overcome, practitioners face the difficulty of deciphering sets of physical and mental symptoms that come from a cultural code different from their own. Kleinman and Good (1985) believe that a patient's condition must be evaluated by his/her social support group in order to get an accurate picture of the meaning of the condition.

The Role of Primary Care Physicians

It has been estimated that as many as 75% of patients utilizing primary care clinics have psychosocial precipitants as opposed to biomedical problems as the main cause of their visit (Rosen, Kleinman, and Katon; 1982). Each society and each family has different norms and rules for coping with problems, including emotional ones. It is within the family circle that children learn appropriate responses to their external world--their environment and their social network--and to their inner world--their emotions. Infants are unable to distinguish between physical and psychological distress, and it is through repeated interactions with their external world that the distinction is learned. In many families, negative sanctions against expressions of emotions exist whereas physical complaints are responded to with concern and nurturance. In these families children learn to use somatic complaints to seek attention and comfort. As a result, emotional and physical problems become fused, and a psychological language for internal mood states does not develop.

It is the nature of the subculture of biomedicine to diagnose and treat physical ailments. When a patient presents a somatic complaint to a physician, the physician's emphasis is on ruling in or out an organic basis for the symptoms. Typically the process is completed when an organic basis is ruled out. The patient is reassured that nothing is wrong and is dismissed. This both reinforces the somatization--the patient knows that seeking care requires a physical symptom--and fails to result in a meaningful diagnosis and treatment

plan. Rosen, Kleinman, and Katon assert that the accurate diagnosis of a somatizing patient requires a shift from the biomedical model to a biopsychosocial one in which the psychosocial and cultural dimensions of the illness are seen as legitimate health care concerns.

A diagnostic approach which they suggest, admittedly time-consuming, is to have patients describe their problems in their own terms. Such descriptions may offer clues to the complex meaning and significance of the symptomology. Merely asking patients if they are depressed is inadequate, as they may lack a language for describing mood states and/or may risk social sanction for articulating them. Rosen et al. recommend the following list of questions to elicit a description of the problem as the patient attaches meaning to it: 1) What do you think has caused your problem? 2) Why do you think it started when it did? 3) What does your illness do to you? 4) What kind of treatment should you receive? 5) What results do you expect from your treatment? 6) What are the chief problems caused by your sickness? 7) What do you fear most about your illness? This mode of questioning both yields a precise picture of the problem as the patient sees it and demonstrates the physician's concern. It also can be the beginning point for negotiating a treatment plan.

In addition to patients' descriptions of their problems, important information can be derived from knowing how the patients' families respond to their problems. For example, a patient may be rewarded more for illness than

for health, as in being relieved of responsibilities when ill but being expected to work long hours when healthy. Another critical dimension to be explored is the availability of a network of social support. Are contacts with family and/or friends frequent? And significantly, what is the quality and intensity of those contacts? That contacts may be frequent does not necessarily mean that they are supportive.

The identification of community resources such as clubs, churches, and senior centers which may be called upon to supplement the available family support is a crucial part of the treatment plan. Shapiro (1994) suggests that facilitating access to a social support network is in most cases more appropriate and potentially more beneficial than referral to a mental health professional. A critical link between the ethnic minority patient and community resource utilization has been found to be the patient's immediate family. In studies of both black and Hispanic elderly populations it has been found that there is a causal link between the use of formal social services and contact with the informal kinship group, a link not found with the white elderly (Markides and Mindel, 1987).

A Culture-Bound Somatic Syndrome

An example of a culture-bound somatic syndrome which may be encountered by physicians is "ataques de nervios," literally, attacks of nerves (Guarnaccia, DeLaCancela, and Carrillo, 1989). Ataques are a syndrome

observed most frequently among Puerto Rican and Central American immigrant populations. Ataques de nervios have some features in common with epileptic seizures, but are without any organic or physiologic basis. A typical ataque de nervios includes such symptoms as shaking, heart palpitations, the sensation of heat in the chest rising into the head, and numbing of the hands. The afflicted individual may shout, swear, and strike out at others before falling to the ground and displaying either convulsive body movements or lying unmoving as if dead.

It is usual for these ataques to occur at times of great stress such as during funerals, when coming upon the scene of an accident, or during a family conflict. When the ataque occurs within the context of the individual's social support network, their response is to focus attention on the individual in some way, such as praying over them and/or by rubbing their face with an alcoholic substance. If these ministrations resolve the episode, it is not given an illness construct by the indigenous group and there is no reason seen by them to seek the advice of anyone in the medical/professional sector.

Articles describing ataques began appearing in the late 1950s, frequently involving Puerto Rican recruits into the U.S. military. Ataques were seen as being evoked in the context of strongly conflicting values--the traditional strong family ties among Puerto Ricans and the breakdown of the family due to industrialization of the Island, mandatory military service, high rates of unemployment, and resulting high rates of migration to the U.S. mainland.

While ataques were previously considered pathologic by Western biomedical professionals, emphasis is more recently being given to appreciating the cultural meaning and social factors which provide the context in which ataques occur. Ataques can be seen as expressions of sadness, anger, and grief in response to the disruption of family systems as a result of migration out from peoples' countries of origin and the lack of traditional social support which ensues.

A study was conducted to explore the meaning of ataques de nervios among Latinos living in the urban U.S. who visited either the physician or the psychologist members of the research team. They were interviewed by the anthropologist member of the team who used an open-ended interview format (similar to the Rosen et al. format described earlier) as follows: 1) What do you call your problem? 2) What are the typical features of this problem that allow you to identify it? 3) What do you think has caused your problem? 4) Why do you think this problem started when it did? 5) What does this problem do to you? What effect will it have? 6) What are the chief problems these episodes have caused for you? 7) What kinds of healers have you consulted for this problem? What did those healers do? Significantly, each of the research subjects, in response to these questions, told stories of their families and of their migration without being directly questioned about these facets of their lives. The common themes which emerged in the stories

included the emotions of grief, anger, fear of being alone, and the experience of the death of a loved one.

A case example which illustrates these themes is that of Sra. Gomez. She is an elderly woman from Central America who has lived in the U.S. for 10 years. Her only episode of ataques occurred upon receiving the news of the death of her 38-year-old daughter who still resided in Central America. She was very distressed at not being able to arrive in Central America sufficiently before the funeral to be involved in preparing for it or to be able to mourn with her family.

Though she had only one full-blown ataques de nervios, she continues to suffer from a milder version, simply called nervios. She attributes these symptoms to her disappointment with her children's lack of attention to her. She worked hard to bring all of her children here and to give them a better life, but they have all turned their backs on her. "Her children are now married and have established independent lives, as is the U.S. cultural expectation. Her children do not respond to her cry for help expressed in her nervios. Thus, she turns to the medical care system for help and support" (Guarnaccia, DeLaCancela, and Carrillo, 1989, p. 53).

In all of the cases studied, the families failed to respond in culturally expected ways to the patients' calls for help and support. Thus, the ataque did not bring an end to the stressful situation. In each of the cases, health care providers were sought out to replace the lost social support network of these

patients. When recently migrated Latinos present in emergency rooms or in the offices of primary care physicians, the individual's symptoms may be labeled in medical or psychiatric terms with inattention to the meaning of the symptoms, leading to the medicalization of what are essentially social problems. Even when the health care professionals recognize the social dimension of the problem, they may be powerless to restore the traditional social supports and thus feel powerless to assist in any way.

Summary of Chapter Three

Evidence for a biologic basis for grief has been shown, suggesting that there are some aspects of the reactions to the separation from significant others which are universal across the human species. Some reactions, however, have been shown to be heavily culturally shaped, with considerable variation in both the duration of the mourning period and the form of expression of the felt emotion. This variation complicates the already challenging task of differentiating between normal and pathological grief, especially for members of ethnic groups whose norms for grief and mourning are significantly different from those of the dominant WASP culture. The predominance of psychologizing as a distress idiom among middle- and upper-class, educated individuals in the U.S. contrasts with the somatizing idiom which predominates among much of the rest of the world, including rural and lower-class, less-educated groups in the U.S. The grief work hypothesis which dominates

Western grief intervention strategies and prescribes cognitive grief work fails to acknowledge somatization as a legitimate form of grief work. It is seen as essential that primary care physicians adopt a biopsychosocial perspective in the diagnosis and treatment of grief-related somatization. Referral of ethnic patients to sources of social support is seen as preferable to referral to mental health professionals.

CHAPTER FOUR
BEREAVEMENT SUPPORT

What Helps?

In the past few decades, interest in bereavement support has grown in the United States, hand-in-hand with increasing awareness of the long-term impact of unresolved grief on over-all health of bereaved individuals (Osterweis, Solomon, and Green, 1984). Individuals who experience the loss of loved ones are increasingly turning to formal support systems to fill the gap which would earlier have been filled by family, church, and neighbors. In an attempt to understand just what it is that the bereaved find helpful, a study was conducted of 94 individuals who had lost either a spouse or a child in a motor vehicle accident 4 to 7 years earlier (Lehman, Ellard, and Wortman; 1986). They were asked to recall what they had found helpful or unhelpful about support attempts by others. Most frequently cited as helpful was contact with a similar other, that is, another who has experienced a similar life crisis. It appears that similar others may be less threatened and upset by signs of distress from the bereaved and may therefore be less likely to close off discussion of feelings or to push toward a quick recovery. Further, advice or suggestions may be less likely to be perceived as judgmental when offered by a person who has been through a comparable experience. In fact, direct advice giving and

encouraging recovery were the two supportive attempt strategies most frequently mentioned as unhelpful.

Another perspective from which similar others can be seen as particularly helpful is when considering the role ambiguity which results from the loss of a significant other. Role ambiguity is known to be a source of considerable stress, since order and definition are what allow individuals to go about their daily tasks with habitual unconsciousness (Keith, 1987). During the transition from the role of spouse to the role of widow or widower, individuals find themselves in ambiguous status, not knowing what is expected of them. Sorting out the various options for appropriate behavior in the company of others who have found themselves in comparable situations provides an opportunity for mutual development of strategies for resolving their role ambiguities. Consistent with van Gennep's view of bereaved individuals as being in a state of liminality, the stressfulness of the ambiguity is eased by solidarity with others in the same circumstances.

A significant development in bereavement support in the past few decades has been the proliferation of support groups (Schneider, 1994). By the early 1970's, self-help groups had become a major ingredient in the human services scene with major implications for the future of mental health delivery (Levy, 1976). It was becoming clear that self-help groups were providing the social support once performed by the family, the church, and the neighborhood. Levy conducted a study of the psychological processes involved in the

activities of self-help groups. His parameters for what qualified as a self-help group were that the agenda and direction of the meeting were under he control of members (though they may have access to professional guidance) and the members themselves, rather than professionals, have primary control over group functioning. At the outset, he acknowledged that it would not be possible to quantitatively assess their effectiveness, as few such groups kept systematic records. The fact that such groups were flourishing, however, presented reason enough to speculate that at least their members felt them to be effective in some way.

Levy distinguished four general types of groups: 1) those who share a common status or predicament which entails some degree of stress; 2) those which were attempting to overcome some discriminatory practice (e.g. gay rights and black pride); 3) those whose members were attempting behavioral control; and 4) those whose members share a common goal of personal growth and enhanced effectiveness. The seven processes which he discovered to be operating in all four types of groups were: 1) providing increased understanding of their distress; 2) provision of instrumental information and advice; 3) expansion of the range of alternatives for coping with their situation; 4) enhanced discriminative abilities regarding cause/effect contingencies in their lives; 5) support for changes in attitudes about one's self; 6) reduction of the sense of isolation regarding the members' dilemma through social comparison and validation; and, 7) development of a social structure within

which members can develop new definitions of their personal identities and new norms upon which they can base their self-esteem.

From the perspective provided by Levy of what self-help groups can accomplish, the proliferation of bereavement support groups is understandable. As discussed earlier, critical challenges during the grieving process include redefining one's relationship with the deceased; redefining one's sense of identity; resolving the role ambiguity which results from the loss; and developing a renewed sense of self-worth which has been diminished by the sense of powerlessness to protect a loved one from death.

Desirable Outcomes

The literature which attempts to evaluate the effectiveness of both bereavement support programs and other types of bereavement intervention is hampered by the lack of agreement concerning what parameters are appropriate to measure, how to measure them, what constitute healthy coping strategies, and what to consider as endpoints (Osterweis, Solomon, and Green; 1987). In order to determine the effectiveness of a specific bereavement support group, there must be agreement as to the desirable outcomes and how they will be assessed. Among the possibilities are: self-reported psychological distress; physiological indicators of stress (depressed immune system); self-reported personal growth; formation of new social relationships; and testimonials by members of the group of the benefit derived. The section in Chapter Three

regarding biological aspects of grief discussed the non-correlation which may exist between physiological and behavioral indicators. Such non-correlation demonstrates that bereaved individuals may be apparently doing much better as measured by their venturing out to form new relationships; yet, may be in continued distress and risk to health as measured by still elevated levels of corticol and the resultant depression of the immune system. Some examples to demonstrate these difficulties follow.

A study by Tait and Silver (1989) found that a "persistent search for meaning" by the bereaved is inversely related to psychological recovery and positively related to the occurrence of intrusive and distressing ruminations about the death. They contend that when a meaningful and acceptable interpretation is not forthcoming the search may persist for extended time periods. They are using the phrase "search for meaning" as attempting to find meaning in the specific negative event, that is, the death. In contrast, Yalom and Lieberman (1991) used the concept "search for meaning" to connote a struggle with the existential question of the meaning of life. They found that a group of bereaved who identified themselves as having been struggling with the question of whether life has meaning or purpose as experiencing personal growth to a significantly greater degree than a group who reported they were not dealing with that question. Interestingly, the increased existential awareness did not protect them from anxiety, depression, or intrusive thoughts of the dead spouse. They continued to be as distressed by those measures as

were the non-existentially aware. But on indicators of personal growth such as doing new things, visiting new places, and exploring new relationships they scored significantly higher than the non-existentially aware.

A study of participants in Compassionate Friends, a bereavement support program for parents who have lost children, produced a comparable result (Videka-Sherman and Lieberman, 1985). The study compared a cohort of participants in Compassionate Friends with a cohort of non-participants. At the completion of the study, non-joiners reported fewer somatic symptoms and greater life satisfaction than the group joiners. However, though participation had no positive impact on depression, involved members did report sustained personal growth over time while nonmembers and the less involved were unable to identify any positive changes in themselves after the loss.

These examples are provided, not to attempt to prove or to disprove the effectiveness of bereavement support groups, but rather to illustrate how complicated evaluation of their effectiveness is. This should not be surprising, however, considering the Schneider (1984, 1994) holistic model of grieving which demonstrates that grief is being experienced simultaneously in five dimensions: cognitive, behavioral, emotional, physical, and spiritual. Progress may be occurring in one or more dimensions while in others there may be little or none.

Parkes (1980) concluded, after a comprehensive review of the literature on bereavement support efforts, that professionally supported

voluntary and self-help services are capable of reducing the risk of psychiatric and psychosomatic disorders resulting from bereavement. He concluded that such services are most beneficial among bereaved who perceive their families as unsupportive, or who, for other reasons, are thought to be at special risk.

The Role of Religion

While studies providing evidence for the importance of social support in moderating the effects of psychological distress have occupied the literature for decades (Cobb, 1976; Turner, 1983), empirical evidence for the association between religion and psychological well-being is less clear. A recent study (Thearle et al., 1995) compared families who had experienced the death of an infant with a control group of parents who had had no such loss, on measures of anxiety, depression, and church attendance. Of the group who lost a child, 60% of those who attended church weekly manifested high anxiety compared to 66% who never attended church. A similar pattern was found among the controls who had not lost a child: 32% of church attenders had high anxiety; 38% of those who never attended experienced high anxiety. This study found that those who never attended church, whether bereaved or not, reported only a 6% greater incidence of high anxiety than those who attended regularly. This difference is not statistically significant enough to conclude that church attendance, in itself, is a post-bereavement anxiety reducer. This is not to say however, that other benefits may not accrue to church attendance.

Another study compared anxiety as measured by blood pressure in a group of church-going immigrants and a group of non-church-going immigrants (Walsh, 1980). The church-going group were found to have, on average, blood pressures 5 mm's Hg lower than the non-church going group. While caution is necessary in drawing conclusions from this study, the author speculates there to be a correlation between assimilation of the immigrant into the culture of his/her new home and lower blood pressure. Walsh acknowledges that the temporal sequence is not known--whether the immigrant felt sufficiently assimilated to attend church, or whether church attendance contributed to smooth, speedy assimilation.

A study by McIntosh, Silver, and Wortman (1993) attempted to discern whether there are aspects of religiosity which are more helpful than others in coming to terms with the loss of an infant. They studied two components of religion (religious participation and religious importance) and related them to three coping-process variables (perceived social support, cognitive processing of the loss, and finding meaning in the death). They found that both the cognitive dimension and the participative dimension were related to greater well-being and less distress 18 months after their infants' deaths. The authors reported that greater religious participation was also associated with increased meaning found in the death. They speculate that this may be the result of a shared sense of understanding of the death that may be offered by the religious community.

Scholars of comparative religions have developed paradigms which may prove useful in the consideration of the role of religion in bereavement support. Leach (1972) suggests that all religious activity is concerned with two universal concerns: the maintenance of life, and reconciliation with death. According to him, these concerns are organized around three levels: 1) the deva or supernatural power, embodying both creation and destruction, birth and death; 2) the devata or mediators; and 3) humans, with their everyday concerns with the maintenance of life. The deva are too awesome to be approached by mortal man; the devata mediate with the deva on man's behalf.

Leach's paradigm is consistent with Obeyesekere's (1985) analysis of Buddhism, with religious activities grouped into two major traditions, the greater and the lesser. The great tradition, Theravada, is practiced by ascetic monks, and is Buddha, deva, death, next-life, and perfection emphasizing. It contrasts with the little tradition, Mahayana, which is practiced by the villagers, the uneducated masses, who are concerned with maintaining life. Each of these traditions employs very distinct categories of rituals. The Theravadic ones emphasize purification ceremonies and are attended mostly by the elderly, who most imminently face their own deaths. The majority of the villagers pay little attention to these deva- and death-focused rituals. They concentrate their attention on the local devata rituals, focused on life-sustaining concerns such as fertility, sex, and harvest.

This distinction between greater and lesser, elite and masses, has corollaries in many religious traditions. Leach contends that ordinary members of religious congregations are not greatly concerned with the subtleties of theology. What matters to them is that their religious experience should offer emotional comfort and a sense of meaning when pure theology is inadequate to the task. This comfort is provided by the symbols and rituals which their religious experience provides. This explanation is consistent with the speculation of McIntosh, Silver, and Wortman (1993) that the positive influence of the participative aspect of religion is in being able to find community meaning in the death of an infant.

Ethnic Bereaved: The Myth of Social Support

According to Sokolovsky (1990b), the literature which portrays ethnic affiliation as a source of support has been overly optimistic. He sees this undeserved optimism as particularly misleading in the areas of family interactions and informal social supports. With remarkable candor, Sokolovsky references his own early work in which he had described the great benefits accruing to ethnic inner-city elderly from the social networks available to them. He states: "Having recently completed the longitudinal and applied extensions of these studies, I am certainly more pessimistic that I was in the late 1970's, when some of my publications helped feed 'informal support systems' euphoria'" (p. 210). He explains that research instruments frequently consist of mass

survey questionnaires which are capable of giving fairly accurate information along such indices as frequency of contact with friends, or the geographic proximity of elderly parents to their children's houses, but reveal very little about the quality of those contacts or to what extent they help or hinder the functioning of the elderly in the family and community.

A widely published study done by Bengston and Morgan (1987) illustrates this point. They compared middle-aged and elderly white, black, and Hispanic populations using four quality-of-life indicators: income, perception of health, life satisfaction, and social interaction. The dimensions of the social interaction indicator consisted of frequency of contact with 1) children, 2) grandchildren, 3) other kin, and 4) friends, neighbors, and acquaintances. The results showed for Hispanics the highest frequency of contacts between the elderly and younger generations but the lowest frequency of contacts with friends and neighbors. Bengston and Morgan concluded from this that the greater frequency of familial interaction among the ethnic minority respondents, particularly Mexican Americans, suggested that primary group needs of Mexican-American aged are more likely to be met within the extended family than are those of white or black aged. Such a conclusion assumes that a contact with a family member has a positive benefit to the elderly member. Yet Sokolovsky (1990b) warns that although it has been assumed that social relations are inherently satisfying and reduce the impact of life stress, it appears that, at least in some instances, such social ties may enhance rather

than reduce feelings of distress. For example, a study of Irish, Polish, and Italian families in Chicago found that there was actually a significant negative correlation between frequency of social contact and self-reported life satisfaction for women embedded in dense social networks with adult offspring and other close relatives (Cohler, 1983).

A comparable popular misconception regarding black families is that when faced with a crisis they can take care of their own because of a closely knit supportive kin network (Eisenbruch, 1984b). While it is true that there is a sense of extended kinship among blacks, in practice these kinship supports may not be available (McGoldrick et al., 1991). Due to the pressures of poverty and the predominance of the female-headed single-parent family unit, it is not always possible for a black family to provide the needed instrumental and emotional aid to a bereaved family member (Henderson, 1990).

Ethnicity and Bereavement Support Groups

If for many bereaved ethnic minorities the family and other informal support networks are inadequate, do they utilize formal bereavement support programs? No literature which directly addresses this issue was located. Drawing from the literature dealing with ethnicity and aging, however, it seems reasonable to speculate that ethnic minorities may not typically take advantage of bereavement support programs for some of the same reasons that they under-utilize other social services programs. Factors such as lack of

transportation, perceived procedural complexity, and lack of knowledge of the existence of programs are frequently cited (Markides and Mindel, 1987). One study found that blacks feared a loss of social security benefits if they participated in an Area Agency on Aging program (Watson et al., 1981). Further, for ethnic minorities, the perception of self as a disvalued, second-class citizen may cast a shadow of doubt as to the extent one is welcome in mainstream programs.

Researchers have repeatedly found that effective service delivery to ethnic minorities requires a conscious effort to respond to the cultural uniqueness of the populations (Markides and Mindel, 1987). One may infer that for the ethnic bereaved, faced with the task of redefining their identity, issues of cultural distinctiveness would be magnified. Culturally prescribed relationships between males and females, sex roles, language differences, and a variety of nuances of cultural etiquette which would be unknown to an ethnic outsider would figure prominently in the ethnic minorities' sense of propriety.

A study which attempted to gain insight into what could be done to increase black students' perception of available services as responsive to their needs looked at black students' use of counseling services at Michigan State University (June, Curry, and Gear; 1990). A profile was constructed showing which kinds of counseling services were utilized for what kinds of identified problems over an 11-year period. Among the counseling services available were: academic advising, health services, learning resources, career

information, counseling center, minority aides, and the Multi-Ethnic Counseling Center Alliance (MECCA). Among the kinds of problems for which help was sought were: financial aid, academic status, living situation, career concerns, and emotional-psychological concerns.

The profile revealed that for students who identified use of counseling services for emotional-psychological problems, 23% used the counseling center, 33% used MECCA (a branch office of the university counseling center staffed by ethnic minority psychologists and counselors), and 71% used minority aides (minority students housed in the residence halls and trained to assist residents by peer advising). This preference for ethnic peers for help with emotional difficulties supports the view that individuals seek out similar others, similar in both ethnicity and in life situation, in times of distress (Keith, 1987).

One of the few reports located which discusses ethnic participation in support groups of any kind is a study of support groups for caregivers of Alzheimer Disease (AD) sufferers (Henderson et al., 1993). In an earlier assessment of the situation, Henderson (1990) had contacted professionals working with aging minority populations in large urban areas which offered AD support groups. He found nearly zero participation in the existing support groups by ethnic group members in spite of their presence in high numbers in the general population. He noted that the need for cultural specificity in Hispanic health interventions is widely acknowledged (Valle and Mendoza,

1978). Some investigators have suggested that family support group intervention may violate the Hispanic concern with privacy and thus be doomed to failure (del Valle and Usher, 1982). On the other hand, as pointed out by Sokolovsky (1990b), ethnicity-based informal supports may be stretched to the point of dysfunction due to changing urban conditions and multiple demands on the physical and emotional resources of the family. Therefore, help beyond the family may be welcomed. Furthermore, Acosta (1982) asserts that an all-Hispanic group can overcome the reticence of Hispanics to discuss publicly their family's medical problems, with the similarity in culture and lifestyle providing an environment that encourages openness and understanding.

Henderson et al. embarked on a project aimed at encouraging minority participation in AD groups. They set out to specifically recruit Hispanic and African American participants by responding to their particular cultural realities. Their hypothesis was that there were sociocultural disincentives which deterred ethnic minority populations from attending the predominantly Anglo AD groups. The disincentives which they identified included: 1) lack of "ethnic competence" on the part of staff; 2) insufficient personal contact in recruitment and maintenance of group members; 3) insufficient attention to both geographic convenience and symbolic factors of location of meetings; and 4) preference for ethnocultural homogeneity of meetings.

The first disincentive was overcome by a commitment to ethnic competence by project staff, that is, by assuring that they were well acquainted

with the ethnocultural reality of the target population. This was accomplished by extensive targeted ethnographic survey of the ethnic minority community. Repeated interviews with open-ended questions and the recording of significant vocabulary, phrasing, and idioms allowed for an increased appreciation for the shades of meaning of their language and the nuances of cultural etiquette of the ethnic group members. To overcome the second disincentive, multiple personal contacts by phone, home visit, and a flier announcing the meeting a few days prior to each monthly meeting were utilized.

Regarding location, the original project design called for the meetings of the African American group to be held at one of the African American churches. The minister of this church, a volunteer group facilitator from this church, and a member of the project staff made educational/recruitment presentations at several black churches. Alas, no one attended for three consecutive meetings which were held at the original African American church. Project staff realized they had asked these prospective group members to violate congregational loyalty boundaries. "The allegiance to one's church and pastor is exceedingly strong and to acknowledge the initiative and visibility accruing to the original church site and its leadership would by default cast a slight taint or pallor on the nonoriginating church and its leadership" (p. 412). Locations which were found to be both geographically convenient and symbolically appropriate were local community centers and libraries.

Finally, to overcome the disincentive posed by ethnically-mixed groups, ethnically-specific groups were formed. An African-American woman said of her earlier one-time attendance at a predominantly Anglo support group that though she didn't exactly feel uncomfortable there, the all-black group she joined later felt more like family. Correspondingly, the Hispanic support group elected to conduct the meetings in Spanish even though most were fluent and articulate in English. For the same reasons that they generally spoke Spanish at home, in the support group they chose the language that communicated their heritage as well as facilitated their expression of subtle aspects of emotion and meaning.

While no rigorous evaluation of the success of the groups was attempted, they were judged successful as measured by sustained participation of members, development of interpersonal linkages between members, recruitment of new members by long-standing members, and direct reports of the comfort received from participants in support group meetings.

Summary of Chapter Four

The lack of agreement among grief theorists and clinicians as to what constitute desirable outcomes in grief recovery poses a challenge in evaluating the effectiveness of bereavement support interventions. The critical factor identified as essential in bereavement support is the availability of social support, particularly support from others similar in both ethnic affiliation and

in the shared experience of a loss. The comfort gained from the participative aspect of religion was shown to be more important than the intensity of identification with the content of the belief system. The notion that ethnic group members can take care of their own was found to be unsupported, given the realities of poverty, single-headed households, and emotional and physical resources stretched to their limits. It was speculated that ethnic group members do not participate in mainstream bereavement support programs due to a variety of disincentives. It was demonstrated that these disincentives can be overcome, however, by designing ethnically-targeted programs.

SUMMARY AND CONCLUSIONS

The linear models of grief, which have dominated the psychology literature since Freud, fail to account for the wide range of reactions to a loss which individuals may exhibit. The holistic models together with family systems theory provide a perspective from which the highly idiosyncratic nature of grief can be more fully appreciated.

Lack of precise and consistent use of terminology by grief theorists and clinicians coupled with lack of agreement on desirable outcomes has resulted in much confusion in the grief literature as well as apparently contradictory research findings. Evidence suggests that there are some aspects of the reaction to separation from a significant other which are universal across the human species. Some reactions, however, have been shown to be heavily culturally shaped. This variation complicates the already challenging task of differentiating between normal and pathological grief, especially for members of ethnic groups whose norms for grief and mourning are significantly different from those of the dominant WASP culture.

The predominance of psychologizing as a distress idiom among middle- and upper-class, educated individuals in the U.S. contrasts with the somatizing idiom which predominates among much of the rest of the world. The grief

work hypothesis which dominates Western grief intervention strategies and prescribes cognitive grief work fails to acknowledge somatization as a legitimate form of grief work. Given that as many as 75% of patient visits to primary care physicians in the U.S. are related to psychosocial distress translated into somatic complaints, it is essential that primary care physicians adopt a biopsychosocial perspective in the diagnosis and treatment of somatization. However, even when health care professionals recognize the social dimensions of somatization, they may be powerless to restore the traditional social support whose absence is contributing to the distress, and thus may feel powerless to assist.

Given the disincentives which deter ethnic minorities from participating in mainstream social services programs, a major conclusion of this thesis is, therefore, that there is a need for bereavement support programs which are targeted to specific ethnic groups. Especially among adults who lose spouses, critical tasks include the reconstruction of their identity, resolution of their role ambiguity, and the formulation of new norms upon which to base their self-esteem. This can best be accomplished in the company of others who share both their ethnicity and their dilemma. The unspoken nuances of cultural etiquette and subtle aspects of shared emotion and meaning which can flourish in an ethnically specific group can provide to the ethnic bereaved an environment of comfort and trust in which to explore the multiple dimensions of their dilemmas.

Large urban areas with high densities of ethnic populations are fertile ground for such programs. A greater challenge is meeting the needs of ethnic bereaved who live in smaller cities or rural areas where their low numbers indicate that it is not feasible to conduct ethnically-targeted groups. In these areas, ethnic individuals could be encouraged to attend mainstream support groups by accommodating to as many of the identified disincentives as possible. Attention could be given to increased personal contact in both recruitment and maintenance of group members. Careful choice of location of the meetings to be both geographically and symbolically accessible would also encourage greater participation. The design of the meetings themselves should reflect the multiple dimensions of grief reactions. In addition to opportunities for cognitive processing of losses, programming should include activities which provide a context within which behavioral, emotional, physical and spiritual reactions can be experienced and affirmed. Such programming would also respond to the needs of the many WASP individuals whose predominant idiom of distress is non-cognitive.

Given the current emphasis on cost-containment in health care, increased attention to strategies which would reduce the number of frustratingly (to both patient and physician) unhelpful primary care visits is in order. In this age of Managed Care and computer data files, there must be a way to make it possible for individuals with similar dilemmas and similar ethnic affiliation to find each other and to provide to each other invaluable social support.

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