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Shifts in Ritual Response to Loss due to Death:
An Assessment of Funeral Service Mourning Trends over Time

A thesis
presented to
the faculty of the Department of Psychology
East Tennessee State University

In partial fulfillment
of the requirements for the degree
Master of Arts in Psychology

by
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December 2015

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ABSTRACT

Shifts in Ritual Response to Loss due to Death:

An Assessment of Funeral Service Mourning Trends over Time

by

Lawrence D. Childress

Bereavement, while universal, is experienced and expressed uniquely; it is both ultimate and particular. As the predominant social expression of grief, funerals are purported to be waning and/or transitioning to emergent, less conventional ceremonial forms. In this research, the possible salutary utility of funerals is outlined, and trends relative to the cost, nature (type), and prevalence of funeral services are examined relative to an extant data set from two funeral homes of shared ownership in northeast Tennessee. This data analysis of specific funeral trends in south central Appalachia is juxtaposed against the broader backdrop of current theoretical, clinical, and socio-cultural understandings of bereavement, grief, and mourning.

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CHAPTER 1

INTRODUCTION

The associated responses to loss of bereavement, grief, and mourning are universal, their interplay having been noted since antiquity (Horwitz & Wakefield, 2007; Wakefield, Schmitz, & Baer, 2011). Ceremonial responses to death are likewise ubiquitous, with evidence of funerary rituals pre-dating written history (Doka, 2002b). Kearl (1989) thus concludes that funerals are virtually impervious to social, geographical, and cultural boundaries, but are they?

Studies from Europe, Australia, and the U.S. note the association between certain types of bereavement and mental and physical health outcomes (Stroebe, Schut, & Stroebe, 2007), and these outcomes may, in some instances, be improved by planning, observing, and/or participating in funeral rituals (Fristad, Cerel, Goldman, Weller, & Weller, 2000; Gamino, Easterling, & Stirman, 2000; Norton & Gino, 2014). Research in the U.S., however, estimates that the economic impacts on households of funeral expenditures are not insignificant (Banks, 1998, 2003; Fan & Zick, 2004), and the socio-contextual contours of dying and loss response have sporadically been characterized as less than stable and in transition over the past half century (e.g., Irion, 1966; Lofland, 1978; Neimeyer, 1999; Walter, 1991).

Albeit somewhat elusive, sparse data indicating a possible decline in funerals and/or in their ceremonial emphasis are emerging, as implied by: (a) a decrease in licensed funeral directors in some states where such licensure is required (Colorado is the only state that does not [Hingston, 2013]), and a halving of the number of licensed embalmers in the U.S. since 2005 (U.S. Bureau of Labor Statistics—see www.bls.gov); (b) the ongoing closure of funeral homes in the U.S. on an annual basis (National Funeral Directors Association [NFDA], 2015); (c) a decrease in Catholic funerals (Walsh, 2014); (d) the dramatic rise in the rate of cremation

(Cremation Association of North America [CANA], 2013) which has been associated with less ceremony (Fristad, et al., 2000; NFDA, 2014); and (e) national survey data underscoring a consumer preference shift toward simpler, less ritualized funeral ceremonies (NFDA, 2014). The cremation rate is expected to surpass the rate of burial in the U.S. in 2015 (NFDA, 2015), rising from a rate of 3.6% in the last half-century (Kahn, 2015). It should also be noted that although cremation is technically a means of final disposition of the decedent's body, it is often viewed as an alternative to the "traditional funeral" (AARP, 2007).

Bereavement is experienced and expressed so uniquely that it has been the subject of much theoretical disagreement and debate (Stroebe, van den Bout, & Schut, 1994). Whereas researchers note improvements in what is understood about grief's typical manifestations (Stroebe et al., 2007), they simultaneously underscore significant areas where more information is needed, particularly regarding evidence bases for assessing intervention effectiveness. Thompson and Neimeyer (2014) more recently described thanatological research in the field of bereavement studies as in ferment (see also Genevro, Marshall, & Miller, 2004; Stroebe, Hansson, Stroebe, & Schut, 2001).

Disparity in understandings of grief in the context of prospective shifts in mourning engenders many compelling questions, few of which have been extensively studied empirically. Important questions are being asked, such as: What is "normal" grief; how is it defined, and (how) is it changing in the context of mourning's possible alteration(s)? When can bereavement be diagnosed as a psychological disorder, or should it ever be; how might mourning trends be impacting diagnostic assessment and subsequent treatment of complex bereavement? And what are the ramifications of complicated grieving; how could socio-cultural trends (such as changes in funeral patterns and practices) possibly be influencing fundamental grief process(es)? Given

the generally lacking base of empirical support in this area of research, in this study I will examine two testable aspects of loss response: (1) possible shifts in the presence or absence of funerals, and (2) their ceremonial emphasis. In doing so I seek to begin building a more stable evidential foundation in this important field of inquiry.

Considering the theoretical disagreement, clinical uncertainty, and scarcity of settled empirical evidence regarding bereavement, grief, and mourning, in this paper I begin by tracing current theoretical understandings of loss response in these three areas— drawing preliminary conclusions based on their confluence. Next I examine existing evidence regarding the potential impacts of funerals on grief outcomes, as well as other factors related to funerals (e.g. the purported benefit of rituals and social support), and their possible decline (in frequency of occurrence and/or ceremonial emphasis). I subsequently explore extant funeral service data from two family-owned and -operated funeral homes in northeast Tennessee with respect to the presence/absence of a ceremony and/or the degree of ceremonial emphasis evinced in funeral services over a five year period (2008-2012).

The core question under consideration, then, is: are funerals as omnipresent as their precipitant, death? Or is the pervasiveness of conventional funerals, including their ritual emphasis in the southeastern U.S. (south central Appalachia), perhaps waning? If variations in funeral prevalence and/or ceremonial emphasis are occurring, then the goal will be to subsequently discuss possible sources of these changes and their prospective ramifications.

Statement of the Problem

Whereas empirical support for the salutary utility of funerals is sparse (Hayslip, Booher, Scoles, & Guarnaccia, 2007; Hoy, 2013), arguments favoring their import following a loss due to death can be persuasive (e.g., Hoy, 2013; Long, 2009; Long & Lynch, 2013; Lynch, 1997). Lines

of reasoning in funerals' favor include improved grief facilitation (Bosley & Cook, 1993) and their therapeutic value (Doka, 2002a). Additional research bases for funerals are the confirmation of better bereavement outcomes for those who view the body of the decedent (often an integral part of the funeral process [Crissman, 1994]) following a sudden death (Harrington & Sprowl, 2011; Singh & Raphael, 1981), as well as for children who attend funeral visitations after the death of a parent (Fristad et al., 2000). Hayslip et al. (2007) note that for adults coping with the loss of a loved one, those participating more actively in funeral rituals reported less bereavement-related distress—possibly lowering the likelihood of grief-related complications (except for those with significant prior adjustment challenges, very limited experience with loss due to death, and/or for those with emotional problems so severe as to impede healthful grieving).

In the U.S. the prevalence of complicated grief, also known as persistent complex bereavement disorder or PCBD (a condition for further study in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-5; APA, 2013a]), has been estimated at 2.4% - 4.8% (APA, 2013a). Others estimate this figure to be as high as 10 to 20% (Hensley, Slonimski, Uhlenhuth, & Clayton, 2009; Middleton, Burnett, Raphael, & Martinek, 1996; Silverman et al., 2000). Given that in the U.S. approximately 2.5 million people die each year (National Center for Health Statistics, 2011), with each leaving an average of five survivors, estimates would then suggest 1 - 2.5 million people may develop PCBD in the U.S. annually. An increase in prevalence is anticipated in coming decades as the so-called “boomer” generation continues to age (Jemal, Ward, Hao, & Thun, 2005).

Regarding outcomes, PCBD is associated with increases in risks for cardiac disease, hypertension, cancer and immunological deficiency; it is commonly comorbid with major

depressive disorder (MDD), post traumatic stress disorder (PTSD), and substance use disorders (APA, 2013a). Of these, depression is the most frequent comorbid condition with PCBD (Maercker & Lalor, 2012), and is accompanied by the significantly increased prevalence of pharmacotherapeutic interventions (Horwitz & Wakefield, 2007).

Not known are the potential effects—conventionally assumed to be negative— of a possible decline or de-emphasis in funeral services (the subject of the current investigation) on grief; however, before any such effects can be investigated, that decline or de-emphasis must be empirically supported.

Significance

Given the dearth of empirical data regarding possible shifts relative to mourning rites, further elaboration on the possible impacts of such trends as declining funeral rates on bereavement and grief is challenging. If purported trends are supported, then perhaps these can be related to broader grieving patterns in order to aid in discerning nuances of how the presence/absence of a funeral service, and/or its degree of ceremonial emphasis, may or may not influence the processes of healthful grieving.

Noteworthy in this discussion is the funeral profession's understandable reluctance to confirm or deny consumer trends publicly, while privately grappling with the reality of a shifting away from conventional patterns of funeral service provision. For example, a survey by the NFDA (2014) indicated that only 15% of consumers associate cremation with a "traditional" full-service funeral (incorporating the display of an embalmed body in an open casket during a wake, followed by a funeral ceremony, and then a procession to a cemetery or mausoleum for final disposition of remains or committal [Salomone, 2003]). The same survey (NFDA, 2014) also reported that 58% of consumers associate cremation with a memorial service only

(including a ceremony wherein the casketed remains of the decedent are not present). The survey also noted that more than half of adult consumers would encourage their loved ones to plan a memorial service, but 14% of consumers would discourage it.

An intentional testing of these possible trends should provide evidence indicating whether or not those mourning the loss of a loved one due to death are moving toward more culturally unconventional responses, including—but not limited to—that of no ritualized response at all. A further exploratory analysis of factors influencing such a shift could also be used by healthcare professionals (including grief care specialists) to enhance outcomes by tailoring interventions for those who may be grieving differently in the context of mourning’s evolving landscape. As Bonanno et al. (2002) assert: “Educating the bereaved, as well as their potential support providers, about the diverse forms that grief may take should be an important national priority” (p. 1162).

The current investigation has translational potential. Translational research has been defined as “the linkage of theoretically driven basic research to understanding interventions or policies that improve human health and well-being, evaluation of interventions or policies for efficacy and effectiveness, and application of field experience to future development of basic theory and its applications” (Pillemer, Sutor, & Wethington, 2003, p. 20). A better understanding of grief, including the possible impact(s) of funerals (or lack thereof) and other alterations in mourning rituals (e.g., changes in ceremonial emphasis) on bereavement, may aid comprehension of the affective, behavioral, and cognitive processes that comprise loss response. This investigation begins with data more toward the applied end of the research spectrum, focusing on possible trends relative to mourning, but could result in future opportunities for researchers to move back-translationally from that starting point, toward an apprehension of the

potential impacts of shifts in the processes of mourning on grief, bereavement, and individual health. (Stroebe et al., 2007; for additional detail, see Figure 1).

Aims

Drawing from Engel's (1977) biopsychosocial model, which he conceived using grief as a foundational element of evidential support, and wherein he asserts that "the boundaries between health and disease, between well and sick, are far from clear and never will be clear, for they are diffused by cultural, social, and psychological considerations" (p. 132), in this paper I will touch briefly on theoretical models of psychology relative to grief, clinical understandings of bereavement, and the social dimensions of mourning. These generally map onto Engel's biopsychosocial schema as follows: psychological → theoretical, biological → clinical, and social → socio-cultural. Following brief definitional clarification, I will thus begin by outlining the theoretical, clinical, and socio-cultural contexts of loss response due to death in the U.S.

Then, following Neimeyer's (2006) convergent framework for grief research (which includes "clinical, conceptual, and evidence-based considerations," p. 37), I will subsequently examine empirical (quantitative and qualitative) sources addressing the purported benefit(s) of funerals, as well as more theoretically-based therapeutic models addressing their utility. The overall, potential benefit(s) of social/community support relative to funerals, as well as rituals/ceremonies in times of stress and/or loss (particularly those relating to grief in response to loss due to death), will also be discussed. Additional factors possibly impacting the frequency of funeral services and/or their ceremonial emphasis, including economic as well as other, carefully selected, non-empirical influences will be outlined. This will serve as the backdrop for a subsequent examination of possible changes in funeral service type over time.

Finally, the primary aim of this research is to explore shifts in funeral service type in one specific geographical context and to further examine factors possibly contributing to these trends. Ideally, such an exploration will: (1) provisionally ascertain (albeit at a highly localized level) the validity of purported national trending away from conventional funeral services by those who are bereaved; (2) inform an articulation of possible explanations for any such patterned change in consumer choice preferences regarding funeral goods and services (should it exist), and (3) enhance the research basis for future studies.

CHAPTER 2

LITERATURE REVIEW

Definitional Considerations

Definitional clarity for terms related to loss response is challenging, as there is often significant overlap, interchangeability in usage, and semantic disagreement (Sanders, 1989). What follows is a terminological overview (see also Figure 1).

Bereavement. The term bereavement refers to “the state of having lost through death someone with whom one has had a close relationship. This includes a range of grief and mourning responses” (American Psychiatric Association [APA, 2013a, p. 818]). Bereavement comprehensively encompasses wide-ranging reactions to loss, including “emotional, spiritual, behavioral, and physical” responses (Cook & Dworkin, 1992, p. 6).

Grief. Grief refers to the emotional distress associated with loss (Zhang, El-Jawahri, & Prigerson, 2006). It is the multifaceted, primarily affective process of reacting to the loss of a loved one through death (Stroebe, 2008). Grief is not exclusively attributed to loss response due to death, and also applies to other loss-related transitions (Papa, Lancaster, & Kahler, 2014).

Mourning. Mourning is the social expression of grief (Kalish & Reynolds, 1976). While grief is typically essential to mourning, some view public mourning as not being a requirement of grief (Wolfelt, 1998). That said, for some researchers and practitioners—particularly in the psychoanalytic tradition—the terms *grief* and *mourning* are often used synonymously (Bowlby, 1960; Stroebe, 2008). Brennan (2001) has noted that “it is in psychoanalysis [that] the work of mourning...is intimately bound up with the work of (personal) identity; only by exploring the latter can we understand the former. Mourning in this sense is not simply the outward or public display...but is instead a process integral to the development of the self” (p. 9).

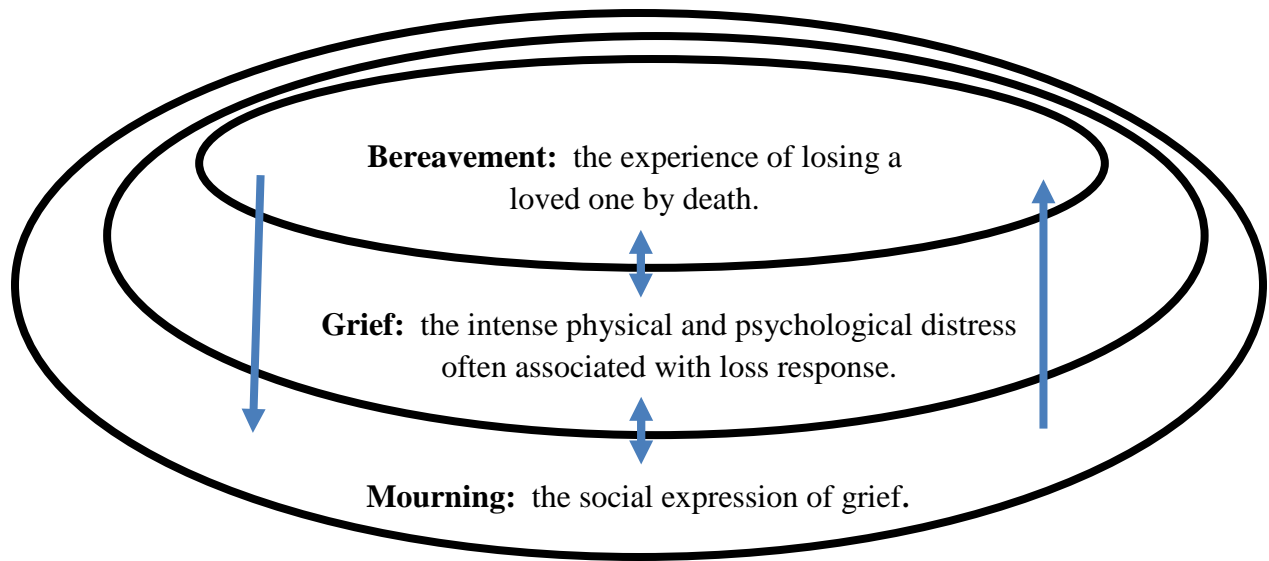


Figure 1. Centered, emanation model of loss response: *bereavement* is viewed as the initial effect, caused by the death of someone close; emanating outward, *grief* is often interpreted as more of an affect (which can include physical distress) resulting from bereavement; *mourning* is conventionally seen as grief’s social expression (molded by and conveyed via cultural norms). As the predominant rite of mourning, funerals (including their presence/absence and/or ceremonial emphasis) may also influence both grief and bereavement, and vice-versa. Thus the arrows depict the potential interplay between and among these three related constructs.

Complex Bereavement. Fujisawa et al. (2010) define complex bereavement as “a deviation from the normal grief experience in terms of either the time course, intensity, or both” (p. 352). Thus it is a chronic, heightened state of bereavement wherein severity and duration both exceed cultural norms. *Complex bereavement* has also alternately been referred to as *complicated grief*, *pathological grief*, *abnormal grief*, *atypical grief*, *pathological mourning*, *neurotic grief*, *traumatic grief*, *unresolved grief* and/or *prolonged grief* (Prigerson et al., 1995). Given the overlapping and often confusing fungibility of terms, in this paper *complex bereavement* or *persistent complex bereavement* will be used. *Grief* will, whenever possible, refer to “normal” grief. This brings the terminology in line with the current [DSM-5 (APA, 2013a)] nomenclature. Also of note, *complex bereavement* will herein be defined within a clinical context.

Funeral. A funeral encompasses all of the ceremonies and/or rituals that take place from death until burial, cremation, or other final disposition of the deceased's remains (Crissman, 1994). For the purposes of this paper, *funeral* refers to the range of rites and ceremonies remembering the decedent; in the U.S., three traditional funerary elements have been predominately featured: (1) a visitation, viewing or wake (typically with the body of the deceased present—most often in an open casket); (2) a ceremony of remembrance (normally with the casketed remains present—more often not open for viewing); and (3) a procession to a cemetery or mausoleum for final committal of the remains of the decedent (Salomone, 2003). In this paper funerals are defined relative to *mourning*, as these ritualized ceremonies have conventionally symbolized the key rite of passage for mourners in the U.S. (Lloyd, 1997).

Memorial service. A memorial service technically designates a ceremony wherein the casketed remains of the decedent are typically not present, although an urn containing the cremated remains of the deceased is sometimes displayed. This type of ritual has more recently been alternately referred to as a *Celebration of Life*.

Ritual. Rando (1993) defines ritual as “a specific behavior or activity giving symbolic expression to certain feelings and thoughts” (p. 71). Genep's (1960/2011) focus on the liminality (from the Latin *limen* or "threshold") of ritual is important with respect to funerals as rites of passage (see also Turner, 1995; Durkheim, 1915/1968). Transitional rituals, such as funerals, have symbolic and/or metaphoric meaning (Cook & Dworkin, 1992) often related to more episodic, one-time life events—including responses to the loss of a loved one due to death (Rando, 1993).

The previous definitions will be assumed throughout the remainder of this thesis. Next I will elaborate on the theoretical context which undergirds the current investigation.

Theoretical Context

Given the socio-cultural variability surrounding bereavement, grief, and mourning, it is prudent to briefly highlight selected theoretical constructs undergirding understandings of loss response. In one of the first scholarly papers comparing depression and grief, *Mourning and Melancholia*, Freud (1917) asserted that both terms encompass a sense of longing for something that has been lost. But as regards the former, Freud used the phrase “the work of mourning (*trauerarbeit*)” to describe a process wherein the griever reclaims psychic energy (*libido*) previously invested in the decedent. This occurs by processing memories and emotions about the deceased until an internalized mental image successfully supplants the prior physical connection.

Following on Freud’s previous use of the term *trauerarbeit* relative to grief, German-American psychiatrist Erich Lindemann (1944) also used *grief work* to apply to the grieving process, which he defined as “emancipation from bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships” (p. 190). It should be noted that Lindemann’s core assumption, that latent grief may always be lurking in the unconscious, has been criticized for a lack of evidence supporting it (Bonanno, 2009).

Stroebe and Schut (1999) critiqued *grief work*’s definitional imprecision, as well as its “failure to represent dynamic processing that is characteristic of grieving..., and [its] limited focus on intrapersonal processes and on health outcomes” (p. 197). They proposed a dual process model (DPM) of coping with bereavement, identifying loss- and restoration-oriented stressors as well as a dynamic, adaptive coping process (termed *oscillation*). It is through this alternating, oscillatory process that the bereaved “at times confronts, at other times avoids, the different tasks of grieving” (p. 197).

Irrespective of *grief work*'s critics (and in some cases perhaps because of them), since 1944 many others have used a variety of terms in place of *work* relative to grieving, including *recovery*, *coping*, *working through*, *resolving*, *accommodating*, and *reconciling*—with the latter two hinting at grief as a process of unending growth and learning (Cook & Dworkin, 1992). Marris (1975) has argued that understanding grief response is essential to clarifying “much that otherwise seems irrational and frustrating in response to change” (p. 25). Thus the experience of change itself (as a threat to our ongoing, interpretive, adaptive, and resilient process of meaning construction), and the resulting feeling(s) of conflict inherent in times of transition, are constantly reconciling via grief. In this way, understanding bereavement may potentiate more positive response(s) to all change, or personal growth. Likewise, Elliott (1999) further asserts that: “Without mourning there can be no self-development, understanding, or change. Without mourning we are psychically ill-equipped for creative living” (p. 5).

Bowlby (1969) likened grief in mourning to the anxiety felt by infants when separated from their mothers, proposing reactive stages of response including: (1) shock and numbness; (2) yearning and protest; and (3) disorganization and despair (see also Parkes, 1972). For Bowlby (1969), these childlike feelings of loss and fear were naturally resolved over time through attachment to new objects; thus, through subsequent work with Parkes (1972), a fourth responsive stage emerged—that of reorganization. Whereas Bowlby's disputations with Freud's (1917) psychoanalytic explanations of mourning have been well documented (for review, see Bretherton, 1992), some have observed that a more comprehensive explanation of grief may be articulated through a selected synthesis of Freud's, Bowlby's, and Parkes' approaches: wherein it is healthful to grieving to form new attachments, but only as one begins to integrate an internalized image of the deceased (Cook & Dworkin, 1992).

Partly inspired by Bowlby's and Parkes' work, possibly the best known stage theory of grief is that established by Elisabeth Kübler-Ross (1969) in her book *On Death and Dying*. Whereas Bowlby's theory was derived from his detailed observation of children and their caregivers, Kübler-Ross's five-stage model (denial, anger, bargaining, depression, and acceptance) came from her work assisting terminally ill patients in coming to terms with the reality of their own mortality. Her model has been criticized for potentially leading individuals who have not experienced intense loss to a "false sense of mastery over grief" through a discrete, stair-step process (Shapiro, 1994, p.3). Also, as Bonanno (2009) points out, while there may be similarities, a theoretical model based on one's grappling with his or her own imminent death is not the same as the experience of one grieving in the aftermath of the death of a loved one. Lastly, it should be noted that Kübler-Ross's five-stage framework of grief remains largely unsupported empirically (Bonanno, 2009; Maciejewski, Zhang, Block, & Prigerson, 2007).

Nonetheless, Kübler-Ross's (1969) work led to a proliferation of public interest in, and published literature on, death and dying (Crissman, 1994). Much of it includes a more nuanced, dimensional assessment of grief—suggesting symptoms that may or may not all be present, may occur in any order, and may be repeated over a protracted period of time (Burnell & Burnell, 1989). Yet the vastness of the subsequent literature has not resolved underlying disagreements in the field.

For example, Wortman and Silver (1989, 2001) argue that many past integral assumptions regarding grief are simply incorrect (see also Wortman & Boerner, 2011). Others assert alternate stage theories of grief, such as Clayton's (1982) three-stage model, which includes numbness, depression, and recovery. Bonanno et al.'s (2002) research maps five bereavement trajectories or essential patterns of grieving using data from the *Changing Lives of*

Older Couples (CLOC) study ($N = 1,532$): common grief, chronic grief, chronic depression, improvement during bereavement, and resilience. Noteworthy is this model's separation of recovery and resilience as distinct trajectories (see Bonanno [2004] regarding the frequent underestimation of resilience to thriving following adverse events).

Worden (2009) proposes an alternative classification system including four tasks of mourning (derived from thanatological literature) including: (1) accepting the reality of the loss; (2) working through the pain of grief; (3) adjusting to an environment in which the deceased is missing; and (4) emotionally relocating the deceased and moving on with life. Prigerson and Maciejewski (2008) prefer evolving, multidimensional *states* rather than distinct, sequential *stages* of grief. Wolfelt and DeBerry (2004) posit no fewer than 10 requisite core elements for healing for the bereaved—for more grief models, see also subsequent section of this paper (below), which includes those of Sanders (1989) and Rando (1993).

Theory relative to productive meaning reconstruction (*meaning-making*) following loss has also been observed as a potentially valuable tool in understanding grief and treating its possible complications (Harvey & Miller, 1998; Neimeyer, 1998, 1999, 2000, 2001). Holland, Currier, and Neimeyer (2006) explore two prominent processes of meaning construal, “making sense of the loss [*sense-making*] and finding benefit in the experience” (*benefit-finding*, [p. 175])—providing yet another theoretical perspective related to grief.

Thus clarity regarding the inner workings of the grief process remains elusive, with extensive scholarship unable to fully address and successfully resolve a range of discrepancies. Even Freud (1917, 1960) revised his position on mourning, especially following the death of his daughter, Sophie, in 1920 (Berzoff, 2011). As Zisook and Shuchter (1986) have pointed out, “there is no prescription for how to grieve properly...and no research-validated guideposts for

what is normal versus deviant mourning.... We are [therefore] just beginning to realize the full range of what may be considered ‘normal’ grieving” (p. 288). Nesse (2005) succinctly summates by stating that: “leaders in the field agree...that we lack, and badly need, a unifying framework for understanding grief” (p. 196).

Conceptual variability relative to loss response is also unsettled in the realm of clinical assessment. Clinicians have grappled with what is “normal” versus what is not with respect to grief for more than 35 years. As was the case with theoretical approaches to grief, an overview of its clinical application is germane to the current investigation.

Clinical Context

Just as Freud (1917) sought to differentiate mourning and melancholia, clinicians establishing diagnostic criteria for complex (versus “normal”) bereavement have likewise sought to discriminate depression and grief. Since first appearing in the DSM-III (APA, 1980), the so-called *bereavement exclusion* fell within the criteria for a major depressive episode, and required licensed psychologists and psychiatrists to not diagnose major depressive episode in instances where depressive symptoms could be better explained by grieving. Lamb, Pies, and Zisook (2010) note that DSM-III (APA, 1980, 1987) and IV (APA, 1994, 2000) endeavored to better establish an impartial diagnostic approach that was impervious to any psychopathological theory, and centered on the “intensity and duration of symptom patterns and on significant distress or dysfunction” (p. 20). Therefore, unless the grieving individual’s symptoms were in line with the DSM-III regarding acuity, longevity, and clinical significance of distress and/or dysfunction for a major depressive episode, then the *bereavement exclusion* criterion meant the experience would be classified as a “normal” reaction to loss (Fox & Jones, 2013; for symptoms and differentiation of “normal” grief versus complex bereavement, see Appendices A & B).

There was a subsequent “narrowing” of the exclusion criterion between the DSM-III-R (APA, 1987) and the DSM-IV (APA, 1994). Key changes between these two versions are that the time frame was shortened from one year to two months, and a diagnosis of major depression was required rather than suggested if complicating symptoms were presented. These complicating symptoms included psychosis for the first time, along with marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (Wakefield et al., 2011). Simultaneous to these changes, bereavement-related depression and pathological grief (complex bereavement) were also introduced in DSM-IV (APA, 1994).

Following the tapering of the exclusion criterion between the DSM-III-R (APA, 1987) and the DSM-IV (APA, 1994), the bereavement exclusion was removed entirely in the DSM-5 (APA, 2013a). Five rationales for the change are outlined (see Appendix C).

Two DSM-5 (APA, 2013a) additions have supplanted the bereavement exclusion. First, the criteria for bipolar I and II disorders (p. 126 & p.134 respectively) and MDD (p. 161) now feature a detailed footnote to assist clinicians in the critical diagnostic differentiation between grief symptoms and those of a major depressive episode, thus addressing “the misconception that grief symptoms are identical to those of MDD” (APA, 2013c, p.2; for a summary of differential diagnostic information, see also Appendix D).

Along with the footnote distinguishing grief from a major depressive episode, the second addition to DSM-5 (APA, 2013a) is Persistent Complex Bereavement Disorder (PCBD) as a condition for further study. Whereas normal grieving has consistently been described as among the most stressful of all life events (e.g., Holmes & Rahe, 1967; Irwin & Weiner, 1987; Prigerson

et al., 1995; Shuchter & Zisook, 1987; Solomon, & Green, 1984; Stroebe & Stroebe, 1993); the functional consequences of PCBD are even more so.

Persistent Complex Bereavement Disorder

PCBD typically features problems with work and social functioning, as well as poor health resulting from increased substance (ab)use and other harmful health behaviors (APA, 2013a). It is also associated with more prescription drug use, disability, and mortality (Prigerson et al., 2009) as well as “significant impairments in health and quality of life” (Boelen, Hout, & van den Bout, 2013, p. 221). Suicidal ideation is more often reported with PCBD (Szanto, Prigerson, Houck, Ehrenpreis, & Reynolds, 1997). MDD, PTSD (especially when the death was violent or traumatic), and substance use disorders are commonly comorbid with PCBD (APA, 2013a). Associated features may include hallucinations of the decedent (often, but not exclusively, auditory and/or visual) during which the deceased’s presence is temporarily perceived or felt (Sacks, 2012). The bereaved individual may also experience diverse somatic complaints such as digestive problems, generalized pain, and/or fatigue. These may include symptoms that had been felt by the decedent prior to his or her death (APA, 2013a). For a complete listing of proposed diagnostic criteria for PCBD see Appendix E; for additional syndrome etiology, epidemiology, and outcomes information related to PCBD, see Appendix F.

Culture-related diagnostic issues must be considered, however. Although the symptomatology of PCBD may be seen in a variety of cultural contexts, individual grief responses are often culturally based. As such, “diagnosis of this disorder requires that persistent and severe grief responses go well beyond cultural norms not better explained by culturally-specific mourning rituals” (APA, 2013a, p. 791). As Rosenblatt (2001) has suggested: “much that is connected to grieving varies greatly from culture to culture” (p. 297).

Additional assessment considerations include the age of the bereaved individual. For example, the death of a caregiver, and his or her subsequent absence, is often extremely disorienting for a child (Melhem, Moritz, Walker, Shear, & Brent, 2007). This may be expressed in developmentally delayed, regressive, anxious and/or protesting behavior (particularly at times of separation and/or reunion with new caregivers or other attachment figures). Whereas separation anxiety may be exaggerated in younger children, social and identity distress and comorbid depression are often more prevalent in older children and adolescents (APA, 2013a).

Differential diagnostic concerns are indicated relative to “normal” grief, depressive disorders, PTSD, and separation anxiety disorder (SAD). PCBD is distinguished from SAD by the status of the attachment figure; in bereavement, this person is deceased (APA, 2013a). Irrespective of some phenomenological and etiological overlapping, some research to date has indicated that PCBD is a “distinct clinical entity” (Boelen & Prigerson, 2012, p. 71; Prigerson et al., 2009).

Although there is evidence supporting the distinction of PCBD from its “near neighbors,” MDD and PTSD (APA, 2013a; Boelen, van de Schoot, van den Hout, de Keijsers, & van den Bout, 2010; see also Appendices G & H), historically there has been considerable contention regarding the differentiation between and among PCBD, MDD, and normal grief—particularly the latter two. First, the aforementioned cultural malleability regarding grief response can be difficult (in some instances impossible) to tease apart (Rosenblatt, 2001). Also, grief’s usefulness may make it seem irresponsible to label some responses to loss as “disordered” (Horwitz & Wakefield, 2007); third, the heterogeneity of grief and mourning often makes defining “normal” problematic, since all bereavement is potentially complicated (Cook & Dworkin, 1992). As Attig

(1992) asserts, an etiological approach to mourning is inadequate, and “grief is more a mystery explored than a problem solved” (p. 362).

For some (e.g., Wakefield, 2011), the removal of the bereavement exclusion from DSM-5 (APA, 2013a) was erroneous and risks increasing both false positive and false negative diagnoses; it should have been expanded to include other stressors in addition to death rather than being removed entirely (Parker, 2013; Wakefield, 2013). In the wake of the bereavement exclusion there is now the detailed footnote (as mentioned previously; see also APA, 2013a, pp.126 & 161). Whereas the footnote aims to aid in distinguishing normal grief from a major depressive episode, some research has underscored their similarities—albeit concluding by stating that “the definitive work clarifying the relationship between ‘normal grief’ and a major depressive episode remains to be done” (Zisook & Kendler, 2007, p. 791). Normal grief, then, “is not a form of depression, but it can become severe enough to be pathological yet unique enough to be differentiated from a major depression” (Fox & Jones, 2013, p. 116).

Further crowding this already complicated field of differentiation is the distinction between PCBD and bereavement-related depression (BRD). Prigerson et al. (1995) have distinguished these two, finding that “the symptoms of complicated grief [PCBD] appear to define a unique disorder deserving specialized treatment” (p. 22). That said, it should also be noted that these researchers isolated a third dimension—bereavement-related anxiety—concluding that “the factors [among these three dimensions] are somewhat associated, but this should not obfuscate their distinctiveness” (Prigerson et al., 1996, p. 1486).

Finally, the clinical difference between PCBD and normal grief is one of acuity and duration (Lamb et al., 2010; see also Appendices A & B). For persistent complex bereavement, grief reactions must severely interfere with one’s capacity to function normally; they must also

last at least 12 months, or 6 months in children (Melhem et al., 2007). Symptoms usually begin within initial months after the death occurred, although there may be a delay of months, or even years, before the full syndrome appears (APA, 2013a). Thus there is a possibility that delayed onset in PCBD may complicate durational diagnostic considerations (e.g., appropriate differentiation from “normal” grief). As symptoms-onset becomes more distal to the death date, an exact durational assessment of the disorder may become more difficult to ascertain.

Therefore clinical understandings regarding what is disordered remain interwoven with what is “normal” relative to grief, with the former relying primarily on a discrimination of the latter (regarding acuity and duration) for diagnostic specificity. As Nesse (2005) has pointed out: “...without understanding why the mechanisms that give rise to grief exist, all criteria for separating normal from abnormal grief are essentially arbitrary” (p. 197).

What defines abnormal bereavement also continues to be the subject of significant ongoing debate among grief clinicians. This includes disputes about the number and nature of bereavement-related disorder(s) meriting discussion/inclusion (PCBD, BRD, etc.), as well as the degree of separation (or potential lack thereof) between and among complicated bereavement and its near neighbors (MDD, SAD, PTSD, etc.). Other factors, such as the potential impact(s) of an increased prevalence of anti-depressant usage (particularly among the elderly, but also throughout the life span [Horwitz & Wakefield, 2007]), on the course and outcomes of mourning (as well as its potential complications) have not yet been studied, and should be examined more fully.

Socio-Cultural Context

Response to death is tied to its frequency and nature; although statistically the risk of dying decreased in the U.S. between 1935 and 2010, the number of deaths increased over this

same time period (Hoyert, 2012). This was due to the interaction of increased births—particularly “boomer” births (Jemal et al., 2005), decreased deaths (owing to a longer average life-span), and increased net immigration. This seemingly paradoxical trend should continue in the coming years: a more populous, older, and more diverse population (American Psychological Association, 2003; Shrestha & Heisler, 2011) wherein there will be longer life-expectancy concomitant with more deaths per annum (Murphy, Xu, Kochanek, 2013)—and thus the potential for more personal experiences of loss due to death.

These quantitative factors are qualitatively impacting the nature of death and dying in the U.S. An increased life span has come at a cost, with significant health care expenditures often occurring in the final months just prior to death (Fan & Zick, 2004; Luce & Rubenfeld, 2002). Possibly attenuating these costs to some extent (Emanuel & Emanuel, 1994), and perhaps partially offsetting the medicalization of death (Kübler-Ross, 1969), it has been estimated that 44.6% of all deaths in the U.S. currently occur under the care of a hospice program (National Hospice and Palliative Care Organization, 2013), and this percentage is increasing.

Thus the context of dying in the U.S. has shifted from home to hospital to hospice over the past century. As Perry and Stone (2011) have observed, however, since the early 1970’s the hospice care movement in the U.S. “has evolved from a modest, grassroots constellation of primarily volunteer-run and community-governed endeavors to a multimillion dollar industry where the surviving non-profits compete with for-profit providers, often publicly traded, managed by M.B.A.-trained executives, and governed by corporate boards” (p. 224). In 2008, approximately 52% of hospices were for-profit, 35% were not-for-profit, and 13% were government- or other-ownership structured (Medicare Payment Advisory Commission, 2010). In their assessment of Medicare costs associated with hospice, Campbell, Lynn, Louis, and

Shugarman (2004) conclude that “hospice is cost-neutral to cost-saving for persons who die of cancer and generally yields added costs for those who do not die of cancer” (p. 275).

Ragow-O'Brien, Hayslip, and Guarnaccia (2000) examined the impact of hospice care utilization on funeral participation and bereavement adjustment. Data from self-report measures of 123 bereaved individuals (*M* age = 36) who had lost a loved one in the past 12 months indicated that those utilizing hospice (*n* = 57) reported more overall positive emotional well-being and more funeral participation than those who did not (*n*=66); the increase in positive emotional well-being was enhanced when hospice users felt that their loved one had been in more pain and suffering prior to death. Interestingly, the researchers note that irrespective of hospice use’s positive effects on emotional well-being and funeral participation, there was “no effect of hospice use...on measures of bereavement adjustment” (p. 302).

As noted previously, mourning rites—particularly the final means of disposition of the decedent (and possibly the associated ceremonial response to death as well)—are thought to be in transition (NFDA, 2014). The U.S. cremation rate has increased steadily over the past half century, from 3.6% in 1960 to 43.2% in 2012, with projections forecasting a national cremation rate of 44.4% to 50+% by the end of 2015, and 55.7% by the year 2025 (CANA, 2013; NFDA, 2014). Although compatible with cremation as a means of final disposition, survey data indicate opinions trending away from “traditional” funerals (with an open casket and viewing of the deceased’s body prior to, during, and/or after a ceremony— often followed by a graveside or committal service at a cemetery or mausoleum) in tandem with the decline in conventional earth burial (NFDA, 2014). These rituals are being supplanted by memorial or celebration of life services, private family gatherings, or by no ceremony at all (Long, 2009; Long & Lynch, 2013).

A more culturally diverse population (American Psychological Association, 2003; Shrestha & Heisler, 2011), decline in church attendance (Hadaway, Marler, & Chaves, 1998), and more distal networks of family and friends (Gross, 2007) may be impacting these shifts away from “traditional” funerals. Funeral pre-planning could also be influencing this trend, as individuals provide advance directives de-emphasizing the need for more elaborate events following death. The aforementioned movement away from burial toward cremation (CANA, 2013; NFDA, 2014) that has been associated, at least in part, with less ceremony (Fristad et al., 2000; NFDA, 2014) may likewise be playing a role in possible shifts in funeral patterns. The lifting of sanctions against cremation in the Roman Catholic Church (1963 [Gillis, 1999; Graves, 2012]) and the allowance of cremated remains to be present during the Catholic funeral mass (1997 [Graves, 2012]) has also probably contributed to the increased rate of cremation in the U.S. (Gross, 2007), thus perhaps also contributing to possible socio-cultural changes in the landscape of mourning. As Gillis (1999) has observed, more Roman Catholic “...families are ignoring tradition and [church] law by creating their own private [funeral] rituals” (p. 23).

Definitional and Contextual Summary

First, bereavement, grief, and mourning are often terminologically confounding. While definable, the relationship between and among the three can be elusive. These terms are frequently used interchangeably, as well as to define one another, and they typically have significant overlap (Sanders, 1989). Second, grief’s theoretical underpinnings can seem enigmatic. Orientations mapping loss response include multiple reference points (e.g., Freud, Lindemann, Bowlby, Parkes, Kübler-Ross, and—more recently—Stroebe & Schut, Bonanno, and Neimeyer) all are noteworthy in their navigational contributions. While their perspectives feature some overlapping areas (Papa et al., 2014), there are also significant differences among

the various theoretical approaches to grief and their respective practical applications—and there are “no *research-validated* ‘guideposts’ available to describe the normal bereavement process” (Bisconti, Bergeman, & Boker, 2004, p. 166, emphasis added). Third, although persistent complex bereavement is emerging as a distinct disorder, clinical discernment between normal and abnormal bereavement continues to appear challenging, as evinced by: (1) the ongoing debate over the *bereavement exclusion*’s excision from the DSM-5 (APA, 2013a); (2) the symptomatological similarities between normal and abnormal grief (differing only in severity and duration, diagnostically determined via clinical judgment); and (3) the significant attention given to differentiating persistent complex bereavement from separation anxiety, posttraumatic stress, and major depressive disorders—as well as from bereavement-related depression and bereavement-related anxiety. Finally, the cultural aspects of mourning (as the social expression of grief) also make it particularly difficult to articulate succinctly.

Possible impacts of the interplay among these contextual factors on funerals and their ceremonial emphasis are not known. Whereas Hoy’s (2013) more recent endeavor to consolidate evidential support for the benefit(s) of funerals cites five studies, he concludes by noting the “sparse empirical evidence of funeral efficacy,” and subsequently posits “anecdotal confirmations of qualitative studies” (p. 168) signaling the value of funerals to those who grieve. Hoy also emphasizes that experts in the assessment of and treatment for complications related to bereavement—as well as prominent grief theoreticians—have enunciated support for funerals as being integral, vital, and healthful in response to loss.

This evidence is the focus of the last section of this chapter, which will include a thorough examination of specific available (albeit limited) empirical research addressing the purported benefit(s) of funerals, as well as the general benefit(s) of social/community support

and rituals/ceremonies in times of stress and/or loss. Additional factors possibly influencing the frequency of funeral services and/or their ceremonial emphasis, including economic and other impacts (not included in the socio-contextual section above), will also be discussed.

Factors Influencing Funeral Frequency and/or Ceremonial Emphasis

According to Lloyd (1997), the funeral is possibly “the most popular expression of grief in our culture” (p. 16), and Irion (1991) has argued that “funeral ritual belongs to the very heritage of the human community” (p. 159). Even given this vaulted status, a variety of factors may affect funeral frequency and/or ceremonial emphasis in response to loss due to death, including, but not limited to: (1) the perceived therapeutic value of funeral rituals (including public perception of the ethics of funeral service practitioners), (2) the purported benefits of social support during times of stress due to loss, (3) the possible utility of ritual/ceremony in relationship to loss response and when under duress, (4) economic impacts, and (5) cultural and other additional influencing factors. These include, but are not limited to: greater cultural diversity; declining church membership and changes in ecclesiastical polity—allowing more flexibility in ritual response to loss (e.g., cremation instead of earth burial); proximity to friends and family members; more funeral pre-planning and/or advance directives; hospice; alterations in end-of-life care; possible environmental concerns; situations where the decedent outlives those who would have been expected to attend the funeral; sanitizing and/or avoidance of death (taboos regarding death and dying, the stigma of bereavement, and the transference of denial regarding death to the means by which it is marked); an increased reliance on social media and information technology; and the prospect that the so called “baby boomer” generation is generally desirous of more choice—particularly when provided with options to make selections

unlike those of their parents. A brief synopsis of rationales and current available evidence in each of these five areas follows.

Perceived Therapeutic Value of Funeral Rituals

Therapeutic benefits of funerals to those who mourn include the perspectives of clinicians and non-clinicians as well as a variety of evidence bases: empirical (quantitative, qualitative, and mixed methods), theoretical, and other (e.g., personal/experiential, anecdotal—i.e., non-empirical). Although, as noted previously, there is a paucity of empirical support regarding funeral utility (Hayslip et al., 2007; Hoy, 2013), much—but certainly not all—research in this area indicates general support for the positive value of funerals to mourners.

Gamino et al.'s (2000) quantitative study tracked 74 participants regarding their funeral experiences following the death of a close other. Utilizing the *Grief Experience Inventory* (GEI [Sanders, Mauger, & Strong, 1985]), these researchers reported that grieving individuals who felt that the funeral was “comforting” and/or were actively involved in the planning of the ceremony (or participated in it) reported statistically significantly fewer grief symptoms on the GEI. Those who reported having experienced an “adverse event” as part of the funeral were more likely to perceive the ceremony as “not comforting.” Given the high incidence of these negative situations (43%), the authors of the study outline possible measures to aid in their attenuation (including better coordination between/among family members, clergy, and funeral service professionals). Also, irrespective of the seemingly high prevalence of such adverse events, the researchers conclude that “this study provides empirical support for conventional wisdom that participation in funeral and burial rituals aids the affective adjustment of mourners grieving the loss of a loved one (Gamino et al., 2000, p. 91).

Again noting the lack of empirical research regarding funeral efficaciousness for grief outcomes, Hayslip et al. (2007) sought a better understanding of how different grievers respond differently to funeral rituals, and how appropriate interventions might be developed and implemented for those assessed as potentially needing “pre-funeral interventions and[/or] aftercare services” (p. 96). The researchers surveyed 348 adults (*M* age = 34) following their attendance of the funeral of a loved one during the previous 12 months (*M* elapsed time since death = 11.83 months). They were quantitatively assessed using the authors’ *Difficulty in Coping with Funerals Scale* (DCFS), a 50-item, Likert-formatted instrument designed to measure coping relative to a variety of death-related events. Additional instruments used included several measures assessing knowledge about and attitudes toward funerals, funeral directors, and the funeral industry; assessments of personality, adjustment, and anxiety about death; and two grief-specific scales.

Findings suggest that older adults tend to report less challenging grief experiences, with those actively participating in planning the funeral ritual reporting benefits for having done so. Multiple caveats are noted, including the correlational nature of the data, as well as two specific categories of mourners who did not receive positive benefits from the funeral event: (1) those having previous adjustment challenges or those with nominal prior experience with death and funerals, and (2) those whose emotional problems are significantly severe as to be obstacles to healthful grieving.

Doka’s (1984) study of 50 bereaved adults 12 to 18 months following the death of a significant other indicated a significant relationship between an expectation of the death prior to its occurrence and improved grief adjustment, but the author’s primary hypothesis that participating in funerals would aid in facilitating positive grief adjustment was not supported.

He thus concludes by asserting that participation in funerals may be important to grief facilitation in instances where the death was unanticipated. This observation also received some support from earlier survey-based research by Khleif (1976) and Swanson and Bennett (1983), who note that those more challenged by adjustment to the death—as well as those reporting a *very close* relationship to the deceased—valued all aspects of the funeral more positively. Doka (1984) further posits that the personalized tailoring of each service to the decedent is pivotal in creating meaningful funerals, and that follow-up after the service is critical in caring for the bereaved.

Given the lack of firm evidence supporting his original hypothesis in this particular study, Doka's concluding statement that his research furthers “the findings of others [indicating] that traditional funeral practices have relatively widespread support” (p. 127) is striking. It should be noted, however, that Doka (2002b) does subsequently articulate the use of therapeutic ritual as an important potential intervention technique in counseling the bereaved. He also reiterates his contention that “A significant body of literature affirms the therapeutic role of funeral rituals (Doka, 2002a, p. 136).

Fristad et al. (2000) researched the grief experiences reported by 318 children (aged 5 – 17) who were interviewed at 1, 6, 13, and 25 months following the death of a parent (54% of the deaths were unexpected). Although there was an insufficient number of participants who did not attend the funeral to compare outcomes based upon that variable, those attending the visitation (89%) reported significantly better outcomes than those who did not. For those not in attendance during the visitation, participants reported a doubling of behavioral, anxiety, mood, and other negative symptoms—as well as more depressive symptoms—at 13 months, and more PTSD symptoms at 25 months post-parental death. The choice of cremation did not affect outcomes, but the authors did note the association between choosing cremation and a lack of other

supportive ceremonies associated with better bereavement outcomes. Noteworthy was this study's wide age-range of participants (5 – 17); the authors distinguish between children and adolescents, noting that the former reported a much greater likelihood of “internalizing/externalizing behavior during the visitation” (p. 335). The researchers did not specifically mention how age was controlled for, nor did they provide information regarding the presence/absence of the body of the decedent during the viewing/visitation. They did, however, underscore the value of ritual participation for children who are grieving—particularly when caregivers are attuned to guiding them in terms of expectations.

In an earlier study focusing on children's understandings of funeral ritual, Weller, Weller, Fristad, Cain, and Bowes (1988) interviewed 38 bereaved children (aged 5 – 12) two months following the death of a parent regarding their reactions to funeral-related activities (92% attended the funeral). Perhaps signaling a prior assumption that these experiences would be unhealthful, the researchers concluded that funeral “attendance is not in itself detrimental to a child's health in the short term” (p. 559).

Silverman and Worden (1992) interviewed 127 children regarding their experiences after attending the funeral of a parent (95% attended the funeral). Whereas in the first months following the death participants reported remembering little about the funeral ritual itself, at 24 months interviewees indicated that attending the funeral aided in their acknowledgement of the death, provided an important way to honor their parent who had died, and served to better enable their receipt of comforting social support.

After 83 people died in a railway accident (the Granville Disaster) in Sydney, Australia, in 1977, a preventative psychiatry program was rapidly organized to reach out to survivors and relatives of those who lost their lives. Singh and Raphael (1981) report results of follow-up

research conducted 15 to 18 months post-accident. Data regarding level of functioning (general health, dimensional assessment of unresolved loss, and social support) were collected via questionnaire for the next of kin of 36 victims (43% of the total number who died in the accident). Factors associated with better grief outcomes included strong social support, professional mental health interventions (rather than lay-counseling or no counseling at all), the relationship to the decedent (widows fared better than parents), and outcomes were enhanced for those who viewed the body of their deceased loved one.

Similarly, Harrington and Sprowl's (2011) in-depth interviews with 16 bereaved individuals following the sudden death of a significant other suggest the value of early viewings of the body to "confirm the reality and circumstances of the death" (p. 77), as well as later funeral home viewings that allow for final goodbyes prior to the last, permanent separation from the deceased's physical body.

Others have echoed and elaborated on this point, positing that the viewing of the body has benefits (Ahrens, Hart, & Maruyama, 1997) on multiple levels (in addition to offering indisputable evidence that the death has indeed occurred); these rationales include, but are not limited to: (a) viewing reinforces the fact that the deceased will not somehow miraculously return, (b) it is an opportunity for a potentially meaningful experience—one emphasizing, as appropriate, that the person who died is no longer suffering, (c) those choosing to participate in a viewing of the body may experience a less lengthy span of denial regarding the death when contrasted with those who did not view, and (d) it may aid griever(s) in separating themselves from the decedent—an important precursor to successfully initiating the process(es) of grieving (Deatherage, 2014).

As regards parental bereavement, Jost and Haase's (1989) qualitative, semi-structured interview study of 14 parents who had lost a child suggests that those parents who viewed were more likely to report its benefits than those who did not, with the latter in some instances later indicating negatively identified feelings such as "anger and regret" (p. 148) and identifying not viewing as a significant hindrance to adjustment following the death. Wijngaards-De Meij et al.'s (2008) longitudinal study of 219 bereaved couples in the Netherlands also indicated that parents choosing to have a visitation where the body of the deceased could be viewed reported experiencing less acute grief in the first two years post-loss than those parents who, for whatever reason, decided not to have an open viewing.

Here it should be emphasized that the presence/absence of the body of the deceased for public viewing at a visitation and/or as a part of the funeral (in a church, funeral home, or alternate location) typically depends on cultural, religious, and other regional and/or familial preferences and conventions (Wijngaards-De Meij et al., 2008). According to the AARP's (2007) *Funeral and Burial Planners Survey*, respondents ($N = 1,087$) were "fairly evenly divided" (p. 16) regarding the importance of an open casket viewing as a funereal element, with 47% favoring inclusion and 43% opposing it. This finding was more pronounced geographically, with those in the West less likely to positively value an open casket viewing than those in the Northeast, North Central, and South. Data for the current study did not specifically track viewing of the body (private or public), but such viewings have historically been common in the south central Appalachian geographical region under consideration in the current study (Crissman, 1994). Thus, although viewings are perhaps declining in prevalence, that possible trend was outside the scope of the present investigation due to limitations of the data.

Bolton and Camp (1987) examined possible relationships between funerals as symbolic acts and positive grief outcomes among 50 widows (M age = 56) by collecting demographic information, data regarding ritualization following the death, and two measures of grief adjustment: the *Affect-Balance Scale* (Bradburn, 1969) and the *Attitude Inventory* (Cavan, Burgess, Havighurst, & Goldhamer, 1949). Although the authors found no statistically significant relationship between funeral ritualization and grief adjustment, they note “sufficient evidence to warrant further study of the use of rituals, especially post-funeral rituals, in the facilitation of grief work” (p. 343).

Kraeer (1981) has asserted that “...ceremonies and customs of the full-service funeral have a pivotal place in our life and value structure.” (p. 256). Citing data including 800 visits to post-death mourners, the author claims higher percentages of arrested progress in grief recovery for those having limited or no funeral services (12 and 34% respectively) than for those experiencing full funeral services (12% grief complications). The author provides no information on the source of the data or how it was obtained; further analysis reveals that he is a former owner of a funeral home in Florida.

Utilizing a thematic analysis of narrative data gathered during an intensive interview-based study of 32 individuals (M age = 32, 7 years post-loss), Bosley and Cook (1993) outline five relevant, emerging themes (rather than phases) related to the value of funeral rituals, which they define as *markers of change*. These themes include: memory as a tool of acceptance, affirmation of faith, emotional expression, social support, and reconnection to family heritage. From this schema they draw several unifying meta-themes (integration of experience, belief, connectedness, and continuity) that serve a greater function than the isolated rituals—thus possibly facilitating more healthful grieving and subsequently enhancing bereavement outcomes.

There is a significant body of clinical theoretical research regarding the efficacy of funerals to those who are grieving, much of it from highly respected sources. It is important to note, however, that often the connection between these scholars' conclusions and their empirical evidence bases is indirect, ill-defined, or is otherwise unclear.

For example, Fulton (1994), an esteemed figure in the field of thanatological inquiry, underscores the need to emphasize funerals as rites of separation and integration rather than as rites of incorporation. However, his subsequent statement that "...there is increasing scholarly evidence today that can support social custom in the belief that a funeral is a ceremony of value for the mourner" (p. 305) is not directly supported empirically in his research as presented, which includes unspecified, unpublished personal research, as well as his use of current events as evidence (see also Fulton, 1995).

Another eminent grief scholar, Sanders (1989), views funeral rituals as having positive benefits for the bereaved, but she frequently mentions the Tampa Bereavement Study (Sanders, 1980) she conducted without specifically indicating how data from this earlier research with widow(ers) in southwest Florida is directly linked to an enhanced valuation of funerals. She does, however, connect her prior bereavement research using the *Grief Experience Inventory* (GEI) that she developed (Sanders et al., 1985) to her development of a five-phase model of grief (Sanders, 1989). These phases are shock, awareness of loss, conservation-withdrawal, healing, and renewal. She subsequently posits that "...the rituals of death become the glue that holds the bereaved together during the first phase [shock]" (Sanders, 1999, p. 57; see also Doka, 2006).

Worden (2009) likewise contributes a theoretical construct from his clinical practice, asserting that "...the funeral service...can be an important adjunct to...the healthy resolution of grief....Seeing the body of the deceased person helps to bring home the reality and finality of

death.... In this way the funeral service can be a strong asset in helping the survivors work through the first [of his four] task[s] of grief” (p. 118), accepting the reality of the loss (see also previous description of Worden’s four tasks of mourning in this paper, p. 24).

While acknowledging the plethora of stage theories on dying and bereavement introduced in recent decades (as outlined above), Rando (1993), a clinical psychologist, thanatologist, traumatologist, and director of the *Institute for the Study and Treatment of Loss*, puts forth a three phase model of grief (avoidance, confrontation, and accommodation) featuring six major mourning processes (recognize the loss, react to the separation, recollect/re-experience the relationship to the deceased, relinquish old attachment(s), readjust, and reinvest). These are then linked—in a manner similar to that of Sanders (1989) and Worden (2009)—to her schema for creating therapeutic bereavement rituals as actions that symbolically express certain thoughts and emotions.

As noted previously (p.24), Allen Wolfelt, a grief expert and director of the *Center for Loss and Life Transition*, has articulated a 10-element model for healthful grieving (Wolfelt & DeBerry, 2004), a 6-need model for understanding the functions of mourning (Wolfelt, 2007), and has published texts for both caregivers and families on how to create meaningful funeral ceremonies (Wolfelt, 2003, 2011). For Wolfelt, an eloquent advocate for funerals and frequent speaker at gatherings of funeral professionals, rituals express what words cannot.

Irion (1966, 1990), a pioneer in the modern death awareness movement, has likewise asserted the import of funerals as ritual responses to the needs of mourners. Hoy (2013), a pastoral and grief counselor, clinical faculty appointee at Baylor University, and director of the *Center for Grief Education*, outlines a variety of evidential support for death rituals, including empirical, historical, and compelling anecdotal information. Additional funeral service

advocates include Thomas Long (2009), a minister and professor of homiletics at Emory University, and Thomas Lynch (1997, 2001), a poet, funeral home owner, undertaker, and strong proponent of funeral service. These latter two recently collaborated to illustrate the high value benefits of funerals for the bereaved (Long & Lynch, 2013). It should be noted that each of the five aforementioned individuals has been invited to speak at meetings of funeral service professionals and/or at community events for other end of life caregivers (including the general public) that were sponsored by funeral homes.

Whereas the previous five authors have primarily addressed their own personal assessments and research of more broadly-based, positive attributes of funeral rituals and their potential benefits to the bereaved, it also bears mentioning that some research isolates specific elements of funerals as perhaps being beneficial and thus meriting further study. These include, but are not limited to, the funeral meal (described as “a common ritual which works itself out in diverse fashion” [Yoder, 1986, p. 150]), the meaning-making role of music for families in mourning in the United Kingdom (Adamson & Holloway, 2012; Caswell, 2012), and the possible psychological benefits of personal experience storytelling during funeral ceremonies in northeast Tennessee (Childress, 2000).

Noting that much of the data regarding rituals is primarily qualitative, Norton and Gino (2013) took the novel approach of conducting three separate experiments ($n = 247$, $n = 109$, and $n = 172$ respectively) exploring the potential grief-mitigating impacts of mourning rituals following losses not only of (remembered) loved ones, but also of (former) lovers and (hypothetical) lotteries. By focusing on the role of ritual in regaining feelings of control, their results suggest that “the rituals of mourning in which participants engaged hastened the decline of the feeling of mourning that accompanies loss” (p. 271). This relationship between ritual and

regained feelings of control was essentially impervious to each participant's personal beliefs (or lack thereof) regarding ritual efficacy. Results also indicated that "rituals appear to be defined by purposeful behaviors designed to achieve some desired outcome, and...the specific behaviors that constitute those rituals are less important than performing some form of ritualistic behavior" (p. 271).

Funerals are not without their critics and detractors, chief among them Mitford (1963, 2000), who focused on the high cost of funerals and the questionable ethics of the funeral industry—and was frequently attacked by funeral service promoters as a result (West & McKerns, 2009). More recently, Sanders (2009, 2010, 2012) has railed against the unseemly practices of some funeral service practitioners, particularly conglomerate-owned funeral home chains. The paucity of empirical research regarding the valuation of funerals relative to their cost applies equally to both proponents and antagonists of their effectiveness. Thus Mitford's (1963, 2000) and Sanders' (2009, 2010, 2012) critiques—as well as sporadic media exposés of dubious funeral service practices—have been largely unsuccessful in tarnishing the overall public image of funeral service providers.

That said, studies specifically designed to survey public opinion of funeral service indicate its potential benefits while simultaneously questioning its underlying trustworthiness (Garmen & Kidd, 1983). Hayslip, Servaty, and Guarnaccia (1999) found adults of middle-age and older were typically more favorable toward the value of the traditional funeral ritual than younger adults. More recently, Hayslip, Booher, Riddle, and Guarnaccia (2006) have suggested a greater complexity of views toward funerals, asserting a multi-dimensionality of funeral attitudes in the general public.

Possibly exacerbating the task of a therapeutic valuation of the relationship between grief and funeral process is the purportedly shifting landscape of mourning itself. For example, Homans (2000) has posited that “this ancient emotion [mourning] and its associated rites have lost their ‘given-ness’ such that it is their absence rather than their presence that has merited scrutiny” (p. ix), and Lubrant (2013) asserts that North American’s choices in terms of the rites and disposition following death are significantly more diversified than in the past. Lastly Walter (1991) goes so far as to state that “[as] communal and religious death rituals that once functioned to affirm culture fall into disuse...personal therapy and one-to-one bereavement counseling [are] arising to support bewildered individuals” (p. 306).

In summary, so long as public perception regarding the overall value of funerals persists, they will likely continue to occur; a declination in this perception may, however, increase their susceptibility to alteration. One possible way they are valued is in relationship to the social support that may be perceived as a part of the funeral process.

Possible Benefits of Social Support

Sanders (1989) provides a theoretical framework underscoring the potential social support benefits of funerals for the bereaved, noting that funeral attendance can be one major way to support someone who is grieving. Singh and Raphael (1981) reported that better support networks meant better outcomes for those who lost loved ones in the Australian train crash. Fulton (1995) similarly indicated that funeral rituals typically deliver much-needed social support for those who grieve, and Gamino et al.’s (2000) study suggests that “not only does this [social support] provide solace to the mourner at the time of death, but [it] also aids subsequent emotional adjustment” (p. 89). More generally, Stroebe et al. (2007) posited that “for most bereaved people, family and friends, religious and community groups, and various societal

resources will provide the necessary support. Professional psychological intervention is neither justified nor effective” (p. 1969).

Additional empirical studies regarding social support’s purported positive impacts on mourning outcomes are less clear, however. For example, Anusic and Lucas’ (2014) study in Germany ($n = 1,195$), Great Britain ($n = 562$) and Australia ($n = 298$) indicated that social relationships established before widowhood (or in its early stages) did not appear to explain individual differences in loss adaptation. In a study of 3 subsets of widows’ friendship networks ($N = 126$), Bankoff (1981) suggested that healthful grief response was dependent on the challenges and adjustment tasks being faced by the widow, as well as the specific nature of the social support—and its source. In a separate study, Bankoff (1983) again found “little evidence...in support of the assumption that support, regardless of its type or source, has a positive effect on the well-being of widows, particularly those who are newly bereaved and still in the midst of intense grief” (p. 831). Further data analysis revealed that the complex nature of social support in relation to widows’ psychological well-being following a major life crisis depends on factors such as where widows are in the adjustment process, the nature of the support provided, and the source of that support.

Greene and Feld (1980) examined the relationship between social support coverage and well-being in 3 groups of widows over the age of 50 from a nation-wide sample. The first group ($n = 151$) were married, the second group ($n = 60$) were widowed in the last 5 years, and the third group ($n = 84$) had been widowed for more than five years. The researchers’ first hypothesis (that support would be associated with well-being in all subgroups) was not supported, nor was their second hypothesis (that support would be more strongly associated with well-being in the subgroups experiencing greater stress). Instead, positive relationships were

seen in some groups and negative ones in others, thus even suggesting negative consequences of social support in some instances.

Stroebe, Zech, Stroebe, and Abakoumin's (2005) quantitative review of longitudinal data from 1,532 married individuals (aged 65+) regarding social support's relationship to bereavement outcome found "limited evidence for the widely held assumption that social support buffers the bereaved against the impact of the loss experience and/or facilitates recovery" (p. 1030). They close with an excellent summary of the complicatedness of research in this particular area, noting that although social support should not be regarded as unhelpful, "it can neither soften the impact of loss, nor does it appear to accelerate the process of recovery (p. 1048). Thus social support (such as funeral attendance) is generally recommended, but evidence regarding social support's subsequent benefit(s) to mourners is situation-specific, and may be less helpful on the whole than conventional wisdom would seem to imply; however, it is the perception of the benefit that likely influences the frequency of funerals. It could be that it is the ritual rather than the sought social support that motivates the bereaved to have a funeral service, but does ritual offer any more benefit than social support?"

Utility of Ritual/Ceremony in Loss/Stress Response

A large body of scholarly information regarding ritual in the context of loss/change is theoretical, and much of it is anthropologically or sociologically based. Durkheim (1915/1968), Genep (1960/2011), Reik (1976), and Turner (1995) all feature prominently in establishing and delineating the contours of ritual and its functional application(s). Crocker (1973) defines ritual as "a statement in metaphoric terms about the paradoxes of the human condition" (p. 47). Thus rituals are non-literal responses to that which cannot be known, such as the exact nature of death.

In addition to the aforementioned research regarding the potential benefits of funeral rituals to healthful loss response (e.g. Bosley & Cook, 1993; Irion, 1990; Norton & Gino, 2014), Canda's (1988) multidisciplinary review put forth a conceptual model of therapeutic transformation in ritual. Goss and Klass (1997) underscored the import of the *Buddhist Book of the Dead* ritual, and Neimeyer, Prigerson and Davies (2002) have recommended the value of ritual to psychological reconstruction and meaning-making in the wake of loss.

Examples of therapeutic techniques incorporating ritual include, but are certainly not limited to: Johnson, Feldman, Lubin, and Southwick's (1995) outline of the benefits of using ritual and ceremony to treat PTSD (utilizing trauma compartmentalization, the provision of transformative enactments symbolizing former broken relationships, and communal/familial reconnection opportunities); as well as applications of ritual in treating childhood sexual abuse through therapeutic clinical gain consolidation and qualitative self-concept transformation (Parker, Horton, & Watson, 1997). Imber-Black, Roberts, and Whiting (2003) provide an excellent overview of ritual in a variety of family therapy settings, including definitional, thematic, and practical applications utilizing ritual as a therapeutic intervention. Hoy (2013) posits the value of co-creating therapeutic rituals with bereaved clients as an integral part of ongoing grief counseling. Also worthy of consideration is the aforementioned experimental study by Norton and Gino (2013), which focused on the positive results of mourning rituals (some participants remembered past rituals and others enacted novel ones) following three loss-based exercises (two remembered and one hypothetical).

Funerals are specialized ritual responses to death that occur near a time of bereavement. As Durkheim (1915/1968) has noted, funerals offer the potential benefits of ritual to those who mourn, and mourning's symptoms are often perceived to be alleviated "owing to the mourning

itself” (p. 402). If funerals are declining, then, it could be at the expense of these positive aspects of ritual.

Economic Impacts

A final arena of possible influence on funeral frequency and ceremonial emphasis is economic climate. Research regarding the precise effects of economic conditions on the frequency and/or ceremonial emphasis of funerals is currently unavailable, with only sparse published sources in the literature regarding funeral expenditures (Fan & Zick, 2004). As previously noted, Banks (1998, 2003) describes the significant impact of funeral costs on households, noting that average death care (funeral) service costs are 25% more than the average annual family welfare payment. Fan and Zick (2004) investigated combined costs for end of life health and funeral expenses, concluding that—particularly for households with low wealth holdings— “their post-widowhood economic position is likely to be even more precarious” (1998, p. 51). Banks (2003) concurs, summarizing by stating that “the economic impact of death on American households can be quite significant. Low-income, minority group households are particularly vulnerable to the adverse economic effects that result from an episode of death.” (p. 609).

Gross (2007) reports that cremation is less costly than conventional burial, and that the consumer shift toward the former may be due, at least in part, to increases in funeral expenses (see also Banks, 1998, 2003; Hingston, 2013; Walsh, 2014). Gross (2007) further observes that the trend away from burial toward cremation has had a significant negative impact on the profits of larger funeral home chains, casket manufacturers, and smaller entities providing funeral and/or cremation services (approximately 86% of funeral homes in the U.S. are privately owned, by families or individuals [NFDA, 2015]). Revenues reported by the NFDA— which represents

more than 10,000 funeral homes—at five year intervals (from 1997 to 2012) indicate negative trends over time, but association membership also declined during this same period (NFDA, 2015). As such, drawing conclusions regarding revenue trending based on these data is not possible. In addition to increased costs for funerals, an NFDA (2014) consumer preference survey cited lowered discretionary household income as another economic factor impacting consumer trends toward cremation.

Harrington and Krynsky (2002) explored the relationship between state regulations, particularly those concerning embalming, and consumer spending on funerals, concluding that “evidence raises the likelihood that funeral directors are inducing demand” (p. 225) to offset profits negated by consumers who are increasingly choosing cremation rather than burial. This was indicated by the 2.6% increase in funeral expenditures (16% reduction in the choice of cremation as a means of final disposition) in those states requiring funeral establishments to have embalming facilities (which are costly to construct, staff, and maintain). LuBrant’s (2013) riposte is to point out that Harrington and Krynsky’s (2001) theoretical model relies on the false distinction between cremation and burial as dispositional choices with discrete ceremonial implications, which they are not. The choice of ceremony is not defined by the means of final disposition, and survivors may freely “select certain elements of ‘traditional’ funerals, including embalming and interment of cremated remains, in addition to their choice that the body be cremated” (LuBrant, 2013, p. 44).

Ludvigson (2004) addresses the intricacies of economic influences on consumer spending relative to consumer confidence (see also Desroches & Gosselin, 2002). Labor/employment rates and wages may also play a role. Dées and Brinca (2013) provide an interesting statistical assessment of the possible relationship between consumer confidence and expenditures for the

U.S. and the euro area, concluding that confidence is a good predictor for the latter, but not necessarily for the former, and that the relationship between the confidence and spending is non-linear—with the contribution of confidence in explaining spending expenditures increasing during times of instability.

The interplay between/among funeral costs, employment rates, per capita income, consumer spending, healthcare costs, savings patterns, consumer confidence, and other economic factors is likely impacting funeral purchasing trends. Given that this is particularly evident during times of economic instability (Dées & Brinca, 2013), it was likely the case during the initially volatile and subsequently depressed economic period (Barello, 2014) under consideration in the current investigation.

As noted previously, Mitford (1963, 2000) and Sanders (2009, 2010, 2012) offered strong criticism regarding the high cost of funerals (for summary, see Kopp & Kemp, 2007). Some have linked the funeral consumer trend toward cremation as the means of final disposition to funeral expense (Banks, 1998, 2003; Gross, 2007; Hingston, 2013; NFDA, 2014; Walsh, 2014), which may in turn be associated with less ritualization following the death of a loved one (AARP, 2007; Fristad et al., 2001; NFDA, 2014).

Possible Cultural and Other Additional Influences

Several cultural and other factors possibly affecting funeral frequency and/or ceremonial emphasis have been addressed in the Socio-cultural Context section above. These include: (1) an increasingly diverse population in terms of cultural backgrounds (American Psychological Association, 2003; Shrestha & Heisler, 2011); (2) declining membership in religious institutions (Hadaway et al., 1998) and shifts in policies previously restricting cremation in the Roman Catholic Church (Gillis, 1999; Graves, 2012; Gross, 2007)—perhaps contributing to a decline in

Catholic funerals (Walsh, 2014); greater distances to relatives and friends (Gross, 2007); (3) an increase in funeral pre-planning (AARP, 2007), including the prospect of advance directives regarding ceremony and the final disposition of the deceased's body—transitioning away from “traditional” funerals with earth burial toward less ritualized, simpler memorial services and cremation (NFDA, 2014); (4) hospice (Campbell et al., 2004; Perry & Stone, 2011); (5) and the changing context of end-of life care and its increasing cost (Banks, 1998, 2003; Fan & Zick, 2004).

Additional influences include environmental concerns. Among these are land-use limitations of cemetery space (primarily evinced by the consideration of a means of disposition other than earth burial [Harris, 2011]), and the potential negative environmental impacts of embalming chemicals (for example, the European Union has considered banning formaldehyde, a substance essential to conventional embalming techniques). The AARP (2007) indicated that “slightly over one-fifth of all respondents reported that they would be “very interested” or “interested” in burial that is more environmentally friendly than a traditional burial with embalming” (p. 15). Cremation, however, requires the use of non-renewable fossil fuels, and has been subject to “considerable research into the environmental impact of mercury emissions from crematoria” (Lubrant, 2013, p. 48). Some alternatives to burial or cremation are already in use, such as alkaline hydrolysis (i.e., reducing the body to bone fragments using water, an alkali additive, heat, and pressure—see www.greencremation.com); others are currently pending, such as the application of *decompiculture*, an accelerated decomposition technique through which the body's accumulated toxins are remediated by clothing the dead body in a “mushroom death suit” for earth burial (Lee, 2011; Myles, 1995; Pac, 2014).

Other factors possibly impacting funeral choices, as reported by Hingston (2014), include concerns that those outliving their friends will have funerals in empty churches, that funerals represent a failure to successfully deny death, and that technological innovations are obviating the need for funerals entirely. Additional research also implies that the “baby boomer” generation is generally desirous of more choice—particularly when provided with options allowing them to make selections unlike those of their parents (e.g., “traditional funerals”). These option-seeking individuals are also, interestingly, much more likely to pre-arrange their own funerals than their parents (AARP, 2007).

Influencing Factor and Chapter Summary

On balance, factors influencing funeral frequency and ceremonial emphasis tend toward favoring their overall utility to the bereaved. However, as noted previously, empirical evidence supporting this assertion is lacking. Also, when considered within the unsettled theoretical, clinical, and socio-cultural contexts of bereavement, grief, and mourning, the stability of factors favoring funerals, and the retention of their ceremonial emphasis, is further diminished. What is still not known empirically, regardless of the actual impact of the presence of a funeral service or its degree of ceremonial emphasis, is whether the purported decline in funeral services or ceremonial emphasis within funerals is actually occurring.

CHAPTER 3

METHODS

Specific Aims

Over the past 50 years it has been episodically asserted that death response is in a state of anomy (e.g., Irion, 1966; Lofland, 1978; Neimeyer, 1999; Walter, 1991). Considering others' reliance on the accuracy of such a position and its implications regarding possible shifts in funeral service trends (e.g., Doka, 1984), an argument may be made for directionally hypothesizing that conventional funeral services in the U.S. are in decline. This would align with surveys indicating such a trend in funeral consumer opinion (AARP, 2007), as well as published media reports regarding a downturn in the rate of funeral services (e.g., Boring, 2014; Hingston, 2013; Walsh, 2014). It would also reinforce my own experience as a funeral director (families seemed to be increasingly requesting that there be no funeral, or— in some exceptional situations— they even asked that the death itself not be disclosed to the public); this was integral to my interest in conducting the current study.

But noteworthy occurrences do not necessarily evince longstanding patterns. As such, the primary aim of this research was to examine whether there has been a shift in funeral service rate (was there a funeral or not?) over time in a dataset from a small family-owned funeral business in south central Appalachia. A secondary aim was to further explore the nuanced terrain of this purported trend by examining possible changes in service type (e.g., a visitation or wake, funeral service, memorial service, committal service, or some combination thereof—with or without the body of the decedent present, or no service at all). The objective investigation of these questions should serve to accomplish a third aim, that of enhancing the scientific evidence base supporting (or not supporting) a trend that has been assumed and likely acted upon by

funeral service professionals—and others— without empirical study. Potentially significant impacts on decision-making regarding service type or whether a funeral was chosen (e.g., cost, geographic location, and local economic indicators), were included as covariates. In the end, the study was hypothesized bi-directionally, as doing so reflected a more conservative and stringent approach statistically.

Human Subjects Approval

Data for this study came from an extant source. This archival information was anonymized prior to its examination in order to safeguard against any possibility of identification of individuals represented in individual data points. As such, human subject approval for this study was neither sought nor obtained.

Dataset

Archival data from a funeral home in northeast Tennessee were utilized in this investigation. These data ($N = 2,581$) spanned the years 2008-2012. Data sources included one metropolitan funeral home location (population 52,962 in 2013), and one smaller branch or satellite funeral home owned by the same company, located in a census-designated place (population 1,291 in 2010). Whereas the former historically serves approximately 90% of the families choosing the firm as a whole, predominantly following deaths in and around Sullivan County, TN; the satellite location (serving an estimated 10% of families) is located in Washington County, TN. The initial goal for capturing this information was to track changes from the perspective of the business itself, in order to: (1) better understand consumer choices on an ongoing basis, (2) perhaps predict future trends in customer choice-making in a funeral service context, and (3) better serve client-families given their (possibly) shifting preferences over time. Ensuring financial viability for the firm going forward was also an important

business-related aim in the original data-collection. Given that the dataset was from one business entity, located in two communities with multiple other options available regarding the provision of funeral services, it should be noted that some selection bias was likely inevitable. However, it should also be noted that the firm's pricing structure for funeral goods and services falls in the middle range of those for all funeral homes in the area, thus a selection effect solely based on cost was unlikely.

Study Variables

The focal predictor variable for this study is time, coded annually into 5 bins (BINS) by the year in which the death occurred (2008, 2009, 2010, 2011, and 2012). Both outcome variables (binary: ceremony/no ceremony and ordinal: degree of ceremonial emphasis) were determined from a single data entry (funeral service type). The data were coded in the original dataset as follows: 1 = Funeral/Burial Evening with Visitation; 2 = Funeral/Burial Day Prior Visitation; 3 = Burial Partial Service; 4 = Funeral Same Day Visitation; 5 = Direct Cremation; 6 = Cremation Partial Service; 7 = Cremation full service; 8 = Social Service; 9 = Graveside/infant/other; 10 = Infant/soc. service/other. Of these, the only one that definitely does not include any type of ceremony is number 5 (Cremation Direct). Several, however, are definitionally ceremonial, including numbers 1, 2, 3, 4, 6, and 7 (some of these are more ceremonially-derived than others, but all have at least some element that could be construed as ceremonially-related). Social Services (coded 8) are provided for indigent clients, designating those instances where services were paid for, in part, by the county (Sullivan or Washington County, TN). As such, data from this category were not included because these client-families were somewhat limited in terms of the choice of service type available to them. Service types 9 and 10 represent changes in the coding system over time and are unclear due to overlapping

responses in each category. Given the low percentage of cases in categories 9 and 10, and the inability to reliably categorize them for this study, these data points were also excluded. It should be noted that, considering the grey areas between and among some of the categories (and given the fact that there were multiple persons entering the data) there was likely some variability in categorization. That said, there is no compelling rationale for why this would have been done outside of guidelines set forth prior to data entry.

Table 1

Summary Description of Variables Used

<u>Variable</u>	<u>Variable Type</u>	<u>Possible Responses</u>	<u>Description</u>
Direct Cremation	Binary	Y/N	Cremation as means of final disposition; <i>no ceremony</i> .
Burial Partial Service	Binary	Y/N	Earth burial as means of final disposition; graveside ceremony / committal service.
Cremation Partial Service	Binary	Y/N	Cremation as means of final disposition; partial service (e.g., visitation or memorial service—but not both—or committal service).
Funeral Same Day Visitation	Binary	Y/N	Visitation and ceremony; no time interval between.
Funeral/Burial Evening with Visitation	Binary	Y/N	Evening funeral following visitation; burial day following. This service type represents the maximum involvement of funeral home staff.
Funeral/Burial Day prior Visitation	Binary	Y/N	Evening visitation with funeral the following day.
Cremation Full Service	Binary	Y/N	Cremation with viewing/visitation; ceremony.

Table 1 (continued)

<u>Variable</u>	<u>Variable Type</u>	<u>Possible Responses</u>	<u>Description</u>
Ceremony/No Ceremony	Binary	Y/N	Yes: Burial Partial Service; Cremation Partial Service; Funeral Same Day Visitation; Funeral/Burial Evening with Visitation; Funeral/Burial Day Prior Visitation; Cremation Full Service No: Direct Cremation
Ceremonial Emphasis	Ordinal	1,2,3,4	1 = Direct Cremation; 2 = Burial Partial Service, Cremation Partial Service; 3 = Funeral Same Day Visitation; 4 = Funeral/Burial Evening with Visitation, Funeral/Burial Day Prior Visitation, Cremation Full Service
Time (BINS)	Ordinal	1,2,3,4,5	1-2008; 2-2009; 3-2010; 4-2011; 5-2012)
Geographic location	Binary	K FB	Kingsport Fall Branch (both in Tennessee—TN)
Non-declinable funeral home charge	Continuous	\$ amount @ date	Minimum funeral home charge for services.
Labor Market (Kpt.)	Continuous	# / pop. @ date	Labor force—using currently employed / population in Kingsport, Tennessee
Retail Sales (Kpt.)	Continuous	\$ @ date	Retail activity (per capita)—Dollars spent per capita in Kingsport, Tennessee

Covariates include location (which of the two funeral homes), the non-declinable funeral home charge (for basic services of the funeral director, staff, and facilities— plus initial transportation of the body of the deceased to the funeral home), and other regional economic factors (urbanized labor market and retail sales activity [per capita] from Kingsport, Tennessee).

Data Preparation

Prior to study outset, the original dataset was completely anonymized by a funeral home employee; all names and identifying information were removed. Data were examined for possible entry errors, including inconsistencies and outliers. Data from the study variables were available in different files, which were combined into one study file. Missing, minimum, and maximum values were also checked for accuracy. Data that were not eligible for examination as a part of the study (e.g., data coded 8, 9, and 10) were excluded.

Statistical Analyses

A generalized linear model (GLM) was fit to the data with annualized time (BINS, 1 through 5) as the focal predictor variable and two outcome variables: (1) ceremony or no ceremony (binary), and (2) ceremonial emphasis (ordinal). The noncontinuous nature of these outcome variables necessitated the use of GLM, extending linear regression through the utilization of logit link functions and maximum likelihood (ML) estimation (Aldrich & Nelson, 1984). The following covariates were included in the model in order to more accurately assess the focal variables of interest: (a) *Non-declinable funeral home charge* (basic cost of funeral goods and services plus transportation of the decedent's remains to the funeral home); (b) *Labor Market* (local labor market survey data from the Kingsport urbanized area); (c) *Retail Sales* (retail activity [per capita], also from the Kingsport urbanized area); and (d) *Geographic location* (Kingsport or Fall Branch, TN). Among these covariates the first three provided additional economic information; these were grand mean centered and appropriately scaled prior to conducting the analyses. The fourth covariate was an indicator variable included to address possible model clustering around one of the two geographic points of interest, located within 11 miles of one another. Given the nature of the outcome variables (one binary, the other ordinal)

logistic (or logit) regression was utilized for these analyses, with the ordinal data analyzed using an ordered logit model. Analyses were conducted with IBM SPSS Statistics (Version 21, Release 21.0.0.0, IBM Corp., 2012).

The logistic regression model was run four times (twice per outcome variable). For each outcome variable (binary: ceremony/no ceremony; ordered categorical: ceremonial emphasis) the model was run once excluding the covariates (geographic location, non-declinable funeral home charge, employment, and retail sales) and a second time including them.

Table 2

Summary Description of Outcome Variable Coding

Variable	Original Number (Coding) of Item	Ceremonial Emphasis: Ordered Categorical Outcome Variable Coding	Binary Outcome Variable (Ceremony / No Ceremony) Coding
Direct Cremation	5	1	0
Burial Partial Service	3	2	1
Cremation Partial Service	6	2	1
Funeral Same Day Visitation	4	3	1
Funeral/Burial Evening with Visitation	1	4	1
Funeral/Burial Day prior Visitation	2	4	1
Cremation Full Service	7	4	1

CHAPTER 4

RESULTS

The sample consisted of 2,581 funeral service records collected during the five year period (from January, 2008 through December, 2012). No data were missing. Because multicollinearity can be problematic in regression models, prior to running any data analyses all correlations in the model were examined. Two of these, the non-declinable funeral home charge and the local labor market indicator, were greater than $r=.7$. This indicated that these variables were both inter-correlated with the focal predictor variable of annualized time (BINS). Following additional multicollinearity testing, iterative ordinary least squares (OLS) regression indicated the tolerance limit for the non-declinable funeral home charge was below the acceptable limit of .2 (O'Brien, 2007), thus it was removed from the model. Also, the labor market indicator variable was highly correlated ($r=.895$) with time BIN 4, therefore it was likewise withdrawn from the model.

Here it should be noted that OLS regression was utilized only for the purposes of multicollinearity diagnostics (e.g., variance inflation factors [VIF's] and tolerance), as OLS is would not an appropriate model for use in this context otherwise. This usage was acceptable because multicollinearity affects only the "X" (predictor) side of the model equation; the behavior of the "Y" (outcome) side of the equation had no consideration in assessing multicollinearity.

A binary logistic regression was then run in SPSS with annualized time (BINS) as a predictor of the binary outcome variable (ceremony/no ceremony). An omnibus test of the fitted model against that of a constant/intercept-only model was not statistically significant, indicating that time alone—irrespective of covariates— did not reliably predict whether there would be a

funeral ceremony or not [$\chi^2(4) = 6.558, p = .161$]. The binary outcome data (ceremony/no ceremony) by location, and across time bins, are shown in Figure 2 (descriptive) and Figure 3 (inferential).

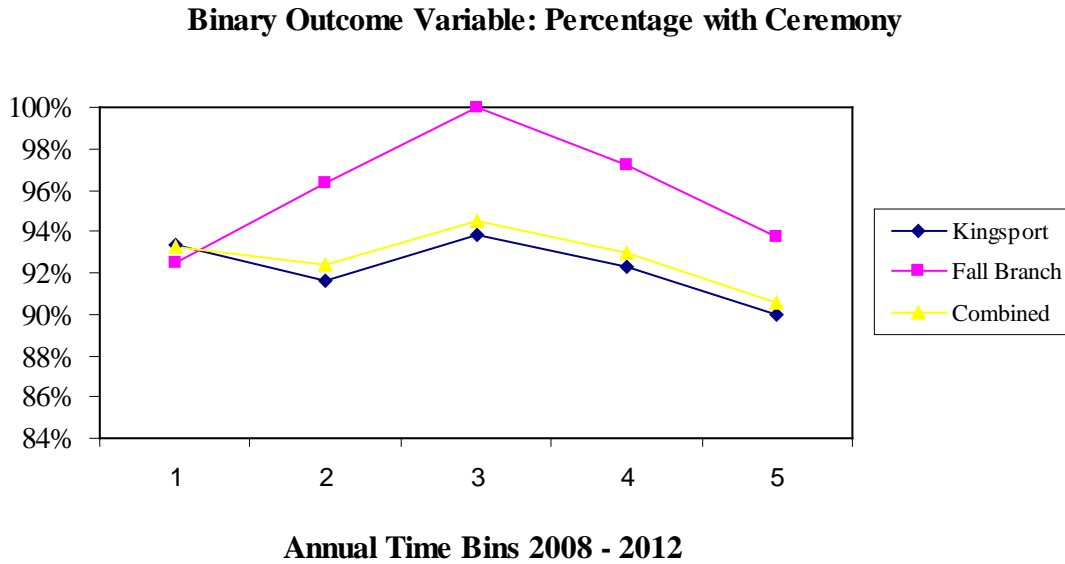


Figure 2. Binary Outcome Variable: Percentage with Ceremony by Location Across Time Bins

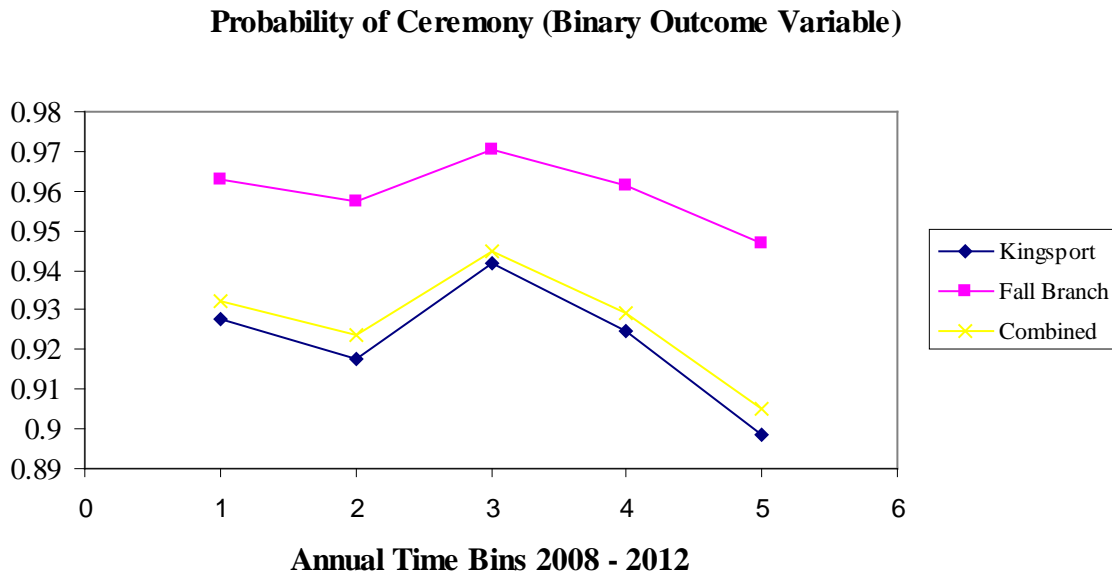


Figure 3. Probability of Ceremony (Binary Outcome Variable) by Location Across Time Bins

Running the second, ordered logistic regression indicated problems due to a violation of the proportional odds assumption (also known as the parallel lines or parallel regression assumption). One of the assumptions of ordered logistic regression is that the pairings of outcome groups are similarly related (i.e., the coefficients describing the relationship between categories are the same irrespective of which categories are being compared/contrasted). In this case, they were not (the assumption was not met); therefore a multinomial logistic rather than ordinal (as originally planned) regression model was utilized.

The following requirements of multinomial logistic regression were met: (1) the dependent variable was non-metric and the independent variables were metric or dichotomous; (2) the minimum ratio of valid cases to independent variables was at least 10 to 1; and (3) the preferred ratio of valid cases to independent variables (20 to 1) was exceeded. The ratio of valid cases ($N = 2,156$) to the number of independent variables (7—retail spending, location, and time BINS 1-5) was 308 to 1.

Inspection of model predictors/covariates in relation to the outcome variable indicated that the Fall Branch location only had three cases categorized as emphasis 3 (the designation for funerals preceded or followed by a visitation on the same day—rather than funerals spanning at least two days) in the entire sample, thus the emphasis variable was collapsed to three levels—with codes 3 and 4 being combined to form category 3 in order to reduce model instability. Thus the “new” category 3 included all cases from categories 3 and 4, with categories 1 and 2 remaining the same.

Ceremonial emphasis (merged as described above) was regressed using a multinomial logistic model in SPSS with annualized time (BINS) as the only predictor. Model fitting information indicated a statistically significant difference between the final model (including the

predictor) and the intercept-only model, suggesting that annualized time (BINS) reliably predicted the degree of ceremonial emphasis [$\chi^2(8) = 149.570, p < .001$; see Table 3] in the absence of covariates.

DeMaris (1995) has noted that “Predicted probabilities are perhaps most useful when the purpose of analysis is to forecast the probability of an event, given a set of...characteristics” (p. 962). Since the focus of these analyses was primarily predictive (was there a ceremony or not, and, if so, then what was its degree of ceremonial emphasis—and how well were these predicted by annualized time), the results in this study were interpreted in terms of probability rather than in terms of odds. This was done by substituting sample parameter estimates into the logistic regression equation, $\log(\pi/1-\pi) = \alpha + \beta_1X_1 + \beta_2X_2 + \dots + \beta_KX_K$, which provided the estimated log odds, or logit. The $\exp(\text{logit})$ therefore represented the estimated odds, and the probability was indicated by $\text{odds}/(1 + \text{odds})$. The latter is conventionally referred to as the inverse logistic (logit) transformation.

Also, since the interest of this inquiry was each level of ceremony in comparison with the other two (1 vs. 2 + 3, 2 vs. 1 + 3, and 3 vs. 1 + 2), the data were dummy coded and a binomial logistic regression was run to obtain the probabilities of each level of emphasis as compared with the other two levels combined (see Figure 4).

Ceremonial Emphasis (Merged)

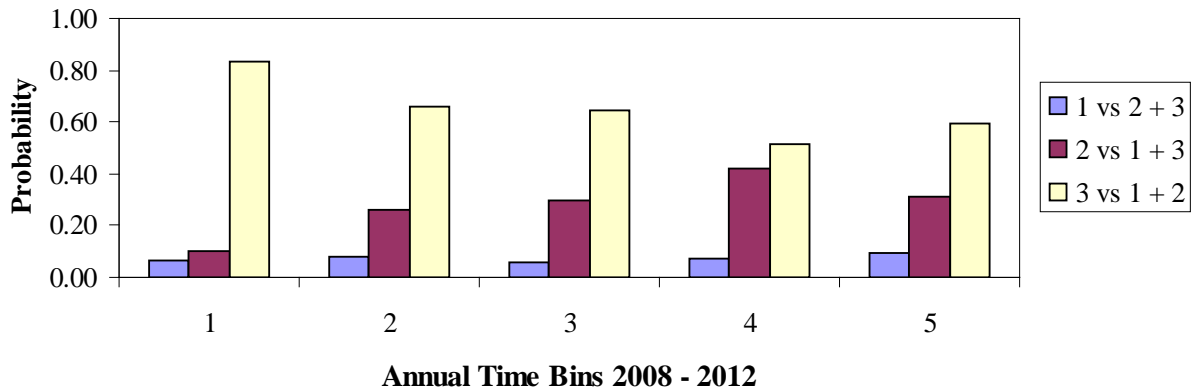


Figure 4. Ceremonial Emphasis (Merged) Probabilities Across Time Bins (lower level = less ceremonial emphasis)

Having sought to avoid the potential pitfalls of result interpretation at times associated with odds ratios, it should be noted that interpreting estimated probabilities can also be misleading. For example, less than half the model's estimated parameters were statistically significant, and the implications of predictors between/among levels of the outcome variable can be tricky to interpret—particularly given the structuring of comparison(s) relative to the reference categories in SPSS (see Table 3 for additional detail of model parameter estimates).

Thus when considering the threshold between ceremonial emphases 1 and 2, annualized time (BINS 1 and 4) are both statistically significant in comparison with BIN 5 (controlling for the covariates of retail spending and location). BIN 1 has an inverse or negative relationship (i.e., in contrasting BINS 1 and 5, ceremonial emphasis decreased), and BIN 4's association is positive (when comparing annualized time BINS 4 and 5, there was a statistically significant increase in ceremonial emphasis).

Table 3

*Summary of Logistic Regression Analysis for Variables Predicting Merged Ceremonial**Emphasis (N = 2,581) Controlling for Location and Retail Spending*

Parameter	Ceremonial Level 2			Ceremonial Level 3		
	B	SE B	Sig.		SE B	Sig.
Intercept	1.27			1.85		
Annualized Time BINS						
BIN 1	-.87**	.29	.003	.62*	.25	.012
BIN 2	-.11	.27	.698	.05	.25	.858
BIN 3	.39	.27	.156	.47	.26	.072
BIN 4	.10*	.23	.019	.09	.23	.694
BIN 5 (reference)						
Location						
Fall Branch	.01	.31	.989	.936***	.29	.001
Kingsport (reference)						
Retail Spending	-.04	.04	.258	-.08*	.03	.023

Note: Controls are location (Kingsport or Fall Branch) and retail spending (grand mean centered and scaled). Exponentiated B (e^B) is not reported. Levels of ceremonial emphasis (1 = Direct Cremation; 2 = Burial Partial Service, Cremation Partial Service; and 3 = Funeral Same Day Visitation, Funeral/Burial Evening with Visitation, Funeral/Burial Day Prior Visitation, Cremation Full Service) are compared to the reference category (1). The reference category for annualized time (BINS) is BIN 5, 2012. * $p < .05$. ** $p < .01$. *** $p = .001$ (see also significance column). The reference category for ceremonial emphasis is Level 1. The reference category for location is Kingsport, TN. Note that all standard errors are < 2 .

As regards a comparison of ceremonial emphases 1 and 3, retail spending, location, and BIN 1 (as compared to BIN 5) are statistically significant. Of these, it is somewhat surprising that retail spending is the only variable with an inverse or negative relationship to the outcome variable of interest (i.e., ceremonial emphasis decreases as retail spending increases when comparing emphases 1 and 3).

Scenario descriptions are a technique sometimes employed to better understand the interplay of impacts of multiple predictors in regression models. In this case, however, they do not—when considered in concert—aid in explaining the statistically significant model parameters' relationship(s) to the outcome variable.

Therefore, although some modest degree of incremental change is apparent, weaving together strands of statistical significance does not result in a meaningful overall explanation of how (and/or why) that change may be taking place. While not statistically insignificant, closer inspection reveals less than conclusive specificity around the underlying change mechanisms in the model. As such, readers should be wary of interpretations based solely on appearance (such as the apparent downward trend in ceremony/ceremonial emphasis implied in Figures 3 & 4 above); evidence supporting clarity around such a patterned change is not overtly borne out by these data on closer inspection. Thus gauging the statistical significance of these results is easier than assessing their substantive significance.

CHAPTER 5

DISCUSSION

Analysis

Longitudinal funeral service type data over the span of five years (2008 – 2012) that were collected from two very specific geographical locations (Sullivan and Washington counties, in northeast Tennessee) do not indicate a statistically significant trend regarding the presence or absence of funerary rituals. Thus, in this limited sample, these results do not support a dichotomized shift (ceremony/no ceremony) in ritualization following a death. Taken in tandem with descriptive information, however, these data also do not rule out a downward trend. Further research is needed to clarify the relationship's directional and durational strength, or possible lack thereof.

These data underscore the probable, subtle alterations in ceremonial emphasis of ritual response to death occurring over the course of time (as annually categorized). Such prospective changes are indicated even while controlling for the covariates of retail spending and geographic location (which also provide evidence as having an impact on ceremonial emphasis).

On the one hand, then, these results appear to go against the notion that funerals are somehow becoming increasingly endangered, which is not surprising given that this is an area (south central Appalachia) that is often considered to be less open to change(s) that counter convention (Crissman, 1994). On the other hand, these results allow for the prospect of incremental alterations in the ceremonial emphasis of ritual response to death, as influenced by the passage of time (demarcated annually), economic impacts (relative to retail spending), and geographic location (even at distances as short as 11 miles—the space between the two co-owned funeral homes examined in this study).

Implications

Whereas this examination may not have substantially reduced uncertainty around possible trends related to funerary ceremonialization, it is not without substantive implications. Results of the current study and its context have revealed the need for clarification in several areas. These include: (1) definitional coherence, (2) an enhanced understanding of funeral cost, and (3) an improved apprehension of the timing of ceremonial response to death.

Although it is likely that the meaning(s) of bereavement, grief, and mourning will remain intertwined, elements of the latter (mourning) merit further scrutiny. Most notably, public perception of cremation's relationship to the mourning process has likely been misconstrued. Cremation is a means of final disposition of human remains; as with burial (or other options, such as the aforementioned alkaline hydrolysis), cremation should not— due to a public misunderstanding of its meaning— delimit ceremonial possibilities.

As Lubrant (2013) has noted (and as mentioned above), the means of final disposition of the decedent does not necessarily dictate ceremonial elements prior to that point, such as viewing of the body (as part of a visitation and/or funeral service). This was a definitional flaw of the AARP's (2007) survey of funeral consumer perceptions, wherein the questionnaire falsely differentiated cremation as an *alternative* to the (traditional) funeral. The ramifications of this misunderstanding are particularly significant given evidence supporting the viewing of the body of the deceased as a potentially healthful component in the mourning process, particularly under certain circumstances—such as unanticipated death and/or following the death of a child (Ahrens et al., 1997; Deatherage, 2014; Harrington & Sprowl, 2011; Jost & Haase 1989).

This relates to a second needed clarification implied by this research, which relates to funeral cost. Cremation is consistently considered to be less costly than earth burial as a means

of final disposition (Banks, 1998, 2003; Gross, 2007; Hingston, 2013; Walsh, 2014). When taken in tandem with the common misperception that cremation is a less-ceremonialized (or de-ceremonialized) alternative to the funeral, consumers (particularly during difficult economic periods—such as the one under consideration in this study) may make choices based upon expense alone. Thus there is the potential for selecting options with fewer benefits (depending on the circumstances surrounding the death) based solely on cost-related concerns. These choices may not, however, be mutually exclusive (i.e., there may less expensive funeral alternatives that include more ceremonial elements—and are followed by cremation as a means of final disposition). This scenario may also be related to pre-arranged funerals and advance directives, where the person making prior arrangements focuses on matters related primarily to cost, but the context of her or his eventual death indicates better options otherwise.

A third possible implication of these results is to consider further exploration and implementation of needed changes to funeral service provision now. Although it is unclear what change(s) in funerals were occurring prior to (or since) the data included in this study were collected, these results indicate that, at a minimum, some change has been recently occurring (even within what is conventionally considered to be a more traditional population). Thus if there are known alterations that would improve the overall effectiveness of funerals, then implementing those changes should be considered sooner rather than later—particularly in change-resistant areas.

For example, research indicates that the timing of the funeral is often too soon following the death to be of maximum value to those closest to the deceased (Sullivan, 1981). Although offering an allowance for delaying funeral services may seem counter-intuitive to funeral service providers initially, and selecting such an option may not appeal to some client families at first

either, these data indicate a certain measure of openness to change, one that may not last indefinitely. Such a tailored improvement could also enhance service provision given the fact that friends and family of the deceased are likely at a greater distance than in the past (Gross, 2007), thus allowing more time for planning and travel to the ceremonial destination.

Strengths and Limitations

This study's sample is limited in several ways: (1) geographically (focused on residents of two counties in the south central Appalachian region of northeast Tennessee); (2) ethnically, racially, and demographically (residents of these counties are far less diverse than the country as a whole in each of these areas—less so for the latter); and (3) as noted previously, these data were compiled from two funeral homes owned by one family (thus increasing the prospect of selection bias—there are five other funeral homes located in closer proximity to these firms than they are to one another). The brevity of the study's time span is also a potential weakness. Each of these limitations may negatively impact the study's generalizability.

One strength of this study is its novelty. Empirical research focused on funeral service type has not been conducted in this or other regions, opening the prospect that similar examinations could be expanded to additional areas. Ideally such an expansion would address some of the aforementioned weaknesses of the current investigation.

The overarching implication of this research, then, relates to its novelty in that this study's results do not support a trend that is frequently publicized. These data do not confirm the central idea that funerals are declining in their rate of occurrence.

Future Research Directions

As noted previously, although data for this research spanned 5 years, the time period should be extended. The timing of the data collected for the current examination coincided with

an historically significant downturn in the economy, both locally and nationally, making it difficult to draw conclusions from it in the long-term.

For example, it is possible that the modest uptick in ceremonial emphasis between time BINS 4 and 5 was a result of regional economic stabilization toward the study's conclusion (2011-2012). It is also possible, however, that declinations in ceremonial emphasis—irrespective of their precipitating mechanisms—may remain in place (i.e., they will persist even after some factors influencing initial changes in them return to previous levels).

As noted previously, an expansion of this research to other regions, particularly those with more diverse populations, is also an important area to consider for future studies. Methodological diversity may be beneficial in future research as well, with mixed-methods approaches integrating qualitative aspects of loss response that are essential to an enhanced understanding of grief.

Finally, although it has been increasingly accepted that funerals (and their ceremonial emphasis) are in a state of decline, these data do not clearly support that purported trend. This research therefore highlights the necessity for additional empirical investigation of factors related to grief and mourning—not only regarding funerals, but in relation to other aspects of the bereavement literature as well. The standard call that “further research is needed” seems understated.

Conclusion

Death and the response(s) to it are challenging to isolate and assess. Even though death is universal, bereavement is personal, often making the research of grief and its associated variables difficult to study empirically. This difficulty should not preclude its study, however.

Rather than discourage additional empirical research, these factors should instead encourage it.

An appropriate response to mystery is one of investigation.

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APPENDICES

Appendix A: Symptoms of Acute, Integrated, and Complicated Grief

COMMON SYMPTOMS OF ACUTE GRIEF THAT ARE WITHIN NORMAL LIMITS WITHIN THE FIRST 6–12 MONTHS FOLLOWING LOSS

- Recurrent, strong feelings of yearning, wanting very much to be reunited with the person who died; possibly even a wish to die in order to be with deceased loved one
- Pangs of deep sadness or remorse, episodes of crying or sobbing, typically interspersed with periods of respite and even positive emotions
- Steady stream of thoughts or images of deceased, may be vivid or even entail hallucinatory experiences of seeing or hearing deceased person
- Struggle to accept the reality of the death, wishing to protest against it; there may be some feelings of bitterness or anger about the death
- Somatic distress, e.g. uncontrollable sighing, digestive symptoms, loss of appetite, dry mouth, feelings of hollowness, sleep disturbance, fatigue, exhaustion or weakness, restlessness, aimless activity, difficulty initiating or maintaining organized activities, altered sensorium
- Feeling disconnected from the world or other people, indifferent, not interested or irritable with others

SYMPTOMS OF INTEGRATED GRIEF THAT ARE WITHIN NORMAL LIMITS

- Sense of having adjusted to the loss
- Interest and sense of purpose, ability to function, and capacity for joy and satisfaction are restored,
- Feelings of emotional loneliness may persist
- Feelings of sadness and longing tend to be in the background but still present
- Thoughts and memories of the deceased person accessible and bittersweet but no longer dominate the mind
- Occasional hallucinatory experiences of the deceased may occur
- Surges of grief in response to calendar days or other periodic reminders of the loss may occur

COMPLICATED GRIEF

- Persistent intense symptoms of acute grief
- The presence of thoughts, feelings or behaviors reflecting excessive or distracting concerns about the circumstances or consequences of the death

(Shear et al., 2011)

Appendix B

Differentiating Normal Grief and Persistent Complex Bereavement Disorder

<u>Normal (“Uncomplicated”) Grief</u>	<u>Persistent Complex Bereavement Disorder</u>
<ul style="list-style-type: none"> • Complicating processes are not present, are mild or are more transient 	<ul style="list-style-type: none"> • Complicating processes are prominent and persistent
<ul style="list-style-type: none"> • More severe grief progressively becomes less acute over time 	<ul style="list-style-type: none"> • Counterfactual, “if only” rumination
<ul style="list-style-type: none"> • Pangs of grief lessen in frequency 	<ul style="list-style-type: none"> • Excessive avoidance and health impairing behaviors
<ul style="list-style-type: none"> • Gradual acknowledgment of the finality of the death—with progressively reduced longing and yearning 	<ul style="list-style-type: none"> • Ineffective emotion regulation
<ul style="list-style-type: none"> • Memories of the decedent are interspersed with other memories and thoughts 	<ul style="list-style-type: none"> • Acute grief persists
<ul style="list-style-type: none"> • Social engagement and pleasure in life gradually return 	<ul style="list-style-type: none"> • Pangs of grief are persistent, prolonged and/or very intense
	<ul style="list-style-type: none"> • Difficulty accepting the finality of the death with persistent intense yearning/longing
	<ul style="list-style-type: none"> • Preoccupation with thoughts of the deceased
	<ul style="list-style-type: none"> • Social withdrawal and avoidance are pronounced

(APA, 2013a, 2013b, 2013c)

Appendix C

Rationales for the *Bereavement Exclusion's* Removal from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)

1. The duration of bereavement is typically much longer than 2 months; physicians and grief counselors estimate its durational course at one to two years (APA, 2013a). Research also indicates that grief is “much more prolonged than generally expected,” often remaining present four years after the death (Zisook & Shuchter, 1985, p. 95).
2. Bereavement is an acute psychosocial stressor that can possibly trigger a major depressive episode, especially in vulnerable individuals. Because bereavement can add an additional risk for suffering, feeling worthless, suicidality, poor physical health, and interpersonal and work-related dysfunction, complications due to bereavement should not be diagnostically excluded at any point in its course if clinical judgment indicates otherwise (APA, 2013a).
3. There is additional risk of bereavement-related major depression for individuals with past family and personal histories of major depressive episodes. Given the complex interplay between bereavement-related depression’s genetic influence, association with similar personality traits, pattern of comorbidity, and propensity toward chronicity, exclusionary language could risk under-diagnosis (APA, 2013b).
4. Some depressive symptoms linked to bereavement-related depression may respond to therapeutic and pharmacological interventions that have shown efficacy in treating non-bereavement-related depression (APA, 2013c).
5. Grief is not unique as a life stressor capable of precipitating a major depressive episode, nor is grieving the only life stressor wherein depression-like symptoms may remit in brief duration, possibly even spontaneously (APA, 2013b).

Appendix D

Differentiating Normal Grief and Major Depressive Disorder (MDD)

<u>Normal Grief</u>	<u>Major Depression</u>
<ul style="list-style-type: none"> • Primary affect is one of emptiness and loss 	<ul style="list-style-type: none"> • Persistent and pervasive depressed mood and the inability to anticipate happiness or pleasure
<ul style="list-style-type: none"> • Dysphoric feelings decrease in intensity over days to weeks, occur in <i>waves</i>, and are often associated with reminders of decedent 	<ul style="list-style-type: none"> • Self-critical or pessimistic ruminations
<ul style="list-style-type: none"> • Positive emotions and humor can coexist with sadness related to grief 	<ul style="list-style-type: none"> • Pervasive unhappiness and misery
<ul style="list-style-type: none"> • Thoughts are often focused on memories of the deceased 	<ul style="list-style-type: none"> • Dysphoria is more persistent
<ul style="list-style-type: none"> • Self-esteem is typically maintained 	<ul style="list-style-type: none"> • Feelings of worthlessness and self-loathing are not uncommon
<ul style="list-style-type: none"> • If self-derogatory thoughts occur, they normally center on perceived failings prior to the loved one's death (e.g., not visiting often enough or not sufficiently expressing caring and affection) 	<ul style="list-style-type: none"> • Thoughts about death and dying (and suicidality) are more likely focused on ending one's own life because of feelings of worthlessness, of being undeserving of life, and/or due to an inability to cope with the extreme pain of depression
<ul style="list-style-type: none"> • Thoughts about death and dying are generally focused on the deceased and possibly joining her/him 	<ul style="list-style-type: none"> • Negative feelings are unlinked to any specific thoughts or preoccupations

(APA, 2013a, 2013b, 2013c)

Appendix E

Persistent Complex Bereavement Disorder (PCBD) Criteria

Proposed as a condition for further study in DSM-5 (APA, 2013a, pp. 789-790), diagnostic criteria for persistent complex bereavement disorder are as follows:

- A. Since the death, at least one of the following symptoms is experienced on more days than not to a clinically significant degree and has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:
- B. Since the death, at least one of the following symptoms is experienced on more days than not to a clinically significant degree and has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:
 - 1. Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including behaviors that reflect being separated from, and also reuniting with, a caregiver or other attachment figure.
 - 2. Intense sorrow and emotional pain in response to the death, including frequent crying.
 - 3. Preoccupation with the deceased.
 - 4. Preoccupation with the circumstances of the death (e.g. the manner in which the person died). In children, this preoccupation with the deceased (or circumstances of the death) may be expressed through the themes of play and behavior and may extend to preoccupation with possible death of others close to them.
- C. Since the death a) at least six of the following symptoms are experienced on more days than not and to a clinically significant degree, and b) have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:

Reactive distress to the death

- 1. Marked difficulty accepting the death (e.g. preparing meals for them). In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.
- 2. Experiencing disbelief or emotional numbness over the loss.
- 3. Difficulty with positive reminiscing about the deceased.

4. Bitterness or anger related to the loss.
5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g. self blame).
6. Excessive avoidance of reminders of the loss (e.g. avoidance of individuals, places, or situations associated with the deceased; in children, this may include avoidance of thoughts and feelings regarding the deceased).

Social/identity disruption

7. A desire to die in order to be with the deceased.
 8. Difficulty trusting other individuals since the death.
 9. Feeling alone or detached from other individuals since the death.
 10. Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased.
 11. Confusion about one's role in life, or a diminished sense of one's identity (e.g. feeling that a part of oneself died with the deceased).
 12. Difficulty or reluctance to pursue interests since the loss or to plan for a future (e.g., friendships, activities).
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The bereavement is out of proportion to or inconsistent with cultural, religious, or age-appropriate norms.

Specify if:

With traumatic bereavement: Bereavement due to homicide or suicide with persistent distressing preoccupations regarding the traumatic nature of the death (often in response to loss reminders), including the deceased's last moments, degree of suffering and mutilating injury, or the malicious or intentional nature of the death.

(APA, 2013a, pp. 789-790; *not for clinical use*--a p. 783)

Appendix F: Persistent Complex Bereavement Disorder (PCBD):

Syndrome Epidemiology, Outcomes, and Etiology

PCBD occurs in both genders. It may occur at any age above 12 months, and an increase in age typically correlates with an increase in prevalence (APA, 2013a). There is a paucity of methodologically sound studies regarding the prevalence of complicated grief in the general population, with research often focusing on elderly populations, aged 60+ (Maercker & Lalor, 2012). The conditional probability, or proportion of bereaved persons who develop PCBD, has been reported to be approximately 10% (Middleton, Raphael, Burnett, & Martinek, 1998).

Genetic/physiological risk for PCBD is increased by being female. An increased dependence on the deceased person before his or her death, such as is the case in the death of a child's caregiver, increases the risk for PCBD; risk is also heightened in the case of the death of a child or traumatic death by violent means—including, but not limited to, death by suicide (APA, 2013a).

Piper, Ogrodniczuk, Joyce, and Weideman, (2011) combined grief complication risk factors into four areas: (1) The nature and means of the death (such as a sudden death, suicidal death, multiple deaths, accidental death, or homicide); (2) Survivor's demographical background and biographic situation, personality traits, and coping styles (significant in a clinical context, these accounted for the most variability of the four categories); (3) The quality of the relationship with the deceased, which was also influenced by kinship and available social support; and (4) The situational context of the individual's loss experience—divided into antecedent, concurrent and/or subsequent stressors. A history of other mental disorders, particularly depression, anxiety-related, and/or personality disorders, as well as incomplete or unresolved response(s) to earlier loss(es), also exacerbate the risk of PCBD (APA, 2013a).

Appendix G

Differentiating Post Traumatic Stress Disorder (PTSD)

and Persistent Complex Bereavement (PCBD)

Traumatic death may result in the survivor's developing post traumatic stress disorder (PTSD) concurrent with persistent complex bereavement disorder (PCBD). For differentiation, DSM-5 (2013a) cites the following distinguishing characteristics and concerns:

- (1) The locus of intrusive memories for PTSD typically center on the traumatic event, whereas those in PCBD focus on the relationship with the deceased (including a spectrum of positive and negative remembrances)
- (2) Yearning for the deceased and a preoccupation with the loss are often absent in PTSD. Even so, it merits mentioning that although the PCBD criteria set is not intended for clinical use at present, DSM-5 lists this condition as an allowable designation under Other Specified Trauma- and Stressor-Related Disorder.
- (3) Mapping the nuanced terrain between PTSD and the traumatic bereavement specifier of PCBD would appear to be daunting; consider, for example, the purported value of concurrently diagnosing PTSD and the traumatic bereavement specifier of PCBD.

(APA, 2013a)

Appendix H

Differentiating Persistent Complex Bereavement Disorder (PCBD)

and Major Depressive Disorder (MDD)

PCBD resembles MDD because of prominent sadness, loss of interest and pleasure, sleep disturbance, and guilt, but *differences* include:

<u>Major Depressive Disorder (MDD)</u>	<u>Persistent Complex Bereavement Disorder</u>
<ul style="list-style-type: none"> • Yearning and longing not usually seen 	<ul style="list-style-type: none"> • Persistent intense yearning and longing
<ul style="list-style-type: none"> • Pervasive loss of interest and pleasure 	<ul style="list-style-type: none"> • Things unrelated to loved one are uninteresting
<ul style="list-style-type: none"> • Pervasive dysphoric mood across situations 	<ul style="list-style-type: none"> • Pangs of emotion triggered by reminders of loss
<ul style="list-style-type: none"> • Preoccupation with low self esteem 	<ul style="list-style-type: none"> • Preoccupation with the deceased
<ul style="list-style-type: none"> • General sense of guilt or shame 	<ul style="list-style-type: none"> • Guilt and self blame focused on death
<ul style="list-style-type: none"> • General withdrawal from activities and people 	<ul style="list-style-type: none"> • Avoidance of activities, situations and people that trigger reminders
<ul style="list-style-type: none"> • Intrusive images are <i>not</i> prominent 	<ul style="list-style-type: none"> • Frequent, recurrent, intrusive images of the deceased
	<ul style="list-style-type: none"> • The initial trajectory is usually toward gradual improvement of symptoms

(Shear, 2015; Shear, Frank, Houck, & Reynolds, 2005)

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