Pathological Grief: The Attitudes And Perceptions Of Maltese Society

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DECLARATION

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Pathological grief: The attitudes and perceptions of Maltese society

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30.04.2013
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Abstract

This study seeks to investigate Maltese society’s cultural attitudes towards pathological grief and thereby obtain an understanding of the point at which locals believe typical grief patterns become a concern that requires clinical intervention. A qualitative approach was adopted as it allows for an in-depth understanding of the personal opinions and perceptions of locals and professionals. Two focus groups were conducted amongst university students and the other amongst psychologists. Data was analysed thematically and yielded four main themes, namely: distinction between normal and prolonged grief, variables influencing course of grief, manifestations of grief, and categorisation of grief. Responses indicated that locals place a greater importance on behavioural manifestations of grief than emotions, preferring to be seen grieving while avoiding talking about their loss. The focus groups conducted suggest that locals expect: the grieving phase to last for more than 12 months, and marked functional impairment, beyond which therapeutic help is recommended.

Key words: Pathological, Grief, Attitudes, Perceptions, Maltese society
Acknowledgements

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Finally, I would like to thank my family for their endless support and enduring patience particularly during the final weeks of my writing this dissertation, when I may not have been the most pleasant person around - my siblings Ilaria and Nicholas who humoured me and helped me immensely with proofreading my endless drafts.
The Elephant in the Room (Terry Kettering)

There’s an elephant in the room.

It is large and squatting,
so it is hard to get around it.

Yet we squeeze by with,
“How are you?” and, “I’m fine”,
and a thousand other forms of trivial chatter.

We talk about the weather;
we talk about work;
we talk about everything else
except the elephant in the room.

There’s an elephant in the room.
We all know it is there.
We are thinking about the elephant
as we talk together.

It is constantly on our minds.
For, you see, it is a very big elephant.
It has hurt us all, but we do not talk about
the elephant in the room.

Oh, please, say her name.
Oh, please, say “Barbara” again.
Oh, please, let’s talk about
the elephant in the room.
For if we talk about her death,
perhaps we can talk about her life.
Can I say, “Barbara” to you
and not have you look away?

For if I cannot,
then you are leaving me, alone,
in a room with an elephant.
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1. INTRODUCTION

1.1 Objectives

The aim of this research project is to investigate what Maltese society’s cultural attitudes and perspectives are towards prolonged grief. At the same time an idea on whether the current proposals being put forward for the fifth Diagnostic and Statistical Manual of Mental Disorders (DSM) are applicable to Maltese culture may also be obtained. I shall be collecting data by conducting two focus groups; one amongst clinical and counselling psychologists, and the other amongst University students.

1.2 Background

Bereavement is a normal, universal experience to loss associated with psychological and functional impairment to which most individuals adequately adjust (Kerstig, Brahler, Glaesmer, & Wagner, 2010; Prigerson et al., 2009). Throughout history, mourning rituals, beliefs, and practices have facilitated this transition. Yet, it appears that in a few individuals, grief can become severe and take the pathological form of complicated grief (CG) or prolonged grief (PG) (Kersting et al., 2010). Having said that, it is clear that there is a lack of agreement on the terminology used to describe chronic grief. For the purposes of my dissertation I shall be using the terms interchangeably.

Literature presents a number of explanations and viewpoints on grief. For instance, Freud (1917/1957) viewed grief as a normal, yet painful experience that involved a necessary, but time-limited process of mourning. Contrastingly, Bowlby (1980) used his theories on attachment to elucidate a new hypothesis on grief. Furthermore, he placed a particular emphasis on grief as a universal feeling of loss, and concentrated his work on the major emotional consequences of loss namely: sadness, depression, grief and
bereavement. On the other hand, Engel (1961) focused his research on whether grief is a disease, and concluded that: “the experience of uncomplicated grief represents a gross departure from the state considered representative of health and well being” (p. 20).

At this stage I believe it is important, although difficult to draw the line, to define when behaviour is considered to be abnormal or excessive as well as what the pathological form of grief is. The definition of abnormal behaviour generally differs across cultures and societies, yet a common ground has been the violation of said society’s norms or rules for correct behaviour. ‘Behaviour that is statistically rare, causes personal discomfort to the person who exhibits it, or is maladaptive, may also be considered abnormal’ (Alloy, Riskind, & Manos, 2005, p. 24).

Naturally, the treatment of abnormal behaviour is dependent upon a given society’s explanation of that behaviour as well as the criteria used to identify or define abnormality. Throughout history, there have been several attempts at explaining and treating non-normative behaviour. For instance the Greeks, Hippocrates in particular, believed that all illnesses were due to natural causes, whereas in the Middle Ages, insanity was believed to be controlled by supernatural forces and thereby treated symptoms with various forms of exorcism (Alloy, Riskind, & Manos, 2005). Nevertheless, the greatest influence occurred in the late 19th Century when Emil Kraeplin developed the first comprehensive classification system for mental disorders which influence all subsequent systems. Eventually, in 1952, the American Psychiatric Association (APA) published its own version of the system; the DSM. This is a manual that essentially provides a foundation for the diagnosis of mental illnesses in the Western world. Each category in the DSM has a description of the disorder in question as well as a set of specific criteria that are required for diagnosis.
The revised fourth edition of the DSM (DSM-IV-TR) defines the above-mentioned criteria by describing the essential features of the disorder, the associated features, listing the symptoms that must be present for a diagnosis, and providing sufficient data that explains how to distinguish the disorder from another. All these features are presented on five axes: the specific syndrome being diagnosed, long standing personality disorders, relevant medical problems, psychosocial and environmental problems, and a numerical assessment of the patient’s levels of adjustment and of the current degree of impairment (Alloy, Riskind, & Manos, 2005).

Presently, there are no fixed or universal definitions of prolonged grief, nor does it appear to be established as a clinical entity in any of the available diagnostic entities. Researchers have come up with a number of explanations based on their own elucidations on the matter and consequently there is still a significant amount of deliberation taking place. This is potentially due to the vague boundary between what is considered to be normal grief, and its pathological form. Nonetheless, chronic grief has commonly been described by a number of researchers (Horowitz et al., 1997; and Prigerson, 1999; in Gentile, 2004) as a maladaptive reaction to bereavement that manifests itself as psychological and physical impairments (Tomita, & Kitamura, 2002; in Gentile, 2004). Moreover, some researchers base their descriptions on the intensity, onset or duration of grief, while others also account for the circumstances of the loss, together with religious and cultural customs.

DSM-IV-TR also makes an indirect attempt at defining PG, however, its main focus is one that creates a distinction between major depressive episodes and bereavement. This edition suggests that mourning should not be attributed to a major depressive episode unless symptoms persist for more than two months or include marked functional
impairment (American Psychiatric Association (APA), 1994). However, throughout the years a number of researchers have criticised and raised several questions on the two-month criterion. Several studies have been conducted so as to establish PG as a separate diagnostic category, though this shall be discussed in the forthcoming chapter.

1.3 Design of study

Given the nature of my study and that no research exists in the field locally, I shall be adopting a qualitative approach as it allows one to obtain an in-depth insight into the personal and perceived opinions of locals and professionals. As previously stated, my data shall be gathered by means of two focus groups composed of 4-6 participants; one group of which includes University students, the other, clinical and counselling psychologists. Wilkinson (2003, p. 347) states that focus groups ‘are appropriate if the purpose of the research is to categorise or compare types of individual and the views they hold.’ Hence, focus groups are an ideal tool to collect data as the purpose of my research is to explore the participants’ attitudes towards the pathological form of grief.

The viewpoints of the participants will be analysed using thematic analysis. Boyatzis (1998) defines thematic analysis as ‘one of several processes that can be used to interpret and encode qualitative information’ (p. 4). It is a technique that increases researchers’ sensitivity and accuracy in understanding and interpreting observations about people, events, and situations (Boyatzis, 1998). A deeper insight into this technique shall be presented in my methodology.
1.4 Overview of forthcoming chapters

Following this brief introduction, Chapter 2 provides a deeper investigation into the literature pertaining to pathological grief and its current and future classification in the DSM. Chapter 3, aims at giving information about the methodology and methods used during the study. The analysis of the common themes that emerged from the focus groups are highlighted in Chapter 4; while a discussion on the results obtained shall be presented in Chapter 5. Finally, in chapter 6, I shall be writing my concluding thoughts and also highlighting the limitations and implications of the study, as well as presenting recommendations for further research.
2. LITERATURE REVIEW

As mentioned in my introductory pages, grief reactions following the loss of a significant person are inevitable, normative processes. Although in most cases the mourning process restores the psychological equilibrium, in a few others, grief becomes chronic, indicating that some form of clinical intervention may be necessary. The purpose of my dissertation is to investigate what Maltese society’s cultural attitudes are towards grief; and through this insinuate when they believe the transition from a normal response to a disabling condition, warranting medical attention, occurs. With this in mind, in this chapter I intend to give a brief background on the history of normal grief and bereavement, as well as explore the current practices and suggestions being put forward for the DSM-V. This will be followed by a critical analysis of the proposal being put forward.

2.1 Grief, Bereavement and Mourning

McFarland Solomon (1977) correctly postulates that there is no universally acknowledged delineation of the experience of grief or bereavement. This is primarily because there is little empirical work - controlled laboratory experiments cannot be set up to simulate loss and grief, nor is it ethical to interview a recently bereaved person about their experiences. Arguably one can obtain relevant information in subsequent months following a grieving period. Furthermore, grief is not a state but rather a process which is unique to each individual. Reactions to bereavement may result from to the interaction of several variables including personality, societal and cultural proscriptions of behaviour, types of support available to the bereaved; and the quality and intensity of the attachment
to the person or object of loss. I shall be tackling this aspect in another section of my literature review.

The terms bereavement, grief and mourning have traditionally been used somewhat inconsistently. Nevertheless, it is now generally agreed that bereavement refers to the objective situation of having lost someone significant to death, whereas grief describes the wide variety of emotional, cognitive, and behavioural responses that normally follow the death of a loved one (Stroebe, Schut, & Stroebe, 2007). On the other hand, mourning refers to the public display of grief, the social expressions or acts expressive of grief that are shaped by the (often religious) beliefs and practices of a given society or cultural group (Stroebe, Hansson, Schut, & Stroebe, 2008).

The loss of an intimate relationship through death poses profound challenges to our adaptation as living beings. In part as an expression of an evolutionary heritage shared with other social animals, we respond to such separation with an array of seemingly hard-wired reactions, including weeping, behavioural disorientation, and yearning for the lost attachment figure (Bowlby, 1973, cited in Neimeyer, Prigerson & Davies, 2002).

The scientific study of grief is a comparatively young field of research (Stroebe et al., 2008). In fact, while reviewing literature, it became clear to me that this area has evolved significantly throughout recent years. Research has gradually moved away from the early notions of bereavement based on clinical population observations to more scientifically sound studies. The earliest studies date back to Freud whose most noteworthy contributions in this field concern the distinction between grief (mourning) and melancholia (morbid grief). This is explored in a paper he published in 1917, entitled ‘Mourning and Melancholia’. In his paper, Freud went on to propose that people whose
loved ones had died needed to work through the loss, in order to detach emotionally from the deceased and let go of hopes for a future relationship. Freud described the grieving process as one that involves hypercathecting and then decathecting the internal image of the lost object, the deceased person (Fraley & Shaver, 1999). According to Freud, if the act of decathecting fails to occur and an ongoing emotional relationship ensues, grief becomes pathological.

Subsequent psychoanalytic theorists carried Freud’s theory forward. For instance, Feifel (1977), as cited in Routhaupt and Becker (2007) stated that “the dead must die before we are able to redefine and reintegrate ourselves into life”. Furthermore, Lindemann’s article ‘Symptomatology and management of acute grief’ (1944) not only perpetuates the above notion that healthy resolution of grief involves breaking the emotional bonds with the deceased, but also proves to be the first researcher to use a more empirically sound method in the study of grief. Although this study has several limitations, (McFarland Solomon (1977), argues that no long-term follow-up was carried and hence no account on prolonged grief is available, also stating that the sample may not be representative of all grief sufferers), major emergent themes are common through all subsequent literature on grief. These include:

- Denial, especially in the initial stages;
- Somatic disturbances;
- Guilt feelings and anger;
- Identification with the person of loss;
- Pathological grief - an exaggeration of the symptoms of normal grief in terms of intensity and duration;
- Prolonged denial of loss, anxiety, depression and self-destructive urges.
As mentioned above, while early studies of bereavement had a significant amount of methodological shortcomings, more sophisticated research designs, methods and statistical techniques have led to an accumulation of research evidence and contributed to new understandings of grief (Stroebe et al., 2008). Moreover, studies on bereavement have also become more theoretically driven. I shall not be giving a detailed account of all the theories as it is not the purpose of this section, which was mainly designated to give a brief historical background of the early studies of grief and to support the forthcoming sections of my literature review.

The most prominent phase-model researchers that contributed to explaining the ‘grief-experience’ include Kübler-Ross (1969), Bowlby and Parkes (1970), Walsh and McGoldrich (2004). A summary comparing the main theories of grief can be found below in Table 1.

Table 1. Comparison of Western Theories of Grief (adapted from Rauthaupt & Becker, 2007)

<table>
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<tbody>
<tr>
<td>Process of hypercahetering &amp; then decathetering the mental image of the deceased person</td>
<td>Numbness; Searching and yearning for bereaved; Depression; Reorganisation</td>
<td>Denial; Anger; Bargaining; Depression; Acceptance</td>
<td>Shared acknowledgement of the reality of death. Shared experience of the loss. Reorganisation of the family system. Reinvestment in other relationships &amp; life pursuits.</td>
<td></td>
</tr>
<tr>
<td>Emotional detachment from loved one</td>
<td>Recover from loss &amp; Reorganisation</td>
<td>Acceptance that the person has died</td>
<td>Adapt to loss; Allow for unique experiences of grief. Strengthen family as a functional unit.</td>
<td></td>
</tr>
</tbody>
</table>

The aforementioned theorists’ models have been commonly used in grief counselling. However they have also received a number of criticisms in recent years. To start with, Wortman and Silver (1989) challenged the assumption of the inevitability of depression and distress, and that failure to experience distress is indicative of pathology. Furthermore, a number of researchers (Field, Gao, and Paderna, 2005; Klass, Silverman,
& Nickman, 1996) have postulated that grief is no longer considered to be a time-limited process, and there is a particular emphasis on the significance of retaining a continuing bond with the deceased, rather than decathecting as Freud suggested. In fact Rando (1985, 1986) was one of the first researchers to challenge Freud’s detachment theory. Her research (which focused on parental bereavement) found that ‘the bereavement experience that was considered abnormal or labeled as unresolved grief was actually a part of most parents’ experiences (Rothaupt & Becker, 2007). Several studies (Attig, 1991; Silverman & Klass, 1996; Stroebe, 1992; Worden, 1996) also agree that a continued bond with the deceased that recognises the end of a physical relationship is part of successful mourning.

Finally, it is worth mentioning that the notion that all bereaved people must mourn in certain prescribed ways to successfully adapt to living has also faded in recent years (e.g. Stroebe and Stroebe, 1991; Stroebe, Stroebe, Schut, Zech, and van den Bout, 2002). The latest trend in bereavement research has moved towards a more growth-oriented paradigm rather than focusing on pathology and how the crisis can potentially lead to impaired functioning.

2.2 Current approaches to classifying grief-related pathology in the DSM

Without standardised diagnostic criteria for pathological grief symptoms, clinicians have been forced to rely on existing diagnoses to facilitate case conceptualisations and treatment of their clients (Lichenthal, Cruess, & Prigerson, 2004). The reality of this is relatively clear especially when reviewing the previous and current diagnostic manuals. Stroebe, van Son, Stroebe, Kleber, Schut, and van den Bout (2000)
observed that there was a greater recognition of grief as potentially pathological between the last two DSM manuals (DSM-III-R and DSM-IV-TR).

In the DSM-III-R (1987) clinicians had to rely merely on matching grief symptoms, which naturally resulted in a broad array of potential disorders including: dysthymic disorder, major depressive disorder (MDD), bipolar disorder, schizoaffective disorder, post-traumatic stress disorder (PTSD), adjustment disorder (AD) with depression, AD with mixed emotional features, brief psychotic reaction, obsessive compulsive disorder (OCD), dissociative disorder and borderline personality disorder. Such a list is enough to mistakenly pathologise the bereaved, who many a time are only exhibiting normal reactions to loss. In fact, studies by Marwit (1991, 1996) revealed that clinicians demonstrated higher inter-rater reliability when using classifications, such as masked and chronic grief derived from thanatological literature, than when using those from the DSM-III-R (1987).

DSM-IV, on the other hand, features an attempt at categorising and defining prolonged bereavement. Presently, DSM-IV classifies bereavement under V code which encompasses “other conditions that may be a focus of clinical attention” but are not counted within the major diagnostic classes, thereby implying that they are not manifestations of a mental disorder, the latter being defined as:

A clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with a present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom (DSM-IV, American Psychiatric Association, 1994, p. xxi).
Current practice is that patients who struggle with their grief, receive diagnosis related to depressive disorders, adjustment disorders, PTSD or other anxiety disorders which may not adequately describe the difficulties experienced by the bereaved (Enright & Marwit, 2002; Maercker & Znoj, 2010). Nevertheless, the initial diagnosis is typically one related to the depressive disorders, as both depression and grief have similar symptoms. In fact, DSM-IV places a particular emphasis on the distinction between normal grief and major depressive disorder (MDD) and therefore attempts to clarify this boundary as follows:

After the loss of a loved one, even if the depressive symptoms are of sufficient duration and number to meet the criteria for a Major Depressive Episode, they should be attributed to bereavement rather than to Major Depressive Episode, unless they persist for more than two months or include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (DSM-IV, American Psychiatric Association, 1994, p.780).

It is worth mentioning that the American Psychiatric Association (2011) has proposed a new specifier for bereavement: “12 months of symptoms are required before diagnosis may be employed”. I shall be discussing this further in a later section.

2.3 Obscurity of criteria for establishing a distinction between normal and prolonged grief

Examination of literature brings to light that there are several criticisms that must be addressed before complicated grief (CG) is established as a mental disorder. The most frequently cited critique is that normal grief may be “pathologised” if CG is enlisted in
standardised diagnostic manuals (Prigerson & Jacobs, 2001; Stroebe et al., 2000). As it happens, Wakefield (1992), as cited in Stroebe et al. (2000) states that pathology may be assumed on the basis of statistical techniques that define deviations from the norm. Additionally, one can argue that functional and statistical abnormality do not necessarily fit hand in glove. This may have a number of consequences: not only is there a risk of misdiagnosing but most importantly, by focusing on statistical deviations, one risks neglecting subjective feelings of maladjustment.

Another common argument in opposition is duration, which so far has been balancing between two extremes: excessive or too little grieving time. This approach is typically adopted by those who agree with the aforementioned phasal approaches to grief since the models identify gradual recovery over time. Assessing these polarities can prove to be harder than expected, and leaning towards one side may either result in inhibited, delayed or absent grief.

Cultural factors such as religious beliefs, customs and expectations also play an influential role in the duration of mourning. However, individual and cultural variability might make it difficult to determine when a reaction is pathological (Lichtenthal et al., 2004). For example, locally, it was traditionally common for the bereaved to go through a mourning ritual. It was expected that family members do not cook for three days but rather accept meals prepared by friends and relatives. Women were also expected to spend around forty days indoors, whereas men were expected to spend a week inside and between a fortnight and a month without shaving. Cremona (1954) in Cassar-Pullicino (1976) also brings to light the ritual of lighting an oil lamp in the death chamber during the forty days. The idea behind this was spiritual in nature, it was believed to help the deceased person’s soul depart. This is not surprising given the strong religious beliefs the
Maltese population holds. In other cultures bereavement practices may be unthinkable to Western society. For instance, in some Muslim and Asian societies grief is concealed and grief-work is not encouraged. Given that symptomatology and diagnostic criteria are standardised in a typical Western culture, it is very easy for practitioners to misdiagnose patients. However, efforts to address such concerns have already begun.

The methods used to make a measure of intensity of grief themselves are somewhat debatable. For example, high scores on grief symptom inventories may be interpreted as grief running a complicated course. Having said that, despite it being a good predictor, many complications in using this criterion still arise; an apparent lack of intensity may mask the presence of a problem.

Researchers (Stroebe et al., 2000; Wakefield, 1992) also comment about the assumed inclusion of the non-specific criterion that underlies all other diagnostic categories in the current DSM, which states that significant suffering and functional impairment must be present for the diagnostic criteria to be met. This is seen as problematic in the context of pathological grief because it fails to take into consideration that dysfunction may serve as an adaptive reaction to loss (Lilenfield & Marino, 1995; cited in Stroebe et al., 2000).

Finally, a number of practitioners have also put to issue the consequences of instituting CG as a mental disorder. Stroebe et al. (2000) argues that informal support networks may be weakened or even replaced as a result of increased availability of mental health professionals. Are these interventions more useful than obtaining support from informal networks?
2.4 Prolonged grief as a potential separate category of mental disorder

Although the latest DSM manual provides a more precise differentiation between grief reactions and other related disorders than DSM-III-R, the criteria for this distinction clearly remain unclear. Furthermore, according to DSM-IV (2000), the task of establishing a diagnostic criteria for CG involves demonstrating that its symptoms are associated with distress and are distinct from those that are “expectable and culturally sanctioned” (DSM-IV, 2000).

Nevertheless, several researchers including Horowitz, Bonanno, & Holen (1993) and Jacobs (1993), strongly argue in favour of the introduction of pathological grief as a separate diagnostic category. A review through literature itself presents a number of empirical studies whose aim is precisely this. For instance, Horowitz et al. (1997) and Prigerson, Frank et al. (1995), cited in Lichtenthal et al. (2004), respectively conducted longitudinal clinical investigations to evaluate symptoms of CG after coming across a cluster of symptoms following bereavement that were qualitatively different from those of bereavement-related depression and anxiety. Both teams used a number of analytical tools to ensure that there are no false measures of PG symptoms. For example, Horowitz et al. (1997) made use of a latent class model to obtain a “gold standard” for diagnosis based on four measures of CG symptoms: ‘two self-report symptom inventories, number of symptoms endorsed by clinical interviewers, and global ratings of presence/absence of CG made by clinicians’ (Lichtenthal et al., 2004). The idea behind this being that different assessment tools will identify true and false positives and negatives.

A similar investigation was conducted by Prigerson et al. (2009) to determine the ‘psychometric validity of criteria for prolonged grief disorder (PGD)’, the result of this being that leading clinicians and researchers (Prigerson et al., 2009; Shear et al., 2011)
synthesised psychometrically validated criteria for PGD for inclusion in the upcoming DSM-V (Refer to Table 2, below).

**Table 2. Criteria for Prolonged grief disorder (PGD) proposed for inclusion in DSM-V and ICD-11 (Prigerson et al., 2009)**

<table>
<thead>
<tr>
<th>A. Event:</th>
<th>The person has experienced bereavement, i.e., the loss of a significant other.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Separation distress:</td>
<td>The bereaved person experiences separation distress; yearning for the deceased, intense pangs of grief, or emotional pain or sorrow, most days and to a disabling degree.</td>
</tr>
<tr>
<td>C. Cognitive, Emotional, and Behavioural Symptoms:</td>
<td>The bereaved person must experience at least 5 or more of the following symptoms experienced most days and to a disabling degree:</td>
</tr>
<tr>
<td>1. Confusion about role in life or a diminished sense of self (i.e., feeling that a part of self has died)</td>
<td></td>
</tr>
<tr>
<td>2. Difficulty accepting the loss</td>
<td></td>
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<tr>
<td>3. Avoidance of reminders of the reality of the loss</td>
<td></td>
</tr>
<tr>
<td>4. Inability to trust others since the loss</td>
<td></td>
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<tr>
<td>5. Bitterness or anger related to the loss</td>
<td></td>
</tr>
<tr>
<td>6. Difficulty moving on with life (e.g., making new friends, pursuing new interests)</td>
<td></td>
</tr>
<tr>
<td>7. Emotional numbness since the loss</td>
<td></td>
</tr>
<tr>
<td>8. Feeling that life is unfulfilling, empty, or meaningless since the loss</td>
<td></td>
</tr>
<tr>
<td>9. Feeling stunned, shocked, or dazed by the loss</td>
<td></td>
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<tr>
<td>D. Duration:</td>
<td>Diagnosis should not be made until at least six months have elapsed since the death.</td>
</tr>
<tr>
<td>E. Impairment:</td>
<td>The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities).</td>
</tr>
<tr>
<td>F. Relation to other disorders:</td>
<td>The disturbance may co-occur with, but is not better accounted for by major depressive disorder, generalized anxiety disorder, or posttraumatic stress disorder.</td>
</tr>
</tbody>
</table>

More recently, the American Psychiatric Association (APA, 2011) work group proposed two bereavement related disorders for the DSM-V: Adjustment Disorder related to bereavement, which will be located in the main body of the text as an official diagnostic entity; and Bereavement-related disorder, including a Traumatic Death Specifier, that will be located in the Appendix as an invitation for further research.
(Kaplow, Layne, Pynoos, Cohen, & Lieberman, 2012). A copy of the proposed diagnostic criteria can be found in Table 3 and Table 4 in Appendix D (pp. 79-80).

However, it should be mentioned that the aforementioned criteria are neither conclusive nor acknowledged by all researchers and clinicians. Debates over the merits of these proposals for DSM-V are currently focusing on evidence for: ‘the inclusion of age-specific manifestations for either disorder; establishing criteria thresholds and altered/additional symptoms within each criterion category of the Bereavement-Related Disorder; and the applicability of the proposed Traumatic Death Specifier for children and adolescents’ (Kaplow, Layne, Pynoos, Cohen, & Lieberman, 2012). Moreover, there still remains a significant degree of scepticism related to the risk of stigmatisation, over-diagnosing or pathologising normal reactions.

By way of conclusion, in the next chapter I shall be presenting my methodology and explaining the research methods I have adopted in my study. The aim of my study is to investigate what locals attitudes are towards prolonged bereavement. In light of this, I thought that a qualitative method would best fit my study. I intend on gathering my data by means of focus groups and interpreting it using thematic analysis.
3. METHODOLOGY

3.1 Introduction

The aim of this research project is to investigate what Maltese society’s cultural attitudes and perspectives are towards prolonged grief. In this chapter, the theoretical underpinnings of the research design and procedures used to carry out the study shall be presented. I shall first start with a brief account on the research design and its theoretical underpinnings. Following this I will delve into the methods of data collection and analysis. The final sections of this chapter shall be dedicated to issues of trustworthiness, reflexivity and ethics.

3.2 Research Design

Given the aim of my dissertation and the limited local literature in the field, I thought a qualitative methodology would be best suited to my project. Unlike quantitative research, the primary objective of which is to quantify phenomena and to predict whether generalisations about a theory are valid, qualitative research is principally concerned with the subjective experiences of the participants, how they make sense of the world and how they experience particular events (Lyons & Coyle, 2008). Furthermore, it enables the researcher to obtain an ‘insider’ perspective on different social worlds (Langdrige & Hagger-Johnson, 2009). Additionally, the open-ended approach adopted in qualitative inquiries enables the synthesis of detailed insights into the studied phenomenon; a characteristic which is not readily available in quantitative methodologies.

Quantitative research tends to be conducted in controlled settings in an attempt to produce objective findings which are unaffected by external influences as possible. It uses
experimental methods and/or the use of structured questionnaires or observation, often conducted with large numbers of participants. This research is concerned more with behaviour than its qualitative alternative. Furthermore it is focused on prediction rather than description (Langdridge & Hagger-Johnson, 2009). Therefore, as might be expected, quantitative researchers believe that social facts have an objective reality.

Qualitative methods, contrastingly, do not easily provide firm and incontestable answers to questions about the research process and data interpretation (Lyons & Coyle, 2008). This is partly due to the fact that said methods have different underlying philosophical assumptions with regard to how to produce psychological knowledge, in other words, epistemology. Lyons and Coyle (2008) define the term epistemology as a branch of philosophy concerned with the theory of knowledge and that tries to answer questions about how we can know and what we can know. Although qualitative methods are rather varied, they share a common assumption that there is no objective reality, and reject the idea that there is a simple relationship between our perception of the world and the world itself. Instead, they are underpinned by the belief that knowledge and the processes which lead to its production are context-specific (Lyons, 2000; Willig, 2001), in essence, being relativistic.

Qualitative research is rooted in social constructivism. The latter is a worldview in which individuals seek an understanding of the world in which they live and work. They develop a subjective meaning of their experiences which are varied and multiple, leading the researcher to look for a complexity of views rather than narrow the meanings into a limited number of categories or ideas. The goal of research therefore becomes an exercise into looking into the participants' views of a situation in a social and historical context since views and experiences are formed through interactions with others and also via cultural norms.
operating throughout individuals’ lives (Creswell, 2007). This implies that social phenomena are not fixed and measurable.

One notable example from previous diagnostic manuals was the categorisation of homosexuality as a mental disorder. Homosexuality was formerly listed, along with rape and paedophilia, as a psychological problem in need of treatment and cure. Nowadays, despite the fact that homosexuality is not accepted by everybody within society, the general outlook of people has changed. It is no longer considered to be a disorder, rather simply another aspect of sexual life. In view of this, one might question whether the latest DSM may be at least partially a cultural artefact.

Finally, it should be mentioned that qualitative research methods have become increasingly important modes of inquiry for the social sciences only in recent years. Traditionally, experts were very critical and apprehensive of qualitative approaches to research, particularly in terms of their validity and reliability; which were not considered to be at par with the more scientific quantitative modes of inquiry. However, the measurement of social facts also hinges on categorising the social world. Social activities need to be distinguished before any frequency or percentage can be attributed to anything (Bauer, Gaskell, & Allum, 2000). It is this fact which justifies the need for the qualitative approach that will be taken throughout my dissertation. Since little work has been conducted locally with regard to this field, it is necessary to first identify potential norms and variables in view of local culture, so as to lay the groundwork for future research.

3.3 Research Tool

As mentioned earlier, I shall be obtaining my data by conducting two focus groups. My choice of this qualitative research tool, stems from the element that group interviews
allow for a synergistic effect that leads to the emergence of information which otherwise may not have occurred. Focus groups tend to explore the feelings and thoughts of participants on a specific issue (Kruger & Casey, 2000). The objective of studying and learning about a particular situation implies that the interview will be singular in focus (Stewart, Shamdasani, & Rook, 2007). Moreover, group interviews present a more natural environment and participants will often speak more openly in a discussion on learning that they are not alone (Langford & McDonagh, 2003). These characteristics are of particular importance in qualitative research and accordingly, focus groups are commonly prescribed for research that is either exploratory, clinical, and/or phenomenological (Calder, 1977). In light of the above, as well as the exploratory nature of my study, I concluded that focus groups would be an ideal research tool.

3.4 Procedure

Following an in-depth review into literature, a semi-structured interview guide was formulated. The interview guide was adapted to suit the group of participants (refer to Appendix B, pp. 63-66) and each was planned to be tested in a pilot study. However, due to difficulties recruiting participants, only one was carried out. Data was collected by means of conducting two focus groups consisting of 4-6 participants which lasted between 40-60 minutes; one among clinical/counselling psychologists, and the other between University students.

Participants and their recruitment: The participants were recruited by means of snowball and convenience sampling. Convenience sampling was used to enrol students from the University population - via an email distributed through the Registrar’s office, and psychologists through the Maltese Psychological Association (MPA) and the Psychology
Department of Mater Dei; while snowball sampling was used to obtain more candidates for
the respective groups.

The focus group among university students consisted of 6 participants between the
ages of 21 and 25, 4 of whom were psychology students while the other two were studying
applied biomedical science. The second focus group consisted of 3 clinical psychologists and
1 counselling psychologist.

**Initial contact:** Prospective candidates were given a brief overview of the research,
and when they met the relevant requirements for the focus group (i.e. Maltese university
students and clinical or counselling psychologists) and agreed to participate, I scheduled a
time and place to hold it. A few days before the focus group, I sent an email to ensure their
willingness to participate and also gave a brief explanation of my research objectives.

**Data Collection:** Prior to the start of the focus group, the participants were given a
consent form to sign wherein they were informed about issues regarding the maintenance of
confidentiality, and that at all times they retained the right to withdraw from the study. The
participants were also informed that they had the right to decline to answer any prompts posed
by the researcher and that the focus group would be recorded and transcribed.

Following this, I presented the participants with an ice-breaker to help them get
acquainted to each other and the environment. I then introduced the objectives of the project
as well as explained the importance of avoiding speaking over each other. A semi-structured
interview guide was used as an aid during the group interviews and the information obtained
was transcribed verbatim and analysed using thematic analysis.
3.5 Data Analysis

Given the nature of my research, I opted for a thematic approach to analysis. Braun & Clarke (2006) define thematic analysis as ‘a method for identifying, analysing, and reporting repeated patterns (themes) within data’ (p. 6). This analytic technique differs from other methods of analysis (e.g. thematic discourse or decomposition analysis, interpretative phenomenological analysis (IPA) and grounded theory) that seek to describe patterns across qualitative data (Braun & Clarke, 2006). While IPA, grounded theory, and other analytical methods are closely linked to a pre-existing framework (for instance phenomenological epistemology in the case of IPA (Smith & Osborn, 2003)), thematic analysis is not, and therefore may be used with different theoretical frameworks (Braun & Clarke, 2006).

The process of thematic analysis involves five phases which are recursive rather than linear in nature (Ely, Vinz, Dowling, & Anzul, 1997). The first stage involved familiarising myself with the transcribed data. At this point it is worth mentioning that researchers such as Riessman (1993), Bird (2005) and Lapadat & Lindsay (1999) state that the process of transcription in itself is a key phase of analysis “where meanings are created, rather than simply a mechanical [process] of putting spoken sounds on paper.” Hence it is important that transcription remains true to its original nature (Braun & Clarke, 2006). I also marked my initial thoughts, notes and potential ideas for coding during this phase. However, I reserved the formal coding process for the second stage.

As stated above, the second stage involves the synthesis of initial codes from the data. Boyatzis (1998) refers to codes as “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (p. 63). During this phase, I worked systematically through the transcripts identifying any aspects that
may indicate potential patterns. Any key statements were highlighted and short notes relating to a potential code were recorded (refer to Appendix C, pp. 68-70).

Once the initial codes were drawn up, I sorted the different codes into latent themes and sub-themes, and collated all the relevant transcript excerpts within the said themes (refer to Appendix C, pp. 71-77). Following this, the candidate themes were reviewed and refined accordingly. According to Braun & Clarke (2006), this process ensures that any overridden data in the early stages is coded.

The final stage of my analysis entailed defining and finalising the names of the main themes.

3.6 Trustworthiness

“Without rigour, research is worthless, becomes fiction, and loses its utility” (Morse et al. 2002, p.2). Hence, accordingly, a significant amount of attention is applied to obtaining reliable and valid results in all research methods (Morse et al. 2002).

In view of the fact that qualitative research is based on theoretical assumptions that promote the subjectivity and unique experiences of the participants’, issues of reliability and validity differ significantly from those in quantitative research. Qualitative inquiry most notably differs from its rationalistic (quantitative) counterpart in that it lacks the certainty of ‘hard’ numbers and p-values (Morse et al. 2002). Hence, given that rigour cannot be obtained as in quantitative inquiry, a number of researchers (Lincoln & Guba, 1985; Leininger, 1994; Rubin & Rubin, 2012; Whittemore, Chase & Mandle, 2001) suggested new criteria and a plethora of terms for ensuring reliability and validity. The most commonly cited being that of “trustworthiness”; a notion, introduced by Lincoln and Guba in the early 1980s, that was
composed of four aspects (credibility, transferability, dependability and confirmability); each with its own methodological strategy for establishing qualitative rigour.

Throughout this study, a number of precautionary strategies were undertaken to ensure that the findings had a significant degree of trustworthiness. One technique involved the use of a digital voice recorder and transcripts to make certain that detailed, accurate field notes were obtained and that findings are open to further research. Credibility was further enhanced by conducting a pilot study to reveal any potential deficiencies in the group interview guide that may significantly affect the findings. Furthermore, following analysis of the transcripts, a peer review was conducted, where, in accordance with Lincoln & Guba (1985), the reviewer questioned “the meanings and interpretations of the researcher” (Creswell, 2007, p. 208). This allowed any assumptions of the researcher to be challenged and ensured that there was agreement on the coding scheme. Finally, the participants were asked to examine the synthesised themes to see whether the essence of their views and perceptions were captured. Lincoln & Guba (1985) consider respondent validation to be “the most critical technique for establishing credibility” (Cresswell, 2007, p. 208).

3.7 Reflexivity

Reflexivity is defined as the process by which a researcher becomes aware of potential pre-existing biases and implications that may influence the object of research. By providing a reflexive account, the researcher acknowledges their own position in the study; thereby “increasing the transparency of the research” (Crowley, 2010, p. 240). The following section therefore gives an overview of my personal views and experiences.

Having experienced the loss of grandparents at a young age and a close teacher in my late teens my initial thoughts about the appropriate length of grief was that of a month to a
month and a half at the most. I believe this initial reaction stems from my positive outlook towards life and my tendency to focus on keeping good memories alive rather than thinking about the negative aspects of loss. This may have been further influenced by the thought of a person ‘being in a better place’ brought on by the religion I was brought up with. Despite this, having had no experience in dealing with the death of very close relatives such as my parents or siblings, I do not know how I would react in such a situation.

I believe that my age and the age of most of my peers may have given me a limited experience with the diverse ways and traditions in which people express their grief, particularly those in older age groups. This may have also contributed to my initial views, as mentioned above. Furthermore, the fact that the DSM-IV and its two-month limit were referred to frequently in the literature used, may have contributed to this expectation as I may not have been exposed to a wide variety of alternative viewpoints. In this regard, the data collection stage of my dissertation may have been approached with a certain mindset.

While a required part of my dissertation, carrying out a review beforehand may have influenced the development of certain probes and questions within my focus group sessions. The knowledge gained from a thorough perusal of said literature may have resulted in my using points, ideas and themes made by other researchers while coming up with the themes for my transcribed data. Although it is understandable that it is not possible to perform thematic analysis wholly independently, there is always a possibility that these ideas may have had an undue influence on the thematic labels assigned to the data collected.

On further thought and background reading, I have gradually become more aware of the fact that personality, coping skills, cultural background, support systems and the degree of attachment to the person of loss play a key role in the way an individual grieves. Given these
variables, I believe that it is very difficult to draw a line which indicates that grief has become excessive.

### 3.8 Ethical Considerations

Advances in the fields of social science have been accompanied by a growing awareness of the attendant moral issues implicit in the work of researchers. Langdridge & Hagger-Johnson (2009) emphasise that the most fundamental ethical principle is that researchers treat their participants with respect. Throughout the study, it was ensured that any ethical issues that may have arisen were considered with great sensitivity. Each of these key issues are discussed below.

During the data-collection process, participants were provided with a consent form explaining the nature of the research. The principle of informed consent ensures that of participants are free to choose whether or not to take part in the research project and guarantees that exposure to known risks is undertaken voluntarily. Moreover, the participants were also given the liberty to withdraw from the study at any time, and ask for any records to be destroyed without providing an explanation.

Another key issue considered was that of confidentiality. Participants were fully informed about confidentiality and its limits. They were made aware that although the recordings would be transcribed and used in the write-up, no identifying information would be disclosed. The use of pseudonyms was key in this respect. The participants were also informed that the transcripts and recordings may be seen by my supervisor and that all recordings would be destroyed following my graduation.
3.9 Conclusion

This chapter analysed the design of this study as well as explained the suitability of the research approach. It also described the process of data collection, analysis and the techniques used to increase trustworthiness. The proceeding chapter shall entail a presentation of my findings.
4. FINDINGS

4.1 Introduction

In this section I shall be presenting the emergent themes following a thematic analysis of the transcribed data. Analysis synthesised four main themes, a summary of which can be seen in Table 5. An illustrated account of the themes below, discussed in the context of literature, will be provided in the following chapter.

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Sub-theme</th>
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<tbody>
<tr>
<td>Distinction between normal and prolonged grief</td>
<td>a) Lack of consistency</td>
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<td></td>
<td>b) Functional impairment</td>
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<td></td>
<td>c) Loss of interest and motivation</td>
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<td></td>
<td>d) Difficulty moving on</td>
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<td></td>
<td>e) Intense emotions</td>
</tr>
<tr>
<td>Variables influencing course of grief</td>
<td>a) Degree of attachment</td>
</tr>
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<td></td>
<td>b) Access to support and age differences</td>
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<td></td>
<td>c) Gender differences</td>
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<td></td>
<td>d) Sociocultural background</td>
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<td></td>
<td>e) Personality and personal definition of identity</td>
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<tr>
<td>Manifestations of grief</td>
<td>a) Behavioural obligations</td>
</tr>
<tr>
<td></td>
<td>b) Perceived lack of emotional expression</td>
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<td></td>
<td>c) Dealing with grief over time</td>
</tr>
<tr>
<td>Categorisation of excessive grief</td>
<td>a) Against</td>
</tr>
<tr>
<td></td>
<td>b) In favour</td>
</tr>
<tr>
<td></td>
<td>c) Applicability of proposed duration</td>
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4.2 Emergent themes

4.2.1. Distinction between normal and prolonged grief

As may have been expected, the salient theme that emerged from the group discussions was the difficulty in defining and distinguishing between the typical progression of grief and the more complicated form. The lack of consistency in this was particularly emphasised by both the psychologists and students.

“there isn’t a consistency...[on] what normal grief is. Some people say there’s a certain set of stages which are normal, other theorists have said that’s abnormal... it doesn’t follow the norm. I think there’s a very fine line between normality and pathology” (Sam, counselling psychologist)

Having said that, a number of participants expressed that despite it being difficult to distinguish between the ‘normal’ and ‘atypical’ forms, they believed that grief may be considered excessive when the bereaved become functionally impaired: “When you don’t go to work, I think that’s a sign” (Jennifer, student) and “when it interferes with your living, even the basic things” (Andrea). Another prominent factor amongst students was the loss of interest and motivation in “what you loved doing before” (Martha), which although considered acceptable initially, is less so after a period of time since “you start going into a cycle of not doing anything and becoming comfortable in your little bubble” (Andrea) and “after a certain time life must go on and am there must be motivation to start over” (Anne).

Participants also felt that the complicated form of grief was characterised by difficulty moving on and intense emotion. As Jennifer and Martha express: “his son died 15 years ago but he was crying as if he passed away just a week ago” “his parents couldn’t live either... they kept crying every time they saw someone, they saw my dad for
example”. This was interpreted as a fear of “facing a new lifestyle” (Thomas) which may make it “difficult to continue fruitful relationships” (Danielle, clinical psychologist).

4.2.2. Variables influencing the course of grief

Analysis revealed that participants agreed that the course of grief was influenced by several variables. Unsurprisingly, there was an emphasis on the role of the sociocultural background for instance locally “it’s almost acceptable for your grief to be a bit more prolonged than in foreign countries” (Zoe).

Furthermore, the way an individual grieves is also dependent on “the relationship you have with the deceased person” (Zoe) as well as the degree of support. According to the participants, the elderly are more prone to struggle with their grief since “they have less resources to discuss their emotions and grief” (Chloe) because “they would not turn to a support group” (Sam) as “it’s way beyond their culture of keeping silent and keeping it in the family” (Chloe). Hence they would rather “suffer alone” (Sam). Contrastingly, the younger generations are more aware of resources to access “[at] our age I think you can find a lot of support” (Andrea).

Gender was also reported to affect the grieving process. As Zoe noted, “males tend to do things and females tend to talk about these things” which leads to her belief that “females tend to be diagnosed more with pathological grief than males because they internalise their difficulties while males externalise them” particularly in relationships. The way a person defines him/herself; “your definition of your own identity and relationship to the attachment you’ve shared with this person” (Zoe) is tightly linked to this. According to Andrea, if an individual’s support and routine mostly came from the deceased, it is only natural for one to struggle to come to terms with the loss. Francesca adds that this may also be related to a
person’s coping skills “some people know how and when to let go of things, they know when certain things become harmful to them, but they make a limit and others live up in denial”.

4.2.3. Manifestations of grief

Maltese society, in particular the older generations, appear to have very strict conceptions about how a person should grieve and it emerged that locally, bereavement more than anything else, is still a behavioural obligation despite depicted by the younger generations as excessive. In fact, a common experience between a number of participants was that of receiving guidelines on what and what not to do; including not wearing cosmetics or setting hair, removing nail-polish and not watching television. “There’s this idea that grief should be visible” (Chloe), for instance Jennifer’s mother expected her to wear black “for a whole month” when her grandfather died. As Martha explains, one must “wear black to show everyone you’re sad... you can’t look decent and be ok in front of people” because “the more you cry, the more after the funeral they come to you’” (Martha). Not following this norm will result in judgemental attitudes, an element that is illustrated clearly in Jennifer’s and Martha’s experiences:

“We were watching a programme at home and this woman still kept going out and doing her hair, and my mother was like ‘she’s not grieving her son, she went to get her hair done.” (Jennifer)

“3 days later and she was talking and laughing and doing things, and my mum came home ‘she should be ashamed, her husband just died, she’s laughing.’” (Martha)

Paradoxically, despite there being an expectancy to cry and look sad, “there’s a lot of fear surrounding talking about it” (Sam). A clinical psychologist infers that this is due to society’s belief that talking about feelings may cause the bereaved to experience more intense
emotions. In her experience, grieving children would want to express their feelings however they aren’t given the opportunity. Moreover, although people may appear to have moved on “emotionally they would be stuck” because “they wouldn’t have gone through the grieving, or they would be going through it but still [are] in the denial stage”.

Finally, participants also pointed out that the intensity of grief varies from person to person in that some take longer to get through a specific Kubler-Ross stage than others. Psychologists drew attention to the fact that it may take over a year to get through the normal grieving process and question whether including a time-frame is ideal. Sam argues that if it takes a year to get through the first three stages of grief (denial, anger and bargaining) and depression emerges after a year, “would then the person... be diagnosed with major depressive disorder or is it just the normal course of grief?”

### 4.2.4. Categorisation of excessive grief

A consensus against the inclusion of bereavement as a separate category was prominent in both focus groups. Arguments relating to the normality and subjectivity of the grieving process were eminent. For instance Chloe, a clinical psychologist, emphasised that defining bereavement pathologises “a human emotion that is quite subjective” and dependent on the aforementioned variables. Andrea adds: “it’s like saying to someone who’s grieving ‘what you’re doing is dysfunctional’ ” which given our culture may result in helplessness and hopelessness due to the stigma associated with mental illnesses - “who him? He’s mentally ill” (Sam). In fact, a counselling psychologist asserted that in light of Maltese culture, this act of labelling would make people give up and lose hope more easily, and the stigma associated with the condition may also reduce the amount of support received from society. Additionally, if a condition is pathologised, the first reaction of many people in Malta would be “send them
to a psychiatrist not a psychologist” and being given a diagnosis means treatment and cure with medication rather than therapy:

“if you go there and the psychiatrist tells you ‘go and do an hour of exercise each day, spend time with your family and change your diet’ for example they’d, they’d come out of there ‘He doesn’t know what he’s doing, he didn’t prescribe me pills, I’m going to someone else’” (Sam)

Counter arguments to the above included the current time-frame being used in the DSM-IV-TR wherein a diagnosis of mild depressive disorder is given just after 2 months. According to psychologists “no one would manage to solve their grief after 2 months” hence including a separate category would give “more acknowledgement of the people’s pain and that it’s almost acceptable in a way for the grief to be so prolonged” (Zoe). Another point that emerged was that some individuals require a diagnosis for them to access help as many times “these people believe they’re just exaggerating their, their normal emotions” so although “it might be pathologising what we feel is normal” a diagnosis may be a route to obtaining support. Having a separate category would therefore mean having an elongated period where grief is considered to be normal.

A degree of scepticism with regard to setting a cut-off point was common in both focus groups. The fact that the Maltese have a tendency not to talk about their feelings and emotions related to their grief indicates that “a 12 month period might be too short for this type of culture” (Sam) and “not everyone’s situation will be exactly within these limits... it has to be more like a personal thing, not just ticking boxes and seeing [saying] ‘ah you have these stuff’” (Andrea).
5. DISCUSSION

As expected, distinguishing between normal and complicated grief was challenging. This is consistent with literature wherein inconsistencies were salient among researchers themselves. Some believe that the determining factors are related to the onset, duration and intensity of grief. Others assert that it is the circumstances surrounding death or the attachment towards the deceased person prior to death, that may cause pathological reactions (Gentile, 2004). Of particular note was the reaction of the participants in the students’ group discussion to the question of when they think the cut-off point of complicated grief lies, finding it difficult to agree upon an appropriate duration, stressing that people and their situations are different and should be treated on a case by case basis.

According to Prigerson et al. (1999), functional impairment is considered to be the sole criterion used to determine complicated grief. This is backed by Bonanno & Kaltman (2001) who contend that these difficulties have been observed in the form of ‘social withdrawal and isolation, or as the inability to fulfil normal social and occupational roles’ (p. 721). While this was not the only indicator offered by participants in both focus groups, it was deemed to be one of the important ones, along with intense emotion and difficulty moving on.

In line with literature (e.g: Bonanno & Kaltman, 2001; Jerga, Shaver, & Wilkinson, 2011), the participants agreed that the intensity and duration of grief is subjective and is influenced by the person who is grieving and the relationship of the bereaved prior to the deceased person’s death. Variables therefore include personality, age, sex (e.g. Chen et al., 1999) or attachment style. Jerga et al. (2011), for instance, mention that attachment anxiety is associated with intense grief while avoidant and emotionally secure individuals tend to cope better. A further example was given by participants in the focus groups who agreed that grief
may take longer to resolve itself in the case of, say, the death of a child, as it is not seen as natural for a parent to outlive their children.

Grief would also be expected to be more keenly felt among the elderly. These people will often have less resources available to them to discuss their feelings for several reasons. These include a decreasing number of close persons who are of a similar age and have had similar experiences as one ages, the reluctance of the elderly to use support services and potentially their lack of awareness that such services exist, and finally the strong degree of attachment formed among people who have spent a large proportion of their lives together. This may be particularly important in elderly spouses.

In the words of Bonanno & Kaltman (2001):

There are, marked individual differences in how intensely and how long people grieve. Some grieve openly and deeply for years, and only slowly return to a semblance of their normal level of functioning. Others suffer intensely, but for a relatively more proscribed period of time. Still others appear to get over their losses almost immediately, and to move on to new challenges and new relationships with such ease as to raise doubts among their friends and relatives as to whether they may be hiding something or running away from their pain (pp. 705-706).

A substantial body of evidence links social background and culture to bereavement reactions. Neinmeyer, Prigerson, & Davies (2002) for instance use the Jewish shivah, the Catholic funeral and secular memorial services as examples stating that they serve the role of giving an order to events among a family or community, allow both the deceased to transition from one social status to another (e.g. from a living participant in the community, from a wife to a widow) and allow the bereaved to share bonds. Local cultures also play a role in moulding the experiences of their members for instance the variability among Chinese
American observances (Braun and Nichols, 1997). The focus groups conducted for the purpose of this thesis gave rise to further examples such as the funeral singing and dancing done by certain Latin Americans, the lack of any outward manifestations of grief among Koreans, and certain African societies where it is common for people to go to the house of a grieving person and spend about two months there, bringing life in the town to a halt.

Maltese society is marked by a certain expectation towards avoiding emotional discussions while behaving in an expected, “proper”, manner. It was traditionally common for the bereaved to go through a mourning ritual where family members would not cook for three days but rather accept meals prepared by friends and relatives. As stated in the literature that has been reviewed in the drawing up of this dissertation, Cremona (1954) and Cassar-Pullicino (1976), clearly indicate that Maltese society's attitudes towards grief are essentially strongly linked to their religious beliefs, which are then manifested through generations as traditions.

Although such traditions are now rare, the mentality that grief has to be visible, that there are certain obligations and that people may be watching and need to be impressed remains relatively ingrained in Maltese culture. Based on the comments obtained, participants spoke of their experiences with people from (mostly) older generations telling them not to attend joyful events, not to play on a computer, not to wear cosmetics, and to cry so that people can notice you and get the impression that the loss of the deceased was keenly felt by you. One participant spoke of feeling uneasy about playing with a younger niece at a funeral to keep her quiet, while another spoke of comments by her mother aimed at a character on television, who had done her hair and was therefore being judged as not grieving enough.
It should be mentioned that these comments were made by people of younger generations, and being aware that further research would be required to confirm this, the mentality that grief brings certain obligations might possibly be more common among those who are middle aged and older. The way the Maltese grieve may be changing, and becoming more “westernised” since the younger generations are showing signs of shedding and shifting more towards discussing emotions, gradually also losing the stigma of talking to strangers about their feelings through use of support services publicly available. A person attempting a diagnosis therefore needs to be aware of the diversity within a culture, let alone within different ones.

This variety leads to the tentative conclusion that while there may well be a range of length of bereavement that is common among people worldwide, the way people grieve and the length for which they grieve is heavily influenced by where they grew up. This makes length of grief a potentially unreliable criterion for pathological grief particularly if used by itself partly because people inherently understand the fact that people are different and that some people may need more time than others. As mentioned before, the suggestions made by Prigerson (1999) and the participants in the focus groups, intense emotions, difficulty moving on and to a greater extent inability to return to being a productive member of society with healthy interests are seen as better indicators. This makes some sense, as a person would be expected to feel sad, but over time people would not expect said person to not contribute to society, not be able to perform basic things in life and to show persistent outbursts of emotion or a lack of change in the emotions felt several years after an event.

The duration of 12 months proposed in the draft of the DSM-V adopts a conservative stance in attempting to avoid pathologizing the normal course of bereavement for many adults, which can vary substantially from person to person and cohort to cohort (Kaplow,
Layne, Pynoos, Cohen, & Lieberman, 2012, p. 248). In this regard, the proposal acknowledges the fact that different people and different cultures grieve differently. The proposal not only does this, but goes a step further and mentions, rather appropriately, that for a person to be diagnosed with prolonged grief, his/her bereavement reaction must be out of proportion with cultural or religious norms. In avoiding specifying what said proportions are, the proposal avoids excessive pathologisation of grief.

Despite this relatively conservative stance taken, participants showed a lukewarm attitude with regard to the proposal. This reluctance was in part because grief is viewed as a normal, subjective experience and that having an official guide to a diagnosis would involve telling people that what they are doing is dysfunctional; a frequently cited critique. The DSM itself was mentioned as being too “black and white” (Chloe), demanding caution in its use. The attitudes of locals towards mental illness and its treatment were also brought up, pointing out that were the condition to become pathologised, many Maltese would give up on other people after they’ve exceeded the twelve month mark. Furthermore, among the Maltese there is the expectation that medication should be given for an illness, and that therefore the suggestion of treatment through therapy would be met with skepticism.

On the other hand, participants favoured the fact that the proposed cut-off time was changed to twelve months as opposed to the earlier period of two months in the DSM-IV which was seen as too short. The longer time-frame would also reduce the number of genuinely, and normally, grieving people receiving antidepressant medication. Giving prolonged grief its own category would be a tacit recognition of people’s pain, that there pain is valid. It would also enable people who require a diagnosis before they seek help to put their mind at rest and know exactly what they are suffering from.
Although the latest DSM manual distinguishes between grief reactions and other related disorders better than its predecessors, its distinction remains limited. According to the DSM-IV, bereavement is a stressor that produces relatively normal and expectable distress. DSM-IV does not offer a complicated grief diagnosis, and allows for bereavement-related diagnoses only in extreme cases when existing diagnostic categories (e.g. Major Depression) may be relevant. In contrast, bereavement theorists have argued for the clinical necessity of a complicated grief diagnosis, and have proposed a number of different types of complicated grief (Bonanno & Kaltman, 2001).

The conceptualization of bereavement in terms of the V-code is clearly intended to represent mourning as a normal phenomenon. In addition, DSM-IV emphasises culturally determined forms of mourning and grief behaviour, and that “the duration and expression of ‘normal’ bereavement vary considerably among different cultural groups” (APA, 1994, p. 684). An important limitation of DSM-IV’s vagueness on this point, however, is that it does not provide a means of precisely distinguishing between individuals who show common grief reactions from those who do not (Bonanno & Kaltman, 2001).

This is perhaps what is necessary in the upcoming version of the DSM, to better distinguish between prolonged grief and depressive disorders while as much as possible not attempting to excessively pathologise what is an essentially normal process which varies between cultures and individuals.
6. CONCLUSION

6.1 General Conclusions

Analysis of my findings revealed that locals place a greater importance on behavioural manifestations of grief than emotions, preferring to be seen grieving while avoiding talking about their loss due to fear that their emotions may get worse. The focus groups conducted suggest that locals believe that the current limit of 2 months is too little and expect the grieving phase among Maltese people to last for more than 12 months. Beyond this, therapeutic help is recommended if functional impairment, or excessive distress is observed.

Results also revealed that social groups most at risk of complicated grief are; the elderly, who may have less access and knowledge of avenues of support, and may also be less willing to seek said support; females, who tend to internalise their difficulties (by feeling or talking about things) as opposed to males who externalise them (by doing things).

With regard to the inclusion of pathological grief as a separate category in the upcoming DSM-V, general opinion indicates opposition because this would involve pathologising an emotion and process that is natural and subjective. Maltese culture would furthermore tend to see individuals diagnosed with this as “ill” and would furthermore expect medication for it rather than therapy.

Finally, as mentioned earlier, if prolonged bereavement were to be made a pathology, it was suggested that allowances should be made for cultural and individual differences. Such differences may need to be assessed by a professional and need to be seen on a case-by-case basis. The fact that the APA (2011) in Greis (2012) suggest that the diagnostic criteria include a specifier that a person should only be diagnosed if ‘the bereavement reaction is out of proportion with cultural or religious norms’, is positive, eliminates excessive normalisation,
and allows for individual subjectivity and the wide cultural variety in manifestations and length of the grieving process.

### 6.2 Limitations

Although every attempt was made to ensure accuracy whilst conducting this research, a number of limitations, nevertheless, must be mentioned:

- A pilot study could not be carried out prior to the psychologists’ focus group as a result of difficulties in recruiting and setting a date and time common for all. Furthermore the focus group itself had only four participants - less than the ideal minimum of six;
- The interaction of the responders with one another and the moderator may have led to results that were not independent of one another - this may have been particularly relevant in the students’ group since four of the participants were psychology students and may have therefore known one another beforehand;
- The psychologists were mainly recent graduates and as a result did not have extensive experience.

### 6.3 Implications of study

The results of this research primarily shed light on the perceptions of Maltese society towards the bereaved and those who struggled with their grief. This is important since locally little or no such work has been performed. Said results therefore help further the growing body of evidence that grief varies among different societies. This research also aids in the delineation of the boundaries of normal grief obtaining at least an indication of what the diagnostic criteria should be.
6.4 Recommendations for further research

The following recommendations are suggested:

- To gain a more in-depth knowledge of Maltese attitudes on grief, further studies should be conducted on other age groups in the population, enabling one to obtain a wider range of opinions and hence a result that more accurately mirrors the general population - this is particularly important to confirm the degree (or lack of) to which older segments of the population adhere to grief traditions;

- Focus groups may be supplemented by quantitative analysis techniques such as surveys or questionnaires.

6.5 Final conclusions

While it is important to have a framework, via the DSM-V, within which to 'assess' pathological grief, it is imperative that there is room for manoeuvre in order to be able to, in Malta's case for instance, take into account the attitudes and perceptions of Maltese society towards grief, which are certainly different to perceptions elsewhere in the world. It is these attitudes and perceptions, based on individual, social, cultural, religious and environmental circumstance that determine a person's transition from grief to prolonged grief. It is therefore essential for these specificities to be taken into account when seeking to determine whether a person is suffering from a pathological form of grief. What has emerged from my dissertation is that the line is so fine that it needs to be addressed with due caution.
REFERENCES


APPENDICES
Participant Recruitment Letter

Dear Participant,

I am a student at the University of Malta, currently reading for an Undergraduate Degree in Psychology. In partial fulfilment of my course, I am undertaking a dissertation entitled ‘Pathological Grief: The attitudes and perceptions of Maltese society’ under the supervision of Dott. Greta Darmanin Kissaun. The aim of this study is to investigate what Maltese society’s cultural attitudes are towards pathological (excessive) grief.

The data that is needed for this study is being collected by means of two focus groups, consisting of 6-8 participants; one between University students, the other amongst Clinical and Counselling Psychologists. The focus group will last for approximately one hour and all information obtained will be recorded and transcribed. After all the information is analysed, any recorded material will be destroyed following my graduation.

Please note that participation in this study is entirely voluntary and you are free to decline participation. Should you agree to participate in this study, please be aware that any information collected will be strictly confidential and your identity will not be disclosed at any point. Moreover, you have the right to not answer questions you would not like to answer, as well as to withdraw from the study at any time without the need to provide a reason for your withdrawal.

I would like to take the opportunity to thank you for your time. If you kindly agree to participate in this research project, please sign the consent form attached. Should you have any queries, please do not hesitate to call me on __________ or contact me via email at ______________ and I will be very happy to answer any questions that you may have.

Kind regards,

Nadine Flores Martin
Consent Form

I, the undersigned, am willing to participate in Nadine Flores Martin’s research project entitled ‘Pathological Grief: The attitudes and perceptions of Maltese society’.

I confirm that:

- I have read and understood the above explanation regarding this focus group.
- I am aware that the focus group will be recorded and that any relevant information shall be collected and processed solely for academic reasons.
- I understand that no personal information shall be disclosed and that all measures shall be implemented to ensure anonymity.
- I understand that the focus group will be recorded and that all recorded material shall be destroyed after my graduation.
- I understand that my participation is voluntary and that I am allowed to withdraw from the project at any time, without having to provide a reason.
- I have been briefed about the nature and aims of the study, and have had the opportunity to ask further questions and seek clarifications.
- I am satisfied by these conditions and consent to participate in this study.

Participant’s Name: __________________
Participant’s Signature: __________________
Date: __________________
After losing her husband of nearly 40 years, Rosalie can’t find the motivation to get out of bed in the morning. She’s lost interest in her daily activities, and she has cut off communication with many of her friends. She claims her thoughts are in no way suicidal, yet she’s clearly expressed that she doesn’t feel she has much to live for either. It’s been eight months since Rosalie’s husband passed. [Getz, L. (2012). Complicated Grief — Does It Belong in DSM-5? Social Work Today, 12(4), 8.]

- What do you think about Rosalie’s reaction?
- Would you see this as an important/necessary phase to go through?

2. How do you think people from different age groups react to a loss?
   - Is there a difference in the way the different age groups/generations grieve?
   - What are some of these differences?
   - What do you think contributed to the change, if any?

3. How would you say grief manifests itself locally?
   - Traditions
   - Behaviours

4. If somebody from say Japan or Africa, and Malta were mourning the loss of someone, how do you think they would react?
   - Any differences?
   - How do you think this would affect the diagnosis of excessive grief?

[DSM is classification system of mental illnesses that is accompanied by a description of the disorder in question, together with a set of specific criteria for diagnosis]

5. Currently clients who struggle with their grief receive a diagnosis related to depressive disorders, adjustment disorders or PTSD. In fact researchers are proposing that prolonged grief should be considered as a disorder and given its own category in the DSM-5. What are your opinions on this?
   - DSM-III proposed 12 months; DSM-IV - over 2 months + functional impairments;
   - DSM-V: 6 or 12 months. Is this arbitrary? Do they even know how long grief “normally”
takes in a person?

- What alternatives are there to medicalisation (pathologisation)?
- Should we include a tentative length of time?

6. Do you have any other comments you would like to add?
Interview Guide - Psychologists

1. Based on your experience and knowledge as a psychologist what are your opinions on prolonged grief?

2. How would you define excessive grief?

3. Which groups of people are most likely to suffer from complicated grief?
   - Does social background play a role?
   - Age groups
   - Person/object of loss

4. Is there a difference in the way the different age groups/ generations grieve?
   - What are some of these differences?
   - What do you think contributed to the change, if any?

5. How would you say grief manifests itself locally?
   - Traditions
   - Behaviours

6. What do you think is the difference between Maltese and foreign cultures when it comes to grief, if any?
   - How do you think this would affect the diagnosis of excessive grief?

7. Currently clients who struggle with their grief receive a diagnosis related to depressive disorders, adjustment disorders or PTSD. In fact researchers are proposing that prolonged grief should be considered as a disorder and given its own category in the DSM-5. What are your opinions on this?
   - DSM-III proposed 12 months; DSM-IV - over 2 months + functional impairments;
   - DSM-V 6 or 12 months. Is this arbitrary? Do they even know how long grief “normally” takes in a person?
   - What alternatives are there to pathologisation?
   - Should we include a tentative length of time?
8. Do you have any other comments you would like to add?
APPENDIX C
Excerpt of Transcript

The table found overleaf is an excerpt showing how the first stage of thematic analysis was conducted.

**Key:** (*names of participants have been changed to protect their identity*)

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<tr>
<td>Moderator</td>
<td>M</td>
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<tr>
<td>Participant 1</td>
<td>P1/Sam*</td>
</tr>
<tr>
<td>Participant 2</td>
<td>P2/Chloe*</td>
</tr>
<tr>
<td>Participant 3</td>
<td>P3/Danielle*</td>
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<td>Participant 4</td>
<td>P4/Zoe*</td>
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**Table:**

<table>
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<th>Transcript</th>
<th>Coding</th>
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<tr>
<td><strong>P2</strong>: Chloe. Am I don’t know if it’s the right time to sort of bring up culture am it’s just when I. I haven’t had any clinical experience with, with grief but am sort of from my family and am personal experiences am or, or friends, there’s this idea that am the grief has to be visible as well. The idea of wearing black, the idea of visiting the cemetery... erm I don’t know like I think about a friend whose brother passed away. Erm her parents obviously every anniversary they do a Mass for him, and err you know there’s the remembrance of him, they go to the cemetery. I don’t see that as prolonged grief, I think it’s, there’s, like Sam is saying, am there is grief and there’s remembering kind of am. I don’t really, I don’t consider that grief anymore.I think you have that grief at that like on an anniversary and you kind of have that, when you remember the person but am I don’t, I don’t see that as prolonged grief am I think it’s more erm sort of reflecting on the life of the person, and am... So it’s rather than maybe like a stage, there are stages, but rather than maybe am continuous stages, there’s also moments when the grief comes up again kind of thing.</td>
<td>Belief that grieving must be behavioural</td>
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<tr>
<td><strong>P4</strong>: Erm Zoe. I think it also depends on the relationship you have with the deceased person. Am I had a case recently of a mother who lost her her son, her disabled son, am at the age of 14 and 7 years later she’s still grieving and according to her husband it’s, it’s time that she moves on but she has still, she still has the the room as he left it, she still has the the clothes, everything as her son had left it and to me that would verge on, on the prolonged grief because it’s 7 years later.</td>
<td>Idea that grief patterns are different and that occasions of re-experiencing sadness is not an extended form of grief</td>
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<td>Type of relationship determines course of grief</td>
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But as Chloe said, **at times I think that in Malta you’re, you’re somewhat expected to have some prolonged grief.** Abroad, in America for example after, between 18 to 24 months you’re expected to be over the grieving process. So this in my opinion, it depends a lot on our culture as well.

P2: Okay.

P4: And it’s, it’s almost acceptable for your grief to be a bit more prolonged than it is in foreign countries.

P3: Err Danielle. I agree with what my colleagues said, sort of it’s very individual, there’s a very fine line between normal and pathology. I think it depends a lot on the personality as well of the individual, the way the person copes usually with other stressful situations. What I’ve, I have, I haven’t had any clinical experience with prolonged grief but I have had with sort of normal grief. Am what I notice in in Malta is this this inability or belief that we shouldn’t talk about grief so maybe there wouldn’t be time for saying goodbye to the lost person, am expressing how each they feel in the family and I think this leads and then to am perhaps pathological grief. People grieve am for a prolonged time especially in my work with children, perhaps the children would want to express their feelings but then their parents say *‘we’d better not talk about it’* because they are fearful that perhaps their, their am emotions will get worse. Though this is what I see in our cultural, in our culture am at present. There’s this belief *‘ahjar ma nitkellmux fuqha’*.

P1: Sam. Am to continue on what Danielle is saying, I, I notice there’s a lot of am behavioural things that, that Maltese people do like they dress in black, they go to the cemetery, am they take flowers, err which which are all different techniques which don’t involve talking about it.

<table>
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<tr>
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<th>Coding</th>
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<tr>
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<td>Cultural expectation - time to grieve is longer in Malta</td>
</tr>
<tr>
<td>P2: Okay.</td>
<td>Fear surrounding talk about death or the deceased.</td>
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<td>P4: And it’s, it’s almost acceptable for your grief to be a bit more prolonged than it is in foreign countries.</td>
<td>Behavioral techniques used as an escape from talking about the loss and experiencing emotions.</td>
</tr>
<tr>
<td>P3: Err Danielle. I agree with what my colleagues said, sort of it’s very individual, there’s a very fine line between normal and pathology. I think it depends a lot on the personality as well of the individual, the way the person copes usually with other stressful situations. What I’ve, I have, I haven’t had any clinical experience with prolonged grief but I have had with sort of normal grief. Am what I notice in in Malta is this this inability or belief that we shouldn’t talk about grief so maybe there wouldn’t be time for saying goodbye to the lost person, am expressing how each they feel in the family and I think this leads and then to am perhaps pathological grief. People grieve am for a prolonged time especially in my work with children, perhaps the children would want to express their feelings but then their parents say <em>‘we’d better not talk about it’</em> because they are fearful that perhaps their, their am emotions will get worse. Though this is what I see in our cultural, in our culture am at present. There’s this belief <em>‘ahjar ma nitkellmux fuqha’</em>.</td>
<td>Behavioral techniques used as an escape from talking about the loss and experiencing emotions.</td>
</tr>
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</table>
Table 6. Excerpts from transcripts organised by major themes and sub-themes

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Sub-theme</th>
<th>Quotes</th>
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<tbody>
<tr>
<td>Distinction between</td>
<td>Fine line/Lack of consistency</td>
<td>“it’s very difficult to say ‘isma if after 6 months you’re still grieving, then there’s a problem with you’” (Andrea)</td>
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<tr>
<td>normal and prolonged</td>
<td></td>
<td>“there isn’t a consistency...am what normal grief is. Some people say there’s a certain set of stages which are normal, other theorists have said that’s abnormal... it doesn’t follow the norm” (Sam)</td>
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<tr>
<td>Grief</td>
<td></td>
<td>“I think there’s a very fine line between am normality and pathology” (Sam)</td>
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<td></td>
<td>Functional impairment</td>
<td>“I think it becomes excessive when, after err I wouldn’t stop working for a year I think” (Jennifer)</td>
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<td></td>
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<td>“When you don’t go to work, I think that’s a sign” (Jennifer)</td>
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<td></td>
<td>“When you can’t live your life normally” (Andrea)</td>
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<tr>
<td>Loss of interest and</td>
<td></td>
<td>“When it interferes with your, you, you living, even the basic things” (Andrea)</td>
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<tr>
<td>motivation</td>
<td></td>
<td>“I think that after a certain time speci life must go on and am there must be motivation to start over” (Anne)</td>
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<td></td>
<td></td>
<td>“you start going into a cycle of not doing anything and becoming comfortable in your little bubble” (Jennifer)</td>
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<td>“if you stopped loving what you loved doing before” (Martha)</td>
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<td></td>
<td>Difficulty moving on</td>
<td>“7 years later she’s still grieving, and according to her husband it’s, it’s time that she moves on” (Zoe)</td>
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<td></td>
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<td>“makes it difficult as well to to e continue fruitful relationships as well” (Danielle)</td>
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<td></td>
<td></td>
<td>“she’s fearing facing a new lifestyle” (Thomas)</td>
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<td></td>
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<td>“every time I see a mother or a father who lost a child, they keep on mentioning it every time they see you. So it must really hurt to loose a [child], to die before your children” (Martha)</td>
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<td></td>
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<td>“It’s like out-living your children is not meant to be” (Andrea)</td>
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<td></td>
<td></td>
<td>“I think that they think it’s not fair that they die so young and she’s [they] are still living” (Andrea)</td>
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<td>“you hear a lot of them [the bereaved] sort of do it... they keep, they keep kissing photos” (Jennifer)</td>
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<td></td>
<td>Intense emotions</td>
<td>“His son died 15 years ago but he was crying as if he passed away just a week ago” (Jennifer)</td>
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<td></td>
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<td>“when my cousin died, erm he was about 40... his parents couldn’t live either. They kept crying every time they saw someone, they saw my dad for example, they would start crying” (Martha)</td>
</tr>
<tr>
<td>Main Theme</td>
<td>Sub-theme</td>
<td>Quotes</td>
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|                  | Degree of attachment              | “it also depends on the relationship you have with the deceased person” (Zoe)  
“Rather than am pin-pointing the different groups, I tend to see it in attachment terms and support terms... I don’t really see like an age group being more vulnerable” (Sam)  
“there’s that separation from their [loved ones]” (Zoe)  
“the attachment plus the am feelings associated with the relationships, so am the distance living in different countries” (Zoe)  
“It depends on what type of relationship” (Francesca) |
|                  | Variables influencing course of grief | “the elder females because maybe they have less resources to discuss their emotions and grief” (Chloe)  
“Tendency for the older generation to suffer more” “especially in Malta because the culture and tradition is more, more engrained” (Chloe)  
“I think it would be very difficult to see a 70 year old woman or 70 year old man even less, attending a support group because its way beyond their culture of keeping silent and keeping it in the family” (Chloe)  
“younger generation might be more aware of resources to access for example therapy, to access support groups” (Chloe)  
“this person who’s elderly, like Chloe mentioned would not turn to a support group, would probably suffer alone” (Sam)  
“I would probably say aha elderly people might find it more difficult to adjust perhaps because of their fear as well of passing through death themselves” (Danielle)  
“elderly and younger age groups they may resort to different methods. The elderly forsi they resort to religion u hekk, young age groups maybe jien naf drinking... different methods” (Anne)  
“When you get older, sort of your children they’re going to have their own lives. If you had friends, probably some of them might have died already so then you’re completely alone but when you’re younger, you have a lot of people to turn to” (Martha)  
“If they’re very young I think, if they’re not able to understand the concept of death and the concept of ‘they’re not coming back’. I think it’s very difficult to understand that cause they’d keep on waiting, keep on waiting, keep on waiting. So they can never actually grieve” (Andrea)  
“When they’re a bit our age I think you can find a lot of support” (Andrea) |
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<th>Main Theme</th>
<th>Sub-theme</th>
<th>Quotes</th>
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<tr>
<td></td>
<td>Gender differences</td>
<td>“I think it’s also a difference in gender. The way different genders, males and females express their, their grieving process” (Zoe)</td>
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<td></td>
<td></td>
<td>“Men tend to do things and females tend to feel, or tend to not feel, to talk about these things” (Zoe)</td>
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<td>“This would lead to my belief that females tend to be diagnosed more with pathological grief than males because they internalise their difficulties while males externalise them” (Zoe)</td>
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<td></td>
<td>Sociocultural background</td>
<td>“at times I think that in Malta you’re, you’re somewhat expected to have some prolonged grief!” (Zoe)</td>
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<td></td>
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<td>“it’s almost acceptable for your grief to be a bit more prolonged than it is in foreign countries” (Zoe)</td>
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<td></td>
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<td>“There’s also this issue that when... he mentions their, the, aw the son tipo they ignore him. Jew inkella they don’t want to talk about the son” “umbaghad when they talk with their family members and they talk, they [the family] don’t want to hear” (Francesca)</td>
</tr>
<tr>
<td>Variables</td>
<td>influencing course of grief</td>
<td>“your definition of your own identity and relationship to the attachment you’ve shared with this person” (Zoe)</td>
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<td>“the mother depended on her son for her self-esteem so she did everything for her son and then when her son died she didn’t know what to do with herself. So most of her identity and her feelings of belonging to the family depended on her relationship with her son and so I think this contributed to the fact that the bereavement process was even more prolonged” (Zoe)</td>
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<td>“you get so accustomed to a person, to having that person in your life that your daily routine, and daily life revolves around that person” (Andrea)</td>
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<td>“If most of her support and most of her whatever came from her husband obviously she [will struggle to adjust]” (Andrea)</td>
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<td>“your life becomes so intertwined with your husband’s life... in the sense that it becomes an essential part of your life” (Andrea)</td>
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<td>“Some people know how and when to let go of things, they know speci ta when certain things become harmful to them, but they make a limit and others they live up in denial” (Francesca)</td>
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<td>“He doesn’t know how to cope with it [the loss]” (Francesca)</td>
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<td>Main Theme</td>
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<tr>
<td>Manifestations</td>
<td>Behavioural obligations</td>
<td>“So it [grief] comes out more as certain <strong>obligations</strong>... like an obligation to <strong>dress in black</strong>, an obligation to <strong>look sad, not do joyful events</strong>, you know, <strong>experiences</strong>” (Sam)</td>
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<td>“there’s this idea that am the grief has to be visible” (Chloe)  \</td>
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<td>“The idea of wearing black, the idea of visiting the cemetery” (Chloe)  \</td>
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<td>“When my grandfather died, my mother expected me to wear black for a whole month... I told her ‘<strong>I’ll do it for a few days imma that’s it</strong>’” (Jennifer)  \</td>
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<td>“Even I remember when my grandfather died, I went to do my hair as usual and my mother ‘ee toqghodx taghmel make-up’”  \</td>
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<td></td>
<td></td>
<td>“And to remove my nail-polish” (Francesca)  \</td>
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<td>“It should reflect your mood, wear black to show everyone you’re sad” (Martha)  \</td>
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<td>“We were watching a programme at home and this woman still kept going out and doing her hair, and my mother was like ‘she’s not grieving her son, she went to get her hair done’” (Jennifer)  \</td>
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<td>“3 days later and she was talking and laughing and doing things, and my mum came home ‘<strong>imissha tisthi [she should be ashamed], her husband just died, she’s laughing</strong>’” (Martha)  \</td>
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<td></td>
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<td>“If they’re family you shouldn’t go out of the house” (Andrea)  \</td>
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<td>“Ma tistax tkun sura quddiem in-nies u ma tistghax tkun orraj” “You can’t look decent and look ok in front of people” “you must cry because the more you cry, the more after the funeral they come to you ‘<strong>iii she was crying so much and I felt really bad for her</strong>’” (Martha)  \</td>
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<td>“I was at the funeral and I had my niece... and children obviously don’t know so I was, you know I starting playing with her to keep quiet. I was feeling odd that I was feeling odd that I was playing in the funeral.I was feeling that I was doing something wrong.” (Andrea)  \</td>
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<td>“You know that people are looking at you and they’ll know if you don’t go out, they’ll know” (Andrea)  \</td>
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<tr>
<td>Main Theme</td>
<td>Sub-theme</td>
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</table>
| Lack of Fear       | Emotional                     | “There’s a lot of fear surrounding talking about it” (Sam)  
but rather than taking about it, we just stood there in silence” (Sam)  
“I notice there’s a lot of am behavioural things that Maltese people do like they dress black, they go to the cemetery, am they take flowers, err which are all different techniques which don’t involve talking about it” (Sam)  
“what I notice in in Malta is this this inability or belief that we shouldn’t talk about grief so maybe there wouldn’t be time for saying goodbye to the lost person, am expressing how each they feel in the family and I think this leads and then to am perhaps pathological grief.” (Danielle)  
“children would want to express their feelings but then their parents say ‘we’d better not talk about it’ because they are fearful that perhaps their am emotions will get worse” (Danielle)  
“people would move on, erm perhaps people would I don’t know, the loss of a wife or a, or of a partner, perhaps they would move on but emotionally they would be stuck.” (Danielle)  
“from a psychological point of view they wouldn’t have gone through the grieving am, or they would be going through it sort of but still in the denial stage” (Danielle) |
| Manifestations of  | (cont.)                        | “There is grief and there’s remembering… I don’t consider that grief anymore” (Chloe)  
“I think you have that grief at that like on an anniversary and you kind of have that, when you remember the person but am I don’t, I don’t see that as prolonged grief. I think it’s more erm sort of reflecting on the life of the person” (Chloe)  
“It can even take a year for somebody to get back” (Danielle)  
“I’m thinking of am normal stages of grief, specifically as Kubler-Ross’s err theory, which there’s five stages of grief, with depression being the fourth. So, so lets say it takes a year to get through the first three: denial, am… there’s bargaining... and anger before, am and depression comes out after a year, which is sort of, which is the normal am, the normal flow of things according to that theory. Would then the person, would then they be diagnosed with major depressive disorder or is it just the normal course of, of grief?” (Sam)  
“there’s a certain set of stages erm some people go through them, some people take longer. There’s some people who are stuck in the denial stage a little longer than others so it sort of seems like there’s absent symptoms am which can even go on for years” (Sam)  
“You would always miss him or her but it gets easier with time to get by” (Jennifer) |
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<tr>
<th>Main Theme</th>
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<tr>
<td><strong>Categorisation</strong></td>
<td><strong>Against</strong></td>
<td>“I don’t think I really agree...I mean it’s a normal human process really, it happens to all of us so I don’t know, I’m a bit sceptical” (Danielle)</td>
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<td>“I don’t know because I mean this new DSM-V there’s a lot of, a lot of debate about... pharmaceutical companies” (Danielle)</td>
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<td>“Is it just losses in death? because then there’s a bit of a different story because somebody who maybe a relationship breaks down, they can, that can be counted as loss.” (Chloe)</td>
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<td>“Like one of the criteria is guilt, am having prolonged guilt, which has nothing to do with events that happened around the time of death” (Sam)</td>
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<td>“It’s quite subjective to say it’s gone beyond because of so many factors” (Chloe)</td>
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<td>“the DSM tends to be quite black and white - it’s either it is or it isn’t, either fits or it doesn’t and this is something a bit, I don’t know, it’s very very subjective so I’m a bit undecided” (Chloe)</td>
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<td>“I see a lot of Maltese become helpless and hopeless in the eyes of am current pathology. So I’m thinking, if it was to become a pathology and recognised as a pathology, would people sort of am give up more on people who passed the 12 month period?” (Sam)</td>
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<td>“it’s pointless pumping pills into these people. If it’s grief, you need to work through it and you do this through therapy in my opinion” (Zoe)</td>
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<td>“If a condition is pathologised, a lot of people in Malta, rather, the first reaction would be send them to a psychiatrist not a psychologist” (Sam)</td>
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<td>“I mean if you go there and the psychiatrist tells you ‘go and do an hour of exercise each day, spend time with your family and change your diet’ for example they’d, they’d come out of there ‘He doesn’t know what he’s doing, he didn’t prescribe me pills, I’m going to someone else’” (Sam)</td>
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<td>“from a medical point of view, I think a person who is, who has anxiety, depression, can be treated with medication without being labelled, I suppose. So, if someone is having difficulty, I don’t know his appetite, his interest in, on going out, and I don’t know... But I suppose you can be treated without having a label.” (Danielle)</td>
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<td>“I don’t think they should put a time-frame on it” (Martha)</td>
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<td>“I wouldn’t put it as a mental illness because it’s such a subjective experience” (Martha)</td>
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<td>“I wouldn’t put the time line either because it’s like saying to someone who’s grieving ‘what you’re doing is dysfunctional’” (Andrea)</td>
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<td>Main Theme</td>
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<tr>
<td></td>
<td>Categorisation</td>
<td>“I agree because as it is right now, after two months I’m sure no one would manage to solve their grief after two months and it’s, it’s just related to the diagnosis of mild depressive disorder, after just two months” (Zoe)</td>
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<td></td>
<td>of excessive</td>
<td>“I agree that it needs to be in a separate category cause that would give it even more acknowledgement of the people’s pain and that it’s almost acceptable in a way for the grief to be so prolonged” (Zoe)</td>
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<tr>
<td></td>
<td>grief</td>
<td>“As it is now, we’re pathologising the normality of, of grief.” (Zoe)</td>
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<td>(cont.)</td>
<td>“At times people would need a diagnosis in order for them to access help. So in a way I’m seeing it from both sides, it might be pathologising what we feel is normal but at the same time they, these people believe their just exaggerating their, their normal emotions” (Zoe)</td>
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<td>“if we were to have a different diagnosis, a different diagnostic criteria and the, the duration would be, I don’t know, 12 or 24 months, it would stand to reason that no, no, no antidepressants would be given during that duration because it’s, it’s understood to be prolonged grief rather than Major depressive disorder. So this is why I am saying that it probably might help in some cases, in other cases I don’t know.” (Zoe)</td>
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<td>“I was thinking about this as well because as much as I think the current period should be elongated from 2 months, which is nothing, to 12 or 24 months. If in the case of people who desperately need help before the 12 month mark, are they going to be screwed by the system because we have to wait those 12 months?” (Chloe)</td>
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<td>“I still agree with the fact that there should be that amount of time (12) because maybe in that period of time that person can work through, obviously there is no reason why they can’t get therapeutic help in the meantime” (Chloe)</td>
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<td>Applicability</td>
<td>“If Maltese in general do not talk about it, I think a 12 month period might be too short for this type of culture” (Sam)</td>
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<td></td>
<td>of suggested</td>
<td>“I don’t think it’s that applicable since we, we seem to have the tendency not to talk that much am about it” (Sam)</td>
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<td>duration</td>
<td>“not everyone, I mean not everyone’s situation will be exactly within these limits... it has to be more like a personal thing, not just ticking boxes and seeing ‘ah you have these stuff’” (Andrea)</td>
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APPENDIX D
Table 3. Criteria for Adjustment disorder related to bereavement proposed for DSM-5 (Greis, 2012)

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
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<td>A.</td>
<td>The person experienced the death of a close relative or friend at least 12 months earlier.</td>
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| B.       | Since the death at least 1 of the following symptoms is experienced on more days than not and to a clinically significant degree:  
  1. Persistent yearning/longing for the deceased  
  2. Intense sorrow and emotional pain because of the death  
  3. Preoccupation with the deceased person  
  4. Preoccupation with the circumstances of the death |
| C.       | Since the death at least 6 of the following symptoms are experienced on more days than not and to a clinically significant degree:  
  **Reactive Distress to the Death**  
    1. Marked difficulty accepting the death  
    2. Feeling shocked, stunned, or emotionally numb over the loss  
    3. Difficulty in positive reminiscing about the deceased  
    4. Bitterness or anger related to the loss  
    5. Maladaptive appraisal about oneself in relation to the deceased or the death (eg, self-blame)  
    6. Excessive avoidance of reminders of the loss (eg, avoiding places or people associated with the deceased)  
  **Social/Identity Disruption**  
    7. A desire not to live in order to be with the deceased  
    8. Difficulty trusting other people since the death  
    9. Feeling alone or detached from other people 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 (eg, feeling that a part of oneself died with the deceased)  
    12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (eg, friendships, activities) |
| D.       | The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. |
| E.       | The bereavement reaction must be out of proportion or inconsistent with cultural or religious norms. |
Table 4. Bereavement-related disorder criteria proposed for inclusion in DSM-5
(adapted from Kaplow, Layne, Pynoos, Cohen, & Lieberman, 2012)

**Criterion A**

The person experienced the death of a close relative or friend at least 12 months earlier. (Recommend that this criterion is amended to 6 months in case of children and adolescents)

**Criterion B**

i) The expression of persistent yearning or longing for the deceased.

ii) Intense sorrow or emotional pain

iii) Preoccupation with the person of loss

iv) Preoccupation with the circumstances of death

**Criterion C**

Includes two sub-categories:

i) Reactive distress to the death
   - Difficulty accepting the death (normal for children under age 5)
   - Difficulty reminiscing about the deceased
   - Bitterness or anger related to the loss
   - Maladaptive appraisals about oneself in relation to the deceased or the death.
   - Excessive avoidance of reminders of the loss

ii) Social/Identity disruption
   - Desire not to live in order to be with the deceased.
   - Difficulty trusting other people since the death
   - Feeling alone or detached from others.
   - Feeling that life is meaningless or empty without the deceased or the belief that one cannot function without the deceased.
   - Confusion about one’s role in life or a diminished sense of one’s identity.