2006

Silenced voices: Experiences of grief following road traffic crashes in Western Australia

Lauren Breen
Edith Cowan University

Edith Cowan University

Copyright Warning

Silenced Voices: Experiences of Grief Following Road Traffic Crashes in Western Australia

Lauren Jennifer Breen BSc (Psych) Hons, Grad Cert Ed (Tertiary Teaching)
Faculty of Computing, Health and Sciences
Edith Cowan University
Western Australia

A thesis submitted in partial fulfilment of the requirements
for the award of Doctor of Philosophy (Psychology)
Date of submission: 24 October 2006

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

Statement of Confidentiality

Ethical clearance from the Edith Cowan University Ethics Committee was granted in July 2002. The confidentiality and privacy of the informants were protected at all times, including in all correspondence between myself, research supervisors, and other colleagues. Pseudonyms for the bereaved informants and their family members are used throughout the thesis. All raw data included in the thesis (i.e., verbatim quotes) were scrutinised for information that could render the informant identifiable.

Abstract

Despite the introduction of road safety measures and media campaigns, crashes are a leading cause of death in Western Australia. While economic costs of crashes are relatively easy to determine, their psychosocial burden remains appreciably under-studied, as are the social, cultural, historical, temporal, and political contexts within which grief experiences are housed. As such, I explored the experience of grief resulting from losing a loved one in a crash in Western Australia and described the influence of contextual factors on those grief experiences.

Constructionist grounded theory methodology was utilised. Data were collected from two informant groups – 10 were employed in road safety and post-crash services in Western Australia and 21 were Western Australians bereaved through the loss of a family member in crashes. Data were collected via in-depth recursive interviews, a 'scoping and profiling' process, and public documents.

The data indicate that the bereaved informants were subjected to a number of silencing processes whereby their expression of grief is constrained - by themselves, their families and social networks, the legal and service systems, and the government road safety discourse. In Chapter 4, I discuss the bereaved informants' experience of grief and demonstrate that their experiences challenge the dominant discourse that constructs grief as a short-term, stage/phase/task-based, finite, and meaningful phenomenon that culminates in the detachment from the deceased loved one. Instead, they described their grief as unique, long-lasting, characterised by an oscillation of emotions, whereby meaning and/or positives were not found. Further, their relationships with the deceased were likely to be maintained, and meaning in or positives from the deaths of loved ones were unlikely to be found. In Chapter 5, I examine the bereaved informants' experiences within their families and social support networks. The informants' social networks often imposed the dominant grief narrative, leading to the deterioration and collapse of many relationships. In Chapter 6, I outline the bereaved informants' experiences of voicelessness within the legal, service, and road safety domains. The legal conceptualisation of crashes, the reactive and superficial service system, and government bureaucracy and rhetoric served to further silence the bereaved informants' experiences of grief. In Chapter 7, I discuss the bereaved informants' attempts to 'break the silence'

by resisting the dominant discourse concerning grief, its enforcement within their social support networks, and the conceptualisations of their experiences as held within the legal, service, and road safety domains. These attempts include peer support, participation in mutual help groups, and active involvement in attempts to change government policies.

I position the findings within the context of existing literature and frameworks and explicate the ways in which my study has made a substantial and novel contribution to understanding the experience of grief following crashes in Western Australia, including the implications for three key tensions in the thanatological literature - the transferability of classic grief theories, the medicalisation of grief, and the efficacy of grief interventions. In addition, I outline the strengths and limitations of the study, draw implications of and recommendations from the findings, and suggest avenues for future research.

Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

(i) Incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;

(ii) Contain any material previously published or written by another person except where due reference is made in the text; or

(iii) Contain any defamatory material.

I also grant permission for the Library at Edith Cowan University to make duplicate copies of my thesis as required.

Signature: _____

Date: _____

Acknowledgments

I would like to begin by thanking the informants in this research, especially those bereaved as a result of a crash. I feel forever privileged to have listened to your stories and thank you for your time and unwavering patience. I would like to thank The Compassionate Friends and Australian Parents Against Road Trauma for assisting in the identification and recruitment of some of the informants to the study.

I would like to acknowledge and thank my supervision team. My principal supervisor, Dr Moira O'Connor, is an amazing supervisor, combining a sharp intellect with empathy, support, advice, humour, and timely feedback. I couldn't have asked for more! I would also like to thank my Associate Supervisor, Associate Professor Margaret Mitchell, who joined the team while I was writing the thesis, and my Adjunct Supervisor, Dr Christopher Sonn (Victoria University), who was instrumental in the conceptualisation and early development of the project.

I would like to acknowledge all those that have shaped the project over the years – the proposal reviewers, Dr Susan Pradip Griffiths and Dr Val Roche, and those that attended my thesis proposal presentation. I didn't give my project justice but I hope you were able to recognise its worth. Your comments and questions during the development stage of the project was invaluable in making the study stronger. I would also like to thank Professor Alison Garton, who acted as a critical reader of the entire draft.

I would also like to acknowledge and thank everyone who aided and supported the study. Thank you to Tracey Ahern, Tamara Breen, Ana Ilijovska, and Sue Timewell for your time and effort in transcribing some of the interviews, which saved me many hours. Thanks are also due to the support staff in the School of Psychology at Edith Cowan University – Trish Burke, Carole Gamsby, Nicky Kemp, Ho Lai Thuan, Sue Timewell, and Alison Young. Thank you to my friends and (fellow sufferers) at university for travelling this journey with me. I would especially like to acknowledge Dr Dawn Darlaston-Jones for her assistance and encouragement at various stages of the study, and reading ALL my chapter drafts before I showed my supervisors!

I would like to thank my family for their unwavering support while I studied at university. I would especially like to acknowledge my mum, Jenny Breen, who rearranged her work hours and used some of her annual leave to look after my daughter one day a week so I could keep writing. Finally, to my husband Shannan Maloney, for always believing I could do it, and our daughter Mia. I dedicate this to you both.

Table of Contents

List of Appendices

List of Tables

List of Acronyms

ABS	Australian Bureau of Statistics
APA	American Psychiatric Association
APART	Australian Parents Against Road Trauma Inc.
DSM	Diagnostic and Statistical Manual of Mental Disorders
FEVR	Federation of European Road Traffic Victims/Fédération Européene des Victimes de la Route
MDD	Major Depressive Disorder
OECD	Organization for Economic Cooperation and Development
PTSD	Post-traumatic Stress Disorder
RAC	Royal Automobile Club (Western Australia)
RTST	Road Trauma Support Team
TCF	The Compassionate Friends Inc.
WA	Western Australia
WHO	World Health Organisation

Chapter 1: Introduction

The aims of Chapter 1 are to provide an introduction to the research reported in this thesis and set the scene for subsequent chapters. I provide a review of crash deaths and their ramifications and present the rationale for the exploration of grief experiences following crashes in Western Australia (WA). The background to and significance of the research are outlined, and although expanded upon in subsequent chapters, justification for the use of grounded theory as the methodology and interviews as the primary method of data collection is presented. The relationship between the research and community psychology is outlined. I discuss my role as the researcher along with the experiences that led to the development of the study. Next, the aims and research questions are outlined. Finally, I provide an overview of the structure of the thesis and the contents of subsequent chapters.

Traffic crashes are a relatively new phenomenon in terms of human history. The first crash is thought to have occurred in 1771 when Joseph Cugnot, a French mechanic, engineer, and inventor of the first self-powered road vehicle, drove one of his vehicles into a wall (Bellis, 2004)[1]. Deaths via road crashes are an even more recent phenomenon, beginning a little over 100 years ago. The first recorded British fatality occurred in January 1896 when a car, travelling at four miles per hour, hit and killed a pedestrian (Mitchell, 1997a). Deaths and injuries resulting from crashes in Britain subsequently became such a problem that from 1909, Britain began collecting data regarding the number and severity of crash deaths and injuries and their causes (Broughton, 1997; Mitchell, 1997a). Other countries followed as the numbers of deaths and injures continued to rise, and by 1974, the World Health Assembly had declared road crashes a significant public health problem.

Today, traffic crash fatalities remain a significant global health issue resulting in a considerable number of deaths per year. As a result of the carnage, in 2004 the World Health Organization (WHO) launched its *World Report on Road Traffic Injury Prevention* and dedicated its World Health Day to road safety. WHO (2004) estimates that almost 1.2 million people are killed (and between 20 and 50 million are injured)[2] in traffic crashes every year worldwide and suggests that the number of deaths (and injuries) will increase by 65% by 2020. In fact, 2002 data demonstrate that traffic crashes were the second leading cause of death for the 5 to 14 and 15 to 29 year age groups, the third leading cause of death for the 30-44 year age group, and the 11th leading cause of death worldwide, accounting for 2.1% of all deaths. Further, because more than 80% of crash fatalities occur in the 15 to 44 year age group, crashes are the ninth leading cause of the global burden of disease (WHO, 2004). WHO (2004) predicts that, if trends continue, traffic crashes will be the 6th leading cause of death by 2020 (accounting for 3.4% of all deaths). In the following section, I present data indicating the comparative fatality rates from crashes across a number of industrialised countries, including Australia.

[1] Accepted as the first road crash by historians who accept steam powered vehicles as automobiles (Bellis, 2004).
[2] Injuries resulting from crashes are beyond the scope of this thesis.

A Comparison of Australian and International Traffic Crash Death Data

One method of assessing Australia's road safety record is to compare rates across Organization for Economic Cooperation and Development (OECD) countries[3]. Prior to 1990, Australia's fatality rate per 100,000 people exceeded the OECD mean. Since 1990, the fatality rate per 100,000 people has been less that the OECD mean (Australian Transport Safety Bureau, n.d.-a). In 1996, Australia ranked 7th in terms of fatalities per 10,000 registered vehicles and 12th in terms of fatalities per 100,000 people (Federal Office of Road Safety, 1999). A year later, Australia's comparative situation improved. In 1997, Australia had 1.5 fatalities per 10,000 registered vehicles. As a result, Australia was ranked 6th, behind Iceland, Sweden, Norway, Switzerland, and the United Kingdom (Australian Transport Safety Bureau, n.d.-b). The same year, Australia ranked 10th in terms of crash fatalities per 100,000 people (Australian Transport Safety Bureau, n.d.-b). The top nine were (in descending order) Iceland, Sweden, United Kingdom, Norway, Netherlands, Switzerland, Finland, Japan, and Denmark. Australia's situation improved again the following year. In 1998[4], Australia was again ranked 6th in terms of the number of fatalities per 10,000 registered vehicles, behind Sweden, United Kingdom, Switzerland, Japan, and Norway, and 8th in terms of the number of fatalities per 100,000 people, behind Sweden, United Kingdom, Netherlands, Finland, Norway, Switzerland, and Japan (Australian Transport Safety Bureau, n.d.-a).

In addition to the fatality rate per 100,000 people and per 10,000 vehicles, the fatality rate per kilometre is also used to account for the size of a country. According to the Bureau of Transport and Regional Economics (2003), data that would enable a comparison across countries of the fatality rate per kilometre are unavailable; however, they note that Australia has a lower fatality rate per 100,000 people than comparably-sized countries such as Canada and the United States. In the following section, I outline the magnitude of traffic crash deaths in Australia.

Australian Traffic Crash Deaths

The date of the first Australian traffic crash fatality is indeterminable as Australia began recording the number of crash deaths in 1925. This was a relatively late development, considering there were 700 crash deaths that year and over 300,000

[3] The OECD countries are generally wealthy with a satisfactory level of infrastructure.
[4] The most recent year these data are available.

vehicles on the road (Australian Transport Safety Bureau, 2003a). A year later (1926), the number of crash deaths had jumped to 901 (Australian Transport Safety Bureau, 2003a)[5]. The fatality rate per 10,000 vehicles peaked at 23.1 deaths in 1926 (Australian Transport Safety Bureau, 2003a). Since then, both the total number of deaths and rate per 100,000 people has steadily declined. In 2002, there were almost 12,822,000 registered vehicles and the population was 19,662,800 (Australian Transport Safety Bureau, 2003b) yet despite the rapid increase in population and motorisation, in 2002 there were 1715 crash deaths nationally, representing a rate of 8.7 deaths per 100,000 people and 1.3 deaths per 10,000 registered vehicles (Australian Transport Safety Bureau, 2003b).

The reduction in fatality rates in Australia has been attributed to many factors, including the introduction of road safety measures such as speed cameras and random breath testing, enforcement by police of road rules, increased use of vehicle restraints, improved road quality, vehicle improvements, mass media road safety campaigns, improved medical treatment, and legislative changes related to the above (J. Clark, 1998, 2000; Federal Office of Road Safety, 1998; McGrath, 2000; Road Safety Council of WA, 2000a, n.d.; WHO, 2004; Vulcan, Cameron, & Newstead, 1995). In addition to these measures of vehicular and behavioural change, road quality has been improved via the Federal Government's Black Spots programs (Federal Office of Road Safety, 1998).

Despite such progress, crashes remain a significant cause of death. In Australia, crashes are a leading cause of death, resulting in 3.2% of all male fatalities and 1.7% of female fatalities in 2003 (Australian Bureau of Statistics, ABS, 2005). Indeed, crashes are the single largest cause of death for Australians aged between 1 and 24 years, the second largest cause of death for Australians aged 25 to 34 years, and a significant cause of death for those aged 35 years or more (ABS, 2005). In the following section I discuss deaths causes by crashes within the Western Australian context.

Deaths Resulting from Crashes in WA

The number of crash deaths in WA peaked at 358 deaths in 1973 (Australian Transport Safety Bureau, 2003a). Since then, WA has witnessed a decreasing trend in the number of crash deaths. In 1990, WA's fatality rate per 100,000 people was the

[5] Northern Territory data are not included in these records, as data pertaining to crash deaths were not collected there until 1962 (Australian Transport Safety Bureau, 2003a).

lowest of all Australian states (Lyhne, 1999)[6]. However, the fatality rate per 100,000 people remained relatively constant in WA during the 1990s, while other states demonstrated significant reductions (Lyhne, 1999). With the exception of the Northern Territory, WA has had the highest fatality rate from road crashes of any state or territory in Australia since 1996 (Kirov, Legge, & Rosman, 2000; Lyhne, 1999; Road Safety Council of WA, n.d.). The numbers of deaths resulting from crashes in WA remained relatively stable during the 1990s, but appears to be decreasing in the 21st century (see Table 1).

Table 1

Crash Deaths and Rate per 100,000 People in WA 1990-2006

Year	Deaths	Deaths per 100,000 people
1990	196	12.2
1992	207	12.7
1992	200	12.1
1993	209	12.5
1994	211	12.4
1995	209	12.1
1996	247	14.0
1997	197	11.0
1998	223	12.2
1999	218	11.8
2000	212	11.3
2001	165	8.7
2002	179	9.3
2003	179[a]	
2004	179[a]	
2005	164[a]	
2006	134[b]	

Note. Adapted from Australian Transport Safety Bureau (2003a)
[a] accessed from the Office of Road Safety's website at http://www.roadsafety.wa.gov.au on 20th March 2006.
[b] as of October 12, 2006, which is 26 greater than at the same time in 2005. Source: *The Sunday Times*, October 15, 2006, p. 2.

Psychosocial and Economic Ramifications of Crash Deaths

Globally, the direct economic cost of road traffic crashes has been estimated at US$518 billion, therefore representing a significant burden worldwide (WHO, 2004).

[6] The Australian Capital Territory, however, has the lowest rates of crash deaths in Australia.

The Bureau of Transport Economics (2000) estimated the economic costs of Australian crashes in 1996 reached almost A$15 billion. The total consisted of human costs, vehicle costs, and general costs. Human costs are those associated with ambulances, hospitals, rehabilitation, long-term care, workplace and household labour, quality of life, legal and coronial processes, correctional services, and funerals. Vehicle costs consist of repairs, towing, and vehicle unavailability. General costs consist of travel delays and the administration of insurance. Fatal crashes account for almost $3 billion of the total $15 billion (Bureau of Transport Economics, 2000). Further, the Bureau of Transport Economics reported that fatal crashes are by far the most costly type of crash, with the average fatal crash costing $1.7 million.

Estimates provided within publications such as that provided by the Bureau of Transport Economics (2000) have been criticised as 'deficient' and 'rough' (Giles, 2003a) because they are based on selective road crash data collection methodology (Giles, 2001, 2003b) and use the non-preferred method of cost calculation (Giles, 2003a). Instead, she estimates the cost of Australian crashes in 1996 is likely to be greater than A$344 billion (Giles, 2003a). Giles (2003a) further argues that the consequences of accepting her estimate are twofold – crash prevention would be a greater priority than its current status, and measures to reduce crashes would no longer be abandoned based on cost-benefit analyses.

The financial costs highlight the economic burden of crashes on the Australian economy. In addition to the economic imperative, crashes have a number of psychosocial implications that cannot be adequately captured by economic estimates. It is estimated that approximately 13 people are significantly affected by every fatal crash (Haywood, 1998), and these include family, friends, colleagues, witnesses, emergency service workers, and even entire communities (Federation of European Road Traffic Victims/Fédération Européene des Victimes de al Route, FEVR, 1993, 1995; Hobbs & Adshead, 1997; Keir, 2000; Lord, 1987, 1996, 2000; Tehrani, 2004; Willis, Cameron, & Igoe, 1997; WHO, 2004).

Despite the economic and psychosocial ramifications, there is a dearth of research on bereavement outcomes following crashes (see Chapter 2 for a full review of grief, including grief resulting from crash fatalities). A number of potential reasons for

the dearth of research and the provision of support are discussed in the literature. The lack of support is likely a result of governments and society denying the lethality of motor vehicles (J. Clark, 2000, 2004; Haywood, 1998; Lord, 2000; Sleet & Branche, 2004), a tendency to avoid viewing offences that lead to crashes as criminal (Ross, 1961; Sprang, 1997), our economic reliance on motor vehicle manufacture, use, and fuel-dependency (Brown, 1972; Browning, 2002; Mitchell, 1997a; Roberts, Mohan, & Abbasi, 2002; WHO, 2004), and even a conspiracy between governments and the motor industry that enables them both to profit from our unquestioning acceptance that individual road users are responsible for road safety (Roberts et al., 2002). For example, according to some commentators (e.g., Brown, 1972; J. Clark, 2000; Nader, 1965; Roberts et al., 2002), the motor manufacture industry has historically opposed and continues to oppose the introduction of alterations in vehicle design that would significantly reduce the quantity and magnitude of crash-related deaths and injuries. Similarly, while seatbelts were invented in 1903, they were not made compulsory in Australia (first in the state of Victoria) until 1970 (J. Clark, 2002).

In addition, the notion of freedom of movement has traditionally been prioritised over safety, public transport, and environmental concerns, and so road safety is seen as a component of the transport sector instead of a public health concern (J. Clark, 1999a; Grigg, 1999; Mitchell, 1997a; WHO, 2004). Indeed, WHO (2004) emphatically argues for a paradigm shift whereby "the perception that [the road traffic injury problem] is the price to be paid for achieving mobility and economic development needs to be replaced by a more holistic ideology that places the emphasis on the total system of road traffic" (p. 3).

Further, crashes have customarily been thought of as inevitable, unpredictable, unexpected, and unpreventable 'accidents' that cannot be avoided (Ball-Rokeach, Hale, Schaffer, Porras, Harris, & Drayton, 1999; Howarth, 1997; Loimer & Guarnieri, 1996; Mitchell, 1997a; Roberts et al., 2002; Sleet & Branche, 2004; Stewart & Lord, 2002; Suchman, 1961; Vigilant & Williamson, 2003; Waller, 2001; WHO, 2004; Zaza et al., 2001). Some have argued that the use of the term 'accident' has a political motive, in that it is often used to excuse criminal negligence on behalf of individuals as well as governments and the motoring industry (Loimer & Guarnieri, 1996; Roberts et al., 2002;

Vigilant & Williamson, 2003). As Kastenbaum (2001) noted, ""Accident" implies that nothing could have been done to prevent the loss of life – thereby contributing to lack of prevention in the future" (p. 239). In fact, decisions regarding life and death might be covertly made in accordance to a judgement of death acceptance. For example, it has been argued that we tend to tolerate vehicle manufacturers who design, make, and market vehicles capable of excessive speeds (R. J. Gregory, 1998).

Despite the frequency of crashes and the prevalence of crash-related deaths, there remains a distinct lack of attention to their outcomes. In fact, WHO (2004) considers road crashes and their consequences are "neglected" (p. 3), J. Clark (2004) described them as "notoriously hidden" (p. 11), and Job (1999) referred to them as "part of the almost unnoticed background" (p. 38). In terms of other causes of death, crashes are thoroughly under-funded when compared to the effort in reducing the number of deaths from heart disease, cancer, HIV/AIDS, malaria, diarrhoeal diseases, and tuberculosis (Vigilant & Williamson, 2003; WHO, 2004). Some commentators have noted that the "steady drip" (Browning, 2002, p. 1165) of crash fatalities is considered trivial whereas other causes of sudden death such as aeroplane and train crashes and war warrant significantly more media attention and are considered to be legitimately traumatic (e.g., Browning, 2002; J. Clark, 2000; J. Clark & Franzmann, 2002; Di Gallo & Parry-Jones, 1996; R. J. Gregory, 1998; Mitchell, 1997a; Reid, 2003; Reid & Reid, 2001; Suchman, 1961; WHO, 2004; M. Williams, 1997). In addition, the aid given to countries affected by the 2004 Indian Ocean tsunami (in which approximately a quarter of a million people died) contrasts with the global reticence to recognise crash fatalities. To illustrate, a quarter of a million people die every year in crashes in China (WHO, 2004). Contrast the apathy with the global effort to prevent deaths via terrorism and the distinct lack of concern regarding crash fatalities becomes apparent.

Given the context of crashes, the potential for psychological distress following a fatal crash is significant. Crashes occur suddenly, the likelihood of injury or even death is significant, and, as crashes are relatively common, there is the opportunity of retraumatisation (Keir, 2000). These issues have the potential to further complicate the grief of people who have lost a loved one in a crash. The gaps in social support and services demonstrate that those bereaved through crashes are not offered the level and

intensity of support granted to those affected by other causes of death or major disasters. As a result of the factors discussed above, the psychosocial consequences of crash-related bereavement remain largely ignored and unsupported (Adshead, 1997; Mitchell, 1997a), "yet the shock and horror are equally real" (M. Williams, 1997, p. 18).

Despite the abundance of literature concerning grief, many areas remain under-researched. For example, there is a dearth of research relating specifically to grief in the aftermath of crashes, despite crashes being a major cause of death and injury worldwide. To ensure those around the bereaved provide appropriate care and support to them, it is imperative that grief following crashes is understood. Pilkington (1993) argued that it is through understanding grief that service providers, including psychologists, are best able to effectively assist with the bereaved. Despite this imperative, there are few studies on the psychosocial experience of grief following crashes (e.g., FEVR, 1993, 1995; Lehman, Wortman, & Williams, 1987; Lord, 1987, 1996, 2000; Shanfield & Swain, 1984; Sprang, 1997; Stewart, 1999; Tehrani, 2004). With the continually high number of people bereaved following crashes, it is crucial to understand how people make sense of their grief experiences.

The Researcher

The act of research is culturally and value laden and subjective and, as such, it is becoming increasingly common for researchers to clarify their personal motivation for and role in their research (Creswell, 1994; Crotty, 1998; Delgado-Gaitan, 1993; Fischer, 1999; Patton, 2002; Prilleltensky, 1997; Unger, 1975) and was a recent recommendation for researchers engaging in bereavement research (Bridging Work Group, 2005; P. R. Silverman, 2000). As a result, I have included the following section in an effort to share with the reader my research orientation. In undertaking this research, I acknowledge my personal experiences influenced my decision to research the experience of grief following the loss of a loved one in a crash in WA. Further, I acknowledge that my experiences also influenced the way in which I have chosen to research this topic.

For some researchers, the motivation for their choice of topic results from a combination of experiences and moments. For me, it began in the very early hours of the 11th February 1999. I was holidaying in regional Victoria with my partner Shannan when his father telephoned to tell him his sister Skye had been killed in a crash caused by a

speeding motorist. Skye's funeral was held a week after her death. Neither Shannan nor I had been to a funeral before. Hundreds of people attended; among them were family friends, neighbours, and Skye's school friends. After the funeral, Shannan's mum and I were talking about it in the lounge room. She looked over at the coffee table, covered in photographs of her daughter, and hesitantly stated, "I guess I should put these away now". I recall feeling uneasy, but I did not know why. Thinking back to it now, this was the first time I noticed how the social norms concerning grief affect mourning practices.

Over the subsequent days, months, and years after the crash, Shannan's family, particularly his parents, came into contact with funeral directors, the media, the coronial process, the justice system, and insurance companies. It became clear to me that the grief resulting from crashes does not occur in a vacuum. People bereaved though crashes likely face police and coronial investigations, and the health and justice systems, among others. Further, grief is experienced within a network of families, friends, and the wider community.

It amazed me how generous people could be. Another family friend whom I had heard of but never met, visited Shannan's parents every day for over a year, making sure they were okay and just being there with them and for them. She was also a great support for Shannan. I was also surprised at how it seemed other people could not 'deal' with Skye's death and 'disappeared'; that is, they stopped telephoning and visiting. It was during this time that I realised the importance of social support and how it does not always come from where you might expect it. Shannan's parents and some of their friends tried to find a support service for people who have been bereaved through crashes but could not find any. It was then that I thought that research would likely have practical implications on the delivery of services and supports for people grieving the loss of a loved on through a crash.

I started to think about the role that psychology could play in providing bereavement support. Out of personal interest, I began to search the literature for information on grief. Two of my findings motivated me to explore the topic in more depth via a thesis. First, I noticed that a significant emphasis in the grief literature was on intrapsychic or individual variables. However, understanding grief primarily as an intrapsychic, individual phenomenon did not fit with my observations of the experiences

of Shannan's family's experiences within legal and coronial contexts, and so on. Nor did it fit my orientation as a community psychologist. It became obvious to me that a thorough understanding of the grief experience resulting from crashes could only be articulated through understanding the wider context within which the grief occurs. It is for this reason that I took a contextual approach to the study of grief. Community psychology, with its emphasis on understanding individuals in their natural (non-manipulated) contexts (Dalton, Elias, & Wandersman, 2001; Duffy & Wong, 2003; Thomas & Veno, 1992), provided a framework for contextual analysis.

Second, I observed that the classic bereavement theories were by and large constructed from data collected from North American, white, middle-class, middle-aged, widows grieving the loss of their husbands, often after a long illness or adapted from models of dying (see Chapter 2 for a review). I began to wonder about the degree to which the findings would transfer to other bereaved populations, such as those bereaved through crashes. I wondered whether or not the findings from the classic studies were being uncritically applied to people with different bereavement circumstances and I became concerned with this possibility. Crash deaths are sudden, unexpected, violent, and usually preventable (Hobbs & Adshead, 1997; Sleet & Branche, 2004; Stewart, 1999; Stewart & Lord, 2002; Waller, 2001; WHO, 2004; Zaza et al., 2001). As a result, the characteristics of crash deaths differ from many other reasons for death, such as illness or old age. In addition, the victims of crash fatalities are of a significantly younger age than those that die from natural causes (ABS, 2005; WHO, 2004). A further characteristic of crash deaths is their 'hidden' or acceptable nature. Crash fatalities are generally not considered to be legitimate in the way that deaths through war, aeroplane crashes, natural disasters, or acts of terrorism are (e.g., Adshead, 1997; Browning, 2002; J. Clark, 2000; J. Clark & Franzmann, 2002; Di Gallo & Parry-Jones, 1996; R. J. Gregory, 1998; Mitchell, 1997a; Suchman, 1961; Tehrani, 2004; Vigilant & Williamson, 2003; WHO, 2004; M. Williams, 1997), yet the experience can be just as devastating to those affected (e.g., FEVR, 1993, 1995; Lehman et al., 1987; Lord, 1987, 1996, 2000; Shanfield & Swain, 1984; Sprang, 1997; Tehrani, 2004; WHO, 2004; M. Williams, 1997; see Chapter 2 also). For these reasons, the social, cultural, historical, and political

contexts within which the bereavement experience is housed became increasingly important to me.

Congruent with this contextual line of thinking, I chose to explore the grief experience in the aftermath of crashes within the Western Australian context. Attending to the context within which a phenomenon occurs is gaining increasing recognition, as an understanding of the context serves to facilitate the understanding of the experience under study. As a result, my research was developed from a constructionist perspective, as detailed in Chapter 3. By focussing on a particular phenomenon within a particular context, I anticipated that understanding the experiences of those bereaved through crashes in WA would likely result in practical implications.

While the death of Skye was not a personal loss to me, I was able to observe the gravity of the situation and came to appreciate the affect the death of a loved one has on those left behind. It was these experiences that I have summarised above that culminated in my choosing to research the grief experiences resulting from crashes in WA. I embarked on the initial stages of thesis development in 2001.

Aims and Research Questions

The broad aims of this research were to explore the experience of grief resulting from losing a loved one in a crash in WA and to describe the influence of the contextual factors on the grief experience, in order to develop a clearer picture of the role of contextual factors on supporting and inhibiting the experience of grief following crash fatalities.

The research questions are as follows:

1. What is the experience of grief resulting from a crash?
2. What factors affect the experience of grief resulting from crashes? In what ways do they affect the grief experience?
3. Are there relationships between these factors? If so, what are they and how do they affect the grief experience resulting from crashes?
4. What are the implications for WA in terms of service delivery pertinent to crash-related bereavement?

Changes to research questions are common in grounded theory studies (May, 1986). The difference in the research questions from that proposed originally is the

addition of the fourth question, which arose out of my motivation for my research to have practical applications relevant to the Western Australian context.

Structure of the Thesis

In Chapter 2 I review the literature of grief and bereavement. After outlining the scope of the review, I first provide an overview of the physical, affective, cognitive, and behavioural outcomes following bereavement. Second, I examine the factors that are thought to mitigate and obfuscate the experience of grief – the circumstances of the death, the characteristics of the bereaved individual, interpersonal support, and sociocultural factors. Third, I summarise research pertaining to grief resulting from crashes. Next, I discuss the three key tensions in bereavement theory and research – the transferability of classic grief theories, the medicalisation of grief, and the efficacy of grief interventions. Finally, I provide a rationale for the contextual exploration of the grief experience following fatal crashes in WA.

In Chapter 3, I outline the methodology of the study. I restate the purpose of the study and the associated research questions and provide an overview of the design of the study, including a discussion on the epistemology of constructionism and the methodology of grounded theory. Next, I discussed the informants, materials, procedure, ethical considerations, and data analysis procedures. Data were collected from two groups of informants. The first group consisted of people involved in the area of road safety and support services in the aftermath of crashes. The second group consisted of people bereaved through crashes in WA. A rationale for the use of in-depth recursive interviews as the primary data collection method is outlined. A 'scoping and profiling' process and documents were additional sources of data. Data from multiple sources were required to uncover the multiple truths concerning the experiences of grief following crashes.

The data are presented in Chapters 4, 5, 6, and 7. The findings indicate that the bereaved informants are subjected to a number of silencing processes whereby their expression of grief is constrained by themselves, their families and social networks, the legal and service systems, and the government. In Chapter 4, I discuss the bereaved informants' experience of grief and demonstrate that their experiences challenge the dominant discourse concerning grief that constructs grief as short-term, finite,

meaningful, and ending in recovery and detachment from the deceased. Instead, they described their grief as unique, long lasting, and characterised by oscillation of emotions. Further, they strived to maintain their relationships with the deceased and were unlikely to find meaning in or positives from the deaths of their loved ones. In Chapter 5, I examine the bereaved informants' experiences within their families and social support networks and show that, here too, their needs and experiences are often silenced within these networks. In Chapter 6, I outline the bereaved informants' experiences of voicelessness within the legal, service, and road safety domains. In Chapter 7, I discuss the bereaved informants' attempts to 'break the silence' by resisting the dominant discourse concerning grief, its enforcement within their social support networks, and the conceptualisations of their experiences as held within the legal, service, and road safety domains. These attempts include learning to rely on themselves, peer support and mutual-help, and overtly political acts. Because grief is not specific to a particular discipline, a multidisciplinary approach was taken to the literature search and review in order to aid the interpretation of the data.

In the final chapter (Chapter 8), I position the research within the context of existing literature and frameworks and explicate the ways in which my study has made a substantial and novel contribution to both theory and practice concerning the experience of grief resulting from crashes in WA. In addition, I outline the strengths and limitations of the study, draw implications of and recommendations from the findings, and suggest avenues for future research.

Definitions

The terms crash, fatal crash, crash death/crash fatality, bereavement, grief, and mourning are defined as follows:

Crash: "any apparently unpremeditated collision reported to police which resulted from the movement of at least one road vehicle on a road open to and used by the public, and involving death or injury to any person, or property damage" (Road Safety Council of WA, 2000b, p. 3, italics in original). The use of the term 'accident' is questioned internationally in disciplines of health and safety, as the underlying assumption of the word 'accident' implies a random event that is unpredictable and inevitable rather than preventable (Ball-Rokeach et al., 1999; Hobbs & Adshead, 1997;

Howarth, 1997; Job, 1999; Loimer & Guarnieri, 1996; Mitchell, 1997a; Roberts et al., 2002; Sleet & Branche, 2004; Stewart & Lord, 2002; Suchman, 1961; Vigilant & Williamson, 2003; Waller, 2001; WHO, 2004; Zaza et al., 2001). The term 'crash', which does not presuppose the cause of the crash could not be prevented, is a reaction to terms such as accident, motor vehicle accident, and its acronym, MVA, which are all commonly used (e.g., Blanchard, Hickling, & Kuhn, 2003; Currier, Holland, Coleman, & Neimeyer, in press; Daggett, 1999; Mitchell, 1997b; Riches & Dawson, 2000, 2002; Rodger, 2005). In recognition of the importance of language, a recent American movement has called for the use of the term motor vehicle collision or crash with the acronym MVC (see Reid & Reid, 2001; Stewart & Lord, 2002). However, the terminology remains subject to debate (see Blanchard et al., 2003; Stewart & Lord, 2002; Stewart & Lord, 2003).

Fatal Crash: "any road crash occurring on a public road which resulted in the death of road user within 30 days which directly or indirectly occurred to vehicle movement" (Australian Transport Safety Bureau, 2003a, p. iv).

Crash death or crash fatality: "any person who, as a result of a road crash, dies within 30 days of the crash" (Australian Transport Safety Bureau, 2003a, p. iv).

Although often used interchangeably (Jacob, 1993), bereavement, grief, and mourning signify different aspects of loss and are generally defined as follows (e.g., Hansson & Stroebe, 2003; Jacob, 1993; T. L. Martin & Doka, 2000; M. Stroebe, Hansson, Stroebe, & Schut, 2001a; M. Stroebe, Stroebe, & Hansson, 1988, 1993a; Walter, 1999; see also Chapter 2).

Bereavement: Situation of having lost a significant person by their death.

Grief: Response to being bereaved.

Mourning: Manner in which grief is expressed.

Chapter 2: Literature Review

The purpose of Chapter 2 is to present the background to my study by providing a detailed overview of the grief literature, including theories, methods, and empirical findings. The chapter is divided into five main sections. I begin by providing an overview of the physical, affective, cognitive, and behavioural outcomes following bereavement. I then outline the factors that are thought to mitigate and obfuscate the experience of grief – the circumstances of the death, the characteristics of the bereaved individual, the type and extent of interpersonal support received by the bereaved, and sociocultural factors. Stemming from the notion that grief following crash fatalities comprises a number of 'risk' factors, in the third section I review research on grief resulting from crash fatalities. Next, I discuss three key tensions in grief theory and research that have informed the development of the research project – the extent to which the classic grief theories, and the dominant grief discourse that emerges from them, can be applied to all grief experiences; the increasing medicalisation of grief, including the debate concerning 'complicated grief' as a diagnostic category; and the efficacy of grief services and interventions. Finally, I conclude with my justification and rationale for the contextual exploration of the grief experience following fatal crashes in WA.

Death, dying, grief, and loss have long been topics considered in religion, philosophy, poetry, paintings, songs, and literature. However, grief has only relatively recently entered the realm of interest for scientific study, which began in earnest early in the 20th century. Consequently, the landscape of knowledge concerning grief has developed substantially over the last century, and is a topic of much interest in health-related disciplines. Research on or related to grief has occurred in a number of disciplines, mostly medicine, nursing, and psychology (Neimeyer & Hogan, 2001), and also includes sociology, anthropology, law, education, history, and literature. Although mourning behaviours and rituals differ across cultures, the phenomenon of bereavement is a universally shared experience, and, therefore, is of multidisciplinary interest. It is this universal characteristic that renders grief amenable to investigation across disciplinary boundaries and perspectives.

I have defined the terms bereavement, grief, and mourning in the following manner[1] – bereavement is defined as the situation of having lost a significant person by their death, grief is the response to being bereaved, and mourning is the manner in which grief is expressed (Hansson & Stroebe, 2003; Jacob, 1993; T. L. Martin & Doka, 2000; M. Stroebe, Hansson, et al., 2001a; M. Stroebe, Stroebe, & Hansson, 1988, 1993a; Walter, 1999). In addition, the review primarily incorporates literature from the three disciplines that are most prolific in grief research – psychology, medicine, and nursing (Neimeyer & Hogan, 2001) – and is also informed from research in others disciplines such as sociology, anthropology, public health, pastoral care/theology, and history. Finally, the main themes and issues in the grief literature are reviewed herein: however, the review is limited by three factors; first, there has been a veritable explosion of thanatological research in recent decades and, as such, many grief publications could be included; second, despite the increased interest in diverse causes of grief via losses such as divorce and chronic illness, I have limited my review of the literature to bereavements caused by the deaths of significant others; and finally, despite the recognition that

[1] However, there remains some controversy regarding the definitions. For example, mourning is often defined as the psychological or intraspychic process of grief (e.g., Hagman, 1996; Horowitz, Wilber, Marmar, & Krupnick, 1980; Rando, 1984, 1993; Raphael, 1984). Raphael (1984) described bereavement as the reaction and grief as the affective response to loss. Further, grief and bereavement are often used synonymously (Center for the Advancement of Health, 2004), as are grief and mourning, particularly by those with a psychoanalytic background (see M. Stroebe, Hansson, et al., 2001a).

bereaved children have experiences and needs that differ to that of adults (e.g., Christ, 2000; Raphael, 1984; Ward, 1996), I have focussed on the literature pertaining to adult grief.

Effects of Bereavement

Grief has emotional, somatic, behavioural, and cognitive components (see Gorer, 1965; Lord, 2000; T. L. Martin & Doka, 2000; Marris, 1958; Parkes, 1986; Parkes & Weiss, 1983; Rando, 1984, 1993; M. Stroebe, Stroebe, & Hansson, 1993b; M. Stroebe, & Hansson, 2001b for reviews). Feelings that are likely to follow bereavement include sadness, anger, fear, guilt, loss, anxiety, depression, despair, loneliness, powerlessness, yearning, denial, vulnerability, hopelessness, relief, and isolation. Somatic reactions may include physical shock, fatigue, hollowness, aches, dry mouth, breathlessness, tightness in the throat and chest, headaches, hypertension, palpitations, twitching, nausea, sweating, agitation, excruciating pain, and noise sensitivity. These feelings and reactions are accompanied by cognitive reactions such as disbelief, confusion, disorientation, suicidal ideation, preoccupation with the deceased loved one and/or the events leading up to the death, and visual and auditory hallucinations. Behavioural reactions may include sleep and appetite disturbances, dreams of the deceased, changes in libido, marital breakdown, social withdrawal, apathy, substance use, suicide, absentmindedness, sighing, crying (including unanticipated crying), restlessness, searching and calling out for the loved one, visiting the grave and other significant places, grief spasms (especially around holidays and birthdays), and treasuring or avoiding reminders of the loved one. Alongside these losses, the bereaved must also cope with additional losses that result from the death. Rando (1984) differentiated between the loss of a person through bereavement and secondary losses that arise as a result of the death. These secondary losses include losses of social standing, financial status, and social networks, as well as unmet expectations, and changes of roles and responsibilities (Kissane & Bloch, 1994; Marris, 1958; Rando, 1984, 1993; M. Stroebe et al., 1988; M. Stroebe, Stroebe, & Hansson, 1993b; Zisook, Shuchter, & Lyons, 1987).

Bereavement has long been recognised as a significant life stressor with the potential to affect physical and mental health greatly. Research has demonstrated that bereavement is associated with an increased risk of mortality. Despite assertions that

research on the relationship between bereavement and mortality is methodologically flawed (see Duberstein, 2000), a few conclusions can be tentatively drawn. Generally, the mortality risk is greater for widowed than married, single, or divorced people and greater again for widowers than widows, with the mortality risk generally peaking in the first few months following bereavement (Christiakis & Iwashyna, 2003; Martikainen & Valkonen, 1996; M. Stroebe et al., 1988). Additionally, it is reported that the bereaved have a higher risk of suicide (Jacobs, 1999) and suicidal ideation (Oliver & Fallat, 1995). One study indicated that 26% of people who suicide have experienced the death of a parent, sibling, or child in the previous six weeks (G. E. Murphy, Armstrong, Hermele, Fischer, & Clendenin, 1979) while another study demonstrated that 70% of suicide attempts followed bereavement (R. J. Gregory, 1994).

In terms of morbidity, bereavement is also linked with an array of physiological responses, such as immune deficiencies and neuroendocrine alterations (Calabrese, Kling, & Gold, 1987; Irwin, Daniels, & Weiner, 1987; Lindstrøm, 1997), and psychological effects. A comparison of widowers and age-matched, married controls demonstrated that the widowers had more symptoms of anxiety and depression, and lower levels of life satisfaction and social engagement (Bennett, 1998). Research also indicates that bereavement is associated with increased alcohol and other drug use (Glass, Prigerson, Kasl, & Mendes de Leon, 1995; Jacobs, 1999; Oliver & Fallat, 1995). In addition, the bereaved are at a significantly higher risk of developing mood (e.g., Major Depressive Disorder, MDD), anxiety (e.g., acute stress disorder, panic disorder, generalised anxiety disorder, post-traumatic stress disorder, PTSD), and adjustment disorders and some develop ‘complicated’ or ‘pathological’ grief reactions (American Psychiatric Association, APA, 1994; Green, Krupnick, Stockton, Goodman, Corcoran, & Petty, 2001; Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 1997; Jacobs, 1999; Jacobs & Prigerson, 2000; Ott, 2003; Prigerson & Jacobs, 2001; Prigerson & Maciejewski, 2005-2006; Rosenweig, Prigerson, Miller, & Reynolds, 1997). For example, the risk of developing PTSD following the sudden, unexpected death of a loved one has been reported to be 14.3% and the sudden unexpected death of a loved one was a factor in 31% of PTSD cases (Breslau, Kessler, Chilcoat, Schultz, Glenn, & Andreski, 1998). Another study revealed that five years after the death of a child,

bereaved mothers were almost three times more likely and fathers twice as likely to meet criteria for PTSD when compared to the general population (S. A. Murphy, Johnson, Chung, & Beaton, 2003).

Factors that Shape the Grief Experience

A significant body of the grief literature focuses on determinants of grief or 'risk' factors that might be associated with poor outcomes following bereavement. Various reviews (e.g., Center for the Advancement of Health, 2004; Jacobs, 1999; Lofland, 1992; T. L. Martin & Doka, 2000; Parkes, 1972, 1986; Parkes & Weiss, 1983; Rando, 1984, 1993; Raphael & Middleton, 1987; Sanders, 1988, 1993; W. Stroebe & Schut, 2001) indicate that these determinants are related to features of the bereavement – the circumstances of the death, the characteristics of the bereaved individual, the type and extent of interpersonal support received by the bereaved, and sociocultural factors.

Circumstances of the Death

In terms of the circumstances of the death, reviews (see Kristjanson, Lobb, Aoun, & Montorosso, 2006; McKissock & McKissock, 1991; Parkes, 2002; Payne, Horne, & Relf, 1999; Rando, 1984, 1993; Sanders, 1988, 1993) indicate that major risk factors associated with 'complicated' grief outcomes are sudden death, violent death, unanticipated death, preventable death, close relationship to the deceased, and the young age of the deceased. Lehrman (1956) was the first to explore in some detail the impact of timeliness of death on grief. He concluded that 'pathological' reactions were more likely following untimely death as the bereaved do not have the opportunity to prepare for the loss. In the circumstance of sudden and unanticipated death, the bereaved (as well as the deceased) is 'robbed' of the opportunity of and meaning inherent in being with a dying loved one (J. E. Gregory & Gregory, 2004). Sudden, unexpected deaths are also often complicated by being violent, traumatic, random, and mutilating to the deceased (Rando, 1993). One study demonstrated that a diagnosis of MDD was associated with sudden and violent deaths, and sudden death was also associated with complicated grief (L. C. Barry, Kasl, & Prigerson, 2002).

Children and young adults are more likely than other age groups to die suddenly (Rando, 1993). The death of younger people violates the assumption of an appropriate time for death in the life-cycle and, for the parents, also involves the loss of hopes,

dreams, expectations and fantasies for the child, parental identity, and immortality (Hindmarch, 2000; Lev & McCorkle, 1998; McKissock & McKissock, 1991; Payne et al., 1999; Rando, 1984, 1993; Riches & Dawson, 2000; Rosenblatt, 2000; Rubin, 1993, 1999). As such, the death of a child is commonly seen as the greatest life stressor (Christ, Bonanno, Malkinson, & Rubin, 2002; Gooch, 2000; Gorer, 1965; Hindmarch, 2000; Littlewood, 1992; Oliver & Fallat, 1995; Rando, 1993; Rubin & Malkinson, 2001; Worden, 1982, 1991, 2002) with serious consequences on the bereaved parents.

Based on interview data and responses the researchers proposed differentiated 'normal' and 'pathological' grief, one study of grieving parents concluded that 22 of the 29 suddenly-bereaved parents exhibited pathological grief (Oliver & Fallat, 1995). These parents were more likely to experience suicidal ideation and reported the use of alcohol and other drugs. Over two years, S. A. Murphy, Lohan, Braun, Johnson, Cain, Beaton, and Baugher (1999) studied 261 parents bereaved by the deaths of their 12 to 28-year-old children through accident, homicide, or suicide. Overall, the parents' health was poorer than an age-comparable sample, they showed deficits in concentration, memory, and decision-making, and many reported being unproductive at or being absent from work in the first 12 months following bereavement. Further, 18% of mothers were taking prescription medication (anti-depressants, tranquilisers, and anxiolytics) two years' post-bereavement. These effects were long-lasting; in a follow-up study over five years, the authors demonstrated that, regardless of cause of death, over two thirds of the parents reported that it took three to four years to endorse a question relating to 'putting the death into perspective and getting on with life' (S. A. Murphy, Johnson, Wu, Fan, & Lohan, 2003). Another study showed that, compared to mothers of living children, mothers bereaved through the perinatal death of a child exhibited significantly more psychological distress for at least 30 months (Bolye, Vance, Najman, Thearle, 1996). Additionally, a 12 to 15 year follow-up of 25 parents bereaved through SIDS demonstrated that the parents were still significantly affected by grief (A. Dyregrov & Dyregrov, 1999).

The perception of death preventability is associated with blame, obsession, rumination, and violations of assumptions, and as such, grief is considered to be 'easier' when the death is considered to be unavoidable (Rando, 1993). These characteristics

may partially explain why Bugen (1977) proposed that the preventable nature of the death is the most important factor in predicting duration and intensity of grief. Using questionnaires and structured interviews, Marcey (1996) compared the long-term consequences of bereavement of 80 people (mostly parents) bereaved either through anticipated death, sudden death, drunk driver crash, and homicide. She concluded that the type of death did not predict outcome, but the perception that the death was preventable was related to intense grief, anger, depression, guilt, and PTSD. Similarly, parents who viewed their child's death as accidental (i.e., could not have been prevented) were less likely to be suffering with 'pathological' grief (Oliver & Fallat, 1995). Perceptions of preventability, along with suddenness, traumatic or violent death, and the young age of the deceased, were associated with more intense grief responses (Currier, Holland, & Neimeyer, 2006; Gamino, Sewell, & Easterling, 1998). Grief following sudden, violent, and preventable deaths is further obfuscated by court (criminal and civil) trials, insurance claims, financial stressors, police investigations, coronial processes, the media, hospital and medical systems, a strong need to understand the circumstances of the death, thoughts of unfinished business with the deceased, as well as acute feelings of unreality, guilt, blame, fear, vulnerability, anger, and helplessness (Currier et al., in press; Doka, 1996; Harwood, Hawton, Hope, & Jacoby, 2002; Lord, 1996, 2000; Oliver & Fallat, 1995; Rando, 1993; Redmond, 1996; Riches & Dawson, 1998a, 2000; Volkan, 1970; Worden, 1982, 1991, 2002).

Characteristics of the Bereaved Individual

Reviews (e.g., McKissock & McKissock, 1991; W. Stroebe & Schut, 2001) indicate that individual factors also impact on the experience of grief, and include one's age, cognitive style, coping strategies, gender, spirituality/religiosity, previous life history, and concurrent crises such as financial and relationship stressors. Cognitive appraisal pertains to how an individual perceives an event and experience and relies on three basic assumptions; (a) personal invulnerability, (b) the perception of the world as meaningful, and (c) the positive perception of the self as deserving (Janoff-Bulman, 1992). These assumptions help us make sense of the world and protect us from threat, stress and anxiety (Janoff-Bulman, 1992; S. E. Taylor & Brown, 1988). Traumatic events, such as the sudden and violent death of a loved one, usually shatter assumptions

concerning self-worth, and the meaningfulness and benevolence of the world (Wickie & Marwit, 2000-2001). It is thought that assumptions about the world must be rebuilt or reframed and the traumatic experience integrated into an individual's belief system for effective functioning to recur (Janoff-Bulman, 1992).

Coping styles influence the experience of grief. The coping technique(s) used by the bereaved results from the way in which the individual appraises or perceives their situation (Janoff-Bulman, 1992; Lazarus & Folkman, 1984). Lazarus and Folkman describe two broad ways by which people cope – problem-focussed and emotion-focussed. Problem-focussed strategies attempt to change the objective situation and help individuals deal with the practicalities of bereavement and emotion-focussed strategies assist individuals in dealing with their grief. Similarly, in a review, Shanfield (1987) cited personality variables such as optimism and self-sufficiency as being likely to predict a better outcome following bereavement. In addition, effective coping appears to lessen the likelihood of experiencing anxiety and depression as a result of bereavement (Lindstrøm, 1997).

Spiritual and/or religious beliefs may also mediate the grief experience. Spirituality is thought to aid the bereaved person to bridge the past, live with the present, and find a path into the future (Angell, Dennis, & Dumain, 1998). Spirituality may also mitigate the effects of bereavement by helping the grieving person find meaning in their loss and protect them from further distress or 'complicated' reactions (Angell et al., 1998; Frantz, Trolley, & Johll, 1996; Gamino et al., 2000; Walsh, King, Jones, Tookman, & Blizard, 2002). For example, participants in a study of mothers' grief spoke of how these beliefs helped them because they knew they would see and be with their deceased children again (Farnsworth & Allen, 1996). However, other studies have demonstrated either no relationship between spirituality and ability to cope (e.g., Frantz et al., 1996) or a relationship between spirituality and greater psychological and physical symptoms (e.g., Richards & Folkman, 1997).

Research suggests that men appear to grieve differently from women. For example, widowers are thought to be more likely than widows to feel distressed and depressed, to develop mental and physical illnesses, and to die within a short period after their spouse's death (M. Stroebe, 1998; M. Stroebe, Stroebe, & Schut, 2001). M. Stroebe

(1998) suggests the reasons for these findings include men's lower levels of social support outside the marriage, men seeking less social and emotional support than women, and the loss of their only confidante in their wife. Similarly, sex-role conditioning means that the 'tasks' of grief, such as the open expression of emotion, many be incompatible with society's expectations of men (T. Martin & Doka, 1996, 2000; Rando, 1993), which may explain Shanfield and Swain's (1984) finding that bereaved mothers express more intense grief than bereaved fathers. Instead, 'masculine grievers' (whether men or women) are more likely to express anger and/or guilt and problem solve, whereas 'feminine grievers' are more likely to express emotions such as sadness (T. Martin & Doka, 1996). More recently, T. L. Martin and Doka (2000) proposed three general patterns of grief – intuitive, instrumental, and a blend of the two. Supporting the notion that gender shapes, but does not determine grief, Hayslip, Allen, and McCoy-Roberts (2001) demonstrated a lack of discernable differences on a number of measures between men and women following bereavement.

Interpersonal Support

A further body of literature relating to risk factors following bereavement pertains to social support. People grieving the death of a loved one rely significantly on the 'natural' support offered from family and friends. Social support describes the comfort, assistance, and information people receive and can be formal or informal verbal or non-verbal (Flannery, 1990). Although it has been argued that the positive impact of social support following bereavement is not empirically supported (see W. Stroebe, Stroebe, Abakoumkin, & Schut, 1996), other research demonstrates that it may have an important role in mediating the impact of the death of a loved one. For example, one study of mothers bereaved through the death of their infants from SIDS found that having a social network that encouraged the discussion of their losses was related to lower levels of depressive symptoms (Lepore, Silver, Wortman, & Wayment, 1996). Helpful behaviours include reassurance, encouragement of emotional expression, acknowledging the loss, empathy, sharing of thoughts and feelings, provision of relevant information, companionship, contact with others who share the experience, and practical support such as the offer of money and the completion of tasks (Flannery, 1990; Jacobson, 1986; Lehman, Ellard, & Wortman, 1986; Rando, 1993; Thompson & Range,

1992-1993; Vachon & Stylianos, 1988). Each is useful at different times and not all are required. For example, emotional support (e.g., reassurance) may be more useful in times of the initial crisis and instrumental support (e.g., preparing meals) may be more salient later (Jacobson, 1986). Lyons (1991) concluded that informational support is best received when it comes from professionals, emotional support is best received from friends and family, and advice and encouragement are best received from people who have experienced a similar event. In terms of the source of the support, one study reported that the bereaved are much more likely to find support from women (e.g., sister, mother, female colleague) than men (Frantz et al., 1996).

According to Rando (1993), the need for support must be recognised by potential supporters, and the support must be available, sufficient, and extended for it to be of use. In addition, social support must also be perceived as helpful by those receiving it for it to be beneficial (Flannery, 1990; Stylianos & Vachon, 1993; Vachon & Stylianos, 1988). Interestingly, the 'natural' support system is not always helpful. Family and friends often add to feelings of guilt, self-blame, shame, and depression by inhibiting the expression of their feelings and the desire to remember their deceased loved ones (Farnsworth & Allen, 1996; Lepore et al., 1996; Oliver & Fallat 1995). Similarly, bereaved individuals often feel unable to express their feelings because family members and/or friends appear insecure and frustrated at being unable to change the situation (Vachon & Stylianos, 1988; Silver, Wortman, & Crofton, 1990), lack interpersonal skills (Flannery, 1990), or may (intentionally or unintentionally) blame the bereaved (Thompson & Range, 1992-1993). While one study revealed that people experience difficulty in imagining the needs of the bereaved (Thompson & Range, 1992-1993), another demonstrated that a close correspondence between the needs of the bereaved and the control participants' perception of those needs (Lehman et al., 1986). Silver et al. (1990) identified a paradox whereby those perceived to be coping well during a crisis are more likely to receive support, whereas those who are severely distressed and expressive the need for support are less likely to receive it. A lack of social support appears to exacerbate other factors and may lead to increased use of medication, high distress, adjustment difficulties, and 'poor' bereavement outcomes (Vachon & Stylianos,

1988), whereas social networks that promote disclosure aid adjustment to losses such as the death of a child (Murray & Terry, 1999).

Mutual-help groups[2] can provide assistance to the bereaved through meeting and talking with others who are sharing a similar experience, counteracting the social stigma that is often associated with grief, affording companionship through allowing contact with others in the midst of a similar situation, and provide support outside of meeting times through informal contact between members (Bernardi & Sanders, 1978; Caserta & Lund, 1996; Lieberman, 1993; Lorenz, 1998; Morgan, Carder, & Neal, 1997; Riches & Dawson, 1996a, 2000; Rock, 1998; Schiff & Bargal, 2000; Walter, 1999, 2000). In addition to mutual help, the provision of information on grief may prevent more serious problems that may result from the bereavement and may be especially important for people who do not wish or cannot afford to see counsellors and psychologists on a one-to-one basis (e.g., Beem, Eurelings-Bontekoe, Cleiren, & Garssen, 1998).

Sociocultural Factors

Social changes have transformed the face of grief, with some authors arguing that the significance of mourning rituals has diminished in modern industrialised societies. For example, Kugelmann (1992) argued that grief, and in particular, its expression, has been constructed or engineered since the 19th century, as a product of industrialisation, diminished community ties, medicalisation, reliance on clock time, the view that progress is a virtue, and the perception that present society is more civilised and superior that in previous times. He cites the loss of ritual, customs and traditions in modern Western societies, where public expressions of mourning are minimised. Similarly, in her analysis of the construction of mourning in Britain from the Enlightenment to the reign of Queen Victoria, Schor (1994) asserted that increasing medicalisation of grief, the rise of the professional role in death and grief (e.g., morticians), and the diminished duration and significance of mourning rituals, have all served to render grief as a individual and short-term state.

Likewise, Rando (1984, 1993) identified a collection of factors that impact on grief, including the rise of industrialisation, secularisation, modernisation,

[2] Although more commonly referred to as self-help (e.g., Constantino & Nelson, 1995; Lieberman, 1993; Schiff & Bargal, 2000; Wheeler, 1993-1994), I have used the term mutual help because those attending the groups rely on support from and sharing with others, rather than self-reliance (Walter, 2000).

deritualisation, family breakdowns, and exclusion of the aged and dying, desensitisation to death, poor communication regarding death and loss, and romanticisation of loss, lack of contact with death in a 'natural' context, and the minimal role of funerals and other bereavement rituals in modern Western cultures. Although rituals concerning death fulfil a number of roles such as a structure, meaning, and a recognition of the role of the deceased in their family and community, funerals are 'one-off' events and therefore fail to acknowledge the longevity of grief, especially with the cultural focus on the 'closure' of saying 'goodbye' to the deceased at the funeral (Romanoff & Terenzio, 1998).

In her research with dying patients, Kübler-Ross (1969) readily identified the pervading fear of dying and death that permeates many Western cultures. She claimed that these fears are evident in the people's demeanour when confronted with dying (ranging from uneasiness to hostility), the use of platitudes and euphemisms when talking about dying, and the embalming procedures and use of make-up on the deceased in order to 'sanitise' funeral rituals. Similarly, Gorer (1965) argued that the use of euphemisms for death such as 'pass on', 'at rest', and phrases such as the deceased has 'gone to heaven', 'gone away', and 'gone to sleep', have confirmed for some (e.g., Gorer, 1965; Rando, 1984; Wass, 2004) that death is taboo.

Further, Gorer (1965) asserted that the public expression of mourning had almost disappeared in England. Instead, he demonstrated that the bereaved either hid their grief, or for those who did engage in active mourning, these practices were generally not maintained longer than a week. Further, he claimed that the lack of socially-sanctioned mourning rituals meant that behaving as if a death has not occurred is the new socially acceptable way of mourning, for both the bereaved and those around them.

> Nowhere is the absence of an accepted social ritual more noticeable that in the first contacts between a mourner and his [sic] neighbours, acquaintances, or workmates after a bereavement. Should they speak of the loss, or no? Will the mourner welcome expressions of sympathy, or prefer a pretence that nothing has really happened? Will mention of the dead provoke an outburst of weeping in the mourner, which might be contagious? (Gorer, 1965, p. 57)

Thus, the absence of mourning rituals presents dilemmas for the bereaved as well as those able to support the bereaved.

The decline of ritual in modern Western cultures has led to these cultures being characterised as death-denying (Rando, 1984)[3]. The terms demoralised loss (Fowlkes, 1990) and more commonly, disenfranchised grief (Doka, 1989a, 2002a), were coined to describe grief that follows socially unspeakable or negated deaths. Doka delineated three types of disenfranchisement – the disenfranchisement of the loss (e.g., perinatal losses, divorce), the relationship (e.g., extramarital affairs, gay relationships), and the mourner (e.g., children, intellectually disabled) (Doka, 1989b, 1995, 2002a, 2002b). Rando (1993) added a fourth component to Doka's (1989b) three reasons for disenfranchisement – aspects of the loss that determine whether or not it will be supported within social networks. She cited the death of a child and mutilating death as examples where support might not be extended because of the need to protect the self from dealing with it. The failure of empathy and understanding (Fowlkes, 1991; Neimeyer & Jordan, 2002) results in the loss being socially unspeakable or negated, and as a result, people grieving disenfranchised losses are usually offered less support.

Grief Resulting from Crash Fatalities

As previously discussed, the literature reveals that curtain circumstances of the death, such as sudden death, violent death, unanticipated death, preventable death, close relationship to the deceased (particularly parents bereaved by the deaths of children), and the young age of the deceased, are major risk factors associated with 'complicated' grief outcomes. All of these risk factors are common in crash fatalities (ABS, 2005; Hobbs & Adshead, 1997; Sleet & Branche, 2004; Stewart, 1999; Stewart & Lord, 2002; Waller, 2001; WHO, 2004; Zaza et al., 2001), but despite this, there is limited research on the psychosocial consequences of crash fatalities. Moreover, some studies are not about crashes per se, but explore grief after a number of types of death, including crashes (usually conceptualised as 'accidental' deaths) (e.g., Cleiren, Diekstra, Kerkof, and van de Wal, 1994; Currier et al., in press; Grad & Zavasnik, 1999; Marcey, 1996; S. A. Murphy, Johnson, Chung et al., 2003; Oliver & Fallat, 1995; Rodger, 2005; J. M. Saunders, 1981; Wickie & Marwit, 2000-2001). Generally, these studies indicate that the

[3] However, others have questioned the assumption that modern Western cultures are death-denying. Seale (1998) cites the prevalence and legitimacy of industries related to death (e.g., medical, insurance) as evidence of the stature death is afforded and Walter et al. (1995) cite the presence of death in the mass media as a further challenge.

long-term consequences of bereavement include intense grief, loss of meaning, mental distress, anger, depression, guilt, and PTSD, which are more pronounced when the death is perceived as preventable, the bereaved have difficulty making sense of the loss, and the deceased is a child of the research participants.

The small number of published studies focussing on grief following crash deaths reveals that the resulting experience of grief can be long-lasting. Shanfield and Swain (1984) investigated the outcome of 40 parents bereaved by the deaths of their adult children in crashes. Two years after the deaths, 30% of parents experienced depression, reported loneliness and guilt, bore a significant increase in the number of health complaints, and significant decreases in satisfaction with work, leisure, and life in general. A survey demonstrated that parents bereaved through the deaths of their children in traffic 'accidents' an average of four years previously showed high levels of psychiatric distress, 'traumatic' grief, anxiety, depression, insomnia, somatic symptoms, and social dysfunction (Spooren, Henderick, & Jannes, 2000-2001). A further study reported that 62% of individuals bereaved as a result of a drink-driving crash met criteria for PTSD just over two years following the crash (Sprang, 1997).

Other studies on the long-term outcomes of losing a spouse or child in a crash indicate that the bereaved participants experienced more depression, more psychiatric symptoms, greater mortality, and less future orientation than do matched controls from a non-bereaved community sample (Lehman et al., 1987). There is also evidence of increased divorce rates of parents bereaved through traffic crashes when compared to matched controls (Lehman, Lang, Wortman, & Sorenson, 1989). Many of the bereaved experienced guilt and pain when thinking about their loved one, and experienced some distorted thinking believing that the death in a crash was not real (Lehman et al., 1987). Lehman et al. (1987) concluded that, "the data provide little support for traditional notions of recovery from the sudden, unexpected loss of a spouse or child" (p. 218).

Tehrani (2004) investigated the prevalence of PTSD in 57 people (48 women, 9 men) bereaved through crash fatalities. The average time since bereavement was 4.5 years. The data revealed that one third were experiencing symptoms of PTSD. The majority were experiencing anxiety symptoms (panic attacks and phobia), depression, suicidal ideation, guilt, anger, resentment, loss of drive, and decreases in both enjoyment

in life and future orientation. The majority also experienced significant difficulties in their finances, relationships, social lives, status, and employment. The changes in relationships and social lives were significantly correlated with levels of depression and anxiety. The participants also reported life style changes, including poor nutrition, reduced exercise, alcohol use, and poor sleeping habits.

The effects on the family resulting from losing a significant loved one in a crash are considerable and damaging. Common outcomes include withdrawal from relationships, communication breakdown, substance use, lack of direction in school and work, and isolation from friends. FEVR (1993) indicated that 90% of people bereaved through crashes reported significant and permanent reduction in their quality of life, and approximately half stated they had suffered an enduring decline in standard of living. A follow up survey (FEVR, 1995) of almost 700 families throughout Europe demonstrated that, following a crash fatality, 49% moved house, 11% experienced separation or divorce, and 91% reported an inability to take pleasure in life. Further, 60% of those who changed jobs did so because of their change in circumstances and 65% of those that lost their job reported doing so for psychological reasons.

Tehrani (2004) also examined the relationship between level of support received and incidence of PTSD symptoms. Of all the lifestyle factors assessed, the change in their social lives was the factor most highly correlated with PTSD symptoms. In one study, people bereaved through crashes were surveyed to determine what helped and did not help them in the time (up to four years) after bereavement (Lord, 2000). Supportive behaviours include friends being ‘there’, visiting, and calling regularly; being understanding and emotionally supportive; providing instrumental aid such as helping with cooking, cleaning and child care and greeting visitors; listening without giving advice; helping with funeral and other arrangements; and talking about the loved one. Unhelpful behaviours to the bereaved included a lack of empathy/understanding from friends and professionals; invasion of privacy; giving suggestions on how and when to grieve and stop grieving; presence of too many people ‘helping’; friends withdrawing/being unavailable, and avoidance of talking about the loved one.

Further, the majority of the participants expressed dissatisfaction with courts, solicitors, prosecution, coroner, insurance claims, ambulance, psychiatrists, and police

(Tehrani, 2004). In addition, many were dissatisfied with the support received from the hospital, their church, general practitioners, mortuary, and counsellors. The lack of support served to exacerbate the grief experience. Other studies have highlighted the potential for marital difficulties and declines in social support, doubts and frustrations regarding lengthy legal, insurance, and health contests, and even unpleasant media exposure also negatively affect the grief experience (Keir, 2000; Kovarsky, 1989; Lord, 2000; Oliver & Fallat, 1995; Sprang, 1997). Despite the substantial practical, emotional, and legal needs of bereaved families, FEVR (1995) concluded that the information provided to families is insufficient and the criminal and civil legal systems are dissatisfactory.

All of the above characteristics are risk factors thought to contribute to the likelihood that the bereaved will experience what have become known as 'complicated' grief reactions (Horowitz et al., 1993, 1997; Jacobs, 1993, 1999; Jacobs et al., 2000; Prigerson et al., 1995, 1996, 1999; Prigerson, G. K. Silverman, Jacobs, Maciejewski, Kasl, & Rosenheck, 2001; Prigerson, & Jacobs 2001; Prigerson & Maciejewski, 2005-2006; Prigerson & Vanderwerker, 2005-2006; Rando, 1993), where the grief reaction does not fit the normative standard. Crash deaths encompass a number of these risk factors – they are sudden, unanticipated, violent, and preventable, and often those who die in crashes are young in age (ABS, 2005; Hobbs & Adshead, 1997; Sleet & Branche, 2004; Stewart, 1999; Stewart & Lord, 2002; Waller, 2001; WHO, 2004; Zaza et al., 2001). In addition, the ease with which the bereaved are able to find the support they need depends upon the availability of appropriate services, service publicity, and effective referrals systems (Hillman, Green, & Silburn, 1999) none of which are readily available for those affected by deaths resulting from crashes in WA.

Grief and Bereavement: Three Key Tensions in the Thanatological Literature

In the following section I outline three key tensions in grief theory and research that have informed the development of the research project I report in this thesis. The first tension centres on the extent to which the classic grief theories, and the dominant grief discourse that emerges from them, can be applied to all grief experiences.
The second tension relates to the increasing medicalisation of grief. Medicalisation refers to the medical profession's appropriation of non-medical domains (Zola, 1977)

and is not a new phenomenon, having been identified in diverse fields such as domestic violence (e.g., Fisher, 2000) and palliative care (e.g., K. White, 2000). I provide a summary of the debate concerning the inclusion of 'complicated grief' in the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM). Finally, in light of the increasing application of psychology to the service economy (McKnight, 1977), the third tension focuses on the efficacy of grief services and interventions.

Transferability of Classic Grief Theories

Grief has long been constructed as a form of madness (see Foucault, 1961). Despite this quasi-medical construction, grief and its effects have only recently been examined within scientific frameworks, primarily because grief is usually considered to be 'natural', 'normal', and universal (Engel, 1964). It is generally thought that Freud (1917/1957) was the first to consider grief in the realm of psychology with the publication of his work *Mourning and Melancholia*[4]. He first suggested that bereaved individuals must engage in a process of grief. The idea that grief is a process to be worked through over time (about one to two years) underpins the notion that withdrawal from the deceased loved one is a necessary component of grief and signifies the end of mourning. Freud's writings on grief are inconsistent – in *Mourning and Melancholia*, he promoted the relinquishment of the relationship with the deceased, yet he later wrote of never wanting to relinquish his relationship to his deceased daughter (cited in Rando, 1993, and Rubin & Malkinson, 2001). Indeed, when a woman consulted Freud after becoming depressed following her husband's death, Freud is said to have responded, "Madam, you do not have a neurosis, you have a misfortune" (cited in Wahl, 1970). However, many theorists and practitioners took *Mourning and Melancholia* literally, hence the emphasis on the breaking of bonds to the deceased and the subsequent differentiation between normal and pathological forms of grief.

Since Freud's (1917/1957) construction of grief as a process to be worked through, there have been moves towards theorising grief as a short-term, stage-based, and finite phenomenon. In his PhD thesis, Fulconer (1942, as cited in Jacob, 1993) was the first to describe grief in stages. Shortly after, Lindemann (1944) described grief as an acute or short-term syndrome where recovery occurred after approximately four to six

[4] Although it is worth noting that Freud had written earlier about bereavement, as had others (e.g., Durkheim, 1897/1952).

weeks. Despite subsequent research significantly extending the duration of 'normal' grief, Lindemann's claim that grief is usually resolved within four to six weeks prevailed. More than 40 years later, Parkes and Weiss (1983) commented that Lindemann's notion of 'acute grief', "has caused many to assume that grief is a much more transient phenomena [sic] than later investigators have found it to be" (p. 13). Lindemann also coined the term 'grief work' to describe the necessity of experiencing and expressing the pain of grief in order to complete the grief process.

From the 1960s onwards, numerous theories of grief were proposed, each with a focus on the stages, phases, tasks, or processes of grief (e.g., Bowlby, 1961, 1980; Gorer, 1965; Hogan, Morse, & Tason, 1996; Kübler-Ross, 1969[5]; Lazare, 1979; Parkes, 1972, 1986; Rando, 1984, 1993; Shuchter & Zisook, 1986, 1987, 1993; Worden, 1982, 1991, 2002; Zisook, 1987). Consistent with the notion of 'grief work', most of these theorists constructed grief as finite and stage-based, where the experience was characterised by a distinct pattern of shock, yearning, and an emergence from the grief after a duration of months or perhaps one to two years. Further, apart from Rando (1993) who tenaciously argued that the processes of grief might never be 'completed', the non-resolution of each the grief process was thought to be associated with 'pathological' forms of grief (e.g., Bowlby, 1961, 1980; Bugen, 1977; Lazare, 1979; Parkes, 1965a, 1965b, 1972, 1986; Parkes & Weiss, 1983; Shuchter & Zisook, 1993; Worden, 1982, 1991, 2002; Zisook, 1987). As an example, Lazare (1979) described the grief process as "minimally disruptive" (p. 499) and suggested that a diagnosis of unresolved grief should be made when 'typical' grief reactions persist beyond six months or one year. Similarly, Parkes and Weiss (1983) considered the absence of recovery after about one year as abnormal. They used a physical analogy to illustrate this point:

> …we would say that normally a person with a broken arm can expect the bone to heal within six weeks. If, at the end of six weeks the bone is still unjoined, then healing is abnormal, and we speak of "complications" having set it. In much the same way we might regard the abnormal persistence of grief as a "complication" of the normal picture. (p. 5)

[5] Kübler-Ross's (1969) five stages of dying (denial and isolation, anger, bargaining, depression, and acceptance), were heartily embraced by health professionals who also applied her stage theory to grief (see Corr, 1993; Daggett, 1999; Doka, 2003; Neimeyer & Gamino, 2003; Rando, 1984), despite the model being criticised for being methodologically limited, conceptually simplistic, and lacking empirical validation (Corr, 1993).

As an alternative to the stage/phase/task/process models of grief, Rubin (1999; Rubin & Malkinson, 2001) proposed the Two-Track Model of Bereavement, which focuses on both the functioning following bereavement and the relationship to the deceased loved one. Concurrently, M. Stroebe and Schut (1999, 2001) presented the Dual Process Model of coping following bereavement, whereby the bereaved individual oscillates between loss-oriented (e.g., focussing on the deceased, yearning) and restoration-oriented (e.g., distraction, avoidance, engaging in new roles) axes. In both models, the dynamic vacillation between two opposing processes stands in contrast to the stage/phase/task/process models of grief that construct grief as a distinct, short-term, quasi-linear process that culminates in the detachment from the deceased and recovery from grief.

In addition to viewing grief as short-term and finite phenomenon consisting of various stages/phases/tasks/processes, most theorists also drew from Freud's notion that withdrawal from the deceased is a requirement of grief. For example, Lindemann (1944) described the work of grief as requiring the "emancipation from the bondage to the deceased" (p. 143). The breaking of attachment bonds to the deceased was a key component of Bowlby's (1961, 1980) grief theory. Indeed, Bugen (1977) encouraged the detachment from the deceased as a way to render the grief experience as less intense. A key component of Worden's (1982, 1991) task theory of grief is to emotionally relocate the deceased and move on with life. Others (e.g., Gorer, 1965; Lazare, 1979) described behaviours that they thought illustrated 'unlimited' or 'unresolved' grief, including maintaining a home or room the way it was before the death of the loved one, purchasing flowers to mark the absence of the deceased at Christmas and their birthdays, a reluctance to part with possessions of the deceased, an inability to talk about the deceased without crying or the voice cracking, and grief pangs at anniversaries, Christmas, and birthdays. However, others encouraged the maintenance of the relationships or the development of a new relationship with the deceased (e.g., Rando, 1993; Shuchter & Zisook, 1986, 1987; Worden, 2002).

However, some researchers and practitioners (e.g., Klass, Silverman, & Nickman, 1996; Neimeyer 2000a, 2001; Walter, 1996; M. White, 1989) suggest that the preoccupation with disengaging from the deceased may lead to prolonged harm rather

than ‘recovery’. The notion that the bereaved must detach from the deceased was systemically and empirically questioned in the book *Continuing Bonds* (Klass et al., 1996). The maintenance of bonds to the deceased by the bereaved is now largely accepted, at least within the thanatological literature, as adaptive rather than a failure of grief work and/or a sign of pathology (e.g., Klass, 1995, 1996a, 2001; Klass & Goss, 1999; Klass et al., 1996; Klass & Walter, 2001; Malkinson & Bar-Tur, 1999; Reisman, 2001; Richards, Acree, & Folkman, 1999; Riches & Dawson, 1998b, 2000; Rosenblatt, 2000; M. Stroebe, Gergen, Gergen, Stroebe, 1993; M. Stroebe, 2001; Vickio, 1999; Walter, 1996; M. White, 1989; Wortman & Silver, 2001). Thus, the disengagement from the deceased might be one of a number of acceptable outcomes following bereavement (M. White; M. Stroebe & Schut, 2005).

Following R. D. Eliot’s (1932) assertion that the resignation and rationalisation of deaths (for example, it is ‘God’s will’), were components of ‘successful’ grief, because meaning in the death is found, there has been increased interest in and support for the notion that finding meaning is necessary for the successful adaptation following crises such as bereavement (Cassem, 1975; Janoff-Bulman, 1992; Moos & Schaefer, 1986). The ability to make sense of the loss is thought to be related to experiencing less distress following bereavement (Currier et al., in press; C. G. Davis, 2001; C. G. Davis & Nolen-Hoeksema 2001; C. G. Davis, Nolen-Hoeksema, & Larson, 1998; Gamino & Sewell, 2004; Gamino et al., 2000; Janoff-Bulman, 1992; Neimeyer, 2001; Nolen-Hoeksema, 2000). Neimeyer (1998) argued that the search for meaning following bereavement is central to the process of grief. Further, the search for meaning in grief is a key component in descriptive articles aimed at service providers (C. G. Davis, Wortman, Lehman, & Silver, 2000).

In addition to attempts at making sense of loss, the notion of meaning-making has been used to describe deriving benefit from loss (C. G. Davis, 2001; C. G. Davis et al., 1998). Some theorists assert that personal growth is thought to occur following the ‘successful adaptation’ to bereavement (Calhoun & Tedeschi, 2001; Hogan et al., 1996; Neimeyer, Prigerson, & Davies, 2002; Schaefer & Moos, 2001; Tedeschi & Calhoun, 1995), with the latter coining the term ‘post-traumatic growth’. These positive outcomes might include a reassessment of priorities, increased empathy and compassion,

development of personal strength, living with 'purpose' and in the present, losing the fear of death, increased spiritual understanding, improved interpersonal relationships, and changes in employment relating to their experiences of loss (Balk, 1999; Farnsworth & Allen, 1996; Frantz, Farrell, & Trolley, 2001; Neimeyer et al., 2002; Nolen-Hoeksema, 2000; Richards et al., 1999; Schaefer & Moos, 2001; Tedeschi & Calhoun, 1995; Van, 2002; Wheeler, 2001). Some researchers have even specifically investigated parents' perception of benefit following the death of a child (e.g., Polatinsky & Esprey, 2000).

Inherent in the historical construction of grief are a number of key assumptions – (a) grief follows a relatively distinct pattern; (b) grief is short-term and finite; (c) grief is a quasi-linear process characterised by stages/phases/tasks/processes of shock, yearning, and recovery; (d) grief needs to be 'worked through'; (e) meaning in and/or positives gained from the death must be found; (f) grief culminates in the detachment from the deceased loved one; and (g) the continuation of grief is abnormal, even pathological. In essence, where grief was once a normal, public, and non-medicalised experience, it is now examined within a clinical framework whereby grief experiences that differ from a perceived norm may be pathologised.

In summary, the focus on grief as a process to be worked through and recover from dominated grief theory and research for many decades, despite a deficiency of supporting empirical evidence (see Bonanno, 1998, 2001; Bonanno & Field, 2001; Bonanno & Kaltman, 1999, 2000; Center for the Advancement of Health, 2004; Kristjanson et al., 2006; T. L. Martin & Doka, 2000; M. Stroebe, 2001; M. Stroebe, Gergen, Gergen, & Stroebe, 1992, 1993, 1996; M. Stroebe, Hansson, et al., 2001b; M. Stroebe & Schut, 1999, 2005; M. Stroebe, Stroebe, & Schut, 2001; M. Stroebe, Stroebe, Schut, Zech, & van den Bout, 2002; Walter, 1996; Wortman & Silver, 1989, 2001). Indeed, assumptions inherent in the notion of grief work have been challenged by researchers who began examining the medical/scientific (i.e., dominant) discourse of grief and its 'truths' that had been largely unquestioned. Many put forward the notion that grief is unique to each individual (Center for the Advancement of Health, 2004; Kellehear, 2001; Rando, 1993; Winslade, 2001). Further, others critiqued the use of terms such as 'recovery', 'resolution', 'closure' or 'completion' (Center for the

Advancement of Health, 2004; Shuchter & Zisook, 1986; Rando, 1993; P. R. Silverman & Klass, 1996; M. Stroebe, Hansson, et al., 2001a), because they argue that the bereaved never return to their prior states. As Fulton, Madden, and Minichiello (1996) stated,

> The basic assumptions of the biomedical model are so inextricably linked with the ways of thinking and working in medicine that health professionals tend to forget that it is but one of a number of conceptual models or ways of thinking about the world. (p. 1354)

Bonanno and Kaltman (2000) suggested that the notion of working through grief is "conceptually limited" (p.165) and argued that is instead a product of historical and cultural assumptions within the Western late 19th and 20th centuries. As in almost every domain under scientific scrutiny, North American research and conceptualisations are featured heavily in thanatological research. A reassessment of these culture-bound assumptions of grief suggested that the hegemonic view of grief is not relevant for many individuals (Shapiro, 1996). Indeed, cross-cultural research has provided a number of challenges to the taken-for-granted assumptions inherent in the thanatological literature and demonstrated the extent to which the dominant discourse is ethnocentric (Rosenblatt, 2003; M. Stroebe & Schut, 1999; Walter, 1999). For example, Corwin (1995) argued that it is acceptable in other cultures to grieve and mourn for years without an end. Wikan (1998) described grief and mourning rituals in Egyptian and Balinese Muslim communities and demonstrated that, rather than being universal, cultural constructions of death impact on the expression of grief and mourning practices. Klass (2001) showed that, although people in both North America and Japan continued to foster relationships with the deceased, cultural, economic, and political forces shape the practices with which they do so. However, cross-cultural research must be interpreted cautiously: rather than one notion of grief for each culture, there are differences both *within* and *between* cultural groups that must be taken into account (Rosenblatt, 2001).

In addition to the cultural critique, grief studies have been critiqued on methodological grounds. Much of the classic grief research focussed on samples with many or all of the following features - North American, white, middle-class, middle-aged to elderly, widows grieving the loss of their husbands after a long illness. Contemporary grief research remains dominated by these samples (see Center for the

Advancement of Health, 2004; Schlernitzauer et al., 1998; M. Stroebe, 1998; M. Stroebe, Stroebe, & Schut, 2003). Interestingly, thanatological research is one of perhaps only a few research domains where women participants have outnumbered men. The research samples were and are influenced by the differential rates of widowhood along gender lines, whereby women are more likely to be widowed than men, but the outcome is a gender-biased literature base.

In recent decades, many studies have been published whereby the authors have examined grief within a different sample, such as parents grieving the loss of a child (e.g., Dowdney, Wilson, Maughan, Allerton, Schofield, & Skuse, 1999; Farnsworth & Allen, 1996; D. Gregory & Longman, 1992; S. A. Murphy et al., 1999; Oliver & Fallat, 1995; Riches & Dawson, 1996a, 1996b, 1997, 1998a, 1998b, 2000), and/or within cultures beyond the dominant North American culture, such as Asian and Pacific Islander Americans (Braun & Nichols, 1997), Egyptian and Balinese Muslim communities (Wikan, 1998), and Japan (Klass, 1996b, 2001), and/or resulting from a different type of death, such as HIV/AIDS (e.g., D. Gregory & Longman, 1992; Richards & Folkman, 1997; Richards et al., 1999) suicide (e.g., Hillman et al., 1999; Provini, Everett, & Pfeffer, 2000), and vehicle crashes (see previous section).

These issues of sampling and data collection perhaps explain why, in a critical review of the grief literature, Neimeyer and Hogan (2001) concluded, “although the human experience of bereavement has often been studied, it has not often been studied well” (p. 110). Further, they highlighted the inverse relationship between the volume of research on grief and the amount of information contained within it. The dominant grief discourse drawn from the classic theories is not necessarily ‘wrong’. However, it may be that it is more likely to capture grief experiences of those on whom the theories were based (i.e., primarily North American, white, middle-class, and mature women bereaved through the deaths of their husbands through illness) and might be less able to account for the grief experiences of others.

The Maintenance of the Dominant Grief Discourse. The dominant discourse (see Foucault, 1961) pervades professional and lay understandings of grief. In community psychology terms, this dominant discourse is a ‘dominant cultural narrative’ (Rappaport, 2000, p. 4). It is communicated through mass media, known by most people in a given

cultural context, and ritualised, meaning that we are unaware of them and implicitly accept them. For example, a comprehensive review of grief literature concluded that both Freud's (1917/1957) and Lindemann's (1944) constructions in particular, and especially the grief work hypothesis, significantly directed both popular and professional understandings for decades (Center for the Advancement of Health, 2004). In addition, despite recent research that questions the ideas inherent in the most popular and influential grief models and theories, the above assumptions are drawn upon by grief researchers, service providers[6] working with the bereaved, those in the media, as well as laypersons (Center for the Advancement of Health, 2004; Lindstrøm, 2002; Payne, Jarrett, Wiles, & Field, 2002; Parkes & Weiss, 1983; Rando, 1993; Riches & Dawson, 2000; Rosenblatt, 1996; Walter, 2000; Walter, 2005-2006; Walter, Littlewood, & Pickering, 1995; Winslade, 2001). Jordan (2000) asserted that "many of the clinical constructs that have guided bereavement interventions over the years may be not much more than collectively shared assumptions …that "everyone knows" to be true" (pp. 461-462). Consequently, many service providers have not questioned their fiercely-held beliefs, despite the increased attention to these assumptions in the grief literature. Further, Walter (2005-2006) stated, "the rank and file of the grief police are not doctors, psychiatrists and counsellors; they are ordinary family members in ordinary families" (p. 75). Foote and Frank (1999) asserted, "lay talk, and lay thinking, increasingly is saturated with professional opinion offered through television and radio, self-help books, workshops, and support groups" (p. 169). Providing an Australian perspective, Murray (2002) stated that phase-based models remain the most recognised grief models in the wider community. Importantly, she argued that "many people come to adopt as "fact" the model of grief to which they have been exposed by local "experts" or the media, or force their own personal models of grieving on others" (p. 50). A recent exemplar of the dominant grief discourse in the media appeared in a newspaper article. Written by a therapist, the piece focuses on "the stages of grief and how to get over it" (C. Saunders, 2006, p. 2).

The assumptions within the dominant discourse of grief have been labelled as 'myths'. In a review of the literature, Wortman and Silver (1989) identified myths of

[6] I have used the generic term service providers to indicate all those involved in the care of the bereaved, including clergy and other religious figures, counsellors, therapists, nurses, doctors, and funeral directors.

coping with loss derived from theoretical traditions and clinical wisdom, including intense distress is necessary, the failure to experience distress indicates pathology, the loss must be 'worked through', the bereaved must detach from the deceased, and the loss is resolved within a short time. They concluded that the notion that a loss is resolved in a short duration by 'working through' it is just one of many possible patterns of adaptation. However, their summaries of research and conclusions were criticised (M. Stroebe, van den Bout, & Schut, 1994). In 2001, Wortman and Silver revisited their myths and concluded that they remain the prevailing normative expectation concerning the 'proper' way to respond to loss. Similarly, Rando (1993) identified the following 'myths' - grief declines steadily with time, the grief response for every loss is the same, the expression of feelings is necessary and sufficient for the solution of grief, the bereaved must detach from deceased, sudden unexpected bereavement is the same as any other loss, and grief is resolved within a year. In addition, Shapiro (1996) identified North American culture-bound norms that grief should be private, that it is necessary for expression of grief be immediate, that grief ends, and that attachment to the deceased is abnormal, even pathological (Shapiro, 1996). Likewise, based on studies of bereaved spouses and parents, C. G. Davis et al. (2000) critiqued the notion of the necessity to find meaning in the deaths of loved ones.

Despite being pervasive, these 'myths' have the potential to have deleterious effects on the bereaved. For example, the bereaved are often treated by service providers and their social networks according to the myths, leading to insufficient support and/or maltreatment based on erroneous assumptions. Rando (1993) contends that service providers pay lip service to the notion of grief as an individual process, and are instead focussed on timelines of grief. She stated that the following behaviours are often assumed to be indicators of complicated mourning, when she believes they are not – having a continued relationship with the deceased, maintain aspects of environments in order to promote memories of the deceased, experiencing feelings other than sadness, engaging in attempts to promote the memory of the deceased in others, experiencing some aspects of grief over many years/forever, or grief that does not decrease in a linear fashion over time. Further, she argued that 'helping' the bereaved to forget the deceased and move on has the capacity to interfere with the development of a healthy connection

to the deceased. In fact, grief may become 'pathological' as a result of this potentiality misguided interference (Rando, 1993). According to Wortman and Silver (2001), adhering to the assumptions of the dominant discourse leads to three potentially deleterious outcomes for the bereaved - service providers are likely to be unhelpful, family and friends of the bereaved are unlikely to be able to provide adequate support, and third, the bereaved themselves might become distressed when their experience of grief differs from their beliefs about 'normal' grief. Similarly, Kauffman (1989, 2002) used the term self-disenfranchisement to describe the individual that disenfranchises his or her grief, while Walter (1999) described the self-regulation or 'policing' of one's grief. Narrow conceptions of a phenomenon, including grief, can be accepted as 'fact', leading to an oppressive state (Fox & Prilleltensky, 2003) by colouring the understandings of their 'illness' and the 'treatment' they 'require'.

Despite the dearth of empirical support and the presence of alternative theoretical models, the 'myths' inherent in the dominant discourse remain so powerful. Wortman and Silver (1989) argued that these 'myths' are remarkably impervious to challenges because of the tendency to search for and interpret data that supports held beliefs. More recently, Lindstrøm (2002) suggested that the notion of grief work persists because of three strong cultural norms – emotional expression following bereavement is regarded as 'natural', the absence of negative emotion following bereavement is deemed offensive, and the deceased is perceived to be 'owed' and thus needs to be 'properly' mourned.

It is apparent that grief has historically been characterised as a short-term and distinct syndrome that needs to be 'worked through'. Despite the literature having 'moved on' from endorsing the assumptions in the dominant discourse, the prevailing construction of grief, endorsed by laypersons, mass media, and many service providers, remains a stage-based reaction, where recovery occurs within a relatively short time frame, where there are normal and abnormal reactions to grief, and continued attachment to the deceased is pathologised. Given the potential lack of transferability of the dominant grief discourse, its uncritical application might give rise to situations where the bereaved might be judged according to the dominant cultural prescription and possibly labelled. The development of a diagnostic category for complicated grief and the

subsequent debates regarding its inclusion in the DSM (APA, 2000) are discussed below.

Medicalisation of Grief

Theorists have distinguished between 'normal' and 'pathological' forms of grief for almost a century. Freud's (1917/1957) assertion that there are 'normal' and 'pathological' forms of grief eventually inspired numerous publications on grief reactions that were thought to differ from 'normal'. Indeed, Deutsch (1937) is acknowledged as the first to identify a 'pathological' grief reaction, which she called absent grief. She asserted that bereavement must produce an emotional reaction and the absence of an expected reaction indicated pathology. Soon, the term pathological grief to describe an intense and chronic grief reaction was in use (Anderson, 1949).

Grief was increasingly being viewed through the application of a medical lens. Engel (1961) added further fuel to the controversy over the increasing medicalisation of grief by arguing that grief should be conceptualised as a disease. The basis of his claim was grief and disease share features of suffering, an identified cause, temporary functional impairment, and an expected symptomatology and pattern. Engel surmised that, just because grief is 'natural', 'normal', and ubiquitous, did not mean it could not be pathological. Indeed, he declared that all grief, complicated or uncomplicated, should be conceptualised as pathological! In his conclusion, Engel called for more research in order to subject grief to the "same kind of rigorous and systematic exploration and examination that has been applied to other phenomena of disease" (p. 21). Parkes (1986) also argued that grief is a mental illness, albeit a neglected one, and called for grief to be classified with anxiety disorders[7]:

> I know of only one functional psychiatric disorder whose cause is known, whose features are distinctive, and whose course is usually predictable, and that is grief, the reaction to loss. Yet this condition has been so neglected by psychiatrists that until recently it was not even mentioned in the indexes of most of the best-known general textbooks of psychiatry. (p. 26)

Before long, others (e.g., Bowlby, 1961, 1980; Gorer, 1965; Horowitz et al., 1980; Klein, 1940; Krupp, 1972; Lazare, 1979; Lindemann, 1944; Parkes, 1965a, 1965b,

[7] Although Parkes (2005-2006a) later tentatively suggested complicated grief could be included alongside Personality Disorders (see discussion later this chapter).

1972, 1986; Parkes & Weiss, 1983; Rando, 1984; Volkan, 1970; Wahl, 1970; Wretmark, 1959) were describing a range of 'pathological', 'abnormal', 'neurotic', 'morbid', 'maladaptive', 'absent', 'chronic', 'unresolved', 'unlimited', 'inhibited', 'conflicted', 'unanticipated', 'prolonged', 'exaggerated/distorted', 'intense', and 'delayed' grief reactions in their psychiatric samples. Essentially, these constructions considered grief to be 'pathological' when the work of grief was not progressed to completion. Indeed, these medicalised terms have increasingly been used to describe grief that deviates from a standardised or 'typical' norm (Kristjanson et al., 2006; Rando, 1993; M. Stroebe, van Son, Stroebe, Kleber, Schut, & van den Bout, 2000).

Given the increasing focus towards medicalisation, it is perhaps no surprise then that calls for a separate diagnostic category for complicated grief have been occurring for two decades (Hartz, 1986; Horowitz, Bonanno, & Holen, 1993; Jacobs, 1993, 1999; Kim & Jacobs, 1991; Marwit, 1991; Parkes, 1986; Raphael & Middleton, 1990), and the trend is rapidly gaining impetus. In the last decade or so, two distinct groups of researchers have proposed complicated grief as a distinct mental disorder - Horowitz and his colleagues on the west coast and Prigerson and her colleagues on the east coast of the United States.

Horowitz et al. (1997) recruited 70 widows and widowers (aged 21 to 55) through a local newspaper. After completing a number of self-report instruments on their grief response and current symptoms, each participant was clinically interviewed and their grief symptoms were rated. The result was the development of criteria for Complicated Grief Disorder (see Table 2). Analyses revealed that, at 14 months post-loss, 41% (n = 29) of the sample met the criteria for complicated grief, while only six participants (9%) met the criteria for both complicated grief and MDD, suggesting that complicated grief and major depression are distinct. They concluded that,

> …major depressive disorder does not adequately cover the picture. Adjustment disorder is too nonspecific to serve as the relevant additional category. The event criteria of PTSD exclude some common loss-induced reactions from use of this diagnosis. A new diagnosis could help clinicians to formulate and treat pathology that is not adequately covered at present in our nosology in DSM-IV. (p. 909)

Table 2

Proposed Diagnostic Criteria for Complicated Grief Disorder

A: Event criterion/prolonged response criterion
Bereavement (loss of a spouse, other relative, or intimate partner) at least 14 months ago (12 months is avoided because of possible intense turbulence from anniversary reaction)

B: Signs and symptoms criteria
In the last month, any three of the following seven symptoms with a severity that interferes with daily functioning

Intrusive symptoms
1. Unbidden memories or intrusive fantasies related to the lost relationship
2. Strong spells of pangs of severe emotion related to the lost relationship
3. Distressingly strong yearnings or wishes that the deceased were there

Signs of avoidance and failure to adapt
4. Feelings of being far too much alone or personally empty
5. Excessively staying away from people, places, or activities that remind the subject of the deceased
6. Unusual levels of sleep interference
7. Loss of interest in work, social, caretaking, or recreational activities to a maladaptive degree

Note: Adapted from Horowitz et al. (1997).

Concurrently, Prigerson et al. (1995) developed the Inventory of Complicated Grief (ICG) based on the notion that certain symptoms are distinguishable from depression and anxiety and are linked to long-term functional impairments. They subsequently proposed criteria of Complicated Grief Disorder[8] that centred on symptoms of yearning, intrusive thoughts, and preoccupation with deceased (Prigerson et al., 1996). Also largely based on research of widows and widowers, Prigerson and colleagues' argue that complicated grief is distinct from depression, anxiety, and 'normal' grief (e.g., Chen, Bierhals, Prigerson, Kasl, Mazure, & Jacobs, 1999; Prigerson et al., 1996; Prigerson & Jacobs, 2001). Essentially, they argue that, while grief itself does not predict negative physical and psychological outcomes, the presence of complicated grief symptoms does (e.g., Prigerson et al., 1997; Jacobs & Prigerson,

[8] Prigerson et al. (1995) initially used the term complicated grief but subsequently used the term traumatic grief (e.g., Jacobs & Prigerson, 2000; Prigerson et al., 1996, 1999; Prigerson & Jacobs, 2001). Following the 2001 attacks on the World Trade Center in New York City, Prigerson and colleagues reclaimed the term complicated grief to avoid its confusion with exposure to traumatic events (see Kristjanson et al., 2006).

2000). In one study, a complicated grief reaction was associated with a number of physical and psychological outcomes, including serious illness and suicidal ideation (Prigerson et al., 1997). Additional studies demonstrated that complicated grief was linked to suicidal ideation (Prigerson et al., 1999) and impairments in quality of life (G. K. Silverman, Jacobs, Kasl, Shear, Maciejewski, Noahiul, & Prigerson, 2000).

Table 3

Criteria for Complicated Grief Proposed for DSM-V.

Criterion A: Chronic and disruptive yearning, pining, and longing for the deceased.
Criterion B: The person must have four of the following eight remaining symptoms at least several times a day or to a degree intense enough to be distressing and disruptive: 1. Trouble accepting the death 2. Inability to trust others 3. Excessive bitterness or anger relating to the death 4. Uneasiness about moving on 5. Numbness/detachment 6. Feeling life is empty or meaningless without deceased 7. Bleak future 8. Agitation
Criterion C: The above symptom disturbance causes marked and persistent dysfunction in social, occupational, or other important domains.
Criterion D: The above symptoms disturbance must last at least six months.
Complicated Grief Diagnosis = Criteria A, B, C, and D must be met.

Note: Adapted from Prigerson and Maciejewski (2005-2006).

The team continued refining their conceptualisation, and proposed diagnostic criteria including preoccupation with the deceased, numbness, excessive anger, meaninglessness, and impairment in social and/or occupational functioning (Jacobs, Mazure, & Prigerson, 2000). Despite criticisms (e.g., Lister, 1998) of Horowitz et al.'s (1997) stipulation that the presence of symptoms 14 months post-loss indicates the existence of complicated grief, Prigerson and colleagues (e.g., Jacobs & Prigerson, 2000; Prigerson & Jacobs, 2001) originally specified that the symptoms need only be present for two months (although in her most recent paper, Prigerson (Prigerson & Maciejewski, 2005-2006, proposed six months; see Table 3). Complementing Prigerson's work was Jacobs' (1999) book *Traumatic Grief*. Her definition of normal grief as characterised by "…a progression of the multiple dimensions of grief… with a

reduction in the dysphoria…, growing acceptance of the death, and the gradual return of the capacity for reinvestment in new interests, activist, and relationships" (p. 39), and her assertion that a relatively short duration of distress (two months) is a signal of traumatic grief, reflects the dominant discourse.

Prigerson and Jacobs (2001) argued that complicated grief should be a "distinct clinical entity" (p. 613) and is separate from 'normal' grief, depression, PTSD, and anxiety relating to bereavement. Others are more cautious about inclusion of complicated grief into a diagnostic classification system. Hogan, Worden, and Schmidt (2003-2004) found a considerable overlap between complicated grief and depression, and between normal and complicated grief. However, Prigerson and Maciejewski (2005-2006) referred to Hogan et al.'s study as unfair, biased, and irrelevant (p. 9). Further, an analysis indicated the presence of five diverse conceptualisations of the interface between 'complicated' forms of grief and the diagnostic classification (M. Stroebe & Schut, 2005-2006). Despite reservations, Prigerson and colleagues' conceptualisation appears to be preferred (see Goodkin et al., 2005-2006; Kristjanson et al., 2006); it is certainly more prolific, although both conceptulisations have been criticised for failing to account for other proposed subtypes of pathological reactions, such as delayed or absent grief (M. Stroebe & Schut, 2005-2006).

Currently, grief is specifically excluded from the definition of a mental disorder as specified in the text revision of the fourth edition of the DSM (APA, 2000), where a mental disorder is defined as;

> …a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress … or disability … or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. (p. xxxi)

However, a comparison of the different editions of the DSM and a review of recent literature highlights the developing trend towards the classification of 'complicated' grief within clinical frameworks (Chen et al., 1999; Goodkin et al., 2005-2006; Hartz, 1986; Horowitz et al., 1993, 1997; Horowitz, 2005-2006; Kim & Jacobs, 1991; Jacobs, 1993, 1999; Jacobs et al., 2000; Jacobs & Prigerson, 2000; Marwit, 1991; Parkes, 2002, 2005-2006a, 2005-2006b; Prigerson et al., 1995, 1996, 1997, 1999; Prigerson & Jacobs,

2001; Prigerson & Maciejewski, 2005-2006; Prigerson & Vanderwerker, 2005-2006; Raphael & Middleton, 1990; G. K. Silverman et al., 2000). For example, the DSM-IV text revision suggests that both intensity of grief and length of time since bereavement are significant in determining whether or not grief meets the MDD criteria:

> …if the symptoms begin within 2 months of the loss of a loved one and do not persist beyond these 2 months, they are generally considered to result from Bereavement…, unless they are associated with marked functional impairment or include morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation… (APA, 2000, p. 352).

The tension concerning medicalisation of grief continues today with the highly political debate concerning whether or not 'complicated' grief reactions should be classified as a mental disorder. According to Parkes (2005-2006b), the authors of the DSM had previously not included a distinct category of a pathological form of grief because it could not be readily distinguished from 'normal' grief or other forms of mental disorder, especially depression. However, with the growing evidence for recognition of complicated grief and the ongoing preparation of the fifth edition of the DSM, a special issue of *Omega: The Journal of Death and Dying* (Parkes, 2005-2006b) was devoted to debating the inclusion of complicated grief as a mental disorder. The majority concluded that further empirical and conceptual validation is required. However, Horowitz (2005-2006) suggested that complicated grief should be included, alongside PTSD, in a new category of Stress Response Syndromes; Prigerson and Vanderwerker (2005-2006) recommended that complicated grief be included in a new category of Attachment Disorders; and Parkes (2005-2006a) tentatively suggested complicated grief could be included with Personality Disorders. A compromise of including complicated grief in the DSM-V, but only within Appendix B as a disorder proposed for further study, was also put forth (Goodkin et al., 2005-2006)!

Despite reservations concerning the definition of complicated grief, distinguishing it from other diagnostic categories such as depression, and the potential for all grief to become pathologised (e.g., Hogan et al., 2003-2004; M. Stroebe, Hansson, et al., 2001a, 2001c; M. Stroebe & Schut, 2005-2006; M. Stroebe, Schut, & Finkenauer, 2001; M. Stroebe et al., 2000; Walter, 2005-2006), it appears more and

more likely that complicated grief will be included in a future DSM edition. Despite these concerns, Prigerson and Maciejewski (2005-2006) countered;

> …as has been repeatedly demonstrated, …bereaved subjects who meet our criteria for CG are at heightened risk of serious adverse outcomes such as suicidality, high blood pressure, increased smoking and alcohol consumption as well as physical and social impairment and distress, then it appears that concerns about pathologizing, stigmatizing, medicalizing, and labeling the grief reaction are unfounded. (p. 16)

They and others (e.g., Bambauer & Prigerson, 2006; Horowitz, 2005-2006; Kristjanson et al., 2006; Parkes, 2002), have fervently argued that the presence of the diagnostic category might in fact lead to better identification of those 'at-risk', improved treatments, increased funding for treatments, and greater social recognition of the needs of those with the disorder. However, those concerned with being labelled with a psychiatric diagnosis are significantly less likely to seek professional help (Bambauer & Prigerson, 2006).

A number of conceptual issues emerge from the discussion of 'complicated' grief. First, estimates of the incidence of complicated grief range from 10% to 20% of all bereavements (Kristjanson et al., 2006), to one in every five bereavements (Hansson & M. Stroebe, 2003), to one third of all bereavements (Raphael, 1984). Rando (1993) disputed Raphael's estimate as conservative, because it failed to account for all of those potentially affected by death, such as friends, neighbours, and colleagues of the deceased. In a review, Jacobs (1999) stated that estimates of the incidence of pathological grief range from 8 to 34% (depending on the definition of pathology). However, if complicated reactions are so common, can they really be 'abnormal'? The question has been debated in the literature, with Parkes and Weiss (1983) describing as a "paradox" (p. 170) the interplay between 'pathological' forms of grief and the unique circumstances of the bereavement. They remarked, "it may well be that the pathological variations are no more than extreme forms that appear in response to particularly unfavourable circumstances" (Parkes & Weiss, 1983, pp. 15-16). Further, it has been argued that complicated grief is a cultural construction that potentially serves the needs of service providers and those who want to censure the bereaved (Walter, 2005-2006). In fact, Foote and Frank (1999) allege that complicated grief is a form of resistance to the dominant discourse. Despite such acknowledgements, theorists and practitioners have

continued to differentiate between normal and pathological reactions, as though a clear distinction exists. What is clear is that the notion of a separate diagnostic category for 'complicated' grief remains a complex and much debated issue, particularly in regard to consensus regarding its definition and its distinction from 'normal' grief, as well as the diagnosis and treatment of these non-typical reactions (Goodkin et al., 2005-2006; Hogan et al., 2005-2006; Horowitz, 2005-2006; Kristjanson et al., 2006; Neimeyer, 2005-2006a, 2005-2006b; Prigerson & Jacobs, 2001; Prigerson & Vanderwerker, 2005-2006; Rando, 1993; M. Stroebe, Hansson, et al., 2001c; M. Stroebe & Schut, 2005-2006; M. Stroebe, Schut, & Finkenhauer, 2001; Walter, 2005-2006).

Efficacy of Grief Interventions

The recent conceptualisation of grief within clinical frameworks has increased the importance of understanding grief to service delivery. One of the potentially great barriers to effective grief intervention is the general lack of understanding of grief in the service professions, which is at least partly explained by the discord between grief researchers and service providers (Center for the Advancement of Health, 2004). Despite the existence of an "industry" concerned with grief interventions (Kugelmann, 1992, p. 41), a gap exists between information in the literature and the use of that information by service providers (Bridging Work Group, 2005; Center for the Advancement of Health, 2004; Jordan, 2000; Neimeyer, 2000b). For example, a recent study demonstrated that service providers rated scientific journal articles on grief as least helpful in their practice (Bridging Work Group, 2005), despite journals being the most popular avenue for researchers to disseminate their findings and containing the most recent information. Instead, the service providers preferred to gather information from books, colleagues, and workshops. The discrepancy means that there is a modest overlap in the tactics used by researchers to disseminate their research and the avenues used by service providers to acquire the latest information. The result is that, although the above assumptions have been subject to robust challenges in recent years (see later this chapter), they remain the dominant discourse. These assumptions do not just exist in the grief literature – they are evident in university training in a number of disciplines and continue to be a significant influence on both grief education and grief interventions.

Grief Education. The divide between researchers and service providers is complicated by two factors – the state of grief education of service providers and the efficacy of their interventions. Despite little research on the grief education of service providers (see Center for the Advancement of Health, 2004, for a brief review), the existing literature reveals two trends – service providers either receive no grief education in their academic and professional careers, and the education pertains more to end-of-life care than grief per se.

Surveys of American and British medical, nursing, pharmacy, and social work schools demonstrated that most presented at least some information on grief but the information was limited (Dickinson & Field, 2002; Dickinson, Sumner, & Frederick, 1992). Further, of the nursing and medical schools in Canada and the United Kingdom that provided grief education, the majority reported that their curriculum endorsed 'stages of grief' models, particularly those of Kübler-Ross, Parkes, and Worden. In a review of the current state of death education for service providers, Wass (2004) estimated that less than a fifth of students in health-related professions are exposed to sufficient death education. She further characterised death education in medical and health-related fields as "inadequate" (p. 293).

The situation improves somewhat following graduation. A survey of Welsh general practitioners indicated that, while only a quarter reported receiving any grief training as a medical student, 70% reported receiving grief training as a GP registrar (Barclay, Wyatt, Shore, Grande, & Todd, 2003). Importantly, 17% reported receiving no grief education in any aspect of their academic and professional careers. Further, a survey of nurses employed in accident and emergency departments in London revealed that less than half (42%) reported having received any death education and 56% reported feeling ill-equipped in doing so (Tye, 1993). Another survey of accident and emergency nurses in Glasgow demonstrated that almost half reported that they had not received education or training in caring for suddenly bereaved families (Hallgrimsdottir, 2000). Additionally, 61% reported that their practice is not based on empirical evidence, with 60% stating that they are not familiar with current literature. Similarly, in a recent survey of nursing homes in the United States, 63% reported being dissatisfied with the training of staff on death and dying (Moss, Braunschwieg, & Rubinstein, 2002).

These few studies and reviews highlight that death education of health providers is an overlooked area. Further, the education that does exist usually emphasises 'end-of-life' issues relevant to hospice settings and palliative care (Barclay et al., 2003; Dickinson & Field, 2002; Wass, 2004) and the quality of the information presented on grief (in terms of theorists, models, etc) is generally not known. Thus, research shows that death education is limited, and where it does exist, it is based around end of life issues, not grief in general.

Grief Interventions. Despite little research on the efficacy of grief interventions (see Center for the Advancement of Health, 2004, for a brief review) the existing literature reveals a trend toward interventions being based on the dominant grief discourse. For example, Payne et al. (2002) interviewed 29 grief counsellors in the United Kingdom. Although they recognised the grief experience is unique to each client, they reported drawing primarily on stages/phases/tasks/processes models in their work. Despite their acknowledgment that the stages are not progressive or necessary, the counsellors believed that client could become 'stuck' within particular stages, articulated that grief is time bound, and many prioritised facilitating closure of the relationship between the client and the deceased. Similarly, Wiles, Jarrett, Payne, and Field (2002) interviewed 50 general practitioners in the United Kingdom. The general practitioners also drew solely upon constructions of grief as linear, stage/phase-based, and time-bound. These findings are perhaps unsurprising, given that material directed at helpers and popular press often reflects the assumptions inherent in the dominant discourse (Wortman & Silver, 2001).

Foote and Frank (1999) further outline therapeutic practices that establish and maintain the dominant discourse. First is the demarcation between 'normal' and 'abnormal' grief, where therapy is assumed to be able to transform 'abnormal' responses into 'normal' ones. Second is medicalisation, where grief is conceived as a disease, symptoms are identified, abnormal responses are specified, and recovery or acceptance is considered necessary. Third is the process of individualisation, which ignores social, historical, cultural, and economic contexts. Fourth is the necessity of 'grief work', which prescribes mastery over bereavement. Finally, they describe the social customs that 'police' grief, rendering it private, quiet, and quick, according to the dominant discourse.

As an illustration, Parkes (2001) wrote,

> …the sequence was never intended to be more than a rough guide, and it was recognised from the start that people would move back and forth through the sequence rather than following a fixed passage. Even so it was adopted with enthusiasm by some psychotherapists and counsellors… (p. 30).

The acceptance of the assumptions in the dominant discourse, often uncritically and without significant supporting empirical evidence, was (and remains) rife in grief interventions. For example, Rando (1984) noted the trend that some service providers rigidly attempt to fit the person to the theory rather than using the theory to inform their care, especially as the word 'stage' implies linear progression through fixed phases of experiences. She later stated that professional helpers often hold unrealistic expectations about grief, especially concerning the timeline of 'healthy' grief and the detachment from the deceased (Rando, 1993). According to others (e.g., Foote & Frank, 1999; Pilkington, 1993; M. White, 1989), grief theories that assert a stage-based and finite conceptualisation of grief led to the situation where service providers were engaged in a process of the assessment and diagnosis of and intervention with bereaved individuals, according to their 'progress' through the grief process. Worden (1982, 1991, 2002) encourages service providers to identify the task or tasks of mourning that are not completed and help the bereaved to resolve each task. D. Cook, White, and Ross-Russell (2002) recommended that staff in paediatric intensive care units detect "unusually absent or excessive reactions" (p. 38) as signs of 'pathological' grief. Further, despite Complicated Grief Disorder not (at least yet) being officially recognised in DSM nosology, Kristjanson et al. (2006) recommended that service providers screen the bereaved for the disorder if symptoms persist beyond six months and/or are severe. Indeed, the Center for the Advancement of Health (2004) highlighted the serious problem that has plagued grief interventions – the failure to distinguish between the description of grief in unrepresentative samples and the subsequent prescription of these 'normal' reactions to other samples.

Grief interventions are further complicated by the belief held by most service providers that their interventions are efficacious (Jordan & Neimeyer, 2003). However, in a review of four major meta-analyses and literature reviews, Jordan and Neimeyer (2003) concluded that grief interventions showed little to no effect, and in a high

proportion of cases, the bereaved participants would have been better off without the intervention. Others have also suggested that interventions for 'normal' or 'uncomplicated' grief are not effective (e.g., Schut, Stroebe, van den Bout, & Terheggen, 2001). In another review, the authors stated there is a lack of empirical evidence supporting primary prevention interventions for 'uncomplicated' reactions such as;

> …crisis teams visiting family members within hours of the loss, mutual-help groups with the goal of fostering friendship, programs to educate bereaved persons about the tasks of working through one's grief, cognitive-restructuring and behavioural-skills programs, treatment involving the sharing of information, emotions, and support, and brief group psychotherapy. (Hansson & Stroebe, 2003, p. 519)

Interventions are thought to be more effective for those with 'complicated' grief reactions or grief with 'risk' variables. In a review, Neimeyer (2000a) reported a positive effect for treatment without the iatrogenic inducement of deterioration for those with 'risk' variables including the violent, sudden, and untimely death of a loved one. In another study (Murray, Terry, Vance, Battistutta, & Connolly, 2000), parents bereaved perinatally (e.g., stillbirth, neonatal death, SIDS) were assigned to either an intervention (n = 84) or control group (n = 60). The intervention consisted of resource materials and at least one visit by a grief worker. The researchers concluded that the intervention lowered parental distress for those parents assessed initially as 'high-risk' but had little effect for those assessed as 'low-risk'. Thus, interventions are likely to be effective, but only when focussed on those deemed to be 'high-risk' (Jacobs & Prigerson, 2000; Jordan & Neimeyer 2003; Schut et al., 2001).

In addition, grief support is far more likely to be provided when the bereaved are 'known' to service providers, such as in end-of-life care or hospital-based settings. Although some interventions consist of just a telephone call following the death of a family member in hospital (e.g., Kaunonen, Tarkka, Laippala, & Paunonen-Ilmonen, 2000), other interventions are comprehensive. For example, a recent survey of Californian hospices demonstrated that almost all provided grief support to families following the death of patients (Foliart, Clausen, & Siljestrom, 2001). The support incorporated a variety of services, including telephone calls, mailings, pamphlets on grief, pastoral care, home visits, professional counselling, support groups, workshops,

support for particular members of the family (e.g., children, teenagers), and memorial services. Similarly, Nesbit, Hill, and Peterson (1997) described a comprehensive bereavement program for families grieving the deaths of children admitted to hospital. The program consists of a grief information package for the family, one year follow-up contact with the family, a newsletter, and a remembrance program. Another program provided 12 weeks of structured support for couples grieving the death of their babies in a neonatal intensive care unit (Reilly-Smorawski, Armstrong, & Catlin, 2002). The provision of support may be directly contrasted with the lack of structured supports provided to those bereaved through the sudden death of a loved one, despite the increased likelihood of 'risk factors' and 'complications'. In a recent study of 91 widows, the authors ascertained that those meeting the criteria for traumatic grief were significantly less likely to seek medical help for physical health issues, and no more likely to seek help from mental health professionals for psychological difficulties, than were widows that did not satisfy the criteria for traumatic grief (Prigerson et al., 2001).

Finally, the provision of support following bereavement is further complicated by people's discomfort with and anxiety concerning death. Studies have shown that counsellors experienced significantly higher levels of discomfort and displayed low empathy in dealing with death and dying when compared to other potentially sensitive issues (Kirchberg & Neimeyer, 1991; Kirchberg, Neimeyer, & James, 1998). Another study demonstrated that 30% of nurses looking after critically-ill patients reported feeling uncomfortable with dealing with the bereaved family members (Kojlak, Keenan, Plotkin, Giles-Fysh, & Sibbald, 1998).

Despite the interest in and the proliferation of grief interventions, empirical research has shown that the interventions are likely to be of benefit, but only for grief that is deemed 'at-risk' or' complicated'. In fact, interventions are likely to be deleterious for 'normal' grief. However, despite some exceptions (e.g., Murray et al., 2000) interventions remain largely focussed on grief following end-of-life and hospital care, rather than following bereavements that are more likely to result in 'complicated' outcomes. Further, complementing the trend that grief education remains based on the dominant discourse, grief interventions also remain based on the dominant discourse, and are additionally obfuscated by factors such as death anxiety and discomfort. In the

following section I provide a rationale for the exploration of the experience of grief resulting from the death of a loved one in a crash in WA, with an emphasis on the role of contextual factors on supporting and inhibiting the experience of grief following crash fatalities.

Discussion and Rationale for the Study

There is a plethora of research on grief, with the bulk focussing on intraspsychic variables, 'symptoms', 'risk' factors, and outcomes. However, while bereavement is a universal phenomenon, the experience of grief is not. Grief is a unique experience that occurs within a historical, social, cultural, and political context. These contextual factors all affect an individual's grief experience and as such, must not be omitted or viewed as extraneous variables. Instead, they need to be held in as much regard as the grief experience itself.

It is widely regarded within psychology, especially within community psychology, that social phenomena are unreservedly embedded within a context (Maton, 2000; Prilleltensky & Nelson, 2002). Community psychology endeavours to make psychology more relevant to the 'real world' by recognising the importance of the context on a person's behaviour. However, in contrast to the recognition of the role of contextual variables on a person's grief, there remains a tendency in thanatological research to examine individual factors in isolation with no or minimal attempts to look at the complex interplay between the variables that influence an individual's grief experience, such as the impact of family and friends, professional helpers, social norms, legal and medical systems, and so on. In addition, these factors are important in terms of mediating and moderating the grief experience. For example, understandings of grief may affect the amount and type of support one receives from family and friends, the status of a particular bereavement might impact one's access to professional help, and cognitive appraisal may affect how one perceives the support he or she receives.

Despite recent developments in thanatological methodology and theory, the dominant discourse concerning grief remains that which describes grief as a short-term, quasi-linear progression through stages culminating in recovery (Center for the Advancement of Health, 2004; Foote & Frank, 1999; Jordan, 2000; Klass & Walter, 2001; Kristjanson et al., 2006; Lindstrøm, 2002; Murray, 2002; Payne et al., 2002;

Parkes & Weiss, 1983; Rando, 1993; Rosenblatt, 1996; Shapiro, 1996; M. Stroebe et al., 1992; Walter, 2000, 2005-2006; Walter et al., 1995; M. White, 1989; Winslade, 2001; Wortman & Silver, 1989, 2001). Given the contemporary critiques of the dominant discourse enveloped by the historical construction of grief, there is a need for empirical data that has implications for practice. However, grief research is;

> …complicated by the fact that the losses are varied: spouse/parent/child/relative/friend; sudden/unexpected; accident/natural/inflicted/self-inflicted; and that cultural norms are religious/philosophical convictions also are parts of the intricate field of bereavement. Any investigation would have to take these factors into consideration. (Lindstrøm, 2002, p. 19)

The ability to incorporate all factors into a research project presents both an academic challenge and one that would require substantial resources (Center for the Advancement of Health, 2004). However, the ability to conduct applicable research is further complicated by three factors that also explain the discord between grief researchers and service providers – flawed dissemination of research findings to service providers, deficiencies in communication between researchers and service providers, and the inadequate application by service providers of research findings (Center for the Advancement of Health, 2004). Further, researchers and service providers experience diametrically-opposed pressures: the culture of academia requires publications with theoretical rather than practical significance whereas service providers give a low priory to research that is not specifically applicable to the demands of their workplace (Bridging Work Group, 2005; Jordan, 2000; P. R. Silverman, 2000).

Two developments are required for greater interdependence between research outcomes and service provision – researchers must attend to the applications of their findings so that they can inform service provision, and present this information in a format that is most likely to be incorporated by service providers (Center for the Advancement of Health, 2004; Jordan, 2000; Wolfe & Jordan, 2000). While most grief research focuses on quantitative methodologies and measures, service providers are most likely to utilise research findings when those findings complement their experiences in the service settings; that is, it is ‘natural’, contextual, involves multiple stakeholders, is relevant to service provision, uses cases as examples with verbatim data from informants, and incorporates the research literature (Bridging Work Group, 2005; Center

for the Advancement of Health, 2004; Jordan, 2000). Thus, until both researchers and service providers embrace methodological pluralism, researchers need to present research in ways that render findings most useful to and valued by service providers.

In addition to the above imperatives, I have identified gaps in the literature in a number of areas. First, there is a dearth of Australian grief research generally. It is important to note that much grief research is North American, while little research has occurred within Australia, with Australian participants[9]. Second, much of grief research has focussed on 'natural' deaths following illness. There remains a dearth of research grief following crash-related deaths. There is a need for research especially given that crash deaths are relatively common (see Chapter 1) yet the psychosocial consequences of crash fatalities are relatively under-researched and thus are a significant area for study.

Third, although qualitative methods and/or the collection of qualitative data are perhaps more common in grief research than in other domains, quantitative studies dominate the literature (Neimeyer & Hogan, 2001; Thorson, 1996). Qualitative studies have been proposed as alternatives to the positivist paradigm typical in grief research that is "often atheoretical, objectivistic, superficial, and decontextualized" (Neimeyer & Hogan, 2001, p. 106) and that "dismisses the subjective experiences of people and minimizes the importance of relationships in the human experience" (P. R. Silverman & Klass, 1996, p. 21). Perhaps related to the reliance on quantitative methods is the dearth of research on the experience of grief from the perspectives of the bereaved themselves. For example, Neimeyer (2000b) argued for the greater integration and exchange of ideas between grief researchers and practitioners. However, another group can be included in the dialogue – the bereaved. As Fulton (1999-2000) argued, health care professionals and researchers must be sensitive and not impose their views about the grief experience on to those living the experience. Instead, he suggested that health care professionals must first identify "how the individual constructs their experiences and the meaning attached to it" (p. 50), before suggesting the type of support (if any) that may be appropriate. In addition to the voices of the bereaved, service providers also need a

[9] Notable exceptions include Beverly Raphael (e.g., Raphael, 1984, Raphael & Middleton, 1987, 1990), Judith Murray (e.g., Murray, 2002; Murray & Terry, 1999; Murray et al., 2000), Allan Kellehear (2001) and Mal McKissock (e.g., McKissock & McKissock, 1991).

voice, especially if the aim is to build a greater alignment between research, service providers, and the bereaved (Center for the Advancement of Health, 2004). Qualitative methodologies, and in particular grounded theory, allow the collection of multiple types of data from multiple sources especially when the research is exploratory, applied, and situated within a non-manipulated context (Creswell, 1994; Denzin, 1972; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1990, 1998; see also Chapter 3).

With these conceptual and methodological requirements in mind, research that utilises multiple perspectives from multiple informants (service providers and the bereaved) in order to investigate the context of grief experiences following crashes was essential. Such an approach has been used in other settings such as investigating the experience of recovery from work-related trauma (Edmondson, 2001) and the experience of victim-survivors of domestic violence (Fisher, 2000). Thus, I aimed to address the issues identified above by exploring the experience of grief resulting from the death of a loved one in a crash in WA and to describe the influence of the contextual factors on the grief experience, in order to develop a clearer picture of the role of contextual factors on supporting and inhibiting the experience of grief following crash fatalities.

Chapter 3: Research Methodology

In Chapter 3 I describe the research process, beginning with restating the aims of the research and the associated research questions. Next, I emphasise the epistemological and methodological perspectives of constructionist grounded theory and outline the research design. Primarily, data were collected from two groups of informants. The first group consisted of people involved in the area of road safety and support services in the aftermath of crashes. The second group consisted of people bereaved through crashes in WA. A rationale for the use of in-depth recursive interviews as the principal data collection method is outlined. A 'scoping and profiling' process and documents were additional sources of data. Data from multiple sources were required to uncover the multiple truths concerning the experiences of grief following crashes. Information on the recruitment and demographics of the key informants, materials and procedures used to collect the data, ethical considerations, and the processes of data analysis used in the research are discussed.

Purpose Statement and Research Questions

The broad aims of this research were to explore the experience of grief resulting from losing a loved one in a crash in WA and to describe the influence of the contextual factors on the grief experience, in order to develop a clearer picture of the role of contextual factors on supporting and inhibiting the experience of grief following crash fatalities.

The research questions were as follows:

1. What is the experience of grief resulting from a crash?
2. What factors affect the experience of grief resulting from crashes? In what ways do they affect the grief experience?
3. Are there relationships between these factors? If so, what are they and how do they affect the grief experience resulting from crashes?
4. What are the implications for WA in terms of service delivery pertinent to crash-related bereavement?

Research Design

In the study on grief following crashes in WA, constructionist grounded theory was utilised because research aims were exploratory, applied, and situated within a non-manipulated context (Artinian, 1986; Chenitz & Swanson, 1986; Creswell, 1994; Denzin, 1972; Strauss, 1987; Strauss & Corbin, 1990, 1998). I discuss the epistemology of constructionism and grounded theory methodology below.

Constructionism. Constructionism[1] is defined by Crotty (1998) as the perspective whereby "*all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context*" (p. 42, italics in original). The primary assumption of constructionism is that humans interpret the world around them through their social, cultural, and linguistic

[1] I have consistently used the term constructionism throughout this thesis. Denzin and Lincoln (1994) use the terms constructivism and interpretivism interchangeably, while Lincoln and Guba (2000) view constructivism as a component of the subjectivist epistemology. However, Crotty (1998) disputes such usage and argues there are true distinctions between these epistemologies. Crotty (1998) also distinguishes between constructivism and constructionism, yet also uses the terms interchangeably. Gergen (1999) differentiates between constructivism, radical constructivism, social constructivism, social

lenses and therefore 'reality' is constructed rather than objective (Patton, 2002). Thus, constructionism presents a challenge to the logical positivist perspective where scientific investigation is characterised as neutral and value-free.

Karl Mannheim (1893-1947) is generally perceived to be the founder of constructionist thought, although constructionist thinking can be found in the earlier writings of social critics such as Karl Marx (Crotty, 1998; Gergen, 1999). The development of constructionism occurred via the analysis of the construction of scientific knowledge. Essentially, constructionism suggests that different people will construct their understanding of an experience in different ways (Crotty, 1998). Multiple perspectives exist but no one perspective is regarded as more 'truthful' than others (Crotty, 1998; Patton, 2002). At the core of constructionism is the notion that phenomena, including psychological phenomena, are interrelational, multiple, and dynamic, and that meanings are derived through our engagement with the social world, and as such, there is no one objective truth to be found (Burgess-Limerick & Burgess-Limerick, 1998; Crotty, 1998; Gergen, 1985; Shotter, 1993; Patton, 2002). Gergen and Gergen (1991) argue that meanings are common across individuals but are never exactly the same. Therefore, no one interpretation is true and valid. Instead, reality is ascribed through our interactions with the world, that is, truth is constructed (Burgess-Limerick & Burgess-Limerick, 1998; Crotty, 1998). Social constructionism suggests that both the participant and the researcher are actively involved in ascribing and co-constructing meaning (Crotty, 1998)[2].

McGuire's (1983) contextualist constructionism assumes social behaviour is embedded within its cultural, political, temporal, economic, and situational contexts. The goal of research then is to make sense of or interpret human experience, given the context. An analysis of the wider context is essential because behaviour is a function of the interaction between an individual and the environment in which he or she operates (Lewin, 1951). In essence, constructionists propose a contextual rather than an

---

constructionism, and sociological constructionism. Despite these distinctions, the terms are often used synonymously, and confusion as to the definition and language of the epistemology remains.

[2] For an overview of the development of constructionism, see Gergen (1999), especially his second chapter.

acontextual focus to understanding. As evident in Chapter 2, the experience of grief is influenced by these contextual factors.

Finally, constructionism is based on the principle of *Verstehen* (Weber, 1921/1968), which stresses observation, description, understanding, and meaning (Moustakas, 1990; Patton, 2002). *Verstehen* holds that the complexity of human phenomena requires different research methodologies to that of other natural phenomena (Crotty, 2002; Patton, 2002). If we accept the notion that 'reality' is constructed and idiographic, an appropriate research methodology for investigating experiences would allow the phenomenological character of the experience under study to remain at the forefront (Burgess-Limerick & Burgess-Limerick, 1998). Constructionists assert that phenomena can only be understood within the context in which they are housed and investigated, potentially minimising generalisability but maximising local relevance (Patton, 2002). Within their research, constructionists are likely to attempt to portray multiple perspectives, focus on the role of language and how 'reality' is constructed, attend to the relationship between the researcher and that being researched, consider the role of power in the research process, and how relationships and power affect the results (Patton, 2002). For these reasons, constructionism is the epistemology behind much qualitative research, including research utilising grounded theory methodology (Crotty, 1998).

Grounded theory. Grounded theory is a systematic, interpretative, and data driven methodology aimed at generating theory of a phenomenon (Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin 1990, 1998) such as the experience of grief. Strauss and Corbin (1998) define theory as "a set of well-developed categories (e.g., themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework than explains some… phenomenon" (p. 22). The theory specifies the relationship between concepts in an organised manner and enables interpretation, explanation, and prediction (Chenitz & Swanson, 1986). The emergent theory enables a greater understanding of phenomena, and therefore has relevance to both research and practice (Chenitz & Swanson, 1986; Strauss & Corbin, 1998).

Grounded theory was first articulated in the book *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). However, the approaches of sociologists Glaser and

Strauss began to differ from one another soon after. Essentially, Glaser (1978, 2002) has always maintained that a grounded theory emerges solely from the data while Strauss (1987, Strauss & Corbin, 1990, 1998) argued that grounded theory is constructionist: it is both inductive (data-driven) and deductive (relying on interpretation). Glaser (2002) remains critical of Strauss and others (e.g., Charmaz, 2000; Crotty, 1998; Strauss, 1987; Strauss & Corbin, 1990, 1998) that argue that, despite minimising bias, the researcher remains a co-constructor in the development of theory[3].

Despite originally emerging from sociology, grounded theory is regularly used in a variety of fields including nursing, education, psychology, and business. In fact, grounded theory is the most common qualitative methodology in thanatological research (Neimeyer & Hogan, 2001). The focus of grounded theory research is complex social and psychological phenomena occurring in non-manipulated contexts (Chenitz & Swanson, 1986; Strauss, 1987). As a result, grounded theory is well suited to the investigation of applied topics and the derivation of practical applications (Chenitz & Swanson, 1986; Strauss, 1987). In fact, the original impetus for grounded theory research often stems from the researcher's experience (Strauss & Corbin, 1998).

Key Informants

In order to understand the influence of the context on the grief experience resulting from crashes in WA, I focussed my research on two groups of informants. These were (a) people bereaved through crashes and (b) those working in the setting relevant to road safety and the aftermath of crashes. For clarity, each group will be discussed separately throughout the subsequent sections of this chapter.

Bereaved Informants. The bereaved informants were accessed via a number a sampling and recruitment techniques in order to minimise sampling bias, which is a major concern in thanatological research (M. Stroebe et al., 2003). Criterion sampling, where certain parameters are utilised to identify respondents (Patton, 2002), was the first type of sampling used. The criteria for inclusion were that bereaved informants were at least 18 years old, English speaking, had lost a loved one in a crash, and resided in WA at the time of the interview. Those in the first 12 months after the death of their loved

[3] For more on the historical development of grounded theory and the similarities and differences between the two approaches, see Bartlett and Payne (1997).

one were not asked to participate for two reasons; first, to avoid causing for them unnecessary distress and second, to elucidate more information regarding the influence of the context on the grief experience. There was no 'ceiling' on the time since the death as recent literature (see Chapter 2) suggests that the experience of grief is continuous rather than finite (e.g., M. Stroebe et al., 1992, 1993; M. White, 1989; Winslade, 2001). The bereaved informants were purposively sampled in an attempt to achieve maximum variability in their grief experiences (Maykut & Morehouse, 1994; Morse, 1994; Patton, 2002). Purposive sampling assists in gaining access to information-rich cases, enabling the researcher to acquire a thorough understanding of the phenomena under investigation (Patton, 2002). Purposive sampling ensures maximum variability and richness of data, thereby affording quality descriptions of cases and permitting the similarities across respondents to be identified (Burgess-Limerick & Burgess-Limerick, 1998; Morse, 1994; Patton, 2002). Consistent with grounded theory, theoretical sampling was also utilised. Theoretical sampling, a form of purposive sampling, allows the expansion and refinement of the sample, according to the emergent data (Chenitz & Swanson, 1986; Strauss, 1987; Strauss & Corbin, 1990, 1998). Theoretical sampling was used to ensure the bereaved informants represented the range of individuals that are affected by crash deaths in WA – both sexes, diverse ages, different relationships to the deceased, and so on.

I used two primary methods in order to identify and attract bereaved informants to the study. First, an information letter (Appendix A) about the research was sent to the convenors of three relevant grief-related self-help groups (e.g., The Compassionate Friends) and a small, grass-roots road safety advocacy group (Australian Parents Against Road Trauma) operating in WA. I knew of both The Compassionate Friends and Australian Parents Against Road Trauma, and the remaining two self-help groups were located using the *Directory: Self Help and Support Groups* (Western Institute of Self Help, 2001). One of the self-help groups did not reply to my letter and the other replied in a letter that stated they had no current members that matched the criteria for selection into the study. Alongside this, a media release similar to the letter (see Appendix B) calling for bereaved informants was sent to the Community Newspaper Group in an

effort to recruit informants. Community newspapers are recognised as an effective method of obtain participants for bereavement research (Schlernitzauer et al., 1998). The three methods of attracting bereaved informants likely increased the variability of the sample, thereby contributing to the research rigor (Morse, 1994). Snowball sampling, where respondents provided information on accessing additional potential participants (Berg, 2001; Patton, 2002) was useful in accessing three additional informants. These interviews enabled different perspectives on the same death to be explored and provided a further insight into the phenomenological experience of grief, as although the family members had lost the same loved one(s), their experiences of grief were not necessarily identical.

These sampling and recruitment techniques resulted in 21 bereaved informants. Medium-sized samples such as this enable in-depth information to be accessed while capturing and illustrating diverse perspectives (Patton, 2002; Swanson, 1986a). Demographic data of the bereaved informants are provided in Appendix C. Informants ranged in age from 24 to 71 years (M = 47.95, SD = 10.83). Sixteen were women and five were men. The informants included two sets of couples, a mother and her son, and another couple and their son. The time that had passed since the death of their loved ones ranged from 13 months to 23 years (M = 6.84 years, SD = 6.64). The age of their deceased loved ones ranged from 6 to 73 years (M = 30.17, SD = 20.64). All bereaved informants resided across the metropolitan area of Perth, WA. Residential information is not presented in the table to prevent the informants from being identified (Morse, 1994; Sullivan, 1998). The bereaved informants were interviewed between July and November 2002.

All bereaved informants reported losing a loved one in a crash, with the exception of two informants – one had lost both her husband and a son in the one crash, and one had lost his father and brother in the one crash. These two informants were mother and son. The loved ones that died in the crashes were predominantly children, followed by siblings, parents, a spouse, and a grandparent. Six of the informants' loved ones had died as a result of being hit by a vehicle while as a pedestrian. Five died as a result of two-vehicle crashes and five died as a result of single car crashes. Two deaths

occurred in regional areas in the southwest of WA, one in the Northern Territory, one in Melbourne, and two occurred overseas (one each in South Africa and New Zealand).

There was considerable diversity in the formal education and current occupations of the informants. Two have university degrees (one has a Bachelor of Social Work and the other a Master of Psychology) but neither was employed in their field of training at the time of interview. Two were enrolled in their first year of university (one in psychology, the other in psychology and theology) at the time of the interview.

I did not ask the informants about their ethnic or religious identities. Despite these omissions, all appeared Caucasian. Two were born in England, one in Scotland, one in South Africa, and one in the Netherlands. Another told me of her family's Polish background and another mentioned her family's Greek background. Those that discussed their religious identification were Christian, with some mentioning the specific denominations of Catholic, Anglican, and Seventh Day Adventists.

Setting Informants. The 10 setting informants were interviewed between October 2002 and November 2003 and were sampled because of their experience and expertise in their field of employment, termed intensity sampling (Morse, 1994). The service providers were identified through a 'scoping and profiling' exercise (described later in this chapter) that included referring to the Road Safety Co-ordination in WA hierarchy table (see Appendix D). The aim was for the sample to provide information concerning road safety and support services in the aftermath of crashes pertinent to WA.

One informant each was recruited from the Office of the State Coroner, Victim Support Service, Road Safety Council, Office of Road Safety, RoadWise, Health Department of WA, Lifeline, and the Insurance Commission of WA. Two police officers were interviewed, one from the Road Safety Section and the other from Major Crash.

Materials

A clearly written information document (see Appendix E) was available for all potential informants in the form of a letter, which also served to facilitate informed consent and enabled all potential informants to study the merits of the proposed research in their time (Parkes, 1995). The consent form (see Appendix F) clearly articulated the

processes relevant to participating in the study, and like the information document, facilitated informed consent.

One way we engage with our social world is via conversations (Gergen, 1985; Shotter, 1993). It is via conversations that "people acquire, develop, convey, and confer upon others the symbolic cognitive tools through which we manage our psychological engagement with the world" (J. Martin & Sugarman, 1997, p. 375). An interview is generally defined as a conversation with a purpose and is the most common method of data collection in qualitative research (Berg, 2001). As such, interviews were the main method of data collection in my study (Chenitz, 1986a; M. Z. Davis, 1986; Swanson, 1986a). The interviews for the two informant groups differed somewhat and as such will be discussed separately.

Bereaved Informants. I chose to use recursive in-depth interviews as the central method of data collection for the bereaved informants. Recursive interviews are conversational in nature and position the informants as partners in the co-construction of knowledge by allowing each informant to share his or her unique perspectives and experiences (Burgess-Limerick & Burgess-Limerick, 1998; Minichiello, Aroni, Timewell, & Alexander, 1995). The structure of a recursive interview is influenced by the interaction between interviewer and interviewee. As Minichiello et al. (1995) explain, recursive interviews allow the researcher to "start with some questions on a theme, then he or she allows the conversation to meander according to the informant's responses and the subsequent verbal interaction between him or herself and the informant" (p. 83). The semi-structured approach provides some consistency in topics covered while allowing the researcher to adapt and generate questions and probes depending on the situation and the topics that emerge (Berg, 2001; Smith, 1995). Semi-structured interviews are thought to be the optimum way to gain a detailed description of individual accounts of an experience (Smith, 1995).

In-depth interviews are commonly conducted using the recursive process, which involves attending to both the content and process of the interview (Minichiello et al., 1995; Patton, 2002). My in-depth interviews with the bereaved informants ranged between two to four-and-a-half hours in duration, which facilitated the development of rapport and provided rich data (Minichiello et al., 1995; Smith, 1995). Using this

interview format allowed flexibility in the interview process. For example, one of the first questions I posed to all bereaved informants was "can you tell me something about your experiences since (name of loved one) died?", allowing them to direct where they started their story. My subsequent questions explored the answers as well as other topics relevant to their experiences.

An interview guide (Minichiello et al., 1995) consisting of topics and issues to explore was used to give direction to the interviews, and is commonly used in grounded theory research (Swanson, 1986a). The aim of the interview guide was to facilitate the exploration of the informants' grief experiences since the death of their loved ones. Topics included help-seeking behaviours, support received, experience of coronial/legal/police investigations, and advice for others (see Appendix G). The wording and order of the questions derived from the guide were not predetermined; rather they were constructed 'in the moment' according to the interaction (Minichiello et al., 1995; Moustakas, 1990; Strauss & Corbin, 1990). The wording of questions was based on Minichiello et al.'s question types. For example, some questions were descriptive (e.g., "Tell me about …?"), while others asked about opinions/values (e.g., "Was that assistance useful?"), feelings (e.g., "How did that make you feel?"), and knowledge (e.g., "What services do you know about to assist you during this time?"), as well as background demographic questions. The different types of questions allowed me to access different types of information and demonstrated that I was listening and understanding. Probes were used to clarify and access further details (Minichiello et al., 1995). Examples include "Hmmm", "so what was that like?", or "what happened next?". Minor subsequent revisions to the guide were made after some interviews (particularly the first few interviews) to ensure the language and issues covered were appropriate for each informant (Burgess-Limerick & Burgess-Limerick, 1998). The use of open-ended questions and probes enabled informants to provide answers in their own words (Patton, 2002). Great care was taken so that questions were not double-barrelled or leading and did not include double negatives, assumptions, or jargon (Breakwell, 1995).

Consistent with the recursive method of interviewing, the interviews differed from informant to informant. Some interviews followed a storytelling method (Minichiello et al., 1995). In these interviews, the informants shared their experiences in

a roughly chronological order, starting from when they found out their loved one(s) was seriously injured or had died. Other interviews followed a funnelling structure whereby the informants would talk to an issue and I would probe for further information. Funnelling an interview permitted the data collection to be emergent as the questions and topics began very generally and then become more specific (Morse, 1994; Smith, 1995). Allowing the informants to share their experiences in a way that made sense to them also facilitated the development of a relationship with each informant (Minichiello et al., 1995).

The formal interviews ended with statements or questions such as "Well, I have no more questions", "Is there anything else you would like to add?", and "Thank you for your time. I really appreciate your taking the time to speak to me today". The method used to end the interview was decided at the time based on the interview context. It provided a check that each informant had shared his or her experience and that the interview had come to a conclusion (Moustakas, 1990; Patton, 2002).

Setting Informants. The aim of these interviews was to understand further the context of road crashes in WA. As such, the interviews were more structured that those conducted with the bereaved informants. In addition, these interviews were usually more formal and less in-depth than the interviews with the bereaved because the interviews occurred in their workplaces. However, interview guides and recursive interview strategies were employed (Minichiello et al., 1995) as outlined above (see Appendix H).

Procedure

In the following section I outline the procedures involved in conducting the interviews with the two informant groups. All interviews were conducted between July 2002 and November 2003.

Bereaved Informants. Via a letter, I requested The Compassionate Friends and Australian Parents Against Road Trauma to contact potential informants on my behalf. Those who were interested in participating were asked for permission for their first name and telephone number to be given to me. Those recruited via the newspapers made the initial telephone call to me.

I spoke to all bereaved informants over the telephone before their interviews. During the initial telephone conversation I informed them that I would like to audio-record the interview with their permission. All informants were offered the choice of whether or not their interview was recorded, but none objected to the recording.

The interviews occurred in their homes, either in their living room or at their dining table, as directed by them. Most of the interviews occurred on weekdays with a small number occurring on weekends to accommodate their work schedules. The home setting encouraged each informant to remain relaxed, facilitated open communication (Smith, 1995; Sullivan, 1998) and also aided my understanding of their behavioural responses, surroundings, and in some cases, their family members.

The visits at their homes ranged from two to four-and-a-half hours in length, with the formal interviews ranging from 75 minutes to 3 hours in duration. This length of time is not unusual in qualitative research as it allows the researcher to build rapport and trust with each respondent and facilitates a "rich discussion of thoughts and feelings" (Maykut & Morehouse, 1994, p. 80).

Couples were interviewed together on two occasions. Despite the potential for less disclosure, there are advantages to interviewing couples together such as gaining two perspectives, the potential for respondents to clarify each other's recollections, and the access to their relationship via verbal and non-verbal behaviour (Swanson, 1986a). Interviewing some couples together and some separately was reported by Riches and Dawson (1996a) and Rosenblatt (2000). Additionally, in his study of parental grief, Rosenblatt (2000) reported that he found no difference in topics covered regardless of whether or not the couples were interviewed together or separately.

Before being interviewed, I explained the purpose of the study to each informant. I then explained the timeframe for the interview, that the interview would be audiotaped and later transcribed for analysis, and that I would also be taking notes. I informed all informants of their confidentiality, as only myself and/or a professional transcriptionist would transcribe the tapes, only I had access to the tapes, and the transcripts would not contain any identifying information. All informants were assured verbally and in writing that they could withdraw from the study at any time (A. S. Cook, 1995) and that there was no incentive, financial or otherwise, to participate (Parkes, 1995). I also asked the

informants if they had any questions and answered any that arose. I assured the informants that there were no right or wrong answers to the questions and that they could request the recorder be turned off at any time throughout the interview (Parkes, 1995). This occurred in two interviews[4]. After reading the information letter, each informant completed and signed the consent form.

Spending time before the interview getting to know each other created a comfortable atmosphere, established a relationship between each informant and myself, and set the tone for the interview (Berg, 2001; Smith, 1995; Sullivan, 1998; Swanson, 1986a). Topics discussed before the interview began included finding their home, the weather, my university studies, previous interviews, and shared interests such as movies. Most of the bereaved informants asked me why I was interested in grief resulting from crashes. Consistent with Burgess-Limerick and Burgess-Limerick (1998), I would answer the question by disclosing that a member of my extended family died in a crash. Being honest and open and sharing some aspect of the experience with the bereaved informants served to demonstrate that I was comfortable with the topic and gave permission for the informants to talk openly (Swanson, 1986a). My awareness of grief following crashes facilitated the development of empathy and understanding but I was clear that I did not identify with their experiences. The average length of these informal conversations with the bereaved informants before the interview began was approximately 20 minutes. The conversations facilitated the collection of data from natural contexts because of the absence of formality (Chenitz, 1986a).

The interviews began with a small number of demographic questions. These questions allowed each informant to begin the interview by answering relatively easy questions and later aided the interpretation of the data. The first open-ended question posed to the bereaved informants was, 'Tell me something about your experiences since the death of [name]' which allowed them to choose where to begin their stories. On one occasion an informant appeared visibly anxious by this opening question. She immediately requested me to turn off the tape recorder. After it was turned off, she explained that she never spoke of her loss as she felt she was not 'allowed' to by those

[4] The first time, a woman found it difficult to start her story, as discussed in detail later in this chapter. The second time, a woman reported instances of paranormal incidents connected to her deceased brother

around her and, as a result, she needed to start more generally. She suggested she read some of her diary that she had written not long after her son's death and allowed me to record her reading. After reading some of her diary, she was able to commence the interview by reflecting on her writing. The flexibility afforded to the informants in how they began talking about their experiences helped to build rapport and ensured the interview process was responsive to their needs (Burgess-Limerick & Burgess-Limerick, 1998) and built trust and confidence in the interview process. In addition, at appropriate intervals (e.g., the end of a tape side) I asked all informants if they wanted a short break. All declined, with the exception of one informant who took time to go to the toilet and have a cigarette. Flexibility in the interview process served to legitimise the informants' roles as co-constructors of knowledge.

Rapport was further developed during the interviews by communicating my understanding to the informants. Minichiello et al. (1995) suggests this can be achieved by engaging in behaviours such as matching the informant's posture, language, volume of voice, and speed of speaking. In addition to facilitating the development of rapport, my use of the words used by the informants aided the later interpretation of data, as I was clear about what the informants were referring to (Patton, 2002).

Tape recording each interview provided an accurate record of the conversation and was used in conjunction with note taking to record non-verbal behaviour and topics to probe. Utilising both audio recording and note taking are recommended as interviews consist of both verbal and behavioural aspects (Breakwell, 1995; Creswell, 1994; Minichiello et al., 1995; Smith, 1995; Swanson, 1986a). According to Breakwell (1995), there is little evidence that demonstrates audio recording limits the respondents' willingness to respond. My note taking was kept to a minimum to prevent it from being obtrusive (M. Z. Davis, 1986). As a result, the notes consisted of words and ideas and assisted in the formulation of new questions based on responses (Patton, 2002). In addition, note taking facilitated the development of early insights and interpretations, assisted later analysis, and provided a backup when one side of a tape could be adequately transcribed (Patton, 2002). The notes taken during interviews were expanded

---

and did not want this information recorded on tape (see also Chapter 4).

upon by the addition of my reflections on the process and outcomes of each interview, questioned asked and topics probed, and the development of rapport (Patton, 2002).

After completion of each interview, I again engaged in an informal conversation with each informant. The main aim was to ensure they were feeling comfortable after the interview (Breakwell, 1995; Sullivan, 1998). In addition, in some cases it enabled me to clarify some aspects of the interview. For example, one woman spoke about her family and showed me photos of them. While not requested, some of the informants shared with me copies of materials they considered important to their experiences of grief, a phenomenon also reported by Riches and Dawson (1998b). These included letters they had written to family members overseas to explain the events surrounding their loved one's death, death certificates, photos of their loved ones, their loved ones' drawings, newspaper reports of their loved ones' deaths and trial coverage, diary excerpts, death notices, eulogies, brochures outlining the order of proceedings at funeral services, and recordings of television news segments. These non-technical materials (D. Silverman, 1993) supplemented the interview data. The average length of these conversations was approximately 30 minutes.

Before leaving the informants' homes, I provided them with information about support services such as the Coronial Counselling Service (a service provided by the Office of the State Coroner), Samaritans, Lifeline, Grief Support Group, The Compassionate Friends, and the Edith Cowan University Psychological Services Centre, where applicable. Providing information about support services gave informants access to assistance if they became upset after the interview (Breakwell, 1995). I thanked every informant for their assistance verbally and all received a thank you letter for their participation within a few days of the interview (Sullivan, 1998).

Setting Informants. I wrote to all setting informants identified in the scoping and profiling exercise to explain the purposes of the research and to request an interview. I then spoke to them or their secretaries prior to the interview to set a day and time convenient for the interview and answered any questions.

The interviews with the setting informants occurred at their office workplaces and lasted approximately one hour. One request for an interview was originally declined and then accepted on the condition that the questions were answered via email. All other

interviews were conducted in person and audio-recorded. Although I did engage in informal conversations with the setting informants prior to the interviews, less time was needed to develop rapport, as they were not required to talk about their personal experiences of grief and they were limited in the amount of time they could give me. As a consequence of time restrictions and the formal settings, almost all of the interviews with the setting informants were more formal and less conversational than with the bereaved informants. In addition, most of the setting informants used 'closed' language consisting of concrete responses and less enthusiasm or feeling. Fisher (2000) also reported these differences in interviews between participant groups in her study of women victim-survivors of domestic violence and setting informants.

Scoping and Profiling. Throughout the preliminary and middle stages of my PhD, I participated in a 'scoping and profiling' exercise in an effort to familiarise myself with the context of road crashes, crash fatalities, and grief in WA. Specifically, I attended meetings of the Australian College of Road Safety (WA chapter) between December 2000 and May 2001; a meeting of The Compassionate Friends in July 2001, which permitted me to listen to a number of people's stories about the loss of their children, as well as facilitated my understanding of the organisation; the initial Pre-driver and Youth Driver Road Safety Education Working Party meeting in August 2001; meetings of the Road Trauma Counselling Project steering committee between August 2001 and September 2003; the unveiling of the crash fatality remembrance memorial in December 2002; and completed a practicum with Australian Parents Against Road Trauma (APART) Inc. between October 2000 and May 2001.

Public Documents. The data from the interviews were augmented by the collection and analysis of relevant documents. From 2001 onwards, I perused *The West Australian* and *The Sunday Times* (WA's main newspapers) for newspaper articles on road safety, crashes, and grief. I also familiarised myself with the websites of the various setting informants' organisations, reports and brochures issued by their organisations, and mass media campaigns concerning road safety. As methods of triangulation, the collection and analysis of these materials in addition to the scoping and profiling fieldwork aided my understanding of the setting and context of the crash deaths in WA (Berg, 2001).

Ethical Considerations

Ethical clearance from the Edith Cowan University Ethics Committee was granted in July 2002. A discussion of ethics is particularly pertinent given that bereaved informants are considered a vulnerable population. Talking about the personal experiences of grief and bereavement may arouse intense emotional responses (Cowles, 1988). However, bereaved people often experience a need to talk about their deceased loved one (A. Dyregrov & Dyregrov, 1999; Riches & Dawson, 1996c, 2000; Romanoff, 2001) and the emotional expression that might occur during an interview is thought to be a function of their grief rather than of the research interview (A. S. Cook, 1995).

Researchers conducting interviews with the bereaved need to be empathic, open, and considerate, without assuming the role of a therapist (A. S. Cook, 1995; A. S. Cook & Bosley, 1995; McSherry, 1995; Romanoff, 2001). Minichiello et al. (1995) suggest that researchers engage in preparatory work before commencing interviews. To this end, I attended workshops on sensitive interviewing in bereavement research in 2001 and 2002 (before data collection commenced). Experienced grief counsellors and grief researchers conducted both workshops. Further, I participated in the scoping and profiling process described earlier and as a result communicated with people bereaved through crashes and started to become familiar with the wider context of crash deaths in WA. Furthermore, my principal supervisor is a grief researcher and closely and regularly supervised me to ensure the research was conducted in an ethical and sensitive way (Parkes, 1995).

Given the ethical obligations to assist research informants who may become distressed through their research participation (A. S. Cook, 2001), I ensured that the Edith Cowan University Psychological Services Centre could provide services to informants if required (see Appendix I), and, in the information document, provided informants with the details of the Centre (M. Stroebe et al., 2003). I also ensured that any potential bereaved informant who contacted me but did not meet the criteria for participation (as outlined above) would be referred to an appropriate service (e.g., The Compassionate Friends, Edith Cowan University Psychological Services Centre, Lifeline, the Coronial Counselling Service) to receive the support they required. However, no one who was not eligible according to the selection criteria to participate

contacted me to participate. In addition, arrangements were made so that the transcriptionists and I were able to participate in confidential debriefing at the Edith Cowan University Psychological Services Centre if and when required. Again, this was not required.

The confidentiality and privacy of the informants was protected at all times, including in all correspondence between myself, research supervisors, and other colleagues (Parkes, 1995). For example, the transcripts, along with the audiotapes and other details, were stored in a locked cabinet in the researcher's office and my computer was password protected. Each of the four transcriptionists completed and signed a confidentiality agreement (see Appendix J) to indicate her commitment to confidentiality. All informants and their family members were assigned pseudonyms and it is these that are reported in the subsequent chapters. Although some authors (e.g., Morse, 1994) caution against the use of pseudonyms because respondents might still be identifiable from piecing together all quotes attributed to the one person, they were utilised with the use of two precautions. First, only a small amount of verbatim text from each informant's transcript is included in the thesis. Second, all quotes were scrutinised for information that could render the informant identifiable (Parkes, 1995).

Data Analysis

The use of a computer-assisted qualitative management and analysis program was considered to assist data management and analysis but was not determined appropriate for this study for two reasons. First, despite the increasing sophistication and acceptability of packages (C. A. Barry, 1998; Robson, 2002), Patton (2002) asserts that such programs are not necessary and may in fact impede analysis. Second, the School of Psychology at Edith Cowan University did not have a site licence for any program that would assist qualitative data analysis.

The overarching aim of the data analysis was to generate theory (Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin 1990, 1998) concerning the phenomenon of grief following crashes in WA. The analysis began with accurate transcription, reading and re-reading of the transcripts and notes. Reading the transcripts many times was essential as it ensured immersion in the data, facilitated understanding, and enabled

me to become intimately familiar with the data (Breakwell, 1995; Miles & Huberman, 1994; Smith, 1995).

All interviews were transcribed verbatim to ensure authentic records for analysis. The accuracy of the language and punctuation of each transcript was ensured by reading each one while listening to the relevant tape, a procedure recommended by Morse (1994) to provide a true record of the interview. I also checked each transcript for internal consistency on an individual basis (Minichiello et al., 1995). The interviews were transcribed and I began analysis as soon as possible after each interview to guard against inaccurate interpretations of the data and to aid theoretical sampling (Strauss & Corbin, 1998; Swanson, 1986a).

Reviewing the interview transcripts in light of the handwritten field notes made during and immediately after each interview enabled me to identify inaccuracies and inconsistencies in transcription and note taking (Miles & Huberman, 1994). In addition, the recording of one side of a tape of one interview was inaudible in sections and could not be transcribed verbatim. Handwritten notes that were taken during the interview were used to augment the audible sections.

The grounded theory analysis process is first concrete and then increasingly abstract (Strauss, 1987; Strauss & Corbin, 1998; Swanson, 1986a). Analysis began immediately, with the comparison of the first two interviews (Swanson, 1986a), line-by-line, then paragraph-by-paragraph, then on an interview-to-interview basis (Strauss, 1987; Strauss & Corbin, 1990, 1998), facilitating an idiographic approach to analysis (Moustakas, 1990; Smith, 1995). Interim analysis led to further exploration of ideas in the next interview (Swanson, 1986b).

Analysis followed the three primary techniques used concurrently in grounded theory - coding, memoing, and diagramming (Strauss & Corbin, 1990). The coding process involved underlining and circling aspects of the transcripts and rewriting it as an abstract concept in the margin of the transcripts and enabled the discovery and naming of categories, the detection of links between them, and the identification of the ‘core category’ or storyline in the data (Glaser, 1978; Strauss, 1987), which is evident in the title of this thesis. The codes were then collapsed into categories, which were subsequently developed, refined, and integrated according to similarities and differences

in the data (Strauss, 1987; Swanson, 1986b) and as a result of questioning the data, for example, 'how does X relate to Y?', 'under what circumstances does Z occur?', and 'when Z occurs, who is affected?' (Strauss & Corbin, 1998; Swanson, 1986b). The process of searching for negative cases and alterative explanations is akin to ruling out other explanations in experimental designs (Patton, 2002). Questioning aided the process of constantly comparing data to search for similarities, differences, and links (Chenitz & Swanson, 1986; Strauss & Corbin, 1998).

After categories were sufficiently dense, they were linked using the 'six Cs' to achieve conceptual order (Strauss & Corbin, 1990). The six Cs are causes (explanations), context (wider setting), contingencies (the direction of relationships), consequences (outcomes), covariances (relationships between concepts and variables), and conditions (under which the phenomena occurs) (Glaser, 1978). The questioning process served to continually move the data analysis to higher levels of abstraction.

The second major analysis strategy was memoing. Memo writing is useful in identifying and developing the grounded theory by aiding the exploration of commonalities and differences in the data, and provides hypotheses or questions, and reflections (Strauss, 1987; Strauss & Corbin, 1990, 1998). The memos included summaries of daily research activity, reminders, ideas, relationships between categories, data struggles, summaries of previous memos, summaries of meetings with supervisors, and reflections (Strauss, 1987). These reflections were written in a journal (or transposed from notes into the journal) and provided an audit trail (Nagy & Viney, 1994) of the data analysis process and helped to ensure rigor.

I used diagramming as a third major analysis strategy. Diagramming resulted in a visual representation that outlined the relationships between codes and categories generated from the entire data pool (Artininan, 1986; Strauss & Corbin, 1990, 1998). Diagramming assisted me to identify relationships between concepts and categories as well as underdeveloped sections (Strauss, 1987), and helped me to conceptualise the focus of each interpretations chapter.

Data collection and analysis occur concurrently until no new information is uncovered (termed saturation), as identified via the recurrence and verification of data and themes from the informants (Chenitz & Swanson, 1986; Morse, 1994; Strauss &

Corbin, 1998). In grounded theory, confidence in the theoretical scheme is high when saturation is achieved, ideas are well-developed, and there is both repetition and variation in the data patterns. Typically, 20 to 50 interviews are considered appropriate in a grounded theory study, especially if the respondents are theoretically sampled to maximise variability (Swanson, 1986a). Despite the variability in experiences of the bereaved informants, there was huge amount of similarity and more than I originally expected. No new categories were identified from the later interviews despite my search for novel material in the data.

The theoretical scheme was continually refined throughout the analysis process and write-up of results (Strauss & Corbin, 1990). The process was aided by the comparison between the data and the existing literature, enabling a data-driven approach to interpretation and ensuring the substantive nature of the findings (Crotty, 1998; Miles & Huberman, 1994; Rose & Webb, 1998; Strauss & Corbin, 1990). The integration of literature demonstrated support for the components of the theoretical scheme and aided the wider interpretation of the data (May, 1986). Literature was accessed during analysis (as well as prior and subsequent to analysis) as a data source to facilitate the elaboration of ideas that emerged from the data (Strauss & Corbin, 1998). The reasons accounting for similarities and differences between data and existing literature were explored (May, 1986). The analysis process mimicked an iterative cycle of induction and deduction, as the data yielded hypotheses concerning the relationships between concepts, and immersion in the data confirmed or disconfirmed these hypotheses (May, 1986; Strauss, 1987; Strauss & Corbin, 1998).

Finally, quotes from the informants were used throughout the findings and interpretations chapters to illustrate the themes and ensure their own words were at the forefront of the research (Breakwell, 1995; Morse, 1994; Strauss & Corbin, 1998). The inclusion of the quotes allows the reader to judge the extent to which the theoretical scheme is grounded in the data (May, 1986).

The quotes were edited according to criteria posited by Morse (1994) who suggests that minor editing is justifiable if the meaning of the quote remains untouched. For example, ‘ums’ and ‘ahs’ and stammers were omitted. In addition, she suggests that extraneous sections of sentences and sections may be replaced with ellipses. I used the

following conventions in reporting data in this thesis, based on those suggested and used by K. White (2000):

> An ellipse (…) indicates words have been omitted from the transcript. The meaning of the passage remains intact.
>
> *Italics* are used to indicate quotes from the informants.
>
> Underlined text highlights words the informants emphasised in their interviews.
>
> Words contained within square brackets [] are my own, and are used to augment quotes in order to maintain clarity.
>
> Words contained within parentheses ( ) indicate behaviours such as sighing, crying, pausing, and laughing.

Research Rigor

Rigor within the research process was maximised via the data collection and analysis procedures outlined above as well as the adherence to a number of processes recommended by and for qualitative researchers. Traditional research outcomes like internal and external validity, reliability, and objectivity are not considered appropriate in qualitative methodologies. Instead, other terms are used, such as credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985; Nagy & Viney, 1994). Methods that aid the researcher in ensuring a rigorous research process are outlined below.

Multiple sources of data and methods of data collection were utilised to maximise rigor (Berg, 2001; Maykut & Morehouse, 1994, Morse, 1994; Patton, 2002; Strauss, 1987). Data were collected from interviews with and observations of purposively sampled informants, the perusal of public documents, scoping and profiling process, and the examination of the technical literature. The various materials provided by the informants substantiated the clarity of the interview data and presented a secondary opportunity for them to reveal their points of view (Creswell, 1994). The additional materials supplemented the interview data and added to the rigor of the research as data gathered from a variety of methods and sources provides provide rich, complex, and substantive interpretations of the data and assists in verifying these interpretations (Berg, 2001; Morse, 1994; Nagy & Viney, 1994; Strauss, 1987).

In addition, rigorous research is facilitated by the presence of an audit trail. My audit trail primarily consisted of a reflective journal. In it I documented the research process, such as the tasks (initially on a daily basis) and ongoing development of the study, as well as other memos (Etherington, 2004; Lincoln & Guba, 1985; Maykut & Morehouse, 1994; Morse, 1994; Nagy & Viney, 1994; Strauss, 1987; Strauss & Corbin, 1990, 1998).

A third technique to maximise rigor involved checking interpretations with the informants to ensure accuracy (Maykut & Morehouse, 1994). I invited three bereaved informants to participate in a short second interview to clarify my interpretations of the data (D. Silverman, 1993). This process is termed member checking and is considered as effective with a subset of the original sample (Breakwell, 1995). All three appeared satisfied with my interpretations. In addition, I sent all informants a summary of my results (see Appendix K) and invited them to provide comments and clarifications where necessary. Further, an article similar to the results summary was published in The Compassionate Friends Australian National Newsletter in July 2004 (Breen, 2004), and was an example of the transformational psychopolitical validity of the research (Prilleltensky, 2003). I did not receive any feedback from the summaries or the article. Finally, sampling from both setting and bereaved informants added to the rigor by contributing to a rich description of the context and understanding of the phenomenon under study (Denzin & Lincoln, 1998; Morse, 1994).

In addition, Strauss (1987) suggested that the theory can be verified or 'trialled' by presenting it to different audiences for comment. I have presented my interpretations at three international conferences (two in community psychology, one in critical health psychology), and three local conferences (one in psychology, another in community psychology, and the third in humanities). I also regularly met with fellow PhD students in psychology to discuss our research and consulted with researchers in psychology, sociology, and nursing. I usually received positive feedback, and was open to their suggestions. Sharing the interpretations with these audiences has strengthened the theory.

A fourth measure that facilitated rigor involves conducting the research either in a team or under supervision (Maykut & Morehouse, 1994). Although this thesis

represents my own work, the research supervisors are experienced in constructionism, qualitative methods, and grief. Although used in some qualitative research, I did not use multiple analysers of data. Doing so can violate the inductive process of qualitative research because the additional analysers usually are not intimately involved throughout the research process (Morse, 1994). In addition, Morse (1994) argues that multiple analysers might create the illusion of validity but is more likely to add to the delegitimisation of qualitative research because inter-rater reliability is based on assumptions of logical positivism.

The final criterion for maximising rigor is the provision of a detailed description of both the setting and the informants involved in the study so readers can determine the credibility and transferability of findings to different contexts based on the level of similarity between research setting and other settings (Burgess-Limerick & Burgess-Limerick, 1998; Nagy & Viney, 1994). Engaging in all of the above processes ensured the rigor of the research.

As a result of this study, the research questions were addressed as outlined below;

1. The experience of grief resulting from crashes was established;
2. Other factors that affect the experience of grief resulting from crashes were identified and the manner in which they influence the experience of grief were revealed;
3. The relationships between these factors and how they affect the grief experience resulting from crashes were determined; and
4. The implications for WA in terms of service delivery pertinent to crash-related bereavement were outlined.

Conclusion

In this chapter, I reviewed the aims of the research and the associated research questions; outlined the overarching research design; provided information on the recruitment and demographics of the informants; specified the materials and procedures used to collect the data, and the processes of data analysis used in the research, and emphasised the ethical considerations pertaining to interviewing bereaved informants.

The reader should be able to see that the method of the research was the most appropriate way to answer the research questions.

The following four chapters outline the research findings and interpretations. The emergent theoretical scheme is presented and discussed in light of existing literature (Chenitz, 1986b; May, 1986). Quotes from the informants are used to illustrate their experiences in their own words (Breakwell, 1995; May, 1986; Morse, 1994). The data and interpretations are positioned in relation to the research literature, in order to compare and contrast my findings with the existing body of knowledge. These chapters are followed by the discussion (Chapter 8).

Chapter 4

Beyond the Dominant Discourse: Experiences of Grief Following a Crash

In Chapter 4, I discuss the bereaved informants' experiences of grief in order to demonstrate that their experiences challenge the dominant discourse concerning grief. Rather than endorsing notions concerning timeframes, stages, recovery, detachment from the deceased, and meaning in their loss, the bereaved informants described their grief as unique, long lasting, and characterised by oscillation of emotions. Further, the bereaved informants' relationships with the deceased were likely to be maintained, and meaning in or positives from the deaths of loved ones were unlikely to be found. In addition, I discuss the characteristics of crash deaths and reveal the role they play in the grief experience following them. Finally, despite it not adequately reflecting their experiences, I demonstrate that some of the bereaved informants have internalised the dominant discourse concerning grief. Those who internalised the dominant discourse judged themselves and others harshly for grieving in a manner different from that outlined in the dominant discourse.

As outlined in Chapter 2, social phenomena are constructions of the historical, political, social, and cultural setting. Foucault (1961) argued that what is referred to as knowledge within a context is the particular constructions or discourses that are deemed credible and are thus given that stamp of 'truth'. Similarly, Rappaport (2000) would argue that these common, powerful, and pervasive understandings are the foundation of the "dominant cultural narrative" (p. 4) concerning the grief experience. The primary assumptions inherent in the dominant discourse of grief are (a) grief follows a relatively distinct pattern; (b) grief is short-term and finite; (c) grief is a quasi-linear process characterised by stages/phases of shock, yearning, and recovery; (d) grief needs to be 'worked through'; (e) meaning in and/or positives gained from the death must be found; (f) grief culminates in the detachment from the deceased loved one; and (g) the continuation of grief is abnormal, even pathological (e.g., Bowlby, 1961, 1980; Calhoun & Tedeschi, 2001; R. D. Eliot, 1932; Engel, 1961; Frantz et al., 2001; Freud, 1917/1957; Goodkin et al., 2005-2006; Horowitz, 2005-2006; Horowitz et al., 1980, 1997; Jacobs, 1999; Jacobs & Prigerson, 2000; Krupp, 1972; Lazare, 1979; Lindemann, 1944; Neimeyer, 2001; Nolen-Hoeksema, 2000; Parkes, 1965a, 1965b, 1972, 1986, 2002, 2005-2006b; Parkes & Weiss, 1983; Polatinsky & Esprey, 2000; Prigerson & Jacobs, 2001; Prigerson et al., 1995; Prigerson & Maciejewski, 2005-2006; Prigerson & Vanderwerker, 2005-2006; Rando 1984, 1993; Schaefer & Moos, 2001; Shuchter & Zisook, 1986, 1987a, 1993; Tedeschi & Calhoun, 1995; Volkan, 1970; Wahl, 1970; Worden, 1982, 1991, 2002; Zisook, 1987).

In Chapter 4, I begin by describing the bereaved informants' experiences of grief and demonstrate that their experiences challenge the dominant grief discourse. Next, I state the characteristics of crash deaths and discuss how these characteristics affect the grief experience. Finally, I demonstrate that some informants internalised the dominant discourse concerning grief, and as a consequence, judge themselves and others for not grieving in the manner dictated by the normative standard.

Challenging the Dominant Grief Discourse: Grief as a Process of Upheaval and Adaptation

The bereaved informants tended to describe feelings of shock and numbness as initial characteristics of their grief experiences. These feelings often occurred

simultaneously and occurred most often immediately upon being informed of the deaths and during the first few days and weeks after their loved ones' deaths. A sense of disbelief and confusion was associated with the feelings of numbness and shock. They reported questioning the reality of what was occurring, and felt confused, stunned, shocked, emotionally detached, and found it difficult to follow events. The informants reported that it was difficult to recall these events in detail during the interviews, because many things did not register at the time. For example, Nick stated, *"I don't have much of a memory for things. Like I remember stuff that's happened, kind of, but I don't remember how I felt or I can't put things into a timeframe."*

In addition to reporting feelings of shock and numbness, some informants equated the experience of losing a loved one in a crash to watching a movie, especially a horror movie, or having a nightmare. Some thought the news of their loved one's death was a hoax, prank, or practical joke.

> *"…when I first got the call, it was a day like today - sunny, perfect… [I was] sitting in the backyard having a coffee. The phone rang, and it was my brother saying he had some bad news, that dad and Ian had been killed in a car accident. And I said, because of the kinda [sic] day and the mood I was in, said 'I don't like this kind of joke, cut it out' and [he] said 'I'm not, I'm telling the truth' but I still didn't know whether to believe him or not…"* (Patrick)

Some informants reported difficulties with concentrating and deficits with their cognitive functioning after the death of their loved ones. This was especially likely in the first few months after the death. They reported a poorer memory, difficulty following conversations, and making mistakes at work.

> *"My memory just went absolutely to pot…and when I had my appointment with my supervisor I hadn't done anything [on my thesis]. I hadn't realised I hadn't done anything I'd just been sitting there doing nothing… It took me another year just to do the end bit, that's how bad it was… I had blockage, I just couldn't think and I also found…I'd be talking to people [and] I couldn't hold a conversation because I couldn't think of the words, just words wouldn't come to me and…I think I even might have been tutoring [at university] as well and I had to give that up because I would stand there and I would forget what I was supposed to say, what I was supposed to be doing…"* (Lorraine)

For the bereaved, grief was physical as well as emotional and cognitive. The physical experience of grief was described by informants variously as *"an assault"* (Karen), *"like a thousand horses kick you at once"* (Sharon), *"like someone had got my*

heart and torn it out of my chest" (Patrick) *"as though your inside is being ripped out of you, we ached from head to foot"* (excerpt from Natasha and Jim's presentation to medical students), and *"like getting hit on the head with a hammer"* (Dawn). Karen reported that her menstrual cycle began immediately, even though she had just had a period. In addition to the physical pain, their experiences of grief included physical reactions such as vomiting, diarrhoea, waves of hot and cold, tightness in the chest and abdomen, as well as feelings of faintness, heaviness, floating, spinning, and being drained of blood.

> *"…it would've been about the third day, I just lost control of my whole body, where I was just vomiting and couldn't get off the toilet because my whole body just gave in, the grief was just so extensive, and you just have no control. And another thing is the unbelievable pain; you wonder how you're heart survives it. It's just unbelievable."* (Sharon)

In addition to the physical reactions to grief, the informants experienced significant disruptions in their eating patterns, particularly in the weeks and months following bereavement. For example, in the months following her son's death, Joan lost weight and at her lowest weighed approximately 43 kilograms. Patrick stated he lost five kilograms in the first week following the deaths of his father and brother due to disruptions in his eating and drinking patterns. Further, the informants also reported significant disruptions in their sleeping patterns. Dawn described constant and uncontrollable twitching that disrupted her sleep and that of her husband. Nicola described having trouble falling asleep and never feeling rested when she woke.
In addition to the magnitude of the affective, cognitive, and physical impact, the informants also discussed the extent of their shock. Contrary to literature that articulates shock as the first stage of grief, lasting a few days to a few weeks (e.g., Bowlby, 1980; Gorer, 1965; Lazare, 1979; Lindemann, 1944; Parkes 1965a, 1965b, 1972, 1986; Parkes & Weiss, 1983; Rando, 1984, 1993; Shuchter & Zisook, 1993; Worden, 1982, 1991, 2002; Zisook, 1987), some informants reported that their feelings of shock and numbness often lasted a considerable length of time. The informants described their experiences as feeling like a *"zombie"* (Dawn) or being on *"automatic pilot"* (Lorraine) or in a *"fog"* (Joan). The informants reported that these feelings of detachment from reality continued over many months.

> *"The first 12 months, well probably the first 18 months, I was virtually in shock… I remember one day I'd been at work and I remember I was going to the bank or something. I was walking along the pavement and I was thinking I feel like my body is here walking on the pavement, and doing what it has to do, and functioning, but me is up here somewhere and watching. You know the actual, real me was watching what was happening and not part of it. I just seemed to be functioning, all my bodily motions were happening and…I was doing what I had to do, and existing, but I wasn't really living, I wasn't in my body. It was a strange, strange feeling and it was just constantly with me…"* (Dawn)

The bereaved informants' experiences of grief were characterised by other emotions such as sadness, anger, regret, and guilt, all of which feature regularly in both theoretical constructions of, and empirical research on, grief. However, the bereaved informants also spoke of fear, vulnerability, and anxiety as significant components of their grief. These feelings are not as evident in the grief literature. The sudden death of a loved one while engaging in an everyday behaviour like crossing a road, dropping friends off after a night out, or returning home after work had made the informants realise that they are vulnerable and powerless. As Vickio (2000) stated, the bereaved come to recognise the dissonance between their formerly-held beliefs about predictability and control, and the reality of their sudden bereavement experiences. Heather described the realisation as *"scary"*. Sylvia stated that she tried to avoid thinking about the circumstances of the deaths of her husband and son, as it was difficult to comprehend that they died when their vehicle was travelling at 50 kilometres an hour. Anxiety concerning feelings of powerlessness and vulnerability was still present at the time of the interviews, many months and years following the deaths of their loved ones. Continuing insecurities, fears, and thoughts of disaster were also present for many years in a study of parents bereaved through SIDS (see A. Dyregrov & Dyregrov, 1999). The informants reported feeling and acting more protective of their loved ones, especially children and grandchildren. For some, the fear and anxiety interfered in their daily lives, such as limiting travel interstate or overseas and employment opportunities. Karen explained how her feelings of fear have contributed to her wariness to take on greater responsibility at work.

> *"I was going to do education assistance level three. Now part of that would be taking on the responsibility you know of duty of care of the student one-on-one especially if you were going out and about with them and at the moment I'm sort of holdoffish, standoffish [sic], thinking 'do I really want that?' …it's changed*

> *my (trails off). Before [Mikey's death] I would have said 'no problems'…"* (Karen)

The informants' fear translated to feelings of anxiety and vulnerability while on roads, which is a common consequence of crash-related bereavement (e.g., Keir, 2000; Sprang, 1997). Many informants were fearful on the roads because they know first hand how easy it is to die on the road. George reported that he found the thought of the *"absolute lunatics*" on the road as *"terrifying"*. Lorraine stated that she was now very cautious while driving, especially around four-wheel drive vehicles and when pulling out into traffic, and would often get tearful and upset whenever she got into a car. Some informants reported feeling anxious about their loved ones driving and being on the road.

> *"…you're aware of it… It's like when my daughters say well, 'I'm gonna [sic] go for a drive up [to] Karratha[1]' and I think 'oh my God it's so many miles' you know and you don't know what pricks are out there but you can't send yourself into a panic about it you've just got to hope to God everything's fine… It's always there, even when my husband goes out to work I hope to God he bloody comes home, but if he's not back home by a certain time then I'll start getting a bit panicky 'cause he's like clockwork and…you start knowing a routine of everybody, you know they should be there so, why aren't they and then you think well the phone hasn't rung…"* (Heather)

Importantly, for the most part, the bereaved informants did not talk about their grief in ways that directly matched the assumptions of the dominant discourse reflected in the grief literature such as endorsing notions of stages, recovery, positives, and detachment. Instead, the ways in which they spoke about their grief experiences challenge the dominant discourse concerning grief. For example, the bereaved informants were clear that their experiences of grief were unique (Center for the Advancement of Health, 2004; Kellehear, 2001; Rando, 1993; Winslade, 2001), even when grieving the death of the same loved one. Further, the bereaved informants described differences in the experiences of grief between individuals within the same family: *"… it's like being a parent, there's no handbook…and everybody mourns in a different way. You know a husband will mourn different[ly] to a wife, or a father might mourn a different way to a son…"* (George).

---

[1] Karratha is located in WA, and is approximately 1535 kilometres north of Perth.

The bereaved informants described vacillating between these emotions rather than following set stages in a linear pattern over a predetermined timeframe. For example, the informants described their ups and downs of their feelings as *"waves"* (Lorraine) or like a *"roller coaster ride"* (Jelena). Joan stated that, *"you get your bouts of ups and downs"* and Sylvia commented that grief is *"…not like walking a staircase"*. In addition, George claimed, *"Sometimes it could be okay, …you do laugh again, you do enjoy yourself, it takes time… Sometimes you just wanted to collapse in a heap and say, ' shit it's all too hard… It overwhelms you"*. The notion of vacillating between feelings contradicts the dominant discourse regarding the linear progression through stages and is instead consistent with conceptualisations such as M. Stroebe and Schut's (1999) Dual-Process Model and Rubin's (1999; Rubin & Malkinson, 2001) Two-Track Model, as well as others that emphasise nonlinear and indistinct 'phases' (e.g., Rando, 1984, 1993), or grieving styles (e.g., T. L. Martin & Doka, 2000).

Consistent with M. Stroebe and Schut's (1999) dual-process theory, some of the bereaved informants reported a need for distraction at times to take their minds off their loved one's death and the resulting pain. They yearned to distract themselves and described strategies such as immersing themselves in their work, taking on additional responsibilities or hobbies to busy themselves, physical exercise, and allowing others to distract them by talking about other topics. Many informants described nights as more difficult than days. It was especially difficult to avoid thinking of their loved one during this time, which meant they would not relax and consequently could not fall asleep easily. They also said they were more likely to cry at night. For some, distraction was preferable to being totally consumed by the grief.

> *"I have a TV in my room now, so I just watch the TV, even now, and it's 11 years next month [since Craig died]… I had to find a way to go to sleep because I couldn't… I thought I've got to combat this myself, so that's how I did it. And if I wake up in the night, I have to have the radio on. I can't have a still house; I have to have something to take my mind off [it]. So that's what I've done. I've built this barricade of TV and the radio, it's all current affairs and gets you all interested and all riled up, so my mind doesn't go there because even when I was doing my housework, my mind was going there everyday, <u>everyday</u>, and it was driving me insane. So I have my radio on all day and the TV [on] at night. It gets me through."* (Joan)

The bereaved informants described their experiences of grief as a process of learning to live with their loss rather than recovery from it. The bereaved informants characterised their experiences of grief as a continual process of adaptation where recovery did not occur in the short-term. For example, Dawn stated that, *"it doesn't just lift and go away – it takes a long, long time"* and Sharon stated that, *"you learn to plod on a bit more until the day you die"*.

> *"…eventually you have to start rebuilding your life (pause). Don't ever try to go back. Don't, don't, don't try to find what used to be normal. All of that is fruitless. You'll find yourself driving yourself and everybody nuts. You have to start again… Your life is like to the point of the day of the death of whoever [sic] and then it's the before and the after, and so you have to rebuild your life… No matter how hard you try to think that things could be normal, well there is no such thing as normal. You reinvent your life…so you know, lots of stuff happened before Mikey's death and this is the after…"* (Karen)

Contrary to grief literature that states grief is a relatively short phenomenon (e.g., Bowlby, 1961, 1980; Parkes, 1965a, 1965b, 1972, 1986; Parkes & Weiss, 1983; Shuchter & Zisook, 1993), with some specifying time periods such as six weeks (Lindemann, 1944), six to twelve weeks (Gorer, 1965), or six months (Bugen, 1977; Lazare, 1979), the informants expressed that their grief is a long term phenomenon that usually lasts forever. Sharon reported that, *"…there'll always be a part of your heart that's dead, and nothing will reignite that, not even grandchildren…"*. They disagreed with notions concerning appropriate time frames for grief, especially short periods, and instead spoke of grief being present every day of their lives (A. Dyregrov & Dyregrov, 1999; Klass, 1995, 1996a, 1997, 2001; Klass & Goss, 1999; Klass et al., 1996; Klass & Walter, 2001; Malkinson & Bar-Tur, 1999; Reisman, 2001; Richards et al., 1999; Riches & Dawson, 1998a, 1998b, 2000; Rosenblatt, 2000; M. Stroebe, 2001; Vickio, 1999; Walter, 1996; M. White, 1989; Wortman & Silver, 2001).

> *"…being 23 years down the track, whilst it is easier to talk about, it still needs to be a clear understanding for people that it's not easier to deal with in the context of your life and what you do. You still miss them as close as the day they died and I don't believe it will ever go away. I don't cry and walk around sad every day about that now, but the feelings are as raw and as real today as what they were then…"* (Kelly)

Some of the bereaved informants shared that the intensity of their grief exacerbated with time, and was also noted by Malkinson and Bar-Tur (1999) in their

study of Israeli parents bereaved to war. For example, Natasha recalled she, *"found when 10 years came it was terrible, it was like the first year again…I think it was the shock that I got through the 10 years and it was like reliving the first year…"*. The initial shock coincided with the physiological reactions that protected the bereaved from the full brunt of the grief. However, as time goes on, these protections dissipated and the full reality of their loved ones' deaths sets in. As Joan explained; *"…the shock wears off, because you're cushioned with the chemicals the body releases with shock, and I think mine probably happened at six months, and I think after that six months it seemed to get worse…"*. In addition, some informants implied that they had considered suicide. They explained that they had seriously considered taking their lives but did not go through with it because they were concerned for their living children and/or did not want to put their loved ones through a further bereavement.

> *"If Alex had've been my only child I wouldn't be sitting here talking to you today, because life would not have been worth living, and that goes for my husband and me, we would've just quit, it would've just have been so easy, because the pain just envelops you so much."* (Sharon)

Over time, the informants were able to piece aspects of their lives back together. The process was more like attempting to solve a jigsaw puzzle than a linear process of recovery whereby the thoughts and feelings concerning the loss are behind them. However, the adaptive process does not necessarily mean that closure occurs.

> *"People talk about the closure of it as well… I find some aspect of things do have closure like if you have a marriage split up, when you start your new life well it goes on from there and you don't refer back to the previous marriage all that much…whereas I don't see this [grief] as being able to be done like that… I don't think there is such a thing as closure [with the death of my son], I mean, it just continues on… I don't think the perception of the closure and that's ended with and we start afresh, I don't think that happens at all."* (Pieter)

The adaptation process whereby the bereaved learned every day to live with their grief served to accommodate rather than ameliorate the pain they felt as a result of their losses, so that over time, their grief slowly became less overwhelming. The adaptive process was constantly renegotiated on a daily basis in an effort to prevent their grief from overwhelming and enveloping them. Consequently, the informants did not look too far into the future and instead focussed on each day as it came, even years after the deaths of their loved ones.

> *"I feel like…I could easily go to that state [of continued depression]. I could easily do that. If I was on my own I might have gone into that state. I feel like I could turn at any time. I feel like I'm right on the edge all the time and I just stay above water."* (Maggie)

The informants suggested that 'getting over' the death of a loved one would require forgetting part of their own lives because their deceased loved ones were integral components of their lives. Some recognised that getting over the deaths of their loved ones would be like accepting their loved one never existed. Sylvia stated that she felt privileged to shed tears for her deceased husband and son. With time, others might forget the deceased, but the thought of going through a day and not remembering their loved ones is frightening, a notion also discussed by Klass (1997), Malkinson and Bar-Tur (1999) and Oliver and Fallat (1995) in their research on bereaved parents.

> *"It's just always there, and I know it's always going to be there, and I don't even want it to really go anywhere, I'm happy for it to be there, I want it there, I don't want to not have it, not remember…"* (Maggie)

None of the informants articulated acceptance of his or her loved one's death. This is not to be confused with a denial that the loved one is deceased. All informants understood the physical loss and the fact of the death but clearly stated they would never accept that they were taken so suddenly and so pointlessly (see later in this chapter). However, the dominant discourse in the grief literature suggests that acceptance of the loss is an initial component of grief and is necessary for recovery (e.g., Jacobs, 1999; Parkes & Weiss, 1983; Worden, 1982, 1991, 2002). Further, difficulties with acceptance of the loss have been linked with the development of complicated grief (e.g., Prigerson & Maciejewski, 2005-2006).

The bereaved informants described their continual attachment to their deceased loved ones as a key component of their bereavement experience. Contrary to the dominant discourse drawn from the work of a number of influential theorists (e.g., Bowlby, 1961, 1980; Engel, 1961; Freud, 1917/1957; Gorer, 1965; Lazare, 1973; Lindemann, 1944; Parkes, 1965a, 1965b, 1972, 1986; Parkes & Weiss, 1983; Shuchter & Zisook, 1993; Worden, 1982, 1991, 2002; Zisook, 1987), the informants did not report detaching from their loved one, nor did they view detachment as necessary. In fact, they reported actively remembering and maintaining their relationships with their

deceased loved ones, which supports the emerging literature on the continuation of bonds with the deceased (e.g., Klass, 1995, 1996a, 1997, 2001; Klass & Goss, 1999; Klass et al., 1996; Klass & Walter, 2001; Malkinson & Bar-Tur, 1999; Marwit & Klass, 1996; Reisman, 2001; Richards et al., 1999; Riches & Dawson, 1998b, 2000; Rosenblatt, 1996, 2000; Rubin, 1996; M. Stroebe, 2001; M. Streobe et al., 1993; Vickio, 1999; Walter, 1996; M. White, 1989; Wortman & Silver, 2001). The deceased loved ones were on the minds of the informants often, and almost always every day. They focussed on the fond memories, but not only the 'good' things their loved ones did. In fact, some reported that they liked to laugh at the silly things their loved ones would say or do. They also thought about how their loved one would be had they not died. For example, Heather said of her sister, *"you daydream of what she would be like [now]"*.

Instead of detaching from the deceased, the informants possessed a desire to maintain connections with their deceased loved ones. Some informants discussed times when they felt the presence of their deceased loved ones or thoughts of their loved ones suddenly came to them, as well as dreams of the deceased. These dreams and events sometimes were interpreted as messages from the deceased (e.g., Klass, 1996a, 1997; Riches & Dawson, 2000) and were recalled positively. Lorraine described a time when she sensed her father's presence as *"calm and peaceful"*. Others stated the events helped them feel better about their relationships with their loved ones and feel more comfortable concerning the whereabouts of their loved ones' spirits.

> *"…I had another dream…more like a vision…and it was like there was sort of like glitter and I knew instantly that's my brother, it looked nothing like him but I knew that was him and it was like he come up towards me and it was like I had to step in where he was and I did and then it was like I was actually taken off to another plane and that was just the most incredible place. I didn't see it, was all sense you know, I felt it and I was allowed to stay there for a while and then it was like now I have to go back and then it was like I was just put back into my body and all of a sudden it was like being back in concrete. I didn't realise how heavy our body was until I went back and it was like then I knew I had to step out which I did and then all the glitter went and formed a love heart and then I started to cry and cry and then he just…disappeared and then when I woke up I still was crying and I think that that was his way of showing me 'I'm okay, this is the place I'm at and I still love you', so for me, that's another thing that helped me."* (Jelena)

In addition, Jelena, Joan, and Maggie actively sought out psychics and spiritual healers in the hope that it would enable them to maintain contact with their loved ones.

Further, the informants often talked about their memories of their loved ones with others in order to keep the deceased person 'alive' and maintained the deceased person's role within their families. Often, memories of the deceased loved one were shared with family members, especially children, and were catalysed by the sharing of photographs of the deceased. Doing so aided remembering their deceased loved ones and kept them 'alive' in their lives (A. Dyregrov & Dyregrov, 1999; Riches & Dawson, 1998b, 2000; Rosenblatt, 2000; Vickio, 1999; Walter, 1999) and was referred to by Walter (1996) as a process where the bereaved can "jointly construct a biography" (p. 17) of the deceased.

> *"The hard thing now is the boys often ask what their grandma was like, and [my husband] does, too, because he never met her. And talking to them about how mum died and that sort of thing has been hard at moments but good too… I've always shown pictures to make her a part of our lives…"* (Kelly)

Most informants kept many photographs of their loved ones on display in their homes. Others felt that only one or two photographs were necessary. For them, remembering their loved ones was personal and did not need to be displayed on the walls. The relationships with the deceased were also maintained by keeping possessions belonging to their deceased loved ones (A. Dyregrov & Dyregrov, 1999; Rosenblatt, 2000; Vickio, 1999). Volkan (1972) termed these possessions and photographs 'linking objects' to the deceased. These included clothes, jewellery, keepsakes, locks of hair, and ashes. Some informants would wear certain pieces of clothing and jewellery for the comfort of feeling close to their deceased loved ones.

> *"I wear some of her clothes, things like these dirty old slippers (she's wearing; laughs). It doesn't feel morbid, it just feels natural. It took me a long time but I did clear out her wardrobe and get rid of a lot of stuff, 'cause some of it I could never possibly wear; [and] even if I could I would never be able to wear all those clothes. That was something that I really dreaded, 'cause I thought how am I ever going to do this? But all of a sudden one day I just knew it was time and I could do it. It was still hard but I knew I could do it and it was alright… I did keep a few special things. One funny little dress that I could never wear, it would be up to here on me (gestures to the top of her thigh), and she only ever wore it around the house, and that's just packed away."* (Dawn)

Many informants collected items related the deaths of their loved ones. These items included photographs of the scene of the crash (Riches & Dawson, 1998b), as well as photographs of the plaque/burial plot, the death notices for their deceased loved ones, funeral outlines, newspaper reports of the crashes, newspaper reports of legal trials, post-mortem reports, and audiotapes of the funeral. These objects of remembering provide a mechanism for the release of emotions from time to time.

> *"Sometimes I've sat out [in the garden], because I've kept all the death notices and that and I'll read through them, then I'll start crying but I think you've got to release it every now and again…because [otherwise] it just builds up…"* (Heather)

Losing their loved one's possessions or reminders of them was considered to be extremely difficult because these physical reminders are important in maintaining relationships with the deceased. Over time, things change, and physical reminders of the loved ones are lost, damaged, or altered with time (Riches & Dawson, 1998b).

> *"When we were changing the bedroom…and Jim was painting it and then he called me…[and said] 'this is the last stroke of her colour, taken out', he said 'it's really hard'. Funny isn't it, the last stroke, like you paint everything, but to take this last colour out of her bedroom, it's been so hard."* (Natasha)

As well as keeping photographs and belongings of the deceased loved ones, the bereaved informants reported holding ceremonies and creating effects to honour the memories of them in the longer term (see Rosenblatt, 2000). On special dates such as the birthdays of the deceased and anniversaries of their deaths, the informants described lighting candles, attending the final resting place of the deceased, holding memorial services at church, releasing balloons, and scattering ashes. Natasha and Jim have postage stamps and return stamps made with Jess's photograph together with a road safety message. Patrick set up a memorial website for his brother. Dawn named a rose after her daughter and George and Debra named a daffodil after their daughter. George and Debra also had a swimming award named after their daughter at the high school she attended. In a similar vein, some informants kept in touch with their loved ones' friends, allowing them a window to what their loved one would have been doing if they had not died (Rando, 1993).

> *"…that was really, really good for me to see how his mates were… Just to see how his mates were getting on and what level he would be at and how he would [be], just to see the things that I'll never get to see with Mikey."* (Karen)

In addition to photographs, the deceased loved ones' possessions, and other reminders, particular places facilitated the maintenance of the relationships to the deceased. These places included the scenes of the crashes and their loved one's resting places. Many informants reported constructing roadside memorials by planting trees or flowers and/or erecting crosses or a plaque at the crash scenes (J. Clark & Cheshire, 2003-2004; J. Clark & Franzmann, 2002, 2006; Haney, Leimer, & Lowery, 1997; Reid, 2003; Reid & Reid, 2001). For some of the informants (e.g., Di, George, and Dawn), visiting the crash site was perceived as a 'need' in the early weeks and months following their loved ones' deaths because it provided them with a sense of peace, calm, and quiet. Many continued to visit the site on a regular basis. Riches and Dawson (1998b) proposed that visits to these places of death provide the bereaved the opportunity to be present at the sites of their loved ones' deaths, albeit after their deaths, while others proposed that the visits help the bereaved 'communicate' with and care for the deceased (J. Clark & Franzmann, 2006; Reid, 2003; Reid & Reid, 2001).

> *"I go down there [to the crash site] every year, I'm going down there this year, …this will be the fifth time that we've gone down… [It's] bizarre, but it is nice down there. Very quiet, just in the bush, all the flowers start to come out in the bush and the cross just stands out on the road and it's nice."* (Maggie)

Similarly, the final resting places of their loved ones provided comfort and a sense of peace, calm, and quiet. Most of the informants reported visiting the cemetery often, especially on anniversaries, birthdays, and other important dates. Kelly described driving to Busselton one day (232 kilometres south of Perth) where her mother is buried just because she felt the need to go there. As well as visiting their loved ones' gravesites, some informants reported that they spent time tending to the gardens of the cemetery as a way of letting the deceased 'know' they were cared for (Reid & Reid, 2001).

> *"Going to his grave, [my de facto partner] used to say to me 'oh don't go so much' but I had to go everyday and he couldn't understand, to me it was like going to visit [my son]. He thought it was upsetting me to go, but it wasn't, it relieved a lot of the pain. It's like I can't do anything for him anymore. I can't buy clothes, I can't buy him shoes, I can't buy him Christmas presents, birthday presents, nothing, so all I can buy him is flowers and sit there and I cut the grass,*

> *but it's a labour of love. We do that for our children. And when I come away a feel a big (sigh) like I've done something for him… I still enjoy going down there too."* (Joan)

Although the deceased loved ones were usually remembered every day, there were certain days of the year where remembering the deceased loved one is more painful, such as the anniversaries of their loved ones' deaths. These 'anniversary reactions' were first identified by Birtchnell (1981). Rando (1993) later identified various types of what she called STUG (Subsequent Temporary Upsurges of Grief) reactions, and include cyclical reminders (e.g., anniversaries, holidays, seasons), linear reminders (e.g., weddings, births, graduations), and stimulus-cued reminders. For example, Kelly described the anniversary of her mother's death every year as a *"struggle"*. In addition to the dates of their loved ones' deaths, the bereaved informants reported that certain times and activities we share with family and loved ones such as Christmas, birthdays, weddings, Mothers Day, Fathers Day, and certain types of music and food, as extremely painful.

> *"Christmas time forget it, …I just start bawling. I try and get all my shopping done before the carols happen. Once the Christmas carols have been turned on, you can't get me there no matter how hard you try because it's just too hard… You associate all the good times that you've had… To associate Christmas and all the fun and all the joy and all the hype and you know the school play and all that sort of stuff and yeah [it's] just too hard. I haven't had a Christmas tree since [Mikey]'s died it's (pause), I just don't want one, it's just not the same."* (Karen)

Finally, the bereaved informants spoke of their difficulties in finding meaning in the deaths of their loved ones. Many grief theorists and models emphasise the need for bereaved people to find meaning in their loss. For example, the grief literature states than meaning and/or 'positives' often arise from traumatic or negative experiences such as bereavement (e.g., Balk, 1999; Calhoun & Tedeschi, 2001; Cassem, 1975; Janoff-Bulman, 1992; Moos & Schaefer, 1986; Farnsworth & Allen, 1996; Neimeyer et al., 2002; Richards et al., 1999; Schaefer & Moos, 2001). Some theorists suggest that meaning-making is linked to 'successful' or 'resolved' grief (e.g., Currier et al., 2006; C. G. Davis 2001; R. D. Eliot, 1932; Gamino et al., 2000; Gamino & Sewell, 2004; Janoff-Bulman, 1992; Neimeyer, 1998, 2001; Nolen-Hoeksema, 2000; Polatinsky & Esprey, 2000). Many informants reported engaging in activities such as reading police and

coronial reports, going to the crash scenes, and attending the legal trials in order to make sense of the circumstances of their loved ones' deaths (Howarth, 1997; Rando, 1993; Riches & Dawson, 2000; Rosenblatt, 2000). Often, the exact details of their loved ones' deaths were not known, despite coronial inquiries. Both Joan and Sharon described their attempts at piecing together the events of their sons' deaths as a *"jigsaw"*.

> *"At the beginning, you still <u>want</u> them so much that you want to know absolutely everything, you want to see them no matter what it is like, you just want to be part of it, you still want them so you want every part of what's happened. You do need to know, you do need to know. I want to know what no one can tell me because she was on her own, and on a road with no traffic… I would've liked them to…pinpoint a time [of death], but in the coroner's report all it says is she died between when she left and when she was found, so I would've liked a time and I would've like to know [her death] was straight away, more or less. Not at six o'clock the next morning, but they didn't have that in the report… It's hard to not know, and I'd liked to know if it happened because she was asleep or whatever, or saw a kangaroo or a rabbit and swerved to avoid it or anything. There are a few different possibilities."* (Maggie)

These activities did not shed light on the meaning of their loved ones' deaths. The majority of informants rejected the necessity of finding meaning in the death of their loved ones and instead they stated that they had not been able to find meaning or make sense of their loved ones' death over time, which supports emerging literature that questions the necessity of finding meaning in loss (e.g., C. G. Davis et al., 2000; Wortman & Silver, 1989, 2001).

> *"I thought if maybe I could know why [this happened], just for a few seconds, it would be cope with this nightmare and come to terms with what has happened. Life now just doesn't make any sense or meaning anymore."* (Joan)

Instead, the deaths of their loved ones were perceived as tremendously unfair. Some informants questioned why their loved ones had died as opposed to someone else's love one. In the crashes that were caused by someone other than their loved ones, the bereaved informants reported that the perpetrators suffered minor injuries, while their loved ones, who were innocent victims in the crashes, were killed. Some of the bereaved informants reported questioning why it happened to their loved ones and not to someone else, such as those who commit crimes or are ill or disabled. Instead, their young, healthy, and law-abiding loved ones died.

> *"…that just seems to be the way it goes, it always seems to be the innocent ones that cop it you know. I don't know why he couldn't have just driven into a lamppost and killed himself, but he didn't. How he got where he got and how that happened, I don't know. It seems to be the way it goes, that someone innocent get hurts, it's never, it's not very often them, it's usually somebody else. And that's (pause), …to just say that it's not fair is not even the right words."* (Dawn)

For those bereaved informants that were successful in finding meaning in the deaths of their loved ones, their notions of meaning concerned the belief in destiny or fate that pre-determined their loved one's lifespan and/or purpose in life which was achieved early (C. G. Davis & Nolen-Hoeksema, 2001). Hence, these informants believed that their loved ones' deaths could not have been prevented.

> *"But what also keeps me going, and I have to keep saying it to myself otherwise I really do think I would slip into the depression is…that we choose, we choose what we are going to do in this life, and I think, well if that's what they've chosen to learn in this life then you know, they've gone when they've done what they've had to do, and hopefully you know, you meet up when (trails off)… I have to just feel that there is something a lot bigger than what we know, and this is just a human life that we are leaning something from, no matter how hard it is! I sort of have to just keep reminding myself of that, and other people have lost more than one child and I try to think it's a path that they've chosen and one I must have chosen as well, it's really stupid but it keeps me going to believe that they've done what they had to do."* (Maggie)

For some informants, their spiritual beliefs assisted them in coping with the deaths of their loved ones. The belief in a higher power and the idea that the death was part of a bigger 'plan' (C. G. Davis, 2001; C. G. Davis & Nolen-Hoeksema, 2001), helped to ease the pain and minimise attempts to look for or question the meaning behind their loved one's death. They reported believing that they will be reunited with their loved ones in the afterlife. In addition, they believed that God or other higher power did not cause their loved ones' deaths but will help them deal with the loss.

> *"I don't believe God has let this happen, I believe God helped us through. Even with planning the funeral, we were saying 'oh what should we do? Where do we start?' and then there'd be a knock on the door. Someone will come in and offer a hand. And to think that that would just happen (trails off). But in terms of why they died, I have no idea."* (Patrick)

For others, the deaths of their loved ones led them to question their faith. The informants reported asking questions such as – What kind of God does this?; What is God?; I prayed and the prayers weren't answered, so has God abandoned me in my time

of need?; and If there is no God, there can't be a heaven, so what did this mean for my loved one?

> *"…I'd always believed in God and everything and of course when [Claire died] everything I believed just went straight out the window and I couldn't figure out where God was in all of this… This God that I had always had this image of was suddenly not there anymore, it had been shattered, so I had no, nothing to hold on to anymore. So that threw me into the thought that if there is no God, then there is no Heaven so then what? What does that mean for Claire, you know? That threw me into this whole thing of trying to figure out well where is she now? …Eventually I worked through that and came to a peace about, I still don't know what Heaven's about but of knowing that she is okay and I have this sense of her being with me all the time. But it had thrown everything that I believed you know out the window. And I'd obviously had a Sunday School image of God, that when you die you go up to Heaven and there's all pretty grass and you're all sitting you know and I don't think it's like that now, I don't think like that at all, but at that time, that had been the image I had and all of a sudden that was gone. I had nothing and I had to start from the ground again and that was all part of my grief… It was such a big part of my grief that it was my grief, and I couldn't separate it, and I had to work through those issues."* (Dawn)

Almost all of the informants stated that they struggled to find anything positive from the death of their loved ones. In fact, most found the idea of finding positives in the deaths of their loved ones as offensive or ridiculous. Indeed, Riches and Dawson (2000) wrote that the notion of benefit from bereavement "could easily be perceived as insensitive by bereaved parents and siblings" (p. 127). The informants were however able to identify factors that would have made their experiences worse. Mostly, these factors related to the outcome for their loved ones where the informants thought that death is better than some alternatives. For some, the sudden deaths of their loved ones was considered to be a 'positive' because it prevented their loved ones from getting old or from dying from an illness. However, the notion of a 'positive' was reported by informants who lost a parent (Lorraine), a grandparent (Brooke), a sibling (Heather), and a spouse (Sylvia), but was not mentioned by those that had lost a child. Some reported that hindsight allowed them to see that the quick death of their loved ones was preferable to chronic and severe physical and intellectual disabilities.

> *"I'm glad she died and didn't come out a veggie [sic] or something, I'm glad that she actually died rather than had horrific injuries at her age yeah, and have to go through [that], she probably would've wanted to die if she had've half died you know…[and] I feel granny would be up in heaven thinking, great, I died that way in an instant…"* (Brooke)

The informants spoke of reassessing their lives, with a particular emphasis on reprioritising their lives according to changes in their perception of what they consider to be important (see A. Dyregrov & Dyregrov, 1999; Farnsworth & Allen, 1996; Frantz et al., 2001; Janoff-Bulman, 1985; Nolen-Hoeksema, 2000; Rosenblatt, 2000; Vickio, 2000). They reported that the things that used to concern them and take up a lot of mental energy did not concern them anymore. Instead, they tended to focus on what they consider to really matter, such as spending quality time with family and recognising the inherent value of people, over material goods such as their homes, work, and money, which the informants considered trivial.

> *"My whole attitude has changed. Things that were important before are not important anymore. Material things are just things… I realise what's important is how we live this life… What is really important is people… Things that were really important before, like worrying about the house and all the rest of it, is not – they're just things."* (Dawn)

Some had incorporated their experiences of grief into their aspirations for the future, and expressed a desire to help others in their careers. Transforming losses into professional roles was also found by Van (2002) in her study of women's perinatal losses and Riches and Dawson (2000) in their studies of grieving families. At the time of the interview, Karen was working as a teacher's assistant for a boy who was hit by a car and suffered physical and intellectual injuries. Maggie expressed an interest in doing volunteer work for the aged. Jelena was studying psychology and had applied for a position within a funeral director's company. Dawn was studying psychology and theology and had applied to train for the ministry.

> *"I do see myself eventually, at some stage, working with people, whether it be on a psychological basis or within a ministry or a church, but I will be working with people, so…I guess I've got a dream, some of my dreams have come back and Claire is a big part of that (crying) in that if from all this pain I can be there for someone else, 'cause I know more people are going to go though it, if we can maybe just, if all of us could use our pain to help someone else then maybe make the world a little bit of a better place."* (Dawn)

So far in this chapter, I have established that the bereaved informants' experiences of grief are not congruent with the core assumptions concerning grief that are evident in the dominant discourse in the literature. There are many reasons for these differences. One important reason is the characteristics of crash deaths, which are

explored in the following section. Other reasons, such as the context within which bereavement from crash deaths occurs, are explored in subsequent chapters.

Characteristics of Crash Deaths: The Sudden, Unexpected, Violent, and Often Preventable Deaths of Loved Ones

Crash deaths, as established in Chapters 1 and 2, are sudden, unexpected, violent, and are often caused by another person or event. Further, frequently those that die in crashes are young in age. In sum, crash deaths are not natural deaths. The characteristics of crash deaths are significantly different to those circumstances of death that formed the basis of much of the grief literature. For example, much of the 'classic' grief research was conducted using samples of North American, middle-aged women grieving the loss of their spouses, usually after a long illness (see Chapter 2). As a result, the experience of grief resulting through crashes is likely to differ to grief resulting from other deaths. Through the words of the bereaved informants, this section highlights the characteristics listed above and demonstrates the impact of these on the informants' grief experiences.

The informants described the deaths of their loved ones as traumatic because they did not die naturally. The bereaved informants talked about the mode of their loved ones' deaths as being difficult to deal with because their healthy loved ones were killed suddenly, violently, and unexpectedly. The informants described the circumstances of their loved ones' deaths as *"horrific"* (Brooke), *"tragic"* (Lorraine), *"traumatic"* (Jelena and Lorraine), *"horrible"* (Dawn), and *"terrible"* (Heather). Heather said the perpetrator *"ploughed"* into her sister on his motorcycle and Karen shared that her son was *" hit clean out of his shoes and they were still on the road"*. Pieter, who attended the crash scene where his son died, stated that the scene *"…looked like a major disaster scene from a movie… A couple of ambulances that had left [the scene] early had people from the crowd in them who had collapsed from the trauma…".* Brooke described the events that led to her grandmother's death as follows:

> *"…these two young guys…were having a drag race, they were doing about 120 [kilometres] in a 60 [kilometre] zone and where she was turning, they were coming over a crest and…because they were probably approaching a lot faster than she anticipated…she turned and they just, the black Monaro just collected her, her car rolled 11 times, that's how hard the impact was. From her being stationary…and they would have braked as well, you know, so they estimated they were doing about 120 [kilometres] or more. So her car rolled and smashed*

> *in to, through someone's house, like into their back yard and their fence…"* (Brooke)

The violent method of death inflicted injuries on their loved ones that were often evident at the hospital, during identification, and during mortuary and funeral viewings. Seeing their loved ones' broken and bruised bodies was difficult and traumatic. For example, Maggie's daughter had to be identified via a tattoo near her navel, because of injuries resulting from the crash, her body being exposed to the weather on a hot day, and being flyblown. For others, the injuries were less obvious but the medical apparatus keeping their loved ones 'alive' after brain death were traumatic.

> *"After arriving at the hospital, the doctor told us what to expect when we went into the intensive care ward. But no amount of words could ever have prepared us for what we were about to see. Jess had bolts drilled into both sides of her head to stabilise her neck. There were numerous tubes going into her body draining unwanted fluids into large bottles standing beside the bed and other tubes carrying much needed substances to help keep her stable. The awful swellings and bruises all over her face and body, but worse of all, it was the lifelessness of our most precious and beautiful daughter…"* (Excerpt from Natasha and Jim's presentation to medical students)

The extent of their loved ones' injuries were significant, and included injuries such as spinal damage, brain damage, bone fractures, lacerations to major blood vessels and the heart, collapsed lungs, other internal injuries, bruises, and swelling. Despite being informed as to the condition of their loved ones, it was still a shock to see them, both in the hospital and at the mortuary. In particular, the informants were surprised as to how cold and hard the bodies of their loved ones' were, particularly when they had died suddenly and signs of 'life' remained.

> *"…and that's probably the saddest moment that I've ever had, …actually being there, going into that small room, with a glass partition across it, so you couldn't get real close, and then they wheeled two trolleys through and they were both covered, and they pulled the covers back to their chests, and I just lost it then, …I thought 'my brother, my brother'. And they hadn't cleaned them up, 'cause it had only happened the day before, they still had blood on them. To see them both lying there, Dad looked like he was a sleep. Ian, …when I saw him, his eyes were half open, and I find that most disturbing, 'cause it looked like he was just looking through his half-shut eyes, and I expected him to turn his head at us. But there's no light there, it's like someone else. It's hard to take you know, you look at them and you think they're still there, but they're not there."* (Patrick)

The violence of their loved ones' deaths precipitated the informants imagining their loved ones' deaths. The informants found the possibility that their loved ones' experienced death in a violent way and potentially painful way was particularly difficult to deal with. They hoped their loved ones died immediately and peacefully, without awareness. Some informants reported trying not to think about it the reality of the terror and trauma their loved ones likely experienced before their death.

> *"… [my grandmother's] face was alright in the coffin, her face was fairly intact, you could see the nose had heavy make-up or whatever it is you have to put on applied… Normally at a funeral I'm no worries with a corpse, I touch it with my kids [and] when their other grandparents died [I] took them and showed them the body and all that, [but] at granny's [funeral] I was a bit scared of what I was going to see…but they covered her with a cover so…goodness knows what, and <u>that</u> image itself is in my mind, the imaginary image of what was under that cover (trails off)… That upset me. Her dying didn't upset me, the terror that she experienced at the point of death would have been terrible yeah, and…you imagine all those things, and you see it, you put yourself in her shoes…"* (Brooke)

The suddenness and unexpectedness of the deaths was difficult to deal with because they could not be predicted. Instead of dying from an illness or old age, their loved ones died engaging in 'normal', every day activities such as going out for a drive, coming home from work, dropping someone off, crossing a road, or walking on the footpath alongside a road. Furthermore, the suddenness meant that the informants could not say goodbye to their loved ones.

> *"One minute we had a beautiful, vibrant 18-year-old and the next we stood and watched, with tears streaming down our faces, while a hole was being dug out of the ground in preparation for me to place this small box, all that remained of our Jess."* (Excerpt from Natasha and Jim's presentation to medical students)

The suddenness also meant that Nicola was not able to attend her brother's funeral (held in the Northern Territory) because the cost was prohibitive. For Patrick, attending the funeral service in Melbourne for his father and brother led to a financial crisis.

> *"…we didn't have a lot of money. [My wife] was studying part-time, and I'd just finished up [work], so she had to put it on the credit card to come over [to Melbourne with the children], which was an additional expense that we <u>really</u> couldn't afford 'cause [in] September, just before the accident, a month before, we had been over in Cairns for a month because my wife's parents are in Cairns, to see them, so to incur that expense to go to Cairns and then to come back and*

> *then to have my wife and two kids over to Melbourne for the funeral we were really, really feeling the pinch money-wise."* (Patrick)

In addition to the sudden, unexpected, and violent characteristics of crashes, the relationship to, and age of, those that die in crashes also impacted on the grief experienced by the informants. The relationship with the deceased loved one is important in determine the impact of their death on the bereaved. The closer the person was to the person that died, the more affected he or she is. The informants reported that it was easier to deal with the death of friends or extended relatives than that of close family members. As Jelena explained, *"…nobody's death impacted me so much as my brother's and I suppose it was because…it was immediate family…and it was somebody that I knew personally and close…"* . It was considered that the experience of grief was easier when the deceased loved one was older, because they had had a full life, despite it being cut short. The young age of many of those that died in crashes was seen as a tragedy. Those that did not lose a child saw the loss of a child as worse than the loss of their loved one.

> *"…it's much easier to cope with because my dad was 70 and he'd lived a very full life. So in that way it makes it easier to cope with… It's sort of almost like a natural progression of things. You expect your parents to die sometime you know but I think…if it was my daughter or something like that I don't know how I would cope with that, I don't think I would cope anywhere near as easy [sic]."* (Lorraine)

Further, those who lost a child described the death as especially difficult to deal with. The death of one's child was described as *"the ultimate tragedy"* (Joan), *"against the cycle of life"* (Joan), *"a living hell"* (Joan), *"unfair"* (Debra), and *"unnatural…horrific, devastating, it's hell"* (Excerpt from Natasha and Jim's presentation to medical students). Jim explained that *"losing a child I'd say is the most devastating type of loss you could have because it's not normal, you normally die before your children…"* . Those who lost children described the continual losses that they incurred as a result of their children's deaths. They described the loss of events they had anticipated such as their children's birthdays, weddings, and grandchildren, as a loss of the future they had anticipated (Bowman, 1997; Rando, 1984, 1993; Rosenblatt, 2000).

> *"…everyday you've got a reminder, it hits you in the face, of what you're missing. Every year that goes on, another birthday, like my son would've been 30*

> *this year, he would've been married, I would've been a grandparent. I would've loved to have known what he would've been doing. I got the other two boys building their houses; I'm missing that with Alex. He never enjoyed the love of a woman; he never enjoyed the birth of a child, his child, and I know he would've loved that, and then seeing [my sons] and knowing that they've got one less to share their joys with, 'cause they used to share everything. It just goes on and on and on."* (Sharon)

Some informants were very specific about the ages of their deceased loved ones in order to mark the age their loved ones had achieved or almost achieved, such as saying *"6-and-a-half"* (Karen), *"19, almost 20"* (Pieter), and *"18 and two weeks"* (Natasha). However, although it was those who had lost children who usually did this (see also Klass, 1997), Jelena described her brother as *"25, almost 26"*.

An additional characteristic of crash deaths is that they are usually preventable (Hobbs & Adshead, 1997; Sleet & Branche, 2004; Stewart, 1999; Waller, 2001; WHO, 2004; Zaza et al., 2001). The fact that, in most cases, someone else's irresponsible actions had caused the deaths of the informants' loved ones was difficult to deal with. The deaths were described as *"avoidable"* (Dawn), *"unnecessary"* (Di), and *"senseless"* (Sharon). This characteristic of their loved ones' deaths contributed to the informants stating that there was no purpose or meaning to their deaths.

> *"…there was an injustice involved in that tragedy… It wasn't just like a freak accident or that she fell asleep behind the wheel or something… It's an unnecessary tragedy, like if…she was drunk driving [it would be different but] …when someone else has done it, and it's someone else's fault, you feel really angry, and really ripped off."* (Brooke)

Crashes are sudden, violent, unexpected, and largely preventable. In addition, those that die in crashes are often young, and even if they are not young, their lives still end prematurely. It is these characteristics of crash deaths that contribute to the grief experience following crashes and go towards explaining why grief following crashes differs to most of that discussed in the grief literature.

Internalising the Dominant Discourse: The Bereaved Informants' Appropriation of the Dominant Discourse Concerning Grief

In Chapter 2 I discussed the notion that, as a consequence of the application of a scientific lens, grief has been examined within a medical framework whereby the 'normal' grief experience is constructed as short term, finite, linear, stage-based,

meaningful, and culminates in detachment from the deceased. As established previously in this chapter, in describing their grief experiences, the bereaved informants did not tend to support the dominant discourse of grief. However, some appeared to internalise the dominant discourse concerning grief, despite it not accurately reflecting their experiences of grief, a process Kauffman (1989, 2002) termed self-disenfranchised grief while Walter (1999, 2000) referred to 'policing' one's grief. Further, this self-disenfranchisement or policing of grief is an example of the ways in which the socialisation of the one 'legitimate' ideology may be oppressive (Fox & Prilleltensky, 2003). Instead, they compared and contrasted their experience with the dominant discourses, and as a consequence judged themselves harshly for not meeting the socially sanctioned ideal of grief. There is a potential that the bereaved could come to see themselves as failures or not grieving properly or even going mad. Some informants (Pieter, George, Nicola) expressed thoughts and feelings of confusion and disappointment, because they were still grieving and had not progressed through their grief as fast as they had expected or thought they should.

> *"I would have thought that it wouldn't have been as it has over such a long period of time… I was under the impression the worst part [of grief] is immediately afterwards…but I thought it would dull right off exponentially from that point but it doesn't seem to be that way at all, it just keeps carrying on."* (Pieter)

Likewise, others described that they had tried in vain to find meaning or reason in the deaths of their loved ones. For example, Karen thought there was something 'wrong' with her because she was not able to find a positive in her son's death.

> *"…the worst thing people could say back after Mikey had died and maybe even for the first 12 months or even, even a bit beyond that would be, 'oh there's got to be some good come out of this'. Well I'm sorry but there hasn't, what good can come out of it already, I'm still, and I've struggled with that and I've thought maybe I'm not seeing it, maybe I'm taking the wrong view or maybe I've got blinkers on or something but four years down the track, no (emphatic)."* (Karen)

Some informants reported feelings of guilt and judged themselves harshly for being able to enjoy aspects of their lives, as they thought taking any pleasure in life it meant they did not care for their deceased loved one or were not honouring the memory of their deceased loved one like they 'should'. For example, George commented, *"we do have light moments and we probably had light moments from not long after Kate died*

and you think yourself to be a terrible parent, a terrible parent…". The informants were also able to say that they were aware that they were 'supposed' to accept their loved ones deaths and find meaning and/or positives in their deaths. For example, George stated, *"Kate could have been taken from us earlier…from some dreaded disease or anything, you know I guess she got to 17 and we had to be really happy with that, or relatively happy with that…"* .

Earlier in this chapter, I stated that some informants had experienced paranormal phenomena concerning their loved ones after the deaths and that some had accessed psychics and spiritual healers in order to contact their deceased loved ones. However, not all the informants were happy to openly discuss such a phenomenon. For example, Nicola showed me photographs taken at the scene of the death with a white formation in one of the photographs. She also spoke about her brother 'contacting' her after his death, but did not want these aspects of the conversation tape-recorded. Instead, she hinted about the spiritual connections rather than discussing them explicitly. After the conclusion of the formal interview when I had turned off the tape recorder, Nicola then felt comfortable to discuss in detail the photographs and their relevance to her spiritual connections with her brother[2]. Riches and Dawson (1996a) also described the increased willingness of participants to describe these experiences when the tape recorder was off.

In addition to the paranormal phenomena, some informants appeared to feel embarrassed about revealing certain details, especially related to length of time after their loved ones' deaths. They qualified the information with comments judging themselves as *"silly"* (Heather) or *"weird"* (Jelena, Nicola, and Karen) or *"stupid"* (Jelena, Maggie, and Karen) or *"mad"* (Dawn and Jelena), or sometimes accompanied their 'admissions' with embarrassed or nervous laughter (Jelena, Karen, Maggie, Dawn, Patrick, and Nicola) (see also Riches & Dawson, 1996a). For example, Karen stated, *"I like to leave his [bed]room almost (pause), his cupboard's still full of toys. I know that sounds really, really weird four years after [his death], I just like to leave things as natural and normal as possible."* In addition, some informants expressed worry, concern, and anxiety about whether or not their experiences and reactions were 'normal'

[2] Perhaps Nicola shared these experiences with me after the tape recorder was turned off, as it was not part of the formal interview. As such, none of the material discussed is included in the thesis.

or 'crazy'. For example, at the end of our conversation, Nicola asked me, *"So do you think I'm okay for two years and two months?"*. The possibility of 'going mad' was considered frightening by some of the informants. These qualifications of their thoughts and behaviours suggest that they are aware of what they are 'supposed' to think or say, and evaluated their grief according to an amorphous standard.

As well as judging themselves, the informants also felt judged by others for their ways of coping and also judged others on their grief. Earlier in the chapter, I discussed the notion that grief experiences many vary between individuals, including those within the same family. However, some informants described incidents where they felt others, including family members, were judging them for the way they coped with their loss (see Chapter 5). They also compared and contrasted the ways in which their loved ones coped with their grief with their own ways, and sometimes judged other members of their family for the ways they chose to deal with the loss of the loved one. For example, Jelena criticised her mother for keeping the coroner's report and photographs of her son (Jelena's brother) in his coffin.

> *"[My mum] knows how much this [bodily organ] weighed and how much that [organ] was, and whether this [organ] was in good condition and…I find that a bit creepy… I know that my mum went and took photos of my brother in the coffin and to me that's got to be the worse way of remembering him 'cause he looked a mess…but I know she's got them and I know she's got them with the papers from the…inquest and I know she's got them in that little tin that's locked up in her bedroom. But it's like she's hoarded [these things] and I don't think that's terribly healthy…"* (Jelena)

In addition, Patrick criticised his mother for her lack of emotional expression over the deaths of her husband and son, and her ability to 'get over' her grief.

> *Things that, not so much upset me but make me a little bit angry, is probably mum (nervous laugh). I hate to say it but really, she does get my ire up… She never cried at the funeral, she never cried at all, even when I first got to Melbourne…and she was upset, you could tell she was upset, but she couldn't shed a tear. And that's funny, 'cause even now there are moments where she doesn't shed any tears. Sometimes I just feel she's bottling it up inside her. She needs to get angry and take it out on something or someone, or break down and have a good cry… Even now, it's two years this month, since the incident, and she still has her ups and downs… I kept putting myself in mum's shoes [thinking] 'how must mum be feeling?' but after a while I think, well I've dealt with this, I think it's time she should've dealt with it.""* (Patrick)

Dominant discourses ultimately affect the ways in which people perceive themselves and others (Foote & Frank, 1999; Foucault, 1961; Fox & Prilleltensky, 2003; Kauffman, 1989, 2002; Rappaport, 2000; Walter, 1999; Wortman & Silver, 2001). In this section, I argued that there is a potential that those bereaved through crashes come to understand their experiences through a lens coloured by the dominant discourse. Consequently, they may harshly judge themselves or others for not grieving in the 'appropriate' manner sanctioned in the dominant discourse. The net result is that the grief experience is judged as legitimate if it is expected, or illegitimate if different to the expected norm.

Conclusion

In this chapter I discussed the extent to which the assumptions represented in the dominant grief discourse (Foucault, 1961) or the dominant cultural narrative (Rappaport, 2000) of grief align with the experiences of grief reported by people bereaved through crashes. The applicability of the assumptions in the literature concerning grief resulting from crashes was limited. The dominant discourse concerning grief fails to capture a number of components of the grief experiences described by the informants. They described the sheer intensity of their grief, with its physical, emotional, and cognitive effects. They spoke of their grief as a unique and long lasting phenomenon. Instead of endorsing the notion that grief consists of linear stages, the informants reported oscillating between different emotions rather than a linear progression through prescribed stages. They also spoke of the process of adaptation to the deaths of their loved ones, rather than resolution and recovery. They described in detail their continued attachments to their deceased loved ones, and spoke of the ways in way they maintained these connections. Finally, they spoke of the senselessness of the deaths of their loved ones, rather than being able to attribute meaning to or finding positives in their loss.

There was also evidence that the informants appropriated and internalised the dominant discourse or narrative, resulting in three outcomes. First, some of the informants judged themselves harshly if their grief was not as they thought it 'should' be. Second, some informants judged others, particularly family members, for 'failing' in their grief. Third, some informants came to a realisation that, although their grief might differ to the normative standard, it is still acceptable and healthy, given the

circumstances of their bereavement. I discuss this notion in further detail in Chapter 7, in the context of resistance. Finally, there were also many instances where the informants felt judged by others. These are discussed in the following chapter, which is dedicated to the bereaved informants' families and social support networks.

In this chapter I also discussed some factors that likely explain why grief resulting from crashes differs markedly from the dominant narrative or discourse in the literature. Crash fatalities are sudden, unexpected, violent, and preventable, and often those that die are young in age. These characteristics go some way towards explaining why the informants' experiences of grief did not readily match those in the dominant discourse. Further reasons, such as the amount and type of support from family and social networks, professionalised support, and experiences of contexts such as the legal system are explored in subsequent chapters.

Chapter 5

Family and Social Networks and Crash-related Bereavement: Experiences of Support, Change, and Isolation

Chapter 4 demonstrated that the dominant discourse concerning grief does not adequately capture the experience of grief following crashes. In Chapter 5, I examine the bereaved informants' experiences within their social support networks. The chapter is divided into four sections. First, I outline the ways in which a crash fatality impacts on family and spousal relationships. Second, I discuss the support the bereaved informants received from their social networks. Third, I demonstrate that the informants' social networks often imposed and enforced the dominant grief narrative, especially those concerned with the length of grief and finding meaning in death. Fourth, I outline the deterioration and collapse of many relationships within the bereaved informants' social support networks. Although in some instances, the death of a loved one precipitated closer familial and social bonds, it was more common that relationships were irrevocably changed and some did not survive the death of a loved one in a crash.

Much of the grief literature has focussed on grief as an individual and intrapsychic phenomenon (see Chapter 2). While the experience of grief is unique to each individual (Center for the Advancement of Health, 2004; Kellehear, 2001; Rando, 1993; Winslade, 2001), it is very much impacted upon by many factors, including family systems and social support networks. However, the need for support must be recognised by potential supporters, and the support must be available, sufficient, extended (Rando, 1993) and perceived as helpful by those receiving it for it to be beneficial (Flannery, 1990; Stylianos & Vachon, 1993; Vachon & Stylianos, 1988).

In this chapter, I focus on the bereaved informants' experiences within their social support networks. The chapter is divided into four sections; first, I discuss the bereaved informants' relationships with their family, including their spouses. Second, I outline the support the bereaved informants reported receiving from their social networks. Third, I establish that the informants' social networks often enforced the dominant grief narrative, especially those concerning timeframes for grief and meaning making. Fourth, I outline the deterioration and collapse of many relationships within the bereaved informants' social support networks.

Family Relationships: Development and Deterioration of Bonds[1]

Family support is crucial in times of crisis. While the majority of significant losses throughout our lives occur within the context of the family unit, these losses potentially disrupt the existing balance within it (Kissane & Bloch, 1994; Nadeau, 2001, 2002; Reilly, 1978; Riches, 2005; Riches & Dawson, 1996b, 2000; Wolfe, 2000; Worden, 1982, 1991, 2002). The dynamics between family members can serve to help or hinder the individuals' experiences of grief, and are dependent upon the roles/responsibilities of each member (including the deceased), the extent to which the family members are close to one another, and the family's emotional expression and communication patterns. In fact, one study of family functioning following anticipated bereavement concluded that at six months post-bereavement, 32% were 'supportive', 22% were 'conflict-resolving', 21% were 'intermediate', 15% were 'sullen', and 10% were 'hostile'. The latter two styles were deemed 'dysfunctional' and were characterised

[1] A summary of this section appears as Breen and O'Connor (in press).

by high levels of conflict, low levels of cohesion, and poor expression (Kissane, Bloch, Dowe, Snyder, Onghena, McKenzie, & Wallace, 1996).

Some informants reported that, on the whole, their immediate family worked together to support each other in the time of need. For example, Jelena stated, *"After my brother died the family dynamics started to change and we became closer. I think all of us have re-evaluated the way we deal with…life…"*. Some of the bereaved informants talked about having to support the different ways people within the same family dealt with their grief by recognising and responding to their needs, because they quickly realised that grief is an individual experience that differs from person to person (see Chapter 4).

> *"I think what's important as well is like everybody grieves completely differently, like Natasha is completely different from me in the way she grieves, but I don't argue with her or disagree with the way she does [grieve], I try to support that way…"* (Jim)

Sylvia described how she tried to work with her two surviving sons to make important decisions together so that they were all satisfied with the outcomes; *"…the three of us were making decisions [about the funeral services and the ashes] and we all had to be happy with the end result"*. However, Sylvia and her two sons shared different opinions about reading the coroner's report (Sylvia was unhappy with Patrick's desire to read it), whether or not crosses should be placed at the crash scene, and the extent to which her sons' children should be involved in the funerals, especially in terms of viewing the bodies of the deceased.

> *"…both my sons felt and their wives felt the children should view the bodies. Although I wasn't for them viewing the bodies, and I questioned whether they were certain that that was the right thing, whether children should be put through that trauma, they felt so strongly that they should acknowledge the fact that Dad and Ian had gone, that they were dead. I accepted that fact, although I wasn't happy with it… I could see that [a grandson], he looked, and I could see he wasn't comfortable. Patrick said the same about [his son], and both those boys were eight. Patrick and [my other son] felt that they had done the right thing, and I don't think that they regret it, but we've commented afterwards about my generation and their generation and the different approaches."* (Sylvia)

Although the bereaved informants accessed at least some support from their families, they were more likely to discuss instances where their families were not

sources of support following the death of a family member. The informants cited a number of reasons why they did not receive the support they wanted. First, it was difficult for the informants to find support from within their families, as they were grieving too (see Riches & Dawson, 2000). As Nick described, *"… my family couldn't really help [me] because they were all affected by it in a similar way that I am"*. Debra reflected on the difficulty of providing support to her son while grieving herself.

> *"George and I have asked each other did we help Nick enough? 'Cause you're trying to keep everyone together, yourself together and then different personalities and with children, and what they're feeling, and they're just sort of in the background…suffering in their own way or [they'll] switch off and just will leave when people are talking about it, just go into another room and…just blank off take themselves away from it. And they have different reactions, for one, because they're the brother or the sister and we're the parents…"* (Debra)

Second, instead of bringing families together, the deaths of loved ones, and the different ways of coping with the deaths, tended to exacerbate the relationship problems within the family unit. In many situations, the different ways of dealing with grief continued to be issues of contention, especially in terms of emotional expression, remembering and talking about the deceased loved one, and seeking help from professionals (Riches & Dawson, 1996c, 2000). For example, Patrick exclaimed, *"mum used to say 'men don't cry'. Rubbish! A real man will show his emotions. Have a cry, you'll feel better for it."* Both Jelena and Nick reported that their families criticised their decisions to seek help from psychologists. For instance, Nick stated that his *"parents are somewhat anti-psychological help. I don't think they think psychological problems exist, aside from being sad, or angry or (trails off)"*. The informants reported that members of their family dealt with grief differently, with some wanting to talk openly about their losses and others closing up. Di recalled that her parents avoided talking of Chris and changed the topic of conversion when she talked of him. Di explained it as, *"it's not that they don't want to know, but it hurts them as well"*. Karen stated that her three surviving sons rarely talked about Mikey, and they referred to his bedroom as the sewing room. Sharon said that as time went by, her husband no longer wanted to talk about their son and did not want photographs of him displayed in their home. Sylvia described how her sons (including Patrick) grieved differently from her and had expressed expectations of her ability to handle the deaths of her husband and youngest son (see also Chapter 4).

> *"I could imagine the two boys (her sons) talking behind my back… [One son] used to say, 'you've got to let go mum, you've got to let go'… I would say to him, I'm managing the best as I know how'… I felt they had expectations of me that were beyond my control."* (Sylvia)

Third, some of the informants (all women) reported that they had taken on the role of supporting other members of the family emotionally, in order to maintain a semblance of normality in the family unit. Nicola spoke of trying to maintain her roles of 'mum' and 'wife' while grieving for her brother. Heather described that she had to keep the peace in her family when their emotions were running high and they were looking for answers and potentially to blame the surviving sister for Melanie's death. Lorraine shared that she has tried her best to assist her mother, who was seriously injured in the crash that killed her father, and her brother, who now has psychological issues. Some took on the support role voluntarily, while others had it forced upon them by others within their family. For example, Kelly felt she was forced to replace the nurturing role of her deceased mother within the family unit, a process referred to as 'parentification' (Bowlby-West, 1983).

> *"I'd have [my grandmother] crying on my shoulder one minute, and the next she'd be saying to me 'get it together and sort out the family, look after the boys (her older brothers). The boys are the worry, you're alright' so that was not helpful at all… I remember the first Christmas, which was pretty tough 'cause…mum died in November and we had this Christmas in December, so you can imagine it was pretty emotional for everybody. I was just sitting on the lawn and my grandfather just looked up at me…and said 'if you had sunglasses on you could be my daughter' and I just couldn't cope. I thought 'but I'm not, I'm me'…and that was so hard, so hard, 'cause I was forever trying to fight for them to see that I was who I was and that I wasn't mum, even though the messages were very clearly that I now had to do the mum kind of things. It was a huge burden."* (Kelly)

Some informants reported internal conflict regarding their role in their family, and what they should do. For example, Nick expressed feelings of having been in a 'no-win' situation, as he wanted to comfort simultaneously his grandmother in Melbourne (where he was on holiday at the time of his sister's death) and his parents in Perth. He returned to Perth late on the day he was informed of his sister's death. Similarly, Lorraine shared that she experienced feelings of guilt for not being able to support her

family. She could not stay to comfort her mother and brother in South Africa because she had to return to Perth to look after her disabled son.

> *"I just felt like the worst, worst person just leaving them all to it, leaving them to their grief and, and leaving them all to the hassles with the lawyers and the doctors and everything… I'm torn you know…I've got terrible, terrible guilt about you know, leaving them all in the lurch."* (Lorraine)

Fourth, some informants reported feeling isolated from their families. Joan recalled how she was so focussed on her deceased son that she paid no attention to the other important people in her life, including her surviving son, for a significant period of time. Jelena felt isolated in her family after her brother's death because other family members, particular her mother, were so enveloped in their own grief.

> *"…for a long time, my mum actually forgot that she had four other kids and a grandson… I would get frustrated with mum…like she had forgotten that we were there, it was like you know Sasha this, Sasha that, and eventually it was like, mum, you've forgotten about the four of us that are living…"* (Jelena)

Fifth, communication between family members often suffered. As a result of the non-supportive experiences from family members, at the time of the interviews, there were still some issues concerning the deaths of their loved ones that had never been broached. It is evident that the lines of communication between family members were not always open even years after the death of the loved one.

> *"[My son] was the one that was told [by the police of Sally's death]… 'Cause he was 18, they told him [that Sally had died] but he was on his own. I don't know how he deals with that, I haven't really spoken to him about it…"* (Maggie)

Finally, although at first, the tragedy usually brought families together, in many cases, the grief following the death of a loved one precipitated estrangements between family members. For example, Natasha felt that she was not supported by her sister and as a consequence has not had a relationship with her sister for 10 years. Another cause of family disintegration was quarrels over the estates of the deceased. Generally, if the deceased has not written a will, their belongings go to their next-of-kin. Sometimes, this meant that other close relatives miss out on what they believed was due to them, causing further division in the family. Nicola spoke of how her brother Tom's partner inherited his property in the Northern Territory whereas her niece, Tom's child from a previous relationship, did not get anything. The arguments that ensued led to other quarrels within

Nicola's family. For example, she severed ties with her mother and a cousin who were intent on pursuing money from Tom's partner. As a result of financial accusations, Tom's partner fell out with Nicola's entire family, resulting in Nicola losing contact with her 3-year-old nephew and not knowing where Tom's ashes were.

As a result of issues concerning different ways of grieving, trying to support others while grieving, role changes, poor communication, isolation, and estrangement, the bereaved informants described their families as irrevocably changed following the death of a loved one in a crash. Some described their families with terms such as *"disintegrated"* (Brooke), *"shattered"* (Sharon), *"changed forever"* (Karen), and *"emptiness"* (Heather). Similar issues of family dysfunction have also been outlined in the context of anticipated deaths in the family (Fisher, 2003, in press).

In addition to talking about how they grieved within their family unit, many informants described the impact that the death of their loved ones had on their marriages and spousal relationships. For some informants, the death of a loved one was the catalyst for marital/spousal troubles (e.g., Natasha and Jim; Iris, Sharon, Karen, Dawn, Maggie, and their partners) whereas for others (e.g., Debra and George; Nicola, Lorraine, and their partners), the death of a loved one served to exacerbate existing relationship issues and problems (Oliver & Fallat, 1995; Nixon & Pearn, 1977; Riches, 2005; Riches & Dawson, 1997). The informants candidly described instances where they fought with their spouses because they felt they were not supported or understood. For example, Karen stated, *"I have been accused [by my husband] of maybe even having grown closer to God, at one stage or another since Mikey's death. Well you've got to find comfort somewhere…"*. Sometimes the informants verbally and physically fought with their spouses, possibly because the spouses were the only outlets for their emotions (Riches & Dawson, 1998a, 2000). Natasha spoke of how she often screamed to Jim that she wished he had died, rather than their daughter Jess: *"I used to thump on his chest, and say, 'Why couldn't it be you? I could live without you, but I can't live without Jess!'"* (Natasha). Karen also spoke of quarrels with her husband where they blamed each other for Mikey's death.

> *"I've been through all of that, the guilt feelings, there's naturally guilt feelings yeah and then there's the blame and I've been there too… I know that I have had to forgive myself for any role [in Mikey's death]… You have to reach a point to*

> *go over it and over it [and] believe me, [I] did that millions of times, to see what, what if, what could have happened if this or what if that how could it have been that, how could the outcome have been different you know if we had changed this that or something else. And we fought about it, my husband and I, it's like 'oh yes well maybe <u>you</u> should have been looking after him'…"* (Karen)

At the time of their children's deaths, Iris, Joan, and Maggie were all in long-term relationships with men who were not the fathers of their deceased children. This added an extra dimension to their grief, as their partners could not fully understand and empathise with them. Their grief was disenfranchised as a consequence of their partner appearing unwilling to talk about the deceased person or the bereaved person's experiences of grief (Gerrard, 2002). This phenomenon was also documented by Riches and Dawson (1998b) who noted, "for single parents who lose a child, or for remarried parents who lose the child of a former marriage, there is less likelihood of them finding social settings in which they can comfortably hold these conversations" (p. 134).

> *"Because [my partner] doesn't understand either. (pause) He's been through like a traumatic divorce and separation and misses his [two] girls… He feels like he's lost his two girls, so he sees his situation as having lost his daughters but I don't see that because they're still alive. I feel he feels he's on par with me but I know he's not (exasperated laugh) and it's very difficult sometimes. I find now that I don't say a great deal, I don't say a great deal I find."* (Maggie)

Similarly, Iris's new marriage was further tested during this time as both she and her husband had children from previous marriages. She described having to blend the two families while grieving for her daughter as *"absolutely horrific."* In fact, Iris described instances where her husband used her grief against her.

> *"We went to a barbeque before Christmas it was, so the beginning of December and she died at the end of September, and I was talking to somebody and [my husband] was talking to somebody. We finished our conversation and I heard what they were saying, and he said 'Iris forgets that other people get embarrassed' and I could hear all this <u>and</u> we had to walk past that spot where she was killed [to get to the barbeque], and I remember getting very angry with him. Most of the time I wouldn't let on that I was angry, we'd only just been married, but I did tell him then that I resented him talking over my 'case history' with other people, and oh to <u>only</u> feel embarrassment. So you want me to take my grief, my hurt, and to make sure that nobody else even feels embarrassed? So I'm supposed to carry their embarrassment as well?… Anytime [my husband] and I had an argument of any sort which came many years after [Mary-Anne's death], …he'd always bring her death into it…which was like hitting below the belt as far as I was concerned."* (Iris)

Similarly, Nicola, Jelena, and Kelly stated that their husbands were not particularly supportive after their respective losses of a brother, a brother, and mother, because they also could not empathise with the losses. However, Kelly reported that years later, when her husband's father died, he was able to understand her grief better.

> *"I know at times, for a patch there, [my husband] would lose patience with me a bit and just be like 'come on, just get on with it' and I'd say 'go away, I have to do this, leave me alone' and I had the confidence to say that to him. Then he lost his dad and he doesn't say anything [about how I grieve] anymore. He grieves in his own way, in a different way to what I did, but he doesn't ever question how I feel…anymore and I think it's because probably now he really understands… I think at about the 10-year mark he thought I should be over it. But I think he now understands that you never really get over it."* (Kelly)

There is considerable debate concerning whether or not the death of a child is a catalyst for marital separation and divorce. In fact, the so-called high divorce rate among bereaved parents is considered by some to be a 'myth' (e.g., Dijkstra & Stroebe, 1998; Schwab, 1998). The marital relationships of some of the bereaved informants were tested to the point that they crumbled. Nicola had permanently separated from her husband, and Dawn and Debra reported that they and their respective husbands separated for a time. Although Natasha and Jim did not separate, Natasha described them as leading distinctly separate lives as a result of their differences: *"Jim always goes to the other side [but] he looks like he's on my side… I've got my own car, I've got my [grand]kids. You lead your own life, you can't depend on husbands…"*. In contrast, Patrick reported that his wife was a big support for him, and both Pieter and Di reported that their relationship had strengthened since the death of their son. The notion that marriages are likely either to strengthen or dissolve following the death of a child has been referred to as a 'polarization effect' (Lehman et al., 1989, p. 344).

> *"I found that at the first week after the death, I've known a few people that I used to work with and the death of their sons has split the marriage and all that, so I was concerned about that [but] it seems to have brought us closer together quite a bit…We seem to hang on to each other all the time."* (Pieter)

Often, the bereaved informants' relationships with their family members were not characterised by strong connections and open lines of communication before the deaths of their loved ones, and the loss and subsequent grief served to emphasise existing tensions. Although in some instances, the death of a loved one brought the

family closer, it was more common that relationship issues within the family were magnified for a number of reasons - the difficulty in supporting others when hurting, different ways of grieving, experiences of isolation, expectations and role changes, and estrangements. As a consequence, most familial relationships were irrevocably changed and some did not survive the death of a loved one. In the following section, I discuss the support the bereaved informants reported receiving from their social networks.

The Provision of Support from Social Networks: Colleagues, Family, and Friends

All the bereaved informants wanted support after the death of a loved one. The informants recalled a number of supportive behaviours that were helpful, particularly in the days, weeks, and months immediately following their loved ones' deaths, such as telephone calls, visits, and being sent cards and flowers. Sometimes, the initial support was overwhelming. During this time, it was difficult for the informants to find time and places to be alone to process what had occurred, because they were receiving many visitors as well as being kept busy with organising the funeral and so on. For example, Patrick, his wife, and two children went over to Melbourne (where his father and brother died), to stay with his brother and nephew. His mother Sylvia was already there, resulting in seven people sleeping in a two-bedroom apartment. On top of this, friends were visiting them at the apartment to pay their condolences. Patrick said the only way he could get some time alone was to go for a walk. Di spoke of how she had to take the phone off the hook to get a break.

> *"…just in and out all weekend, we were just so flat out, we actually had to take the phone off the hook to get a bit of a break otherwise, you know, even on the Monday, we had people in and out even though we were out for the funeral."* (Di)

For many informants, an immediate concern was getting time off work. Heather, Brooke, Debra, and Maggie reported that their employers appeared understanding and allowed them to have some time off. However, their decision to return to work was significantly influenced by financial need, and most commenced work within a few weeks of the deaths. As Kugelmann (1992) stated, in a society "where time is money, grief cannot occur" (p. 44). George and Dawn both owned and operated their own businesses, and Nick worked for his father George. Being self-employed, and relying on

that income, they could not afford to take time off from work and consequently returned to work within days of their loved ones' deaths.

> *"At the time of Claire's death, we had a lunch bar so I couldn't just leave work, I had a business to run. I had almost no time off. I took the first few days off, but after the funeral I went virtually straight back to work… Sometimes I think that was a good thing, and sometimes I think it wasn't a good thing…"* (Dawn)

It is common for the workplace culture to avoid, ignore, and disenfranchise grief by promoting the notion that grief in the workplace is inappropriate or unacceptable (Eyetsemitan, 1998; Lattanzi-Licht, 2002; Stein & Winokuer, 1989). For example, bereavement leave is often minimal and tokenistic (e.g., Reynolds, 2002). Despite this, on the whole, the bereaved informants reported that their work colleagues were supportive. An explanation for the provision of support from individual colleagues, regardless of the workplace culture, was provided by Riches and Dawson (1996a) who argued, "bereavement discourses may be found in the workplace, but they are not *of* the workplace" (p. 154, italics in original). Lorraine found that her colleagues supported her by taking her out to lunch, asking how she was, making her cups of tea, and acknowledging her feelings. Jelena's colleagues showed their support by attending her brother's funeral, which she characterised as "*really, really helpful"*. Maggie described her manager as *"great"* and allowed Maggie to alter her job duties:

> *"I walked in the first morning [back at work] and she was like there at the door to meet me and I just burst in to tears straight way and she said 'let's go into my office and stay there until you feel you want to come out and if you don't want to come out don't come out, if you want to go home go home'. (Pause) I think I went home (laughs)! …and that sort of went on periodically for a little while. I didn't have to go out and face the customers, I was able to stay back in sort of the commercial part and just do the money and different things out there…but I didn't have to go and serve which was really good, and I could just go home and sometimes I just had to go, I just couldn't stay, I'd just have to go."* (Maggie)

In general, the bereaved informants reported receiving a range of supports from their social networks. The informants reported a number of instrumental support behaviours that they thought were helpful, including bringing food to the house for a number of days and weeks (Patrick, Sylvia, George). George stated that long-term friends of his family rallied around and devised a roster to provide meals for his family during the first three weeks following his daughter's death. He referred to this as being

like *"meals on wheels"*. Another of George's long-term friends catered his daughter's wake.

The informants also received assistance with writing death notices for the newspaper and organising the funeral services. Sylvia described how two friends helped her with arranging the funerals of her husband and son by assisting her with organising quotes from funeral parlours, choosing a funeral parlour, selecting photographs to be displayed at the service, and getting the order of services printed. Patrick spoke of how many people helped him and his family financially. In addition to a friend buying his plane ticket to Melbourne (where his brother and father died), Patrick recalled;

> *"…when I got to the airport in Melbourne after flying across, my friend said to me 'I know you're in financial hardship at the moment, things are really tight' and he put his hand in my pocket and he said 'just look after this. I don't want it back. I've passed the hat around and got this together and it's for you and the family' and I didn't think of it and it was about a day later I put my coat on and put hand in my pocket and pulled out $1500 from my pocket. So that's a lot of money. Even at the wake after the funeral, I had family members coming up to me saying 'we know it was really hard to get your wife and kids over'. One of my cousins who I hadn't seen in 25 <u>years</u> came up and put an envelope in my hands and it had $500 in it. He said 'this is for you and the kids, go do something nice while you're over here'. People were giving us money, it was amazing. Everyone came through."* (Patrick)

After the initial tasks such as helping with organising funeral services, death notices, housework, and meals, instrumental support continued in other forms. Maggie recalled that her brother organised the making of a cross to go at the site of her daughter's death. She found this helpful, and described it as, *"a really good cross actually he did a wonderful job, [it] stands out as soon as you come over the bend"*. Sylvia recounted that although packing up Ian's house was *"traumatic"*, Ian's company arranged to ship the stuff back to Perth at their expense. Pieter and Di received assistance in their investigation of the circumstances of the crash in which their son died, as they believe the police and coronial investigation was wanting (see also Chapters 6 and 7). Finally, the informants recalled that some people shared coping techniques and ideas of dealing with stressful events. For example, Lorraine described that;

> *"…one of the ladies [at work] was going through a divorce and she…told me this herb she was taking that, that helped calm her down so and she actually got me some and she said 'this is for you, you don't have to pay me for it' you know try that so that was helping…"*.

In addition to the visits, cards, flowers, and telephone calls in the days and weeks following the deaths of their loved ones, emotional support from within social networks often continued over time. Emotional support was provided in the form of listening to the thoughts and feelings of the bereaved informants and providing hugs and unconditional love. The informants really appreciated when people listened and allowed them to talk openly about their feelings. For example, Lorraine commented, *"I thought people would have said things to me, 'oh well he had a good life', and 'he had a long life', but nobody, not <u>one</u> person said that… They really listened to what I was saying"*. The informants said that talking about their loss and being asked questions was much better than being ignored, as it meant that their feelings were legitimised rather than disregarded or judged.

> *"My main support came from my church, my priest… I was…not realising how much impact that was having at the time. One day my husband said to me 'I don't know why you go to anyone else because whenever you are with her you come back with a sense of peace', and of course, obviously that would wear off again, but I was getting what I needed there. And what I was getting was her simply listening, and not making judgements, and not saying 'you'll feel better', and not trying to make me feel better, just listening to me… I had so many questions about God when this happened as well and…I was able to work through those issues with her… She gave me permission to be angry at God. She made me see that it is normal, and that I was allowed to feel that way."* (Dawn)

When people were interested and compassionate, it demonstrated that they cared about the loss suffered by the bereaved informants. Sylvia commented that, *"talking [about it] is like letting a valve go…"* and Maggie stated; *"…it's really difficult to bring up…you're not going to just start [a conversation]. That's why when they do ask you and they are actually interested in listening, it's really good. It does you the world of good"*. Often, just 'being there', physically and emotionally, was helpful.

> *"…there was some people that weren't afraid to just come and sit and cry with us. It was, because you don't have to say very much, I mean really having been there and experienced it myself there isn't anything you can say there isn't very much that you can say or do, you know to, to bring comfort in…but just being there is so comforting and so helpful, it <u>really</u> is."* (Karen)

There were some differences amongst the bereaved informants in regards to whether or not men were as empathic as women. Some (Sylvia, Debra, Pieter, and Sharon) thought that there were gender differences in giving and receiving support, with

men being more reticent to so do. Pieter remarked that women seemed more comfortable talking about their feelings, whereas men were more comfortable talking about the mechanics and 'facts' of the crash. Sharon thought that most men were apprehensive when it came to emotions, particularly older men.

> *"…my husband, …being a male and being from the older [generation], he hasn't been able to express his pain as much as what I can… He tried [The Compassionate Friends] but he said it wasn't for him, he's from the old school [where] you lock it all inside, and unfortunately Alex's younger brother who's just turned 28, he's a bit like his dad, he's held it all inside, whereas the one who's just turned 24, he was 14 at the time [of Alex's death], and he's been very open and we can talk openly about him so I can see he's further on in his grief whereas [my older son] to this day has never discussed, can't discuss Alex, and just finds it very, very hard."* (Sharon)

On the other hand, other bereaved informants (Joan, Maggie, George) said gender was not an issue. Instead, they thought support was more likely to come from people who were willing and able to be compassionate, regardless of gender. Maggie commented that, *"…people, if they've got it in them, are compassionate, whether they are men or women. Some women don't, some men don't, some do"*. George asserted that men often hid their feelings and acted like they were not as emotionally affected as women, because it is more socially acceptable for women to show their emotions. He stated, *"it's all outside. Inside they're hurting, well you know they're hurting as much… It's a sense of bravado…"*. In Chapter 6 I discuss the impact of individual differences in emotional expression has on whether or not a grief experience is considered legitimate, and how the stamp of legitimacy might ultimately affect the compensation process.

In addition to demonstrating empathy, it was considered supportive when people remembered the deceased loved ones. In Chapter 4 I demonstrated the importance that memories of loved ones were to the bereaved informants. Knowing that others cared about the deceased person assisted those left behind because they knew others also remembered their loved ones. It helped them realise that their loved one was important to others and would not be easily forgotten. The informants cited many examples where others remembered their deceased loved ones. Karen stated she *"was just so moved"* that the BMX club that her son Mikey belonged to had a minute's silence and a lap of honour for him. In addition, Mikey's school planted a little garden in the grounds as a way to remember him, and Karen was invited to plant a tree. Sylvia recalled that Ian's

work colleagues had their own memorial service where they planted a rose bush and a plaque. They also gave her a crystal bowl with an inscribed plaque at the centre. Often, others remembered the deceased loved ones on their birthdays or anniversaries of their deaths. The informants also commented positively on the number of people attending the funeral, the kind comments about the deceased that were said at the funeral, and regular contact from the friends of the deceased.

> *"The memorial service [at Ian's workplace], I was staggered… I noticed the flags were flying at half-mast. My mind was going, 'it's not Anzac day, what is it?' and when I got out of the car I saw the general manager and his assistant…and I said to them, 'I was wondering what day it was for the flags to be flying at half mast?', and he said 'they are flying at half mast in honour of Ian and Keith' (crying). That came as such a shock, you know? I felt so warmed, I suppose, by their thoughtfulness…"* (Sylvia)

Similarly, the bereaved informants appreciated it when people fondly recalled their loved ones. Sylvia commented that, when others talked about her deceased loved ones, *"you appreciate it because you know your loved ones are being thought of with joy"*. Likewise, Maggie noted, *"it's nice when people just tell you something [a memory of the deceased loved one], it feels like they haven't forgotten them, they actually do remember things"*. Debra noted that a friend continued to mention her daughter Kate regularly. She described it as *"beautiful because she still talks about Kate as part of us"*. Sharon said that, when people mention Alex, she is *"so grateful that they hadn't forgotten him"*. In Karen's case, some of her friends made an effort as a group to support her in remembering Mikey. She recalled that, *"it became like a monthly thing [where] we would go out together to one or the other's places and have coffee and just sit and reminisce…*". Having others remember the deceased was also considered supportive in Rosenblatt's (2000) study of bereaved parents. Indeed, Riches and Dawson (2000) wrote that others remembering the deceased, acknowledging important dates and anniversaries, and listening to stories about the deceased, are the "most thoughtful and affirming gestures a good friend can make" (p. 162). However, although they are appreciated, the informants said mentions of the deceased usually dwindled with time (Iris, Debra, George, Nick, Di, Sharon, Natasha, Maggie, Patrick, Joan, Kelly, Karen). As an exception, Lorraine stated she received continued support from her circle of friends.

> *"I've got about four…very, very close friends and we've been friends for many years and they are always there for me, so [the support] hasn't dwindled away, they haven't disappeared into the sunset… They still ring, like there's not a day goes by that one won't ring".*

Support from within social networks usually came from friends and some work colleagues. The bereaved informants discussed many different types of support they received from almost immediately following their loved ones' deaths and through to many months and years afterwards. Those in the social support network provided both instrumental (preparing food, assisting in making arrangements, providing money) and emotional support (e.g., compassion, listening, remembering the deceased). However, in most cases, the support from most people within the informants' social support networks diminished with time.

What struck me in engaging in the interviews was the disappointment and annoyance felt by the bereaved informants when discussing their social networks. In fact, when I asked them about the support they received following the deaths of their loved ones, some immediately spoke of who was not supportive. Consequently, in the remainder of the chapter, I concentrate my discussion on the ways in which the bereaved informants' social networks were not supportive.

Social Networks: Imposing and Enforcing the Dominant Grief Narrative

As discussed in Chapter 2, there are a number of key assumptions encompassed by the dominant discourse concerning the experience of grief. The bereaved informants encountered most of these assumptions. In this section, I demonstrate how those in their social networks imposed these assumptions onto the bereaved.

The first assumption is that grief follows a relatively distinct pattern regardless of the characteristics of the loss. The bereaved informants reported that people attempted to show their understanding but failed by making comments comparing the bereaved informants' losses to a loss they had experienced, for example the loss of a pet, such as a dog or even a budgie. For instance, Sharon was told, *"'oh I know how you feel, I lost my budgie three months ago'"* and George commented that family members, friends, and acquaintances *"…thought they knew how you felt, but nobody knows that"*. Similarly, other comments demonstrated that those in the social networks assumed all grief is the same, that grief is grief. For example, Natasha was told, *"I know how you feel, I lost my*

grandmother". Instead of being empathic, these comments showed they did not understand the grief experience of the informants.

> *"…when one of our mutual friends had lost her father and I went up to this lady and said, 'I'm really sorry for you'. I said 'I can't even begin to understand what it feels like, I almost lost my dad' and I said 'I know how horrible that was and how awful that was' and later on this friend took me aside and said, 'of course you know what it's like, you lost Mikey'. And I said 'but that must be so different. Yes I lost a child, I know what grief is like…but losing a son versus losing a father must be different' …and this woman didn't understand but she had the nerve to actually pull me up on that later and tell me off [saying] 'of course you know what it's like'."* (Karen)

Second, the assumption that grief is short-term and finite was also encountered on a regular basis, and again, these comments were very hurtful. The bereaved informants heard platitudes like, *"you'll get over this, you will be okay"* (Dawn), *"time's the great healer"* (Dawn and Sharon), *"come on, chin up"* (Dawn), *"you should be over that by now, that was three months ago"* (Iris), *"you'll be right, you'll get over this"* (Dawn), *"get over it, you've got a life to live"* (Jelena), *"are you still crying? It's been six months, hasn't it?"* (Natasha), *"haven't you gotten over that yet?"* (George), and *"just get on with it"* (Nicola and Dawn). Sometimes these comments were explicated within a short timeframe after their loved ones' deaths. For example, two days after her daughter Jess died, Natasha was told, *"…'Look, it's gone now, it's water under [the bridge]'…"* .

Similarly, some people minimised the loss to imply that the bereaved should be over their grief. For example, Nick said he sensed that people think he overreacted, Lorraine said that she got the impression that people were thinking she "*should be over it in two weeks",* and Karen said that many friends tried to push her son's death into insignificance. As an example, Karen shared that a friend had said, *"…there are legitimate reasons, or valid reasons, for being emotional and some people are just being silly or over the top"*. In an excerpt from their presentation to medical students, Natasha and Jim wrote, *"People think you have gone weird because we are still grieving after a short time"*. Many informants expressed anger at the ideas about how long they should grieve. Nick stated, *"I think I know how people are supposed to react…'get on with life because it's so fantastic'…but I'm not."*

Third, the bereaved informants reported encountering the assumption that grief is a linear process characterised by stages of shock, yearning, and recovery. In Chapter 4, I demonstrated that the bereaved informants described their grief as oscillation between emotions, and thus thought it was sometimes difficult for those around them to understand that they are not necessarily going to be miserable all the time.

> *"You were expected to be sad all the time. It was like sometimes people caught you smiling and you felt that you weren't supposed to do that. Nobody seemed to understand that it's powerful and it's horrible and it's all of those things, but there's still parts of your life that would occasionally make you smile."* (Kelly)

Fourth, the assumption that grief is a process that needs to be 'worked through', which entails grieving in a certain way with the appropriate emotional expression, was met by the bereaved informants. Some informants reported being judged because their experience of grief did not match what those around them expected. For example, Sylvia stated that, *"…my daughter-in-law suggested [I see] a clinical psychologist… The family felt that I should go to someone, because initially I couldn't cry."*

The fifth assumption is that grief culminates in the detachment from the deceased loved one and the sixth is that the continued attachment to the deceased is abnormal, even pathological. The bereaved informants came across both of these related assumptions.

Natasha and Jim, in their presentation to medical students, stated that they had heard comments like, *"if it was my child, I'd get rid of things and get on with life"*. Natasha recalled that a woman that was a close friend before Kim's death now thought Natasha had *"gone funny"* . Likewise, within the first few months of her daughter's death, Debra was asked, *"do you think you're doing the right thing by going [to the cemetery] so many times?"*. Iris stated that most people gave her the impression that she was supposed to forget Mary-Anne after her death.

> *"I can talk about either of my daughters or my son, and that's acceptable but don't mention that other one (Mary-Anne). It's like a dirty word. It's so hurtful. Why can't you acknowledge them? They were a real person, and more so with a child because there's nothing to show they were around, like if they'd had a family or a spouse or something."* (Iris)

In Chapter 4, I discussed the importance of photographs and belongings of the deceased are to the bereaved, because they facilitate their continued bonds with the

deceased and are the catalyst for talking about the deceased with others (Riches & Dawson, 1998b). Natasha and Maggie both had work colleagues telling them to remove photos from their work desks, and Natasha's sister attempted to remove the photos of Jess from Natasha and Jim's own home. By suggesting the removal of photographs, they were actually asking the bereaved informants to forget about the loved one because they were deceased.

> *"…when we were in New Zealand at the time when Jess actually died, [Natasha's sister] thought a good idea would be to go around our house and take every picture of Jess down off the walls so that it wouldn't upset Natasha when she came back in, and luckily we had a friend…who said 'I don't think you should touch anything on the walls, just leave it as it is', bloody good job too."* (Jim)

Finally, the bereaved informants also encountered the assumption that there is meaning in the death that can and should be found. The notion of meaning came in different forms; first, that the deaths of the loved ones were a part of God's plan. Example comments were, *"She's in God's hands"* (Natasha), *"God has a plan"* (Sharon), and *"God only takes the best"* (Jelena and Sharon). Both the religious and non-religious informants considered the religious clichés and analogies offensive.

> *"[People have said] a lot of religious things, 'she's in a better place', 'she's in God's hands', 'it was all for the best', [and] 'it was meant to be'. No it wasn't, if some frigging chap hadn't have drunk drove and rushed home that night, that wouldn't have meant to be, so don't give me that."* (Natasha)

Second, some of the bereaved informants were 'told' to focus on the positives from the deaths of their loved ones, which they also considered to be highly insensitive and offensive. They reported hearing comments such as, *"he wouldn't want you moping around…"* (Jelena), *" he'll never grow old, he'll always be young"* (Jelena), "*she was on holiday then, oh well, she died happy"* (excerpt from Natasha and Jim's presentation to medical students), *"oh you're lucky, you've got no children at home"* (Iris), and *"well aren't you lucky you had him for 20 years"* (Sharon). Natasha, Jim, Sharon, and Joan reported being told to focus on their remaining children, but, as Joan explained, "*at that time, the initial time, you don't care [that you have other children]"* . Rather than people understanding that the death of her grandmother in a crash was a significant and

traumatic loss, Brooke shared that many people told her to see the positives in her grandmother's long life.

> *"… the thing that used to really annoy me…was when people used to say, 'oh she had a good innings'…and at first I kind of thought, yeah, that's sort of true…and I remember thinking, '[if] one more person says that to me I'll crack'…"* (Brooke)

Third, the notion that there was a reason for the deaths was also considered to be offensive. Sharon, who at the time of the interview was involved at the executive level in The Compassionate Friends in WA and has advocated for changes in the coronial process (see Chapter 7), spoke of people telling her, *"Alex was meant to die so you could help others"* and *"make a difference"*. Likewise, Dawn stated that the idea her daughter died for a reason is, "*almost like she's being used as a sacrifice, and I can't cope with that, to me that's just not what it is about."*

Fourth, perhaps based on the notion that there is meaning in or a reason for the deaths, those in the social networks appeared to want to believe there is a reason, and therefore assign blame for the deaths. One meaning is that the loved one contributed to their deaths and thus deserved to die. George reported that, because of his daughter's age (17) and the (erroneous) newspaper report of the crash (see Chapter 6), some people assumed the crash was her fault. In addition, Brooke reported that;

> *"… a lot of people kind of assumed it was her fault 'cause she was old. A bit of ageism went on there you know a little bit, and so I found myself, like I even did it to you, like [always explaining] 'it wasn't her fault' you know what I mean? I found myself feeling like I had to justify that a lot and so did other people in the family…"*

Another way of assigning meaning is that the bereaved informants deserved the deaths of their loved ones. Karen said that, on a number of occasions, people have intimated or explicitly blamed her and her husband for Mikey's death. Iris recalled that she heard a friend comment, *"Iris isn't really a Christian, because if she was the Lord would be helping her and she'd have been over it long ago"*. Similarly, Dawn recalled that a woman had alluded to the idea that she deserved it because she is a strong person.

> *"One lady, which really surprised me, …she said 'God doesn't give us more than we can bear'. I just stood there looking at her, I thought, I couldn't even respond you know, it was like, what a stupid thing to say to someone (exasperated laugh).*

> *I really didn't want to hear that you know. I said 'I think he did this time' and I walked off."* (Dawn)

Finally, some people seemed to believe that bad luck caused the deaths and appeared to develop superstitions regarding the bereaved informants, especially in terms of the 'bad luck' being catching or contagious (see Riches & Dawson, 1996a, 1996b, 1997, 1998a; Rosenblatt, 2000).

> *"One woman came to me immediately, I think it was the day after [Mikey died] with…roses she had bought to plant in the ground…and…I asked her to come in and she said 'no I can't', she said 'I'm genuinely fearful that something might happen to my son if I come into your house'. I don't know, did she think I had like a bad spell set on me?… So I thought haven't heard that one before hopefully I'll never hear it again but that was, it was hurtful…"* (Karen)

From within their social networks, the bereaved informants were met with all of the assumptions within the dominant grief discourse, especially those concerned with the length of grief and finding meaning in death. Some of these comments occurred many years prior to the interviews, but were considered extremely upsetting and were recalled easily in the interviews. Thus, their effect was long-lasting and particularly hurtful, especially as they came from people the informants thought would be helpful in their time of need. These people, for the most part, probably thought they were being helpful unwittingly made these hurtful comments. It is evident that the notions concerning grief inherent in the assumptions from classical grief literature have penetrated society (see Center for the Advancement of Health, 2004; Foote & Frank, 1999; Lindstrøm, 2002; Murray, 2002; Payne et al., 2002; Parkes & Weiss, 1983; Rando, 1993; Rosenblatt, 1996; Walter, 2000; Walter, 2005-2006; Winslade, 2001), and affected the ways in which the bereaved informants' networks dealt with the informants' bereavement. In the following section, I discuss how the bereaved informants' social networks changed following the deaths of their loved ones.

Social Support Networks: Deterioration and Collapse

The bereaved informants reported significant and permanent changes in their social support networks after the deaths of their loved ones. Many relationships weakened, and there were a number of reasons of the changes. Most of the informants reported that the level of support from outside the immediate family dwindled relatively quickly over the days and weeks after the death, leaving them to grieve in isolation.

Sometimes, the avoidance was implicit, whereby those in the informants' social networks avoided making overtures in order to contact the bereaved, either by telephone or in person. For example, Di recalled, *"…all of a sudden people just don't ring you…"* and Jim said that many of his friends *"disappeared"* . Sylvia recalled that her own church minister avoided her for seven months, and when he did finally see her, he was *"uneasy"*. Sylvia described having to maintain contact with people, while coping with the deaths of her husband and son, as *"hurtful"* and Natasha described the lack of support as *"disappointing"*.

> *"…you do not wait to get an invite to a funeral, you do not wait to go around and say sorry, you do not wait to give a hug, you just do it, and that's all you have to do. These people that keep away, that is terrible, because we're not asking them to talk, just say 'sorry…and catch you later', that's all…"* (Natasha)

Some people gave transient or back-handed support by engaging in behaviour such as promising to call but not doing so. Usually, this type of 'support' was said and done by people thinking of their own needs rather than the needs of those that are grieving. Earlier in this chapter, I discussed the notion that words and actions were considered supportive when they took into account the needs of the bereaved. The bereaved informants reported that some people offered their 'help' but it was to suit their own needs. For example, Lorraine recalled that in the days and weeks after her father was killed and her mother seriously injured, her husband wanted to take her out to dinner, and a friend wanted to take her nightclubbing. Instead of helping, these people were adding to the distress because their actions demonstrated they did not understand, and potentially had not thought of, the needs of the bereaved.

The informants recalled that many of those in their social networks ignored or failed to acknowledge the loss, via avoiding the topic, appearing uncomfortable when the deceased is mentioned, attempting to change the subject away from the deceased and the events of their deaths, or avoiding these topics altogether. Patrick recalled that, when he told a friend at work that his father and brother had died, the friend, *"wasn't sympathetic at all to the way I was feeling, what I was telling him. He didn't <u>care</u>. He just didn't want to deal with it [and] I had considered him quite a close friend"*. Similarly, Iris described that people in her network avoiding mentioning Mary-Anne.

> *"…nobody mentions her name because they don't want to remind me. What makes them think I've forgotten? How ridiculous. And I can speak about my other two girls and my son, and that's okay, but if I mention Mary-Anne's name…they seem to panic and think 'how do I get out of here, she's just mentioned that terrible name'."* (Iris)

Some reported difficulties because they were not given a lot of sympathy. Patrick recalled that he, *"…was often asked, 'how's your mum coping?' You think 'well I've had a rough week', but I don't tell them"*. Nick reported that people were more supportive of his parents, particular his mother, than of him. He stated that, after his sister's death, people around him did not treat him, *"…any different[ly] at all…to how they would usually treat me… I don't think anyone asked me really how I was going. [They would ask] 'how's your mum going, how's you dad going?' They still do that!"*. He viewed this is unfair as he *"…was just as related to Kate as they were. And I knew her as long as they had."* (Nick). Surviving siblings are often overlooked, excluded, and unheard, leading to feelings of resentment. Riches and Dawson (2000) described the death of a sibling and the associated 'loss' of parents to their grief as a "double jeopardy" (p. 13) and an "invisible" grief (p. 78).

Sharon, Karen, Dawn, and Iris reported experiencing explicit avoidance, whereby people in their social networks physically and unequivocally avoided them by turning around and walking away, including long-term friends (see also Riches & Dawson, 1996a, 1997; Rosenblatt, 2000). Frequently, the avoidance occurred in public places, such as parking lots and shopping centres, where the informants had unintentionally crossed paths with those trying to avoid them. Iris and Sharon both commented that others are more likely to avoid people grieving the death of a child than another loved one, supporting Riches and Dawson's (2000) assertion that the death of a child is particularly stigmatizing.

> "*…people find the loss of a child more confronting than the loss of a spouse. Having lost two spouses I've noticed the difference. When my first husband died, people would come up to me in the street, pat me on the shoulder and say "how are you?". When Mary-Anne died my…friend told me that a friend Jill had said that she hoped she didn't see me, that she didn't know what to say… So one day I went to the shop…and all of a sudden I saw Jill, and knowing she didn't want to see me, I panicked. I went into a real panic attack. I had the trolley full of shopping and I left it where it was, got in the car and went home, closed up all the blinds, locked up all the doors. I felt as if I'd been caught doing something I*

> *shouldn't have been doing…and this was the difference. When you've lost a child, people will cross the road if they see you coming, it's as if it's contagious, and it could happen to them (exasperated laugh).*" (Iris)

Despite such reactions, the informants report that they did not easily abandon their relationships within their social support networks. Instead, they tried to maintain these relationships in two ways. First, the informants quickly began to realise that others are not supportive, not necessarily because they are uncaring, but because they do not understand the informants' experiences of loss, resulting in Riches and Dawson (1996b, 2000) using the term 'intimate loneliness' to describe the experiences of bereaved parents and siblings. For example, Natasha said, *"I know they can't understand because they've not walked in my shoes…"* and George said, *"you know that they can't be expected to know how you feel unless they've been in the situation"*.

The informants also understood that support is often not given because grief cannot be 'seen'. Maggie stated, *"you can't tell who they [the bereaved] are"* and Nicola stated that this is because grief isn't *"visible"*. Natasha commented that, *"Someone could not have blood on them but be really upset inside…and that's the trouble, unless they see blood they haven't got no [sic] sympathy and yet you're bleeding inside, your haemorrhaging…"*. Consequently, the informants spoke of the ways in which they tried to assist those in their network to understand and thus support them. Iris tried lending books on grief to some of her friends. When she first returned to work following Kate's death, Debra said she;

> *"…made the move, because [her male colleagues] just looked at me. (Interviewer – So what did you do?) I went up and gave one a hug. I just wanted them to know it's okay, because I knew that…if I didn't do that, they wouldn't know [what to do] and there'd be this feeling every time they walked past me as in what do I say to her?"*.

Likewise, Sharon said she used to try to help people put themselves in her shoes, by saying, *"…'just close your eyes and think that one of your children is never coming home again. You're never going to see them again. And that <u>may</u> give you a little inkling'…*". Joan described that she encouraged her friends to talk about her son Craig and let them know that it was more hurtful for them to avoid talking about him.

> *"I used to say to my friends 'I don't want you to not speak his name as if he never existed because he did'…and so I tell them [to] talk about him, carry on as*

> *not to be afraid to mention his name. He lived, and that would hurt me far more if you shy away from talking about him…"* (Joan)

Second, the informants recognised that repeatedly talking about their deceased loved ones can be *"depressing"* (Nick and Sharon), *"embarrassing"* (Sharon), and *"uncomfortable"* (Maggie) for those that are listening. As a result, the informants spoke of attempting to avoid talking about their loss and instead put on a 'brave face' in social situations, so as not to bring others 'down' all the time. Maggie said she almost never starts a conversation about her daughter, because, "*I don't know how, where do you start? Even after this you know, it's four years, I don't know, it's too hard to bring up there's still so much inside (crying). It's too hard. I can't do it",* whereas Joan described how she quickly learned to alter her behaviour and does not speak unreservedly about her son, in order to meet socially sanctioned norms concerning the expression of grief.

> *"You can't live your life showing your grief everyday, this is only me talking of course, it's the way I feel, because people will eventually get fed up and shy away from you [and think] 'I can't be bothered to go up there, all she talks about is blah blah blah and crying'. I didn't want that to happen to my friends, so I gradually eased off myself to them, more than them to me. What I did was, I tried to, was put myself in their position, if it was them, you know. And it's strange because I was at a barbeque about three weeks [after Craig was killed], and I was talking to a lady and someone she knew had lost her child. She said to me 'you don't go on about your son much do you?'. I said 'no, why?' and I knew what she was going to say. She said 'Oh, she drives me crazy. The whole conversation [is about her child], <u>every single time</u> you see her, and this has been going on for years. She drives everybody nuts'. So I learned that from a very early stage not to do it, by putting myself not in their position as such, but I'd think well would I want someone going on like that, every conversation you have? It's got to stop or peeter out sometimes doesn't it?"* (Joan)

Feeling as though they had to change their behaviour to fit the normative standard more closely so as to not offend those in their social networks was considered by the informants to be, *"…bizarre…it's very sad really, in one sense"* (Joan). Some purposively altered their behaviour so as not to seem strange. For example, Maggie commented that, *"…everybody thinks you're okay. Everybody thinks you're fine. Absolutely fine. Like I could just sit and yell at work, I'd love to yell but they'd just look at me like, 'oh God, she's gone off her nut' (laughs)!"*. However, others were aware that conforming to the normative standard created tension between the social 'mask' and the real self. For example, Debra commented, *"…on the outside…you look normal you put*

up a (trails off), you can have fun and you can laugh and stuff like that but on the inside especially when you're on your own it's different…".

> *"I think you just learn how to act, perhaps. Some people don't, they can't be bothered dealing with people like that, and I admire them if they can do that… I can't be like that. I don't want to hurt other people, and I'm just not hard, I'm just not like that. I think I care about what other people think too much, I care about what other people think about me too much, and I shouldn't. Why should you care? You can't go around worrying about what others think of you, and that's what I'm like still!"* (Maggie)

In spite of their attempts to maintain relationships with those in their social networks, the informants reported that many relationships collapsed completely, including family relationships and long-term relationships with close friends. The informants cited two main reasons for the disintegration of these relationships. First, the informants' priorities altered completely following the deaths of their loved ones – they were significantly less interested in maintaining a busy social calendar and instead wanted to spend more time with their families. As a consequence, they were more likely to have smaller, but more meaningful, friendship networks now.

> *"We used to be very social people, we'd have big parties 50, 60 people every birthday… The house we had, we didn't live in this house, the house we had had a big bar in it, swimming pool, 'entertainers delight'. After Jess died we haven't had a party since then, not even one. We don't have parties, that's finished."* (Jim)

Second, they did not view these relationships as supportive in their times of need. They said that, after the loss of their loves ones, they were able to slowly identify those in their circle of friends who were supportive and those who were not, a process also discussed by Riches and Dawson (2000). Dawn said she *"found out who my friends were…"* and Sharon said, *"you find who your friends are. The <u>real</u> friends."* The informants talked about the process of learning whom they can talk openly or *"freely"* (Joan) about the grief and their loved ones to and whom they could not. As Debra described, *"sometimes you can't even talk to your friends about it 'cause you think they're going to think 'oh no, here they come again and all they're going to talk about again what's happened to them'".* Iris recalled an occasion when two of her friends conspired to provide advice to her about helping her 'get over' her grief.

> *"…[a friend] rang me and she had this agenda…that I should put Mary-Anne behind me and let her rest in peace…and she was really giving me a lecture and she used terminology with me that somebody else from church has used just weeks before. They'd both been away at a camp together so I knew perfectly well that the two of them had had their heads together and that's what annoyed me more than anything. I don't call that person a friend now."* (Iris)

As a result, friendships are irrevocably broken. As Natasha stated, *"I haven't got any of those old [friends] now…"* (Natasha). Ultimately, some close and highly valued relationships were *"destroyed"* (Karen). As Debra declared, *"…you're trying to deal with the tragedy in your family and you lose your friends at the same time (sigh), though [it's] no fault of yours"*. However, real friends were those described as willing to listen to and empathise with the bereaved. The bereaved informants were able to rely on their true friends and be honest with them. As Patrick stated, *"A lot of people you call your friend, but when times get really tough, the true friends are the ones that rally around. Our true friends were there when we needed them, and they're still there"*.

As a consequence of the deterioration and collapse of their new social networks, the bereaved informants described the process of developing new relationships. Both Karen and Iris expressed having to find a new church at which to worship. Natasha reported that her current social support network *"are all different friends, there isn't one that's the same, [there is] not one the same that we had before Jess [died]…"*. However, the process of forming new networks was not easy. The informants described their attempts to seek new opportunities and develop new friendships but these overtures were not always reciprocated. Sylvia joined a number of social groups but described a number of incidents where she swapped contact details with people but nothing came out of it.

> *"I would dearly love people to ring me up and say, 'Sylvia I am going into the city, would you like to come and browse around?'. I have tried and tried to find avenues. I have joined the craft class at the Baptist church in Mt Pleasant… [and the] volunteer team at the Heart Foundation… If I say to them, 'how about if we go out for morning tea?', they are always ready. But it is me that does the initiating, and I would like somebody else to initiate every now and again, [to say] 'let's go to a movie'…"* (Sylvia)

The lack of support from family, friends, members of their church congregations, and work colleagues was considered particularly hurtful and insensitive and added to the distress felt by the bereaved. From within their social networks, the bereaved informants

experienced avoidance in numerous guises. Implicit avoidance included making overtures of support that were not followed through, avoiding contact with the bereaved so that the bereaved had to initiate contact, appearing visibly uncomfortable when the deceased was mentioned, avoiding the topic of the deceased loved one and/or changing the topic on conversation, minimising the bereaved person's feelings, a lack of sympathy. Explicit avoidance occurred when the bereaved were actively avoided when they encountered members of their network in public places. Thompson and Range (1992-1993) reported that people bereaved through accidents and suicide recalled more unhelpful and helpful responses from others. Their explanation was that people have difficulty imagining and meeting the support needs of the bereaved. However, Lehman et al. (1986) reported a close correspondence between the support needs of people bereaved through crashes and the perceptions of their needs as imagined by control participants. Silver et al. (1990) argued that those in the position to support the bereaved often feel helpless, vulnerable, and frustrated. As a result, they might engage in behaviour that is not supportive (i.e., dismissing the feelings of the bereaved by acting cheerful) and/or explicitly avoiding them.

The bereaved informants attempted to provide those in their social networks with information and suggestions to help them understand their experiences of grief. They also spoke of developing a social 'mask' in order to more readily fit in with their social networks. Despite these attempts, most informants reported social and emotional isolation. As a consequence, some of those in the informants' social networks ended their relationships with the bereaved. On other occasions, the informants severed the ties. In sum, the informant's social support networks changed irrevocably following the deaths of their loved ones in a crash, with many relationships deteriorating, and several completely collapsing.

Conclusion

Existing support networks were essential in providing support to the bereaved informants. The support provided varied, and included instrumental and emotional support (see also Chapter 7 for a discussion on accessing peer support). However, for the most part, the bereaved informants could not always access the support they wanted or needed from their existing familial and social networks. In addition, despite the

limitations of the dominant discourse in capturing the experiences of grief following a crash (see Chapter 4), the informants' social networks often imposed and enforced the dominant grief narrative, especially those concerned with the length of grief and finding meaning in death. Instead, the bereaved informants reported being ignored, judged, and avoided.

Although in some instances, the death of a loved one precipitated closer familial and social bonds, it was more common that relationships were irrevocably changed. Consequently, many relationships within the informants' networks deteriorated and collapsed following the death of a loved one in a crash. Ultimately, the informants were shocked and angered at the lack of support they received from those closest to them. Riches and Dawson (2000) proposed that the difficulties in receiving support might arise from the mismatch between 'mainstream' culture and the 'culture of bereavement'. Similarly, the "social ineptitude" (K. Dyregrov, 2003-2004, p. 23) of those in the social support network likely arises as a result of the lack of norms to guide them in encountering suddenly bereaved parents. Rando (1993) referred to the lack of response to and/or care of the bereaved as 'secondary victimization'. In the following chapter, I continue and extend on the bereaved informants' experiences that are not supportive, by outlining their experiences of voicelessness within the wider context, consisting of the legal, service, and road safety domains.

Chapter 6: The Experiences of the Bereaved in the Legal, Service, and Government Road Safety Domains: Voicelessness Over Authenticity

In Chapter 6, I outline the bereaved informants' experiences of voicelessness within the legal, service, and road safety domains. The chapter is divided into four sections. First, I discuss the legal conceptualisation of road crashes, which serves to minimise their psychosocial consequences. In addition, although conceptualised within the legal domain, crash fatalities are distinct from criminal deaths and therefore are rendered as more acceptable and less criminal than are other deaths. Second, I outline the current service system for people bereaved through crashes and demonstrate that service provision is reactive and superficial. I argue that the current service setting amounts to an abrogation of responsibility. Third, I demonstrate the medical model of service delivery is heavily relied upon. The power differential between service providers and those bereaved through crashes further subjugates the experiences of the bereaved. Fourth, I discuss the Western Australian government's road safety policies and practices and argue that the sole emphasis of preventing crashes further serves to silence those bereaved though crashes. The legal, medical, and government road safety domains all contribute to what I term a 'culture of neglect'.

In this chapter, I present the experiences of the bereaved informants within the legal, medical, and government road safety domains. These domains serve to delegitimise the experience of those bereaved through crashes and their voices are minimised. I begin by discussing the positioning of road safety, crashes, and fatalities within the legal domain. The legal conceptualisation is evident in the police investigation of the crash, the legal trial of the alleged offender, compensation and insurance claims, and the reimbursement of funeral costs. I then argue that the service setting is reactive rather than proactive and amounts to an abrogation of responsibility. In addition, the medical model of service delivery, which is evident not only in the medical profession but in the service setting generally, serves to render the voices of the bereaved as inauthentic and invalid. Finally, I discuss the government road safety domain, including its focus and education campaigns, which effectively silence those bereaved through crashes.

Road Crashes and Road Safety: A Legal Conceptualisation

In general, road safety and crashes are positioned within the broader legal domain. In WA, road safety is under the control of the Minister for Police and Emergency Services, Justice, and Community Safety (Road Safety Council of WA, n.d.). Further, the development of the Road Traffic Act (1974), and later, the Road Traffic Code (2000), brought all traffic under the control of the WA Police, therefore serving to conceptualise road safety as a legal issue rather than as a health and safety or social equity issue, as proposed by WHO (2004). In addition, the Road Traffic Act (1974) and Code (2000) are separate from the Criminal Code, and offenders are usually charged under the Road Traffic Act or Code rather than the Criminal Code, even when fatalities occur. Indeed, the perception of road users (particularly drivers) as individually responsible for road safety (see later this chapter) was the likely catalyst for the distinction between criminal behaviour and traffic offences, which were viewed "as a lapse of self-control…or a mistake in judgement which lacked the intent that was essential to criminality" (J. Clark, 1998, p. 6). Further, the hesitancy to legislate, particularly in terms of motoring restrictions, perhaps promoted the burgeoning motoring manufacturing industry in Australia (J. Clark, 1999b)[1]. As an illustration, Nick shared that the offender that caused his sister's death was originally charged under the Criminal Code with Unlawful Killing and Unlawfully Causing

[1] For example, the possession of licence was required for identification following a crash, rather than being an indication of driving competency (J. Clark, 1999b).

Grievous Bodily Harm. These charges were subsequently changed to Dangerous Driving Causing Death and Dangerous Driving Causing Grievous Bodily Harm, both in the Road Traffic Act (1974). The net result is that traffic offences are usually perceived as more acceptable and the offenders as less culpable than when compared to other offences deemed 'criminal' (Howarth, 1997).

The distinction between criminal and traffic offences is reflected by the community's apathy towards and complacency concerning the behaviours that potentially lead to crash fatalities, such as speeding, driving under the influence of alcohol and other drugs, and ignoring road conditions. In addition, there is the assumption that offenders will hurt themselves rather than someone else. In Chapters 1, 2 and 4, I discussed the notion that crash fatalities are usually preventable. Community complacency concerning irresponsible road-user behaviours and assumptions concerning the potential for harm provide reasons for why the crashes were not avoided. The wider community is complacent about crashes and the potential for injury and death. As a result, crash deaths and the behaviours leading to them are expected and accepted as par for the course (R. J. Gregory, 1998; Howarth, 1997; Mitchell, 1997a).

> *"…[the bouncer from the pub] put the [perpetrator] in the car, and the [perpetrator] couldn't get the keys in the ignition so the bouncer actually helped him put the keys in the ignition for him. But we can't prove it. But what upset me is that people watched, people didn't do anything, you know they just, I guess they thought 'oh he'll go drive into a pole', but he didn't…and I think if you saw that, why didn't you do something, you know, you could see how drunk he was, he couldn't even hardly walk, he couldn't even get out the car park and everybody just stood there and watched him drive out… I mean yeah, he could have just driven off the road and hit a pole, but he didn't; he drove into our kids."* (Dawn)

The community complacency and acceptability of crash fatalities is also reflected in the discourse surrounding crashes which fuel the notion that crash fatalities are acceptable, therefore rendering crash fatalities as less serious than other deaths (Ball-Rokeach et al., 1999; Howarth, 1997; Mitchell, 1997a; WHO, 2004). Although 'crash' is the official Western Australian government term to describe a vehicular collision and is favoured by others in an effort to question the assumption that crashes are accidental (see Chapters 1 and 2), the word 'accident' is more commonly used, even by most of the setting informants. However, despite the term 'accident' being part of the common vernacular, many (but not all) of the bereaved

informants avoided using the term because it implies that there was no cause of the crash and therefore the person that caused the crash is absolved of responsibility. The avoidance supports Stewart and Lord's (2002, 2003) assertion that the term 'accident' may be offensive to people bereaved through crashes because the word implies that the absolution of the suspect/offender is justified.

> *"I don't like the word accident. It wasn't an accident either; it was to me a traffic crash because [the perpetrator] was too damn impatient to let my son go past. And that's all it took, a few seconds, and he'd still be here today."* (Joan)

The term 'road rules' instead of road 'laws' suggests that they are flexible. The term 'road toll' implies acceptability by suggesting crash fatalities are a price we pay for vehicular mobility and serves to depersonalise the victims. As George stated, those that die *"are not just numbers"*. However, the notion of crash fatalities being 'statistics' was inadvertently promoted via an Australian 1960s road safety campaign slogan that warned, 'Don't be a road safety statistic' (J. Clark, 2004; J. Clark & Franzmann, 2002). Because of the discourse surrounding crashes, such as 'accident,' 'statistic,' and 'road toll', and the notions of acceptability of fatal crashes, some of the bereaved informants discussed what they consider to be a 'hierarchy' of deaths, where some deaths are tolerated more easily than others (R. J. Gregory, 1998). Many bereaved informants reported an impression that some deaths are considered to be more important that others, and that crash deaths are at the low end of the hierarchy.

> *"I know that people's lives don't really matter when they die on the roads. It's just an accepted part of society that…cars crash and people die [from crashes] nearly every day, but oh, it's a tragedy when a plane falls out of the sky (sarcastic)."* (Nick)

The relative unimportance of crash fatalities is also reflected in media reports of crash deaths and associated legal trials (Mitchell, 1997a; WHO, 2004). The bereaved informants thought that the media does not take crash fatalities as seriously as other deaths or news items. Media reports often use the terms 'crash' and 'accident' interchangeably, usually portray crashes as impedients to traffic mobility, and tend to depersonalise the cause of crashes, as though only vehicles or road conditions result in crashes (Ball-Rokeach et al., 1999; Mitchell, 1997a). In addition, media reports focus on the initial carnage aspect of crashes by showing graphic photographs of fatal crash scenes and smashed vehicles (e.g., Friedlos, 2004; Merrin, 1999), describing crashes with terms such as "spectacular" (e.g., Riseborough, 2004,

p. 20), instead of also focussing on their consequences on those involved (Ball-Rokeach et al., 1999). Finally, newspapers also indicate the relative unimportance of crash fatalities by the short length and inferior position of the reports (e.g., Road Death, 2005). All of these techniques serve to delegitimise the psychosocial effects of crashes and render crash fatalities as acceptable[2].

> *"When you have a major crash, irrespective of how many people are killed in the crash, you get [a newspaper story on] page 15 and a little bit about that big (makes a gesture with his hand of about 3-5cm)… It's just an accepted norm, and when you compare that to other areas of crime, there's no comparison… So the distinct focus [in media reports] is not on the trauma side of it, it's not on the bereavement side of it, it's not on the person that's maybe killed, maimed, injured and what's going to happen to them in life, it becomes a focus on all the peripherals that surround it…"* (Police Road Safety Section informant)

According to some of the bereaved informants, the acceptability of crash fatalities and the minimisation of the resulting psychosocial outcomes were evident in the police investigation of crashes. According to Tehrani (2004), compared to deaths occurring in air and train crashes or on other forms of transport, investigations into vehicle crash fatalities are "minimal and occur in an atmosphere where road death is regarded as an unavoidable outcome of a minor road traffic offence" (p. 362). Some believed that the police investigation was incomplete and identified inconsistencies in evidence. For example, Pieter and Di located four crash witnesses by doorknocking residents on the street on which the crash occurred. However, the police discredited three witnesses on the basis of factors such as age and the police stated that the fourth witness was not relevant to their investigation. In addition, other bereaved informants discussed their concerns about the police investigation, including the chain of evidence not being followed. Some reported problems such as the alleged offender not being breathalysed or blood-tested for blood alcohol content, despite these tests being mandatory in a fatal crash.

> *"…[the perpetrator] was never given a breathalyser, and it is compulsory by law that you should have a breathalyser within four hours of a fatal accident. Funnily, one appeared later on, about two weeks later and as my husband said, 'oh that'd be pretty easy to do one up on a computer' and she swore on the stand that she didn't have it, so there was no charges laid."* (Sharon)

[2] There are recent exceptions that do focus on the psychosocial aftermath of crashes. For example, Madden, (2005), Quartermaine (2005), and Spagnolo (2005).

Some of the bereaved informants thought the investigative process was skewed in favour of the alleged perpetrator. The bias was evident in the perception that if the police could not get a bigger charge, they did not appear to bother with smaller charges, so therefore no charges were laid. In addition, some of the bereaved informants thought that the investigation would have been handled more seriously if the deceased victim was considered 'important', rather than being an ordinary person, especially if they were young and had no dependants. In addition, consistent with the hierarchy notion discussed earlier in the chapter, some informants thought that the investigation would also have been more serious if the death was caused by something other than a crash.

> *"…one of the disappointments is the level of the investigation into this death because it was a traffic accident, as opposed to other type[s of] accidents and things…so I am pretty angry with the way things have happened, it's like somebody's life doesn't mean anything, and it upset me when the policeman got blown up in his car and they're all out for him, but [if it's] some innocent person, you can't get an answer anyway."* (Di)

The bereaved informants recognised that the role of the police is to investigate the circumstances of the crash rather than to provide support and counselling. However, they did suggest that the police could have better lines of communication and provide them with more information about accessing support. Some characterised the police involved in the crash investigation as unsupportive. They reported feeling powerless because they were not informed about the process of the investigation from the beginning. Instead of being informed of the circumstances of the crash by the police, some found out by reading the coroner's report or via the media. In addition, some reported that many police officers rather than one spoke to them, making it difficult to get consistent information throughout the investigative process. It is worth noting that police officers attending fatal crashes do not readily attend to the psychosocial needs of bereaved family members for a number of reasons, including being consumed with other tasks such as collecting information and evidence, detaching from the trauma so as to protect themselves, and a lack of training that would adequately enable them to attend to the psychosocial consequences of crashes (Hetherington, Munro, & Mitchell, 1997). Despite the negative experiences summarised above, other bereaved informants characterised the police as extremely supportive and empathic. They described regular and open lines

of communication between themselves and the investigating officers in regards to the investigation.

As a result of the police investigation, many of the informants' cases went to trial. The processes of a legal trial also highlight the acceptability of crashes and crash fatalities and the minimisation of the resulting psychosocial outcomes. The wait for the trial is exceedingly difficult for the families of those killed. While some trials occur relatively quickly, usually when the alleged offender pleaded guilty, others may take many months and even years. The bereaved informants reported that during the delay, their lives are on hold while waiting for the outcome and hoping for justice. During the waiting time, some informants attempted to prepare themselves for a negative outcome. The outcome of the legal trial has the potential to help the bereaved informants in their grief, if they perceive that justice has occurred. Otherwise, it has the potential to make it worse.

> *"It's the waiting that's horrendous because you can't let it rest until that is actually finished with and I think once the trial is finished…you can start healing and let things go, but…if he turns out to be told he wasn't guilty, I think that's going to be horrendous, it's just devastating."* (Heather)

The acceptability of crashes and crash fatalities is reflected in the way the bereaved informants' loved ones' deaths are dealt with within the legal system. The trial process is seen as contributing to the idea that road crashes are not as serious as other offences that cause injury and death. The bereaved informants stated that victim blaming, where the victim appears to be on trial, often occurred as a result of the adversarial environment of the trial. The deceased, whose reputation is damaged by attempts to assign blame onto them, cannot defend him or herself. The process of blaming the dead often began as early as the initial media reports of the crashes and continued into the trial. For example, Brooke thought that the perception of dangerous driving that led to her grandmother's death was minimised because she was an old woman. As a result, her life was devalued and the subsequent impact on her family was not regarded. In addition, the focus of the trial is often on the perpetrator rather than the deceased victim and/or their family, because crimes are against 'the state', rather than against the victims (Lord, 2000; Reiff, 1968, 1979).

> *"…the trial went for two and a half days so these two [perpetrators] got two and a half days to drag out…their story… The [prosecutor] got up, this is what happened, this is what happened, this is the witness, this is the other witness, everybody saw it, they did it, right and then…the rest of the two and*

> *a half days was [the perpetrators] trying to get out of the responsibility for what they did…"* (Brooke)

The bereaved informants described a lack of voice in the legal trial. As Reiff (1979) stated, the legal system's "primary interest is in processing the offender, and it views the victim as nothing more than a piece of evidence" (p. 76). Writing a victim impact statement is a difficult process, especially as the statement must be directed at the magistrate or judge and not the alleged perpetrator. In addition, only the person named as the victim is permitted to write a statement, even when entire families or even communities are affected. As a result, this process, which is supposed to allow the bereaved families a voice within the legal trial, is disempowering because the statement must be vetted and deemed 'acceptable' before being read, and it might not be taken as seriously by the court as the bereaved would like it to be. Thus, writing a victim impact statement is an emotionally risky investment and their voices within the trial process was highly controlled, limited, and tokenistic.

> *"…it is very hard to try to write what you are feeling, and of course I wasn't allowed to direct it at [the perpetrator], I had to write to the judge about what had happened so that made it really quite difficult… I did have to go and show it to [the] Victims Support [Service]. They had to tell me whether it was acceptable or not…"* (Dawn)

In addition to the process of the trial, the legal system contributed to a culture of acceptability through the penalties handed down to offenders. The sentences serve to minimise the perpetrator's culpability and devalue the lives of people that die on the roads. In some instances, the offenders had a record of previous traffic offences, but even in these cases the offenders did not always get a penalty that the bereaved informants thought matched the seriousness of the offence. Further, it was thought by some of the bereaved that the lenient sentences (such as fines) might encourage the behaviour and contribute to further deaths and injuries on the roads by sending a message that traffic offences are not considered serious, and thereby implicitly encouraging others to disregard the road laws. For example, in a four-hour period, a man lost 22 demerit points and was fined $700 for speeding, yet he still has his driver's licence (N. Taylor, 2005a)[3]. Another man with 16 convictions for driving

[3] Drivers have 28 days to pay infringement notices. After 28 days, a final demand is issued with a further 28 days to pay. If the fines remained unpaid, the licence is then suspended. The driver may contest the infringements in court (N. Taylor, 2005a).

without a licence had been banned from driving for life 5 times, yet received a $1200 fine and a suspended sentence for his 17th drink-driving offence (Kelly, 2005a). One month later, he faced his 18th drink-driving charge (Kelly, 2005b). Later that year, his brother was convicted for drink driving for the 19th time and driving while suspended for the 15th time and was fined $1500 and gaoled for 12 months (Kelly 2005c). Another man was recently banned from driving for life for the sixth time (Sixth Ban for Drink Driver, 2006). Further, some motorists drive home from court after having their licences cancelled (King, 2005). While a serious penalty cannot bring the deceased back to life, it would demonstrate the seriousness of the offence. Instead, penalties such as continual fines and numerous life disqualifications of driver's licences turn the system into a farce[4].

> *"I think [the perpetrator had previously] lost his licence for life three times. I mean how do you lose your licence for life three times? You lose your licence for life don't you? You don't keep losing it. I can't actually understand how that works… He got [a sentence of] 12 years [and] he's eligible for parole in six [years]… Because he pleaded guilty he got discounts… You wonder where the justice is in it all, but…we were told don't try and appeal because that's the longest sentence they've ever set down for a manslaughter, so the judge really had virtually thrown the book at him, even though it didn't look like that."* (Dawn)

As a consequence of the disempowering process and outcomes of trials, the legal system often deals an additional injustice (Lord, 2000; Reiff, 1979; Riches & Dawson, 1998a). Some of the bereaved informants reported a loss of faith in the justice system, and reported a growing sense of distrust in the legal system. The Victim Support Service informant echoed the notion of injustice related to trials concerning crashes.

> *"…what many victims of crime-related road trauma experience is a sense that our community generally and perhaps the criminal justice system in particular doesn't pay proper accord or attention to that type of offence, so sometimes, especially family members where a victim has died, will feel particularly aggrieved at the sentence that's handed down… If any other person was convicted of a crime-related death they would almost certainly and invariably suffer a penalty of imprisonment, but quite often what happens [in the case of crashes] is the judicial officers generally, magistrates or judges, may well hand down a non-custodial sentence…and that can sometimes cause victims to feel that the whole process really has been*

[4] The Western Australian government introduced anti-hoon laws in September 2004 to allow police to confiscate vehicles for 48 hours for a first offence of racing or doing burnouts. The penalties are more serious for subsequent offences (Miraudo, 2004) but the laws were criticised by a police superintendent as unclear (Darragh, 2005a).

> *trivialised by the final outcome… [For them] the process of justice hasn't been done."* (Victim Support Service informant)

The Criminal Injuries Compensation Act (1985) permits people to claim compensation for their injuries, including psychological injuries, which have resulted from an offence or alleged offence, and loss of financial support (a maximum of $50,000 each). However, those bereaved through crashes are not generally eligible for criminal injuries compensation under the act (Victim Support Service, n.d.). Providing that negligence of someone other than the deceased can be proved, the Insurance Commission of WA covers the repair or replacement costs of motor vehicles damaged in crashes. Claims for compensation resulting from crash fatalities are subject to the Fatal Accidents Act (1959). The Act covers claims for reasonable funeral costs, medical expenses of the deceased, and financial losses of relatives financially dependent on the deceased (Victim Support Service, n.d.), providing that negligence of someone other than the deceased can be proved. Thus, some of the bereaved informants were prevented from making a claim because their deceased loved one had no dependents. In addition, psychological injuries of relatives are not covered by the Fatal Accidents Act, but are covered in the Criminal Injuries Compensation Act. The separation of compensation acts again reinforces the notion that lives lost in crashes are less important or valued than those lost in 'legitimate' crimes.

> *"I think we were pursuing criminal injuries compensation for a little while. That was a big joke. A big waste of time…because killing someone in a car isn't a criminal offence apparently… We haven't been able to pursue <u>any</u> compensation (pause) in <u>any</u> way."* (Nick)

The experiences of the bereaved informants indicate that accessing reimbursement of funeral costs is not always straightforward. First, many informants were not aware of the entitlement. It is not mentioned in the brochure from the Office of the State Coroner. The entitlement is detailed in other booklets but these are not provided to every family (see next section in this chapter), whereas the brochure from the Office of the State Coroner is given to the next-of-kin. Some that did make the claim found out about the entitlement from friends who had previously made a claim, rather than from the Insurance Commission of WA or any other means. Second, the process of making the claim is difficult, because of the need to prove negligence on the part of an offender. Some of the informants reported that Insurance

Commission of WA initially tried to blame the deceased for the crash, despite another driver being charged. Despite the policy stating that claims are processed as quickly as possible, Heather stated that her family were waiting for the trial outcome before their claim is processed because the alleged perpetrator chose to plead not guilty. Thus, the fault-based nature of the system creates an adversarial environment that contributed to the difficulties of dealing with a loved one's death in a crash. In fact, fault-based compensation systems (like that in WA) have been described as "inefficient, costly and something of a lottery" (Lloyd-Bostock, 1997, p. 135). In addition, those that did get reimbursed for funeral costs found that making the claim was difficult, as the claims officer was cold and unfeeling.

> *"…I rang to speak to someone about it, and the girl I got was really, really, really cold and said…something about we'll just have to wait and see what they say and it will have to go through the normal process or whatever (said in a brisk tone, mimicking the girl). But she was really cold and I started to cry because I was talking about my daughter and she was just talking about a bit of paper, a claim, and it was so upsetting. I came off the phone in tears."* (Dawn)

The system of being reimbursed was considered unfair because of the financial implications that arise in a sudden death. Funeral costs are an expensive additional burden on the bereaved, especially when a death is sudden and unexpected, such as from a crash. In fact, one American study contended that the average burial costs over US$5000 (Banks, 1998). Some of the bereaved informants reported they could not give their loved one a funeral that honoured them because of the system requiring funeral costs to be paid up-front. In addition, in Chapter 5 I discussed issues concerning family dysfunction that can occur or be exacerbated by the sudden death of a family member in a crash. The reimbursement system intensified the family situation for one bereaved informant.

> *"[Getting reimbursed] created a rift in my family that is there to this day…[The insurance company sent it] to my mum's brother who didn't pay for [the funeral], my mum did, and he kept it and spent the money and six months later mum's thinking 'where's this bloody cheque', so she rang them up…and they sent her a copy of the thing, and so what happened was mum was so angry about it and plus it was only six months later and it was when she was sort of declining a bit then…so she tried to blame the insurance company [and] 'said I want my money back', and they said 'no we've already parted with it, you can go and you get it through the police through your own channels', [and] so lumped this other problem onto her that she really didn't need…but it was <u>their</u> mistake…and I think she got a cash advance on her credit card [to pay for the funeral initially] which was a <u>massive</u> amount of*

> *interest on a cash advance of that amount…and she thought 'stuff them'… So she charged her brother and his wife with fraud, they went to court, they were found guilty and they had to pay her it back at a hundred dollars a fortnight until it was all paid back and they don't talk and they never will ever again… The whole experience was a nightmare…"* (Brooke)

Some of the bereaved informants did attempt to make a claim via the Criminal Injuries Compensation Act. In making a compensation claim, the experience of grief is reinterpreted to fit legal discourses (Mitchell, 1997a). There is a narrow definition of trauma eligible for compensation, 'experts' must confirm the trauma (Wheat & Napier, 1997), and delays are common (Lloyd-Bostock, 1997). Joan reported that she was going to claim compensation but found the initial stages offensive, especially concerning having to prove the extent of her grief and the closeness of her relationship with her son. Consequently, she did not follow through on their compensation claim.

> *"…I was very raw and I just broke down. She said I'd have to go to a clinical psychologist…to measure my grief, how do you measure grief? How long you cry and how many times you cry? How do you measure grief? I was disgusted. Who can measure grief? So I've got to have someone sitting there on the other side of a table telling me how much grief I'm in?… They can't tell me how much grief I'm in. So I just said no, forget it, and that was that."* (Joan)

The notion that grief follows a distinct pattern of emotional expression means that differences in the expression of grief between individuals also impacts on the compensation process, because some people's experience of grief more readily fits the definition of trauma eligible for compensation. As I discussed in Chapter 5, men are sometimes reticent to discuss or openly display their feelings. Dawn explained that her grief experience was considered more traumatic than her husband's, because she openly expressed her emotions whereas he did not.

> *"…I have had to go through it on my own and it's been really hard. They just reckon [my husband] didn't show signs of posttraumatic stress disorder because he reacted differently to me, but I knew it was there. In fact, I knew in some ways he was worse than me. I knew it was going to come out… At the time it looked like he was holding himself together and he was obviously able to do that at that point. He got [assessed] like he's okay, but he wasn't okay, he was actually worse, and there is nothing that we can do now… They have realised now that he actually has posttraumatic stress disorder…but because the original reports have gone in, it might be too late to do anything about it. They have said that they'll see whether they can do what they call a token claim."* (Dawn)

Labelling Dawn's husband's claim as 'token' also served to further delegitimise his grief experience. Claiming compensation has a huge emotional impact. Grief is not a physical ailment and as a result, there is a possibility that the experience is more likely to be disqualified. In addition, the credibility of the bereaved might be questioned, as though they are on trial. They need to share their experiences in a potentially adversarial context rather than a supportive and understanding environment.

> *"…it has been going on for about two-and-a-half years now. I think we went after about six months. I just wish it was over because that has been (trails off)… I had to go through the whole series of events with the lawyer and then again with [two] psychiatrists…and then the lawyer's secretary. I had to go through my working life since I left school which took me through all the kids' younger years and brought all that back. It's been really, really hard and there have been times when I want to let it go and just say forget it… It's just so horrible going through it… Every time I go there I feel sick and so flat, I hate it."* (Dawn)

In attempting to claim compensation or launch civil cases over the deaths of their loved ones, the bereaved informants shared a fear that they will be seen to be profiting from their loved ones' deaths. Despite the ubiquitous misconception that those that make compensation claims are litigious (Lloyd-Bostock, 1997), a significant motivation behind the claims is to repair financial losses that occurred after the death of their loved ones, rather than making financial gains. For example, Dawn and her husband sold their lunch bar at a loss because, in their grief, they could not operate the business. In addition to financial reparations, an additional motivation behind compensation claims was honouring their deceased loved one (see also Chapter 4). The fear of being labelled as profiting from the death of a loved one prevented many from seeking compensation (see Rosenblatt, 2000). Instead, they spoke of the importance of the principle of the claim, being justice for the deceased (see Holst-Warhaft, 2000; Rock, 1998), rather than financial benefits.

> *"…we sued the government over my son's death because Main Roads[5] were to blame and in the case they had top lawyers; there'd be six of them. We defended it ourselves. And they threatened taking our house [saying] 'you're going to be penniless by the time we're finished with you, you don't have a leg to stand on'. And we won the case. They paid for Alex's funeral. We just settled, we wanted to clear his name. And the lawyer came up to us and said 'you fools. You could've made a couple of million off this'. And my husband*

[5] Main Roads WA is the state authority responsible for managing national highways in WA, as well as state roads.

> *said 'you still don't know do you? Money's not the object. We just want our son, and his name cleared, he's got two brothers and us, and we will fight for him'."* (Sharon)

Some of the bereaved informants that have been able to secure compensation felt the amount awarded was insulting and not worth the emotional cost of making the claim. Sylvia described the outcome of $4000 minus legal fees as *"…another slap in the face"*. For others, gaining financial compensation was a double-edged sword, because the money was a constant reminder of the death of their loved ones (Rosenblatt, 2000). Maggie reported feeling almost guilty for 'profiting' from her daughter's death.

> *"…we seemed to get money from everywhere… [Sally's employer] had a travel policy, so apparently they fought for us, we didn't know about this until later… Money just seemed to come from all over and it's been a bit of a nightmare really… You know where it's come from and it's just right there all the time… It was quite a bit of money… So part of this house belongs to Sally, and that was a really hard decision to make… I went back to counselling then for a while, to try and get another outlook on it because I was really stuck and I didn't know what to do, and I just remembered that [Sally] used to say that all the time, "buy a house, get a house", so that's what we did… I don't feel guilty, but I do think should I have given it away? Should I have given it to charity?"* (Maggie)

In the above section, I demonstrated the distinction between traffic offences and other crimes, evident in the separation of the Road Traffic Act and Code from the Criminal Code and the separation of the Criminal Injuries Compensation Act and the Fatal Accidents Act. These distinctions serve to reinforce the acceptability of crash fatalities and underpin the state-sanctioned complacency towards crashes and their psychosocial consequences. The acceptability of crash fatalities and the silencing/ delegitimisation of the resulting psychosocial outcomes are further reinforced by media reports of crashes and crash fatalities, discourses surrounding crash fatalities, the police investigation, and the process and outcomes of legal trials.

The Reactive and Superficial Service System: An Abrogation of Responsibility

In this section, I demonstrate that the current system of services and supports relevant to those grieving the death of a loved one in a crash is reactive rather than proactive. The Coroner investigates all deaths that are not natural or where causes are unknown in order to establish the identity of the deceased and the manner and cause of death. A component of the state's Department of Justice, The Coronial Counselling Service opened in January 1995 and consists of two counsellors and six

volunteer staff that act as companions during coronial inquests. The Coronial Counselling Service is situated within the Office of the Coroner in the Perth central business district. The counsellors are available everyday between 7am and 6pm. A counsellor might make one home visit (to people in the metropolitan area), but they usually meet with the bereaved either at the office or talk over the telephone. For those in regional areas, the consultations occur solely via telephone.

The bereaved next-of-kin are informed about the Coroner, the coronial process (including the post-mortem examination and organ donation), and the Coronial Counselling Service via a pamphlet (see Appendix L) issued by the police, on behalf of the Office of the State Coroner, either at the notification of the death or the identification of the body[6]. A key assumption is that the bereaved next-of-kin will keep the pamphlet for future reference. However, the bereaved informants shared that reading and understanding the pamphlet is difficult given their state of mind at the time, especially given the extent of shock, numbness, and changes in cognitive abilities a person that is suddenly bereaved is likely to experience (see Chapter 4).

> "*…you don't remember, you only remember certain things on that night and the days that follow and [the brochures] seem to be insignificant in that time in your life, you've got so much more to deal with. I read through [them] but I didn't follow it up, they seem too immaterial late that night to even think about… When they hand you the pamphlet, it's on the night [of the death]. You're very confused, shocked, and I don't even know what we did with it, I think I binned it not long after…"* (Debra)

In addition, there were others who reported that they had not heard of the Coronial Counselling Service. These included those whose loved ones died before the service came into effect or whose loved ones died outside of WA. However, Karen reported she was not aware of the service, despite her son being killed in WA after the Coronial Counselling Service commenced. There are two possibilities that explain her lack of knowledge. The first is that she was never informed, and the second is that she was informed but did not recall it because of her mental state at the time. She reported that the latter explanation is more likely, supporting the notion that follow-up support is required. The issue of not knowing of the Service and/or

---

[6] Other, more detailed, brochures have existed in the past but were not always in print, including during the bulk of the data collection phase of the current research (e.g., Western Australian Police Service, n.d.). The Victim Support Service (n.d.) book has been available primarily from the Victim Support Service since 2004. Chiefly aimed at assisting families where a loved one is killed violently (e.g., homicide), it includes information of a number of topics including grief, funerals, the police investigation, the prosecution process, support services, and compensation and insurance claims.

what the Service is for was also identified in a study of Western Australians bereaved through the suicide of a family member (Hillman et al., 1999).

An additional barrier is the name of the service. The term, 'coronial' in the service's name was identified as a barrier to accessing support because it has *"a feeling of coldness and (pause) death"* (Debra). In addition, some did not like the term 'counselling' in the service's name, as it suggested they had psychological problems. The name of the service and the information dissemination process likely contributed to some informants thinking the Coronial Counselling Service is located within a hospital mortuary.

A common misconception reported by some of the bereaved informants was that the Coronial Counselling Service provides a single counselling session only. Therefore, they reported that they did not access the service because they thought that one session would not be helpful. Interestingly, even those who did access the service reported this misconception. Dawn stated that she *"…went to the coroner's counsellor once, but that was only a one-off thing, that wasn't something I could do on a permanent basis. So that was okay, but I was still searching [for help]"*.

The Office of the State Coroner informant reported that the two Coronial Counselling Service counsellors are willing and able to see bereaved clients more than once but this information is obviously not well publicised. The lack of follow-up means that the onus in accessing support falls on the bereaved. The current model of service delivery assumes that the bereaved next-of-kin will read, understand, and keep the brochures and information given to them, and that they will be able to recognise their need for support and will have the courage to access the services. These processes are likely to be particularly challenging when grieving the death of a loved one, especially when the death is sudden and violent. The current process means that the bereaved do not always access the Coronial Counselling Service for assistance. Indeed, support is often not readily accessed by people when they are distressed, anxious, or traumatised (Tehrani, 2004). Di reported being blamed for not accessing the support.

> *"We got actually a pamphlet at the scene from the police but that was it, but then when I went [to the coroner's office] and saw the [coronial] file, one of the guys up there said 'well you could've rung in for counselling, we've got one here, working seven days a week', and I just sort of said, 'excuse me, we just lost our son, how can we (trails off)?'."* (Di)

The current model of service delivery relies on the next-of-kin informing other members of the immediate and extended family. The service model assumes that the relationships within the family are functional and will remain functional after the sudden and violent death of a loved one.

> *"I think one of the things we sometimes do is make assumptions that if you're trying to deal with managing grief, that you need support, and that at one level is absolutely true, but the support doesn't necessarily need to come from professional organisations or agencies… Support from those family and friends, that's always often the most powerful form of support…"* (Victim Support Service informant)

However, dysfunctional relationships between family members following bereavement are not uncommon (see also Chapter 5). As a result, both communication and the provision of support within families often suffers. Jelena described her family situation; *"…the communications in my family were, were pretty bad, okay, the grapevine just wasn't working, and I know that everybody was so caught up in their own grief. Nobody was telling anybody else anything…"*. Similar issues of family dysfunction and their impact on service delivery have also been outlined in the palliative care system (Fisher, 2003, in press).

Launched in 1992, The Victim Support Service is a component of the Department of Justice and provides information and support to victims of crime. Services include explanations of criminal and judicial systems, court preparation, court companionship, assisting in the preparation of victim impact statements, and short-term counselling to a maximum of five sessions. The staff is available throughout WA, and in particular, in at least one town/city in each of the nine non-metropolitan regions, ranging from Albany in the South to Kununurra in the North. In addition, trained volunteers provide assistance to bereaved family members during the legal trial. The bereaved informants appreciated the support from the Victim Support Service during the trial, especially from one of the 50 volunteer 'court-buddies', which guided them through and protected them from the system.

> *"We did have some back up…where they came to court with us, like a court buddy, and that was good because after the court case they took us into a room to try to avoid the media which was impossible so eventually we had to walk out into it, but there was some support there… I found we didn't actually understand the way he was sentenced. I came out of there not knowing what he had got. I couldn't understand it. I found that really quite confusing, and that's where these court buddies were really good because we were taken into a room and they went through it all with us…"* (Dawn)

Assistance from the Victim Support Service is not provided until charges are laid or are likely to be laid. The time lag is unique to crash fatalities and injuries, because of the potential for delay in determining whether or not an offence has been committed. Despite the delay in the provision of assistance, the Victim Support Service informant stated that timeliness in the provision of support is crucial, but it is significantly more difficult to provide such assistance when a delay has occurred. Thus, the system of support delays service delivery for some people bereaved through crashes.

> *"[The family would be] offered a service as soon as we were informed by Major Crash that charges were being laid… As soon as we receive a notification, we would send an offer of service to those people by letter explaining who we are, what we do, and that the service is available for them… The complicating factor with motor vehicle crashes is that quite often it is simply treated as an accident until such time as the Police have got sufficient evidence to indicate that charges ought to be laid. So we do have some situations that are fairly difficult for the families obviously in that there might be a need for quite intensive support but until we get a notification that charges are going to be laid, we don't become involved, so there is a bit of a gap there… That's a fairly critical factor, but one we have real difficulty in getting around because we don't have the mandate from our organisation to assist people who have been victims of accidental death."* (Victim Support Service informant)

Both the Office of the State Coroner informant and the Victim Support Service informant acknowledged that the coronial and criminal justice systems can be harmful and traumatic to people grieving the loss of loved ones. However, these services act as a conduit to manage the grieving person through the system rather than acting to transform aspects of the system that could be changed in order to reduce harm and additional trauma (see Chapter 7).

The Road Trauma Counselling Service provides a 24-hour telephone support service for people who have witnessed or been bereaved or injured in a crash. The service is available state-wide for the cost of a local telephone call. The service is provided by Lifeline, which delivers *"professional limited band aid counselling…for an initial crisis situation"* (Lifeline informant).

The catalyst for the development of the service was a double fatality on the South-West Highway in the Shire of Serpentine-Jarrahdale, approximately 45 kilometres southeast of Perth. A local resident, who assisted at the scene of the crash until emergency services arrived, later experienced severe anxiety related to

witnessing the crash and resulting trauma. As a result, Roadwise[7] decided to develop a state-wide support service aimed specifically at witnesses of crashes. The steering committee included a number of relevant stakeholders, including Roadwise, Lifeline, Shire of Serpentine-Jarrahdale, Department of Health, Coronial Counselling Service, WA Police, emergency services, the Insurance Commission of WA, and people bereaved through crashes.

> *"…the meeting was run by one of those power women; she was cute, she had the right coloured suit on, she was on her way to the stars, she was some sort of executive officer with road safety WA, had all the bloody interpersonal skills, the whole bit. Over the first three meetings, she had the ambos (ambulance officers), the coppers (the police), the fireys (fire and emergency services), and the coroner's office, all say it's not that simple, but she drove this bloody card with Lifeline's number and that would be this wonderful service. It isn't a service at all, and no, I don't use the card."* (Office of the State Coroner informant)

The project took a considerable time to develop, with meetings beginning in June 2000. The service was launched on the 7th December 2001. The committee developed a card (see Appendix M) that could be issued by police and emergency services to witnesses at the scene of crashes, as well as to family members, and also could be distributed via a number of points, including Roadwise committees, offices of general practitioners and counsellors, the Victim Support Service, hospitals, and the Royal Automobile Club. To develop the service, Roadwise contributed $5000 total funding, of which $3000 went to Lifeline for training of their telephone counsellors in areas specific to witnessing trauma and experiencing grief resulting from sudden and violent events. The remainder was used to print and disseminate the cards across the state. The intention was for the cards to be disseminated to police stations, general practitioners, emergency services, and so on, but the dissemination process took many months and was still underway when I interviewed the Roadwise informant in March 2003. Consequently, there was an additional time period before the cards began to be disseminated to the public, and the dissemination process continues to focus on supporting witnesses of crashes, rather than the injured or bereaved.

Lifeline consists of approximately five paid counsellors and 200 volunteer telephone counsellors. Training covers suicide, grief and loss, sexual assault, child

[7] Roadwise is the local government road safety strategy. It receives approximately 1.2 million dollars a year from the Road Safety Council.

abuse, trauma, some psychological/psychiatric disorders (bipolar, schizophrenia, post-traumatic stress, and personality disorders), and counselling skills. The small amount of funding meant that the training of the telephone counsellors was potentially not as thorough as it could have been. In addition to the telephone service, Lifeline developed a state-wide referral service of counsellors who provide their first consultation for free or for a reduced fee.

> *"[The money] certainly covered any out of pocket expense, but if I was to charge for training and so on, like you would in an external agency, then no, it wouldn't have covered it… I have telephone counsellors who are policemen, I have telephone counsellors who work in the coroner's office, [and] I have telephone counsellors that work with FESA (Fire and Emergency Services Association). I had them come in and do talks for us… Because I didn't have the money, I just didn't call people in to do the training…"* (Lifeline informant)

At the time of my interview with the Lifeline informant (February 2003), the Road Trauma Counselling Service was averaging about four phone calls per month. The small number of calls was attributed to the difficulty potential users of the service might have in making the connection between being in a crash, witnessing a crash, or losing someone in a crash, and the development of subsequent problems. In addition, the problems are often likely to surface after a number of weeks or even months after the crash, suggesting that the service needs to be advertised more broadly than just at the crash site.

> *"…the calls that we've had so far have been people who haven't quite been sure what's going on. They have witnessed or been involved in [a crash] and then another part of their life falls to pieces, either they start having relationship problems, they get in a car and manage to drive but get the sweats, or they lose their temper for no reason, and they ring up about that and then we go back and we find out [about the crash]… I think it's a catch 22. Most people that have just witnessed it or get involved or family members, they're actually really busy when it's happening. It's not for several months later that you may even identify that you've got a problem or something's happening…"* (Lifeline informant)

Lifeline has attempted to access further funding in order to develop the service but can no longer gain funding from Roadwise or the government in general because of the change to the government's road safety strategic plan (see later in this chapter). In addition, Lifeline needed to know the status of Roadwise's involvement, but the information has not been forthcoming. Instead, the further development of the

program has stalled, but Lifeline cannot develop the service without Roadwise's involvement because Roadwise own the program.

> *"I'm sure there's other places out there that if I wanted to I could perhaps get money from…but I need to know whether [Roadwise are] going to be a part of it and if they're not going to, then maybe we look for funding somewhere else…'cause I think it's a great program, I just (pause) I was just very naive through the process and I've learnt a lot through that process and I think that the people involved had all good intentions, I just didn't understand how that worked… I think it has the ability to take off, even if we had to set up a committee or something that did it through Lifeline and we left Roadwise out of it…"* (Lifeline informant)[8]

Based on a number of reasons, these data suggest that the service is able to provide limited support to people bereaved through crashes. First, approximately 20% of all calls get answered by a telephone counsellor, rendering the majority of calls unanswered. Second, the telephone counsellors possess limited training and skills. Third, the service remains largely unpublicised, and those affected by crashes prior to the launch of the service likely remain unsupported. Fourth, the service remains under funded, given its brief as a state-wide initiative. Fifth, the service is potentially not the most appropriate support service for people bereaved through crashes. Those that are affected by crashes are unlikely to frame their resulting issues as 'road trauma' or as resulting from a crash.

Roadwise, the WA Police, and the Town of Victoria Park initiated the development of a memorial in remembrance of those bereaved through crashes. The memorial is located in a small, grassed area between two very busy carriageways in the suburb of Victoria Park. The area is noisy, open, and surrounded by traffic, and therefore does not encourage quiet reflection. The memorial was launched 13th December 2002, with speeches by the Assistant Police Commissioner, the Chair of the Road Safety Council, the Police Chaplain, and the Mayor of the Town of Victoria Park. During their speeches, the Assistant Commissioner used the forum to promote police road safety campaigns and the Mayor sarcastically criticised the use of speed cameras in the local area. Consequently, their focus was not on the psychosocial consequences of crash fatalities (Hobbs & Adshead, 1997). Some informants questioned the motives of those that initiated the memorial. Debra stated that the impetus of the memorial was from an owner of a funeral company in the area who

[8] Roadwise went outside the strategic plan and their own grants committee process to grant the program an additional $5000 (C. Parker, Roadwise, personal communication, 20 March 2003).

was also on the local Roadwise committee, in an effort to promote the company. The Lifeline informant described the memorial as *"absolutely asinine"*. Further, a Roadwise employee stated that *"having the memorial is more important than people using it"* (C. Parker, personal communication, 20 March 2003).

> *"I stood at the back and spoke to someone who was very upset, for a few minutes, and I left. I just couldn't cope with it, either as a manager of a department who dealt with it or as somebody who's lost a family member [her brother died in a crash]. I just thought it was the stupidest thing I've ever seen… This was 'what are we going to do to make us look good this month. Here's a bit of land, we can't do anything with it, chuck it up [sic] near the park' and that was it, and I was offended on all accounts… I found it to be a publicity stunt…"* (Lifeline informant)

The bereaved informants thought there was more support for people grieving the loss of infants, or loved ones through cancer, suicide, and terrorism than crashes. Similarly, Nick thought that those in a crash or witnesses to it were considered more affected than those bereaved through the crashes. The lack of support services and networks for those bereaved through crashes contributed to the notion of community complacency rather than acknowledging the grief experience following crashes as legitimate.

> *"…no-one came up to you and said, 'look, here's all these people you can contact if you have trouble dealing with it'… [Having such support] might have said to me, 'oh we acknowledge that these things happen and they can be hard to deal with, so here's a bit of help'… I think the attitude is, 'if you're not in the car, you'll be fine. Just get over it. If you don't see it, or not directly involved in the crash, bad luck, get over it, life goes on'."* (Nick)

Some of the setting informants supported the notion that crash fatalities are not considered as important as other deaths. They described the manner in which support was mobilised for those injured and bereaved as a result on the Bali bombings on the 12 October 2002, in which 202 people were killed, including 88 Australians, 14 from WA, and many others were injured. For instance, the Western Australian government implemented a telephone information and counselling service and developed a support website[9]. There was a national day of mourning on 20 October 2002. In WA, there was a memorial service at Government House, a candlelight vigil, and a minute's silence led by the Governor and the Premier. On the

[9] www.bali.communitydevelopment.wa.gov.au

first anniversary of the attack, the Governor and Premier somewhat controversially[10] unveiled a memorial in Kings Park. Similarly, the state Government spent $15,000 creating a memorial to homicide victims housed within a memorial park in a northern Perth suburb (Law, 2004). Whereas impromptu memorials (such as most roadside memorials) are small, simple, temporary, and privately erected, sanctioned memorials (usually for war fatalities and statesmen), are planned, expensive, public, and legitimate (J. Clark, 2004; J. Clark & Franzmann, 2002, 2006; Haney et al., 1997; Reid, 2003; Reid & Reid, 2001)[11]. Further, the Office of the State Coroner informant described the efforts of government departments following Bali bombings as *"…a political area"*.

> *"…with the recent Bali tragedy, we offered a lot of training to a lot of Health Department staff on assisting…the victim's and their families and associated people who were associated with that, with the grief and loss issues associated with some of the people close to them that were killed in the Bali tragedy… The Office of Mental Health coordinated that support for mental health services to that, and that's still ongoing, that group's still meeting and looking at particular needs of the families of the Bali victims and looking at what support they might need…"* (Department of Health informant)

The setting informants relied on a 'circle of referral'. I have characterised the system of referral as a circle because eventually you get back to where you started from when following the circumference of a circle. Between them, the setting informants said they/their agencies/departments would refer on people grieving the death of a loved one in a crash to community mental health clinics, inpatient mental health facilities, general practitioners, community mental health nurses, Health Direct and Mental Health Direct (two telephone referral services run by Department of Health), Coronial Counselling Service, Victim Support Service, Lifeline (including the Road Trauma Counselling Service), private psychologists and counsellors, employee assistance providers, the Department for Community Development, the Disability Services Commission, and the vague 'support groups' and 'non-government organisations'. The indifference to providing support, wittingly or unwittingly, means that:

> …being eligible and entitled to certain government services does not assure victims that they will receive those benefits. In the first place, victims are not

[10] The Bali memorial in Kings Park was controversial because Kings Park houses war memorials. Some people thought that a memorial to civilians killed in non-war times was a slight against the memories of those fighting for Australia.

[11] To put the number of crash fatalities into perspective, almost twice as many people have been killed on Australian roads than Australians lost to war (Federal Office of Road Safety, 1998).

> likely to know exactly what they are entitled to. The difficulty lies in obtaining information… It is not usually to be referred from person to person without ever finding what you are looking for. (Reiff, 1979, p. 183)

The setting informants stated that they refer on when clients require bereavement counselling, or are developing relationship problems, or mental disorders. It is thus likely that the clients have to start their story again and pay for the additional support. Some informants stated that they refused referral on the basis of having to start their story again. Although some of the setting informants acknowledged the potentially prohibitive cost of support, the cost impacts upon the ability of bereaved people to access appropriate support.

> *"…particularly if you look at bereavement counselling, unless people can afford to pay for it themselves, the price they pay if you like is the amount of time they have to wait before they can be seen by anybody, so if somebody is referred to an agency like CAMHS (Community Adult Mental Health Services) or any other public sector organisation or non-government organisation that provides that kind of bereavement support, you're going to have to wait a while to be seen."* (Victim Support Service informant)

In addition, there appears to be significantly more support available for those employed in the service system (e.g., Major Crash officers) than for those grieving the loss of a loved one in a crash. The support includes the provision of training in order to deal with traumatic and emotional topics and events, psychological debriefing, and regular and compulsory 'check-ups' with psychologists. The support offered to those working in the system is proactive and multifaceted, whereas the support for people grieving the death of a loved one is reactive and superficial (Jeavons, 1997). Thus, the potential for psychosocial trauma is recognised for those working in the areas of road safety and crash fatalities, but not for those bereaved through crashes.

> *"…to actually become a member of the Major Crash Section now, you need to undergo a strict psychological test, which takes all day, …that's part and parcel of the application process. On top of that we've decided that every six months win, lose, or draw, our staff will be interviewed by a psychologist… I have to go, our secretary has to go, everybody in this office has to go and a <u>minimum</u> of once every six months… On top of that, part and parcel of our Diploma of Major Crash that we put together, one of the specific subjects is on stress management and the supervisors here are very watchful in relation to their staff and everybody looks after each other in here so we know what to look for and if somebody starts to go off the rails, we will take appropriate action."* (Major Crash informant)

The lack of follow up after these initial processes was considered by the bereaved informants to be a problem. They believed that information and support must be timely because the services lose contact with the families within 24 hours of the death occurring, after being notified of the death and identifying the body of the deceased. Some of the bereaved informants suggested a reminder brochure or telephone call would be useful without intruding on those who do not want support.

> *"It would be good if they did have more information or if there was a service where a couple of days later somebody could ring to find out how you were getting along in your family… If there's any help they could give you, just to make you feel like you were being thought about."* (Debra)

The bereaved informants stated they would have liked to have information provided to them in topics such as coping strategies, what to expect from a sudden and violent bereavement, and where to access support. They stated that they would like to have this information, ideally in a booklet, as soon as possible after their loved one's death. Many identified the need for a structured service for grief via crashes as the current system did not adequately support their needs. However, the needs of families bereaved via crashes were not generally recognised. Sharon commented, *"…what [the government] don't realise too, is for every one person that's killed, there's 10 that at a minimum are affected by that death. That's just the family, that's not the friends, that's the immediate family".*

Some of the bereaved informants supported the view of having a structured, funded, and state-wide service specific for crash-related bereavement. They thought that a specific support was required because of the characteristics of crash fatalities (see Chapter 4), shared experiences (e.g., coronial processes, police investigations), and gaps in current support system. In order to provide the appropriate informant and support, these informants thought that the assistance needed to come from others who understand the experience. However, others saw a role for additional support from people trained in counselling. The need for specialised service was recognised amongst some of the setting informants. Talking to others in similar situations led to a realisation that people who have lost loved ones in crashes have similar experiences (see Chapter 7). As a result, some of the bereaved informants believe a group solely for crash bereavement is necessary.

> *"…It's one of those things that you've got to be able to know that the person that you're talking to has been in the same situation as you…and know what*

> *they are talking about, otherwise it's what I call a pat on the back or a pat on the head and [they] say, 'keep your chin up'."* (George)

A structured and funded support service would legitimise the needs of people bereaved through crashes, especially if the service was provided under the auspices of a large government department such as the Department of Health. However, the potential for drawbacks was also acknowledged because a service enveloped within a bureaucracy is likely to lose touch with the psychosocial experience of people bereaved though crashes.

> *"…if its done by a government body, I think then the true feeling of helping those people may not be there, because if you've got the situation where there's a group set up in the community, which is accessible to most people and is staffed by people that really, really do care and have been there, …they would probably give the best help…but if it's in a government situation, it would lose, I think, that feeling…"* (Debra)

In this section, I demonstrated that the structured support available for people bereaved through crashes is reactive and superficial. With the legal focus applied to crashes and resulting crash fatalities (Mitchell, 1997a), it is not surprising that the psychosocial effects resulting from the deaths of loved ones in crashes are minimised within the support services. Consequently, the needs are not recognised and dealt with by those in the position to do so. The lack of coordinated, timely, and relevant information and support reflects the manner in which crash deaths are viewed by society, and thus reflects an abrogation of responsibility.

Structured Supports: A Reliance on the Medical Model

In the medical model of service provision, the helper is positioned as the expert and is responsible for the solution to the problem (Brickman, Rabinowitz, Karuza, Coates, Cohen, & Kidder, 1982; Newbrough, 1992). The term medicalisation describes the appropriation by medicine of aspects of the everyday life world (Zola, 1977). By positioning the psychosocial experience of grief within the medical domain, the experience of the bereaved is medicalised. Without the recognition that the experience of grief differs from person to person and is influenced by a number of factors, the physical experience of grief is privileged over the psychological. 'Symptoms' require 'treatment' as opposed to being viewed as normal consequences of a traumatic experience. With the view that consequences of bereavement are symptoms, grief is then positioned as a 'disease'. As a result, doctors often prescribe medication such as sedatives and anti-depressants to the

bereaved. The process of medicalisation can be bi-directional as the bereaved often feel that they require medication, at least at first. However, most of the bereaved informants made deliberate efforts to avoid medication and chose to deal with their grief experience in other ways, such as exercise, finding support elsewhere (usually from family members, close friends, and others grieving a similar loss, see Chapters 5 and 7), or 'going with' their grief. For example, Natasha stated, *"…if I can't get to sleep, I'm going to lie there thinking about her. I do not want to have props…"*.

The medical model underpins the delivery of health and social services. The medicalisation of grief is evident through the enforcement of the dominant discourse concerning grief. For example, the provision of short-term support (see previous section in this chapter) echoes the notion that grief is a short-term phenomenon. In addition, the setting informants used terms such as cases, clients, debriefing, phases or stages of grief, grieving process, recovery, and closure. Most distinguished between 'normal' and dysfunctional grief, and stated that professional advice, counselling, and medication is often required. Another stated that grief is synonymous with PTSD.

Some of the setting informants recognised that the grief experience is individual and depends on a number of factors. For example, most of the setting informants identified suddenness as a factor in determining one's grief experience. However, others did not see the importance of other factors such as the age of the deceased.

> *"…I always find it so bloody sad because it doesn't matter at what age [someone dies], it's an incredible waste. Like I'm now pushing 50 and will retire in about 10 years and I think I'm about to get to the best bit. I've raised my kids, it's going to be the two of us, we've got 10 years of good earning capacity maybe we can do a bit of travelling, and if I got wiped out two days after I retire after working my entire life to get all that super behind me, that's sad. That's just as sad as the young 17-year-old who's had his licence and dies within the first two days."* (Office of the State Coroner informant)

On the whole, the setting informants echoed and therefore maintained the dominant discourses concerning both the experience of grief and the acceptability of crash fatalities. Being treated as a 'case' or 'problem' rather than as a person is potentially dehumanising (Foucault, 1961; Freire, 1972). To illustrate, shortly after her daughter died, Iris went to a general practitioner for some assistance.

> *"…he asked what I was there for and I said my daughter had died and I was having trouble coping and I couldn't sleep and he said 'where is she now?'*

> *and I said 'in heaven'…and he said' 'well aren't you being selfish in wanting her back here?'."* (Iris)

The service setting is more likely to view the symptoms, rather than the systemic factors that serve to exacerbate the grief experience, as the problem. If the grief experience is different to the accepted norm, it has the potential to be problematised and labelled. For example, Nick shared that he had been misdiagnosed with antisocial personality disorder after a 10-minute consultation with a psychiatrist approximately 15 months after his sister's death. In addition, approximately four months after her son's death, Di telephoned the Coronial Counselling Service in order to get some answers regarding her son's death and the investigation process and instead was told by a counsellor at the Coronial Counselling Service that she needed anger counselling. The reasons for her anger were not recognised, and she received a hostile reception rather than compassion, understanding, and empathy. Natasha summed up the narrow focus by saying, *"…we're [considered to be] nuts now because we've lost somebody. We're not nuts because we've lost somebody, we're nuts because we don't get the right answers, we get lies, lies, lies all the time, that what we get"*.

Many of the bereaved informants reported that members of the service setting appeared uncomfortable about and unwilling to engage in a discussion concerning grief and emotions. The result was a lack of empathy and emotional support. The bereaved informants questioned the expertise of those in the service setting because they do not have the experience of losing a loved one in a crash. They recognised that the service providers have knowledge and skills, but sometimes these alone are not sufficient in providing support. Instead, they wanted service providers to listen and empathise rather than judge or advise. One of the bereaved informants attended a funded and expert-controlled support group for tragic loss, described by the Office of the State Coroner informant as *"shit hot"*, but did not find it helpful. Instead, her experience was minimised and she was asked not to return to the group.

> *"…when I got there they told me not to ever come again because they don't talk about [their grief], they talk about what they did last weekend, what they're going to do next weekend, and they all end with a big hug and wish everybody goodbye and go home, whereas I was sitting there and said 'who did you lose?' [and was told by the facilitator] 'Natasha there you go again' [and I said] 'I'm only asking who she lost'…so I said [to the person next to me] 'don't you like talking about your son or daughter? Don't look at [the others], we can talk, don't take any notice of what people say' [and was told*

> *by the facilitator] 'Natasha, this is a group discussion, not one-to-one my dear'. I said 'I haven't come here for this, I want to talk, I want to know how people feel and if I'm not going nuts and if people feel the same as me and did they get justice and things like that'. 'Oh dear' she says, 'I think you've come to wrong place, you're a bit overbearing, so we'd appreciate it if you don't come again'…"* (Natasha)

Dawn did not access a mutual help group for grief because a counsellor informed her that she might meet someone in the same state as herself and then discover that the other parent's child died many years earlier. This information discouraged her from accessing peer support. The advice, while probably well-intentioned and correct, promoted professionalised services over peer support. Natasha's and Dawn's experiences demonstrate potential outcomes of the appropriation of mutual help. The Office of the State Coroner informant stated that he would like mutual help groups to be funded so that they could employ 'professional' counsellors. He also believed that mutual help groups require more structure and need to be controlled by professionals to be truly useful.

> *"I do believe that there's a significant role for self-help. I don't believe that self-help in the grief and trauma area is not always as successful as we would hope because they…become a legitimate outpouring for people who still haven't moved through any grieving processes…and that's the danger of self-help."*

While certainly possible, the Office of the State Coroner informant neglected the possibility that those 'further down the line' might also provide models of coping and help to the newly-bereaved (Riches & Dawson, 2000).

The medical discourses were also evident during the coronial process. It is clearly a difficult experience to visit the mortuary to view a loved one's body. For some bereaved informants, it took some courage to view their loved ones, especially knowing that their bodies would likely be damaged. Generally, family members are allowed approximately one hour with their deceased loved one. Debra reported that she wanted to spend more time with her daughter's body but could not because a viewing of another body was scheduled. On the whole, the informants reported that no assistance or support was given to them while at the mortuary. They reported that the mortuary employees spoke bluntly and clinically about their deceased loved ones, or were seen having a joke amongst themselves. The Office of the State Coroner informant justified the behaviour of mortuary employees in the following manner:

> *"Now 99 per cent of the time the viewings are done by the techies (technicians). The techies tell them everything, but they tell them in a fairly distant voice… People get annoyed and say 'oh the techie was polite but he was very cold, very distant' and you can't say to a family 'well in about an hour's time he's going to put a Stryker saw through her head. He can't really afford to get too close to you'."* (Office of the State Coroner informant)

Prior to the introduction of the Coroner's Act 1996 (see Chapter 7), bereaved people identified and/or viewed their loved ones' bodies while separated by a glass window. Gatekeepers often resist people's wishes to view and touch the body in a misguided effort to protect the bereaved (Lord, 1996; Riches & Dawson, 1998a). However, the need to see and to touch the deceased is important in order to make sense of their death (see Chapter 4). Sharon described not being able to touch her son as *"cruel"*, a *"torture"*, and akin to *"a butcher shop window"*.

> *"I gave birth to my son and the first thing I did was hold him to my breast and we formed a bond. That bond didn't stop the day, the moment he stopped breathing; that bond was still there to kiss him and hug him goodbye out of this world. And the poor police officer is standing there [in the mortuary] with tears in his eyes saying 'sorry lady, but I can't let you do it'…and I said…'you can hold my hands behind my back, let me kiss him goodbye', and he said 'I can't, I can't let you in there'…and I just thought this is just so cruel, so dehumanising, that they've become dehumanised…"* (Sharon)

Unless over-ruled by their next-of-kin, crash victims undergo an autopsy because their deaths are not natural. Patrick described the autopsies on his father and brother as *"brutal"*. The procedure is referred to as a 'post-mortem examination' in the brochure from the Office of the State Coroner, which potentially makes the procedure appear less invasive. It is written in the brochure, "Some tissue and blood samples are usually retained for laboratory analysis". However, none of the bereaved informants reported being informed of the details[12], despite the brochure also outlining that "in some cases, it may be necessary for whole organs to be retained for a period of time for further examination. This may need to be taken into account when deciding on the funeral date". Some of the bereaved informants reported feelings of powerlessness resulting from a lack of information regarding autopsy procedures. The bereaved informants were not informed about the specific details of an autopsy, and often find out later that some of their loved one's whole organs were removed. Sharon stated, *"…[people] are told is 'tissue will be taken'. Now anyone*

[12] For example, brains are usually removed and are immersed in formaldehyde for three weeks before they can be examined. As such, they are not routinely returned to the bodies before burial or cremation, unless the family knows of the procedure and requests a delayed funeral service.

thinks tissue is like when they do a little biopsy. 'Tissue' is a hand, a leg, an arm, a brain, but people didn't realise this".

Some bereaved informants were suspicious about the autopsy process but did not seem aware that brains were taken. Others spoke of finding out much later via autopsy reports and/or the media that their loved ones' brains were removed. It was traumatic to discover later that their loved ones were cremated or buried without being 'whole'. As discussed in Chapter 4, the bereaved want to honour their deceased loved ones and this includes wanting to honour their wishes by cremating or burying them whole. However, they later find out that they did not honour their deceased loved ones because of the autopsy procedure and feel that their loved ones were violated. Further, they thought that those in the system would not do it to their own deceased loved ones.

> *"It made me feel that he was treated like an object, not as a person, not as my son. It's like they're treated as a non-entity. (Interviewer - A specimen?) Yes! Like for practicing on, or for study. And that's fine, if you give your permission. And who's to say that they have the right to do that? Who are these people? Where do they come from? It fascinates me where they come from and what goes on in here, in their brain. Would they do that to their loved one, their child? Their mother or their brother or their sister? Don't think so. I don't think they'd bury their's without their brain. And that's something else you have to deal with down the track. It never ends… As I say more and more and more, it's liberty taking, how dare they? If they had to ask for your permission, fine."* (Joan)

Finally, the medical discourses were also evident during the organ donation processes. Donor families tend to remain hidden while all the focus is on recipient. It is socially acceptable to donate the organs of a loved one and perceived as selfish to not donate them (Sque, Payne, & Clark, 2006), despite decisions to donate being underpinned by a number of concerns, such as religious questions, notions of the meanings of certain organs (e.g., the heart, eyes), respect for the donor, definitions of death, and distrust of the system (Hayward & Madill, 2003). Joan's son died at the scene of the crash so his organs in all likelihood could not have been donated, but to this day she blames herself for being too selfish at the time to think of the needs of others. In addition, it is not necessarily a comfort to have donated a loved one's organs. Organ donation has its disadvantages, particularly as the operation to remove organs occurs immediately after the next-of-kin gives consent, leaving a limited time to say goodbye to the deceased.

> *"…not even half an hour [after] I'd signed the forms, they whisked her away, I said 'where you going?', they said 'we've got somebody'. I hated that… That was terrible… I followed her down the corridor, to the operating theatre I wouldn't leave her right to the last second, and I gave her a big hug and a kiss before she went through the plastic doors, strips, and I just thought if she's not dead now she will be when she comes out of there, because she don't [sic] look dead, they're still breathing, her hands were beautiful white, little hands, and her skin was so soft and I was holding it all the time… That is one thing I do regret."* (Natasha)

Some of the bereaved informants were angered by the non-consensual removal of their loved ones' organs. They characterised the removal as a physical violation as well as a violation of individual beliefs. Sharon reported that the police attempted to excuse the unauthorised removal of her son's organs by arguing that she would not have known her son's wishes. Others described the requests for organ donation as coercive and uninformative. For example, families are often not told that the removal of organs occurs while the patient is still attached to the respirator (i.e., the brain or 'higher-brain' is dead but with a 'living' body; see Rodabough, 2003). In addition, the primary manner of becoming an organ donor occurs immediately after passing the driver's licence test, which generally occurs at 17 years of age. Two of the bereaved informants stated that the process was coercive and did not constitute informed consent. Some bereaved informants questioned the extent to which it is possible to get informed consent after the sudden and violent death of a loved one because of the resulting shock and trauma. Iris consented to the donation of her daughter's kidneys, but later discovered through reading the autopsy report that her daughter's liver and spleen were also removed. Iris also found out that the doctor who asked her to sign the consent form was from the transplant team and was not treating her daughter. Both Iris and Sharon believed in a conspiracy concerning the sale of organs for medical research and Sharon reported receiving anonymous phone calls informing her of the cover-up. The bereaved informants who donated organs reported feelings of loss and anger at being cast aside by the medical profession at the most vulnerable time. Iris stated, *"…we all just so thoroughly trusted them… They will promise you the earth until they get you to sign on that bit of paper…"* .

The bereaved informants considered the service providers' reliance on grief theories and medical discourses as problematic. They tended to view bereaved individuals as a homogenous rather than diverse group, and did not tend to reflect on the influence of contextual factors. As a consequence, the service providers often

attempted to 'fit' grief experiences to a theoretical framework rather than listening to the bereaved.

> *"[Professional helpers are] quite bound by the whole process of the therapeutic knowledge, of how a framework should be and move. It ties everything up, nice and tidy and you can think 'my job is done, I've moved them through, my job is done'. And that's the mark I think of someone who's a good counsellor as opposed to someone who's a good talker and listener, someone who's really good but doesn't control the process; they just let someone work through their own process [rather than being] bound by theory, and needing to always be in this tight little framework. Life's not like that… Theories are good and important, and they do give you some tools to use, but as long as you understand that's all they are."* (Kelly)

Assistance from professional service providers was appreciated when an independent perspective was needed. The best support came from those who did not take on the role of the all-knowing expert. Some of the bereaved informants recognised that some helpers within the service setting are starting to accept that others have expertise and knowledge that is worth acknowledging and listening to. Service providers that were compassionate, empathic, and attempted to think about the needs of the bereaved person in order to provide appropriate support, were considered helpful and they did not need to have experienced grief following the death of a loved one in a crash. Those service providers that did not rely solely on grief models were useful as they normalised experiences and feelings. They were considered helpful when they listened to the informants, allowed them to talk about their thoughts and feelings, and provided reassurance that their thoughts and feelings were normal. They gave them permission to express emotion and react the way they wanted to and needed to.

> *"Initially I couldn't [cry], tears just wouldn't come… This clinical psychologist…said we are all different. Although all along I felt that I was coping, [it was good] to have some reassurance there wasn't something worse, that I wasn't going to fall into a crumpled heap down the track."* (Sylvia)

In this section, I highlighted the service setting's reliance on the medical model of service delivery. The power differential between the 'experts' in the service setting and the bereaved as clients led to the experience of powerlessness and voicelessness, as the expert voice is considered truthful and valid. The experience of the bereaved is subjugated to the professionalised 'expert' knowledge and largely

rendered inauthentic. Thus, the viewing crashes through legal and medical lens minimises the psychosocial experience of grief (Mitchell, 1997a).

Road Safety in Western Australia: Bureaucracy, Rhetoric, and Education

Formed in 1997 and formalised under the Road Safety Council Act (2002), the Road Safety Council is the coordinating body for road safety in WA, and comprises representatives from Department of Health, WA Police, Office of Road Safety[13], Main Roads WA, Department of Education, Insurance Commission of WA, Local Government, Royal Automobile Club, Department for Planning and Infrastructure, and an independent chair (see Appendix D). The Road Safety Council develops strategies for road safety and the Minister for Police and Emergency Services, Justice, and Community Safety makes the ultimate decision.

The Council's charter is devised by the ruling government and embodies a primary prevention approach to road safety. The government's road safety strategy is a combination of education[14] and enforcement of road laws. The education and enforcement of road users, despite a lack of empirical support, are the two pillars of road safety establishment (J. Clark, 2000; Nader, 1965). Indeed, for many decades, road safety measures relied largely on appeals to drive safely (J. Clark, 1997, 1998, 1999b, 2000, 2002), despite being "nebulous, untargeted, and statistically unsuccessful" (J. Clark, 2000, p. 3). The bereaved informants supported the government's focus on enforcement and education but they also wanted recognition of the psychosocial effects of crash fatalities. Instead, the psychosocial impact of crash fatalities remains 'hidden' (J. Clark, 2004; J. Clark & Franzmann, 2002; Hobbs & Adshead, 1997).

> *"…[the focus] seems to be that the prevention of road trauma, which is very important, you've got to prevent it, …but when you mention post, as in afterwards for the victims, there doesn't seem to be the same lot of help and yet the amount of people that must end up having counselling, going to hospitals having nervous breakdowns, death in the family because maybe they've suicided because they're children have been killed, the ongoing ramifications would benefit the community monetary wise…"* (Debra)

[13] The Office of Road Safety has four responsibilities, which are to provide policy and strategy advice in regards to road safety to the government; develop and implement the mass media community education road safety campaigns; coordinate agencies' involvement in road safety, including the operation of the Road Safety Council; and financial management and accountability of government monies for road safety.

[14] The Police Service Road Safety Section was scrapped in October 2005 to make way for more 'frontline' officers. Road safety and bike education for school-aged children are now under the auspices on the Education Department (N. Taylor, 2005b).

The road safety strategy in WA is largely driven by political machinations. Elected to power in 1999, the previous Liberal-National Government in WA developed a five-year strategy that they intended would cover the years 2000 to 2005. However, the strategy was altered to suit the political requirements of the present Labor Government, which came to power in February 2002. Consequently, Labor's five-year plan (2003 to 2007) was implemented in November 2003.

> *"What [the Liberal-National party] didn't realise was that after two years the government was going to change and in came Labor. Being politicians, they looked at it and said 'we need a plan but we want it to be <u>our</u> plan' so what we had to do is basically go through a process of refocusing and relooking [sic] at it… So we didn't change the whole plan, because what you could say, was that one wrong? It wasn't, it was pretty right… Now, very soon, they're going to bring out their new strategy, under the Labor Government. I'm sure if they lose the election in two years time, we'll be doing the same thing again for the Liberal Party, but that's politics."* (Road Safety Council informant)[15]

Many of the bereaved informants believed that the government's road safety efforts are not 'strong' enough. Some of the bereaved informants referred to the government departments and agencies and departments associated with road safety as a *"bureaucracy"* (Jim, Debra, George), *"industry"* (George and Debra), and as *"toothless tigers"* (George). They reported incidents where the government appeared to submit to pressure from certain groups. In addition, they felt that that the government should emphasise road safety by providing more police cars on the roads to enforce road 'rules' and to charge those that do not obey the law, and should introduce legislation to allow speed cameras (Multanovas) on roads zoned at 50 kilometres an hour (almost all residential roads in the state)[16].

> *"…[the government road safety organisations] aren't strong enough… Michelle Roberts (Minister for Police and Emergency Services, Justice, and Community Safety)[17] has done that, she's done that <u>twice</u> by removing a very pertinent ad [sic] off the television, and that was because of the hotel industry… She overrides Police recommendations as in the no-tolerance [to speeding]… There are not enough Police on the road. We know for a fact that there are a lot of [police] vehicles…that are just collecting dust… We know*

[15] The Labor Government retained power, so the strategy was not rewritten.
[16] The speed limit on local residential roads in WA was reduced from 60 to 50 kilometres per hour in 2001. Multanovas are still not legally allowed on these roads.
[17] In February 2006, Hon. John D'Orazio was appointed Minister for Police and Emergency Services, Justice, and Community Safety while Hon. Michelle Roberts became Minster for Housing and Works, Consumer Protection, Heritage, and Land Information. In May 2006, Hon. John Kolbelke was appointed Minister for Police and Emergency Services; Community Safety; Water Resources; Sport and Recreation while Hon. John D'Orazio was relegated to the backbench following allegations of corruption (Corruption and Crime Commission of WA, 2006).

> *for a fact that the Multanovas can't [legally] be put on 50 [kilometre] roads, because they'd have to re-legislate to do that."* (Debra)

The government raises approximately 33 to 35 million dollars in revenue per year from speed (Multanova) and red-light cameras, and a third (approximately 11 to 12 million dollars) is given to the Road Safety Council for road safety (Road Safety Council, 2005) with the rest directed to general state revenue. Before and just after their election, the Labor Government promised to use all the cameras-raised revenue toward road safety initiatives (Robb, 2001a), but it still has not happened. It appeared to some of the bereaved informants that the government is more interested in raising revenue than being passionate about road safety. They reported that they would like all the camera-raised revenue to be used towards road safety initiatives.

> *"…[we were told by the Office of Road Safety] that it was better to have a lot of small agencies under the road safety umbrella that having one or two big ones, because they get more money to spend that way. I find that a little bit obscene because with the issue of the road toll and the numbers of people being injured on the roads, I have a problem with these people putting up their hand and saying yes we're going to put our snout in the feeding trough to get all this money and the road toll and the number of people being injured on the roads is not decreasing significantly…"* (George)

Instead of shared responsibility, the whole of government approach to road safety appears to have led to its diffusion in that no government department considers the outcomes of crashes to be a component of their charter. The Road Safety Council informant and the Office of Road Safety informant both stated that the health sector is responsible for the provision of appropriate services for those bereaved through crashes. Consequently, the psychosocial outcomes of crash fatalities are not 'owned'.

> *"…it's certainly not a priority for road safety to look at those sorts of [psychosocial] issues for those people, I guess because of the prevention side of it, but that I think that's a barrier, because who's going to pick up on that? Who's going to pick up on that side of it? So what I'm saying is, strategically it's not seen to be a priority area for road safety. It's probably not also for health… It's probably not well-recognised generally or well-understood."* (Roadwise informant)

Some of the setting informants stated their concerns regarding the experiences of those bereaved through crashes and stated the importance of providing appropriate supports to them. However, these platitudes appeared to represent rhetoric rather than a sincere attempt to recognise the psychosocial experiences of those grieving the death of a loved one in a crash. Instead, these

settings informants cited barriers such as the road safety charter and lack of funding to explain the government's sole focus on crash prevention.

> *"We might think 'oh we'd like to do this or that' but that's not my role because next thing we're going to have a bloody Royal Commission into spending because we went and bought flowers for everyone that's kid died or went and put crosses on the street or you know, a whole lot of things we get asked to do, and at the end of the day we have to say 'sorry that's not our focus'. Yes we agree with it, and we're quite happy to work with you, but we ain't gonna [sic] fund it 'cause it's not our business, our core business. Now the government can change it and add it into ours and then we'll do it."* (Road Safety Council informant)

Some of the bereaved informants were cynical as to the motives of government road safety employees. They perceived the motivation as being more about maintaining their employment rather than preventing deaths and injuries. They reported that those working in road safety move positions and government departments regularly, demonstrating a general lack of passion for or an understanding of the experiences of those bereaved through crashes, which has the potential to be harmful in situations where sensitivity is required. As a result, some bereaved informants reported they did not get the support they required from the departments and services that exist to provide it. Dawn provided the following example concerning a Victim Support Service employee.

> *"The first thing she said was 'well everybody makes mistakes'. This is like two weeks after [my daughters' death]. I know everybody makes mistakes, but I didn't need to hear that. I needed to hear that 'yes he (the perpetrator) has done the wrong thing'… She wasn't really sensitive to where I was and obviously she had been trained to work with offenders…I think that if they are going to be working with victims, they need to be trained for that. So I didn't find that helpful, obviously, at all. I did go back once more and tell her how I felt about what she said and she said she didn't mean it that way but that's alright to say after the event. So I didn't go back to there… I was quite disappointed, because…they weren't doing what they were supposed to be doing."* (Dawn)

As mentioned above, along with enforcement, a significant component of the government's road safety effort is the community education campaigns, which utilise television, radio, and print media. Under the umbrella of the mass media campaigns, the government develops support materials such as fact sheets and pamphlets, and implements smaller, targeted campaigns that supplement road safety messages, such as partnering with the Western Australian Country Football League to publicise the 'belt up' message. The campaign slogans focus on individual road user responsibility

and are simplistic (e.g., Slow down, save lives; Drop 5, save lives; Drink, drive, bloody idiot; Don't turn your break into a wake) and reduce road safety into a marketable product.

Consistent with the marketing of road safety to the people of WA, the Office of Road Safety employs four different advertising agencies. Three create and test the advertisements via conveniently sampled focus groups and the fourth monitors road safety attitudes on a regular basis. Other informants were critical of the development and evaluation of the advertisements and campaigns.

> *"…it's knowing what works best, what has the greatest impact, and I don't mean by recalling an ad. To me that's a false measurement. What you've got to ask the question is 'did this advert change the way you thought about an incident or a crash or speeding or driving tired?' not 'what was the colour of the hair of the bloke who sat on the left-hand side of the car?'… We spend lots of money on advertisements on road safety, lots of money, and I think a lot of that money could be put to better use so we argue, and my biggest argument was, is, what's the measurement of recall? What does that have to do with road safety? To me, that's a marketing ploy on behalf of advertisers to say 'well we did a good job because people saw my ad [sic]'… I think we've got to change that focus."* (Police Road Safety Section informant)

When community education campaigns largely avoiding the personalisation of crashes and their outcomes (J. Clark & Franzmann, 2002), they potentially distort the community's understanding of crashes. The physical nature of death and injury is portrayed via the depiction of blood, bruises, torn internal organs, Y incisions[18], and so on (Vivid Crash Images, 2005), despite the controversy surrounding the efficacy of fear-based campaigns (e.g., Elder et al., 2004). Within the campaigns, crashes are portrayed as culminating in deaths, whereas crashes are just the beginning of the experience for people bereaved via crash fatalities (see also Chapters 4, 5, and 7). In addition, the victims are positioned as secondary to the perpetrators, and the psychosocial effects of crashes, especially bereavement, are rarely shown or detailed. As a result of focussing on the physical outcomes of crash fatalities, the psychosocial experiences of the bereaved are silenced.

In addition, education campaigns, including those in WA, rely on a linear relationship between the dissemination of information and behaviour change (Road Safety Council of WA, n.d.). The Road Safety Council informant stated, *"…it's*

[18] The term 'Y incision' refers to a component of an autopsy procedure. Two incisions are made from shoulders and another lengthways along the abdomen. The incisions meet in the middle of the chest and allow the pathologist to access the thoracic and abdominal cavities.

about attitude. So we're changing attitude. If we can change poor attitudes on the road, we will reduce the death toll". However, education campaigns based on the relationship between information and behaviour change are usually mildly successful or unsuccessful (e.g., Cercarelli & Guilfoyle, 2005; Duperrex, Bunn, & Roberts, 2002; Elder et al., 2004) with some studies demonstrating that driver education programs was associated with high rates of crash involvement (e.g., Vernick, Li, Ogaitis, MacKenzie, Baker, & Gielen, 1998).

There are a number of reasons that likely explain the low efficacy of the interventions. First, mass media campaigns generally increase the perception of risk to others but not to self (e.g., Morton & Duck, 2001), referred to as the 'optimistic bias' (Weinstein, 1980). Second, drivers often overestimate their driving skill (e.g., Horswill, Waylen, & Tofield, 2004; A. F. Williams, Paek, & Lund, 1995), yet underestimate their chances of being involved in a crash (A. F. Williams et al., 1995). Further, many interventions, although well intentioned, do not meet the criteria of successful campaigns: careful planning and implementation, sufficient exposure to the target audience, and execution simultaneously with other interventions (e.g., enforcement) (Elder et al., 2004). In addition, the linear relationship between attitude and behaviour denies the complexity issues such as community complacency to and acceptability of crash fatalities, and factors involved in crash exposure, risk, and severity (Clarke, Ward, & Truman, 2005; Johnston, 1992; WHO, 2004). The advertisements are designed to focus on human error related to the so-called 'big four' (speeding, drink driving, driving without restraints such as seatbelts, and fatigue) (Road Safety Council of WA, n.d.) rather than sociocultural and political factors that might also contribute to crashes (Johnston, 1992; WHO, 2004). For example, it is easier to install speed controlling devices in vehicles that change attitudes towards speeding (J. Clark, 2002) and more politically 'safe' to focus on road users than introduce measures that are likely to be unpopular, such as compulsory vehicle speed limiters (Job, 1999). Consequently, the campaigns are predominantly focussed on what is easier to conceptualise and quantify but not easy to change.

Thus, the education campaigns are based on statistics rather than holistic representations of crash injuries and fatalities. Via the collection of demographic data of those involved in crashes, the advertisements are able to construct those at risk. These constructions influence the campaigns, road safety policy, and legislation.

Young male drivers are especially visible as the primary targets of the campaigns (Road Safety Council of WA, n.d.), as they are significantly over-represented in the injury and death statistics (Australian Transport Safety Bureau, 2003b; Legge, Kirov, & Cercarelli, 2001). Australia-wide, in 2002, 19.53% of fatalities were males aged 17 to 25 years (Australian Transport Safety Bureau, 2003b). However, an age and gender-biased strategy fails to account for older and women drivers that might also engage in unsafe and irresponsible driving behaviour (e.g., Darragh, 2005b; L. Eliot, 2005; Emery, 2005; Quartermaine & Kelly, 2005) and the 80% of fatalities that are not young males (Australian Transport Safety Bureau, 2003b). Perhaps then, the gender-biased strategy is another example of women being marginalised from motoring culture (J. Clark, 2002). Similarly, there are proposals to restrict young drivers' night driving, number of passengers, and demerit points (e.g., Kelly, 2005d, 2005e; Lampthakis, 2005). As a result, the advertisements and proposed legislation potentially demonise this specific demographic group, rather than the behaviour of poor driving.

> *"The ads are particularly targeted at young males. We're a gender-biased strategy in terms of that's where the biggest gains can be made in improving road safety. It's not to say that women aren't killed in crashes or don't cause crashes, of course they do, but it's the extent to which they're involvement is."* (Office of Road Safety informant)

Despite the tenuous link between education and behaviour change, the government's focus on responsibility is highly problematic. On one hand, the government takes the credit when the 'road toll' decreases, but on the other, it blames the community when the road safety message does not get through.

> *"…at the end of the day it's not our responsibility. It's our responsibility to provide the leadership and the resources through government. At the end of the day we need the community responses, community coming with us so it is an individual road user responsibility."* (Office of Road Safety informant)

However, the focus on individual road user responsibility has long been questioned (see J. Clark, 1997, 1998, 2000, 2002; Johnston, 1992; Nader 1965; WHO, 2004). For example, Johnston (1992) claimed,

> "…the road user population comprised sociopaths, underachievers, the infirm, children – the entire normal distribution of both skills and personalities – that exists in the population at large. If we can indeed convert the road user population to "responsibility" we will have unlocked the secret to curing almost all of society's ills." (p. 374-375)

Although some of the bereaved informants could see the value of the advertisements, they also acknowledged that the advertisements reminded them of what happened to their loved ones, especially their last minutes. They describe the road safety advertisements as traumatic, insensitive, offensive, and difficult to avoid. Some of the recent advertisements have utilised humour and sarcasm to promote road safety and bereaved informants found these advertisements especially offensive. Some thought that the advertisements were specifically derived from the circumstances of their loved ones' deaths. In recent years, television campaigns have depicted a young child being hit by a car and actors portraying drink drivers casually discussing causing a double fatality.

> *"I find the adverts…really offensive, especially that latest one that's out about the drunks. The worse thing is, and I am sure it's because ours was a double fatality, they go on about double funerals and I am sure it come from that and every time I hear it, it's bad enough as it is, and I damn well know it's come from that because they have only put them out since then…"* (Dawn)

The bereaved informants reported that the government ought to take crashes and their consequences more seriously. For example, some of the bereaved informants stated that the advertisements service only to further hurt those that are bereaved, as those who have not been injured or bereaved tend to ignore the road safety message. Many of the bereaved informants thought that personalisation is the key to behaviour change on the roads; that a person's behaviour will not change until someone close to them is injured or killed in a crash. For example, Dawn thought, *"[People] just think it happens out there (gesturing away from her body), it happens to everybody else…[so] it's not their problem…"* and Debra commented that people have this idea that crash deaths are *"going to happen but it's not going to happen to them"* . George discussed the effect of personalisation on his own driving behaviour:

> *"… if it didn't happen to Kate we probably wouldn't have thought too much about road crash, and probably still driven 10 [kilometres] over the speed limit everywhere else, same as everybody else does, until they are involved or have one of their loved ones taken away from them by a road crash."*

As a result of community complacency, some of the bereaved informants argued that the mass media campaigns should emphasise the psychosocial effects of crash fatalities, a notion supported in the literature (e.g., Morton & Duck, 2001).

> *"I would prefer them to do something like everyone sitting around a Christmas table and have one blank space there, and [have someone say]*

> *'Gee it would nice if Jarrod was here this year. If only he hadn't been drink driving', or something like that."* (Sharon)

As I discussed earlier in this chapter, the conceptualisation of crashes and crash deaths as legal issues rather than health or social issues has the potential to fuel the notion that the psychosocial outcomes are not important (Mitchell, 1997a). The bereaved informants stated that people are more worried about getting caught making traffic offences than about hurting themselves or others. For example, the road safety strategy includes tactics such as the police launching road safety campaigns and greater penalties (fines and loss of demerit points) during long weekends. The emphasised role of the police in the road safety campaigns reinforces both the legal conceptualisation of crashes and penalties. The bereaved informants stated that, if the campaigns reduce the number of crashes, it is because of the drivers are avoiding penalties rather than thinking about the potential psychosocial outcomes of their behaviour.

In addition to changing the focus of the advertisement campaigns, the bereaved informants suggested a number of additional road safety strategies. Their suggestions tended to emphasise systemic changes that focus on sociocultural forces behind crashes. For example, despite their calls for stronger penalties to correspond to the charges, they do not want extreme punishments. Instead, they want punishments to reflect a greater recognition of the psychosocial outcomes of crash fatalities so that road safety is taken seriously. Some suggested that offenders should attend a seminar where people injured and bereaved through crashes could talk about their experiences. An additional idea concerned the vehicle manufacture industry, which currently is allowed to self-regulate vehicle advertising, despite advertisements emphasising power, speed, and aggression being implicated in the death of a man in a crash (Car Death Judge, 2003). Various advertisements show vehicles racing fighter jets, jet-powered vehicles, and bullets (Robb, 2001b). Some of the bereaved informants would welcome the introduction of legislation that would encourage vehicle manufacturers to emphasise safety rather than power and speed in the design, manufacture, and marketing of vehicles, a move which is also supported in the literature (e.g., Johnston, 1992; WHO, 2004). For example, Lorraine commented that, *"…all these Commodores they have speedometers down to 200 [kilometres an hour]… I think that…all cars should have a limit, a certain speed you*

can ride…". However, the bereaved informants' suggestions would likely attract more controversy than the current campaigns, which are relatively politically 'safe'.

In this section, I demonstrated that the government's political machinations, rhetoric, and the sole emphasis on crash prevention serve to delegitimise the psychosocial experiences of those bereaved through crashes. Reminiscent of the legal and service settings, the government road safety domain renders people bereaved through crashes voiceless.

Conclusion

In WA, crashes and their consequences are positioned largely as legal issues rather than as health or social issues. Therefore, while the Western Australian legal system is equipped to deal with crash investigation and the conviction and sentencing of offenders, it is unable to deal with the ongoing psychosocial effects resulting from crash fatalities. Positioning crashes as legal issues demonstrates a poor understanding of the psychosocial effects resulting from losing a loved one in a crash (Mitchell, 1997a). As these data demonstrate, the legal aspect is just one component of the bereaved informants' experiences. The bereaved informants were often given additional support during the legal trial (e.g., Victim Support Service court companions) because of the privileged position of the legal trial within the bereavement experience. However, this level of support does not exist outside of the legal domain, again serving to privilege the legal discourses surrounding the experience while silencing other aspects of the experience. In addition, the psychosocial experience following crash fatalities is further minimised by their distinction from 'criminal' deaths. As a result of the legal conceptualisation, the psychosocial experiences are marginalised and rendered invalid and inauthentic, and are silenced.

I further propose that the current service setting for people bereaved through crashes is reactive and superficial, thus amounting to an abrogation of responsibility, illustrating Opotow's (1990) notion of moral exclusion, whereby the needs of the bereaved are deflected and the responsibility of the service setting is circumvented. Reiff (1979) wrote of post-crime victimisation to describe the injustices that occur after the crime, such as the lack of access to information or compensation. Rodger (2005) described how the bereaved have to negotiate a "maze of officialdom" (p. 178). Reynolds (2002) proposed that the disenfranchisement of grief within social policy is a form of psychosocial oppression. Similarly, Tehrani (2004) used the term

sanctuary trauma to describe the lack of support, or even malevolence, from those in the system that would be reasonably expected to assist. Despite the expectation of being able to trust the legal and service settings, the reality suggests that the legal system, service settings, and the government together form a 'culture of neglect'.

In contrast to the bereaved informants' construction of grief (see Chapter 4), the setting informants' generally reflected the dominant grief discourse and as such exhibit a superficial understanding of the experience of losing a loved one in a crash. Not only is there the likelihood that the dominant narrative concerning grief will be enforced by family, friends, and colleagues (see Chapter 5), I demonstrated that that the legal setting, service providers, media, and government departments also serve to enforce it. In addition, the application of the dominant discourse within a medical model of service delivery maintains and reinforces the asymmetrical power differential between service providers and the bereaved (Albee, 1992; Brickman et al., 1982; Gergen, 1999; Illich, 1977; McKnight, 1977; Newbrough, 1992; Prilleltensky & Nelson, 2002). Consequently, expert knowledge is privileged while the experience of the bereaved is subjugated (Foucault, 1961; McKnight, 1977). Ultimately, the bereaved are removed from the scope of justice (Opotow, 1996) and the responsibility of the service setting in providing assistance to them is abrogated.

A cultural shift is thus required to provide appropriate support for those affected by the consequences of crash fatalities. Crashes and their consequences need to be recognised as a social issue, but doing so would require massive change in the legal system, service setting, and government policy. Currently, there is a lack of political will to remedy the situation. The current whole-of-government approach means that no department 'owns' the consequences of crashes, thus leading to a situation of state-sanctioned acceptability of crashes and complacency concerning their outcomes.

Chapter 7: Acts of Resistance: Breaking the Silence of Grief Following Crash Fatalities

In this final results chapter, I discuss the bereaved informants' attempts to resist the dominant discourse concerning grief (see Chapter 4), its enforcement within their social support networks (see Chapter 5), and the conceptualisations of their experiences as held within the legal, service, and road safety domains (see Chapter 6). These acts of resistance occur in three spheres – the 'inner world', accessing peer support, and the political realm. The chapter is divided into three sections. First, I discuss acts of resistance that are primarily cognitive and private, such as filtering hurtful comments, learning to rely on themselves, and accepting their experience of grief. Second, I discuss the bereaved informants' attempts to access support from others with similar experiences. Third, I discuss the experience of the bereaved informants who have entered the political realm in order to 'break the silence' by voicing their experiences and advocating for greater awareness of the psychosocial experiences resulting from crashes. Additional barriers to each of these acts of resistance are discussed.

My purpose in Chapter 7 is to outline the various acts of resistance engaged in by the bereaved informants. In describing the informants' attempts to effect change, I have chosen to use the term resistance rather than empowerment. The concept of empowerment implies a linear relationship between the transfer of power and/or knowledge and resultant behaviour change, but in reality, the relationship is not that simple. Empowerment has also been criticised for being a middle class concept that is often used uncritically in health and welfare domains (Baistow, 1995). Resistance is an alternate term because is does not imply the bestowing of power from one group to another.

In Chapter 4, I discussed the notion that the dominant discourse concerning grief influences the ways in which the bereaved are constructed, as well as their constructions of themselves. Fortunately, the power enabled by dominant discourses is not fixed; instead, they can be challenged by acts of resistance (Foucault, 1961; Freire, 1972; Prilleltensky & Nelson, 2002). Alterative discourses, or normative narratives (Rappaport, 2000), continually threaten dominant discourses, and possess the potential to challenge discourses legitimised as 'truth'.

Resistance weakens the processes of subjugation toward liberation (Prilleltensky & Nelson, 2002) and, in the data reported in this thesis, is evident in a number of domains – the personal domain, in terms of how the bereaved see themselves; the interpersonal domain, or how they present themselves to others; and the systemic domain, in terms of advocating for and creating change. The acts of resistance engaged in by the bereaved informants can be conceptualised as representing a continuum, ranging from private and internal thoughts for purposes of protection to conscious and deliberate behavioural and political acts.

Questioning the Silence: The Inner World

Most bereaved informants reported ultimately having to rely on themselves rather than others after the realisation that others will not or cannot provide the support required. They learned quickly that many people around them, both in their natural support networks (see Chapter 5) and from the structured service setting (see Chapter 6), attempted to silence their perspectives. The outcome was that most reported learning to rely on themselves as the most dependable source of support, a strategy also identified

by Van (2001) in her study of African American women grieving perinatal and infant losses.

> *"I've resigned myself, I actually had a really traumatic experience at a wedding this year, in February, and in a lot of respects it actually made me stronger for quite a while, like for quite a few months, I actually felt really strong and thought, okay people who I thought would have supported me in the past, really they think I should be over it. So it made me realise it's up to myself and me only, to help myself, to know that I'm the only one I've got to rely on really."* (Maggie)

The bereaved informants developed a number of strategies that enabled them to rely on themselves. Joan reported that she kept a journal. Nicola attended a church every Sunday as a way of reconnecting with her spiritual side. Some informants attempted to find assistance in books on grief. However, some books can increase anxiety because they bereaved might judge themselves according to the descriptions of grief (Walter, 1999). Dawn and Karen reported they did not like the emphasis on short timelines and stages. For example, Dawn commented that she, *"…read a couple of books on grief and it said you know after six weeks or something you should be over the shock and I thought really they don't know. They really don't know what this is like"* and Karen commented, *"…books were useless because talked about stages and weren't 'real'."* As a result, both avoided books because they delegitimised their experiences. In contrast, Iris shared that she read books on grief that legitimised her experiences. In particular, she cited Mal McKissock's books as "*very open and normal"* because *"years after he got involved in grief counselling, his own daughter suicided, so he's also had the experience of a bereaved parent himself"*.

Others reported engaging in self-talk. Self-talk was a protective behaviour that helped the bereaved informants come to terms with others not understanding their experiences and therefore not 'being there' for them. Karen shared that she would say to herself, *"…do your worst to me, …you can't possibly inflict more injuries than what I've already experienced, …I've had worse, you can't possibly injure me worse than what I have been"*. Similarly, Kelly reported holding back from forming strong relationships because she was scared of losing other people of significance in her life. Her aim in doing so was to prevent further hurt, either via losing them or being hurt by them. Similarly, Sylvia reported teaching her sons her self-talk techniques she used in an effort to help them protect themselves from the insensitivity of others.

> *"I try not to expect much simply because I knew an old lady when I lived in Tasmania. Her husband was an alcoholic, he had died years earlier, [and] she had 12 children. She had lost three sons through accidents. She taught me don't expect anything, then you won't be disappointed. I have taught this to my sons. Whenever I say anything to them [about the way I'm treated] they will quote this back to me."* (Sylvia)

The bereaved informants also engaged in filtering processes, which enabled them to attempt to ignore, justify, and excuse the hurtful comments and actions from others as coming from ignorance and fear of the bereaved informants' feelings rather than purposive malevolence (see also Chapter 5). Sylvia reported that she felt some people might engage in hurtful comments and behaviours to protect themselves from feeling the emotions. She did not think that it was explained by deliberate coldness. Dawn explained that she regarded her friend's avoidance of her as "…*her loss. If she doesn't want to come near me it's her choice and as far as I am concerned, well that's her problem, not mine".* Similarly, when talking about people who make hurtful comments, Sharon said she does not *"bother talking to idiots like that because I think 'oh what's the point, they wouldn't understand'".* At first, these processes were deliberate and controlled, but with practice became automatic processes. The filtering process facilitated the maintenance of relationships with friends and family as it allowed the bereaved to minimise the hurtful comments and behaviours rather than internalising the comments.

> *"I learned to filter those sorts of hurtful comments because I actually believe some people genuinely don't know any better. They haven't experienced grief, let alone at that level… I forgive them because they haven't experienced [it]… I just think 'well you don't really understand'."* (Karen)

However, often it was a struggle to filter and excuse the comments and actions. Despite trying really hard to ignore, justify, or excuse the insensitive comments and behaviours were hurtful and made them angry, especially when they came from people who were expected to be more sensitive.

> *"My [religious] minister gave me statistics about six weeks after Mikey died, saying it was normal for one out of every four sons to die before having a family, but he'd never experienced grief like this. I make excuses [for them], but people in that position should know better."* (Karen)

In Chapter 5 I outlined that grief is 'invisible' and that some of the bereaved informants understood that those in their social network might think they are no longer grieving. In engaging in the processes of ignoring, justifying, and excusing the behaviours of others, some of the bereaved informants recognised that they might have contributed to people around them thinking they were okay when they were not.

> *"I guess because I shelved a lot of it, people actually thought I was okay, and didn't realise that I was a steaming mess underneath what they could see. I was a master of masks. I had a face for everyday. So I created a world around me that people thought I was alright. Perhaps I created part of the situation myself, because people thought I was fine and had gotten over it."* (Kelly)

In Chapter 4, I demonstrated that some of the bereaved informants internalised the dominant discourse concerning grief and/or applied these discourses to the bereaved around them. However, others critiqued these socio-cultural grief norms and most, with time, reported being able to examine their experience of grief within a cultural context. For example, some recognised that British Anglo-Saxons, the dominant cultural group in Australia, tend to maintain a 'stiff upper lip' rather than openly displaying emotion by crying, moaning, and wailing. Some reported that people, especially men, are raised to be emotionally 'strong', and that discussing death and grief is considered *"taboo"* (Sharon and Dawn). In recognising these cultural norms, many of the bereaved informants were able to accept their grief experience as normal and no longer judged themselves by a grief 'standard'.

> *"…it's a whole cultural thing, [in the] western culture [we] don't talk about death… It's one of those no-no's, it's taboo, you don't talk about it until you have to, so maybe it's a whole thing that has got to change in our culture. I mean you do go mad, it is a form of madness, but quite normal to go mad. I think we need to let people know that, when they feel that way, it is actually normal to feel that way… I think we've just got to learn to be more open about talking so that when these things do happen we are not quite so afraid. We don't feel like we have to put it in a box and do it the right way, 'cause I kind of felt like I wasn't doing it the right way. I wasn't doing it the way society expected me."* (Dawn)

Another internal act of resistance was that of self-acceptance. Over time, many bereaved informants reported coming to terms with their experiences of grief rather than hiding it or thinking they were failing because they felt sad or depressed. A significant component of this process was learning to accept their feelings as a normal component

of their grief experiences. The alternative to the normalising process is the thought that their grief experiences, and therefore themselves, are inferior or wrong (see Chapter 4).

> "*I didn't understand that it's okay to smile, it's okay to laugh and I had a real problem with that you know because I felt, well I've just lost a brother, I should be miserable for the rest of my life and I think it took me a long time to realise I'm going to go through a lot of emotions and every single one of them is okay."* (Jelena)

In engaging in self-acceptance, the bereaved start to position themselves as the experts in their situation and in their grief experiences. They reported learning over time to become more comfortable with their experience of grief rather than allowing their grief to be silenced by friends and/or family members. Nicola used the experiences of becoming a mother and the emergence of mothers' intuition as analogous to her accepting that she was the expert in her grief. The bereaved informants emphasise that they had learned to engage in self-care behaviours, refrained from putting pressure on themselves or doing more than they needed to do, and learned to take their time to do things when they are ready rather than when they thought they ought to.

> *"…be easy on yourself and don't think you can do too much because you can't. You think you should be going along as you were before but you really shouldn't, you really shouldn't do that because in the end it takes its toll on you. You really need to be easy on yourself and take time and I didn't take time, and probably most people don't until later maybe, but at the beginning you still feel like you should be carrying on as you did and then you realise that you can't."* (Maggie)

An additional aspect of self-acceptance concerned public displays of emotion resulting from their grief. Many of the bereaved informants reported no longer being embarrassed about crying or showing emotion in public or attending the cemetery where their loved ones' remains are. Rather than internalising the comments from others, they gave themselves permission to display their emotions rather than hiding them. Debra stated, *"…if you want to cry in front of people don't feel embarrassed. If you want to show your emotions, just do it. To heck with it if they can't handle it. That's their problem, not yours"*.

Despite some displaying their grief publicly, others chose to avoid disclosing their bereavement as a matter of course because of the likelihood that those around would not understand the magnitude and longevity of feelings. To protect themselves

from further hurt, they resolved to never show that vulnerability again. Nicola likened the vulnerability of grief to the vulnerability of childbirth.

> *"…when it happens to you, you just haven't got that strength to get up and…defend yourself or, I don't know, you're just totally…at your most vulnerable. I think even more vulnerable to grief than you are in childbirth I think… [In] childbirth you're probably exposed physically I think but [in] grief you're probably exposed completely emotionally."* (Nicola)

Consequently, some of the bereaved informants reported changing the way they behaved and talked about their deceased loved ones and the circumstances of their deaths so people did not have the opportunity to make inappropriate comments. For example, Iris recalled that at church, "*I tried to sing, and I'd have tears streaming down my face and dripping off my chin because I wouldn't put up my hand to wipe them off and make it obvious to anyone that I was crying…"* . Similarly, Kelly reported that;

> *"…I think you get to the point where you have the strength to deal with 'well you should be over that, shouldn't you?' or 'that was such a long time ago, it doesn't matter now'. When I talk to someone about my mum, I talk about her in the context of I miss her desperately still now, and not just 'cause she's my mum, but because of what happened and how it happened, and it was just too early, so I don't give anyone the opportunity to say anything like that. I actually try and make people see that I do feel like that and it's real."*

Some informants did choose to resist publicly the dominant discourse of grief. For example, some were inadvertently placed in the role of the 'grief educator' within their support networks in order to help those around them provide appropriate support, such as letting them know it was okay to talk about the deceased (see Chapter 5). For these informants, they acted as informal grief educators, comforting those around them.

> *"I found a lot of people didn't like to talk about it in case they upset me…and it was a case of I would be turning around and saying it's okay, you can talk to me about it you know… I just found that people tended to tiptoe around…"* (Jelena)

Some also chose to educate others about road safety. They taught their own children to drive and educated them about road rules. They also began educating strangers they saw breaking the road rules. They do it to educate and warn them to deter in order to prevent harm.

> *"…and even to this day, when I see hoons [sic], I'm not scared of them either, I'll bang their cars…if they come too close to me, and when they go past me like that (fast) I go like that (gesturing), [and say] 'I'm getting your number plate'…*

> *It makes me so angry… One of them might belt [assault] me one day… I've had shouting matches and swearing matches with young people… I've got a couple of them at three in the morning when they're doing their 'sex laps' or whatever they do with their subwoofers going and they're doing burn outs…and I've stalked them into the café…and I've gone up to them and said, 'do you know my grandmother was killed by an idiot like you?' and just made them feel so bad…and just humiliated them in front of everybody… I sort of say to people, 'how would you feel if a dickhead like you ran your grandmother over'…and it makes it sort of hit home…and I hound it, hound it, hound it into my boys…I say…'if I ever see you doing that in a car, I'll take your licence off you, I will'…'cause it just makes you look at things so differently…"* (Brooke)

Some resisted participating in behaviours that they felt contributed to the acceptability of breaking road rules, which ultimately lead to unsafe roads. An example of such behaviour is motorists flashing their vehicle headlights to other motorists to indicate the presence of speed cameras.

> *"I don't flash my lights [at other drivers to indicate] Multanovas; people should get caught if they're speeding. But I do flash my lights if people are going too fast because they [will then] think the cops are there or a Multanova…but it's like everything; if there's no deterrent out there, they don't bother."* (Joan)

In this section, I demonstrated that the bereaved informants engaged in a number of learned self-regulatory behaviours in an effort to negotiate their way through and around the dominant discourse surrounding grief. These are primarily cognitive in nature and include self-reliance, protective self-talk, reduced expectations of understanding and support from others, filtering, self-acceptance, self-care, avoiding disclosure, and informally educating others on grief and the importance of road safety.

These internal acts of resistance appear to reinforce the dominant discourse concerning grief because they generally are not active and explicit rejections of the discourse. However, these processes can still be classified as acts of resistance because the bereaved informants were not passively accepting the dominant discourse relating to grief. Instead, they were resisting them privately rather than openly or publicly, a process also reported by Fisher (2000) in her study of domestic violence victim-survivors.

Breaking the Silence: Accessing Peer Support

Hurtful comments and behaviours such as those reported in Chapters 5 and 6 aided the bereaved informants learning who will provide support and who will not or

cannot. Based on identifying their supporters and non-supporters, the bereaved altered their behaviour accordingly. In addition to putting on a 'brave' face for public consumption (Riches & Dawson, 2000; see also above section), in Chapter 5, the bereaved informants reported avoiding certain people, places, and events such as parties. Avoiding certain people meant that some friendships might not be as close as before the death, and some friendship networks change significantly. Some chose to maintain their friendships links by avoiding certain topics such as their feelings, with the result that their friendships were usually not as close as they were before the death (see Chapter 5). Often, the avoidance of certain people and situations exacerbated the loneliness, isolation, and dislocation felt by the bereaved (Riches & Dawson, 2000; Rosenblatt, 2000). Further, it is likely that the bereaved perceived the formation of a boundary between those that are bereaved and those that are not (Riches & Dawson, 1996a). As Natasha described; *"Bereaved parents, we're a different breed, we are. I feel so because we've been pushed off, kicked off the path of reality, 'get over there, not on our path no more, don't walk down here'…".*

As a result of the isolation, the bereaved informants turned to others with similar experiences in order to access support they were not getting from elsewhere, including from their existing friendship networks. Seeking out others with a similar experience provided a safe psychological space where they could be themselves and say what they wanted and needed to say, rather than being judged or given empty platitudes (Klass, 1996a). Peer support provided a reprieve from the day-to-day isolation because others shared a similar experience, understood it, and were sensitive to it (Riches & Dawson, 1996a, 1996b, 1997; Walter, 1999, 2000). A connection or bond was forged by the loss because of the realisation that others understand their thoughts and feelings. Rather than thinking they have to avoid certain topics or act 'happy' despite their true feelings, the bereaved could express their emotions without embarrassment or judgement. As a result, their experiences were normalised because they were recognised as real and authentic. The connection legitimised their experiences, enabling them to talk about topics they felt unable to share with others. Even after the passing of many years, talking about their losses was easier with others with a similar experience and was especially useful when feeling low.

> *"…there's just a barrier that has already been broken… You're on a level where you each know there's, there's some things that don't need to be said do you know what I mean? …All we do is squeeze each other's hand, you don't have to say anything, there's just a different level of understanding, yeah (crying)…words aren't necessary that's, that's probably…the best I can say, words are not necessary… It's different with somebody who hasn't lost anybody, it's like if you tell someone how much you actually miss that person, they sort of understand but they don't understand… I used to try and explain it to people [by saying]…it's like putting your six-year-old on a bus for an excursion and saying 'see you in 30 years time', that's the closest I could get to explaining to someone who has never lost anybody."* (Karen)

These peers were located via a number of means, such as from within their natural support networks, through their church, at the cemetery, through books written by people who had experienced grief and/or loss, and through grief support groups. For some, the connection was made through sharing the experience of the sudden death of a child. As Jim stated, *"we made knew friends, all people in a similar position [to us]"*. For others, the connection was forged because of the method of death. Many informants found comfort talking to others that had lost loved ones in crashes. They reported a connection to each other because of the characteristics of crashes being sudden, violent, often preventable, and the victims are often young (see Chapter 4). In addition, they often share experiences of police investigations and trials.

> *"…they've lost children in the same way, or a similar way to how our own daughter died, and in a violent way, and there is a connection there because they are our children, they are killed in a road crash that could have been avoidable, that should have been avoidable, so you have a connection there as well… especially if it goes through to the courts, you have a connection with them too, because it's the times that you have to wait, the length of times, the outcomes of the trial, whether [or not] there is a conviction… It just seems to be that they're the people that I have an empathy with, I can talk to them…"* (Debra)

For others, a connection was forged via grief itself, particularly through sharing the loss of a particular relationship such as a child or a spouse, rather than similarities in the circumstances of death. Not all of the informants thought people had to experience the death of a loved one to be supportive. However, they recognised that most people who have not had the experience do not know how to behave or what to say. As Nick stated, *"I don't automatically dismiss people that haven't experienced this so I don't*

think, 'oh, they won't be able to help because they don't know what it's like', but people don't know what to do".

Many of the bereaved informants sought peers via the mutual help group The Compassionate Friends (TCF). Formed in the United Kingdom in 1969 (Lawley, 2006), TCF is a non-religious mutual support organisation for bereaved parents, assisting them to meet each other and share experiences in a sympathetic and compassionate environment. Support meetings, called Friendship Nights and Coffee Mornings, are each hosted once a month and held at their office in West Perth. The support from TCF was characterised by many bereaved informants as empathic, accepting, and non-judgemental, as bereaved parents understand the daily challenges of living with the death of a child that those without the experience would not be aware of.

> *"…one of them [at TCF] asked me, 'what do you say when people ask me how many children I have?' I nearly fell off the chair that night, because it was something I'd never ever said to <u>anyone</u>, how I felt about that. I hadn't said it to Jacob, I hadn't said it to anyone. But I used to cheat. I [would say] when Jacob and I got married, we had nine children between us. I didn't say there were only eight left. But I dodged the question by saying that because there was <u>no way</u> I was going to drop down the one child, and I knew perfectly well people didn't want to know that I'd lost one because then they'd go into this panic attack [as if to say] 'get away from me'. So to save them doing that, [and] to save me the pain of trying to deal with denying her [existence], I used to get out of it like that. So I thought I was lucky that I could dodge that question. But I couldn't believe they were saying this to me. Somebody else knew this hurt…"* (Iris)

The West Perth office has an extensive library of books and resources pertaining to grief and loss available free of charge to grieving parents. The office is staffed by bereaved parents who act as volunteers and is open most weekdays. TCF publishes large number of pamphlets on particular aspects of grief and loss (e.g., *When your child dies, Caring for surviving children, How can I help when a child dies,* and *Suggestions for doctors and nurses*) as well as a quarterly newsletter (*Reflections*). The bereaved parents are encouraged to make submissions to the publications. They considered learning from those with the personal experiences of the death of a child was more important and relevant than 'expert' knowledge. TCF facilitates the bi-directional education between bereaved parents via the exposure to other parents' personal experiences of the death of a child, and via the sharing of coping strategies and information.

> *"When Jess died we wanted three lots of ashes, one for New Zealand where we lived, one for here and if I ever went back to England or whoever dies goes with Jessie and the next one goes with these ashes, so we've got three lots of ashes and people say 'I wish we'd known that, I wish we could have done that'…so I did a little thing for TCF, 'I wish, I wish, I wish', so I said these are the things that people wished that they had done. I did that and they print it out in books."* (Natasha)

Although the focus is on parents, TCF also attempts to support grieving grandparents, siblings, and other relatives such as aunties and uncles (The Compassionate Friends, 2003, n.d.). Consistent with the notion that method of death is important in forging a connection between the bereaved (see above), TCF facilitates the development of networks between parents grieving the loss of a child through similar means, such as asthma, AIDS, drug-related, neonatal, suicide, vehicle crashes, and deaths in custody, as well as groupings such as Aboriginal children and young children (The Compassionate Friends, 2003). TCF is also represented in many regional areas in WA, such as Bunbury, Mandurah, Donnybrook, Geraldton, Kambalda, Lake Grace, Northam, Pemberton/Manjimup, Port Hedland, Karratha, Albany, and Esperance (The Compassionate Friends, 2003).

Support from TCF was very important for the bereaved informants that accessed the group. Some of the informants that are bereaved parents reported being sent information from the group in the days following the deaths of their children. The support from TCF became more important over time as the understanding and compassion from within natural support networks friends and family diminished, as TCF allows people to continue to talk about their loss.

> *"Actually I didn't go a lot to [The] Compassionate Friends until later. I went a couple of times but I found it was the following, maybe the second year, that I actually <u>really</u> had to go again, 'cause that's when other people don't talk about it anymore, and that's when I sort of felt that I really need to go there <u>now</u>, and I find it, there are a lot of people that don't start (there) until later 'cause other people don't want to talk about it or have forgotten or it's too hard but you don't forget…"* (Maggie)

Research has demonstrated that people are more likely to access mutual-help groups when the group deals with socially-stigmatised phenomena (Davison, Pennebaker, & Dickerson, 2000). In Chapter 6, I discussed that the bereaved informants were often silenced by the legal, service, and road safety domains, which failed to

recognise their experiences as authentic. TCF provided a place where they feel they belong because they can be themselves, allowing them to share things they would never talk about with those who do not share the experience.

> *"…people there can speak and it doesn't matter what they say, you know they can say what actually happened to them without worrying about who's hearing it, you know? …And nobody's being critical or judgemental or anything… What is said at a meeting of [The] Compassionate Friends, we are told at the beginning, what is said in the room isn't to go outside that room."* (Iris)

Despite being a 'formal' and 'structured' support base, TCF preserves the informality inherent in a casual and conversational atmosphere. Tea and coffee are provided at Friendship Nights and Coffee Mornings, and bereaved parents are invited to bring biscuits, cakes, and sandwiches. These touches create a homely and friendly atmosphere rather than emphasising explicit hierarchies of power that are evident in other support settings. However, the informal atmosphere meant that "the powers that be" sometimes characterised TCF meetings negatively: "all you do is drink and eat cake" (L. Gillam, personal communication, 7 October 2002). In addition to the Friendship Nights and Coffee Mornings, the group also hosts occasional memorial services and social gatherings and encourages the development of telephone and email networks between bereaved parents (The Compassionate Friends, n.d.), which have resulted in the development of new friendship circles.

> *"I can only [talk about Sally] at [The] Compassionate Friends… I've started meeting a couple of ladies from there for lunch and we have a great lunch, we've just done it a couple of times, we'll do it again soon. We just talk about anything, and it's really good. Just to be with, I don't know, it's just easy, I don't know, I just find it so much easier to be with people that have been through it… You can just say anything and they just know, they just know. They don't offer advice to say you should be doing this, that, or the other, they just know not to (laughs)."* (Maggie)

TCF also provides avenues for the development of skills including communication skills, computer literacy and web skills, and editing, via number of roles such as centre staff, librarian, office coordinator, committee members, maintaining after hours telephone service, editor of or contributor to *Reflections*, webmaster, and facilitators of Friendship Nights and Coffee Mornings. Natasha regularly assisted in the office and during Coffee Mornings and Friendship Nights.

> *"…now I just go and visit and make a cup of tea and them lunch, I take some cakes or sandwiches…or buy something off their stall to give them some money…put the kettle on, I don't speak… You don't have to speak, just let them cry and cry with them…"* (Natasha)

TCF would prefer to be able to provide their support free of charge "as each bereaved person has already paid a price beyond comprehension to qualify for our group" (The Compassionate Friends, n.d.). The group has reduced rent office space in a building provided by the state government's Lotteries Commission. Other than that, the group receives no ongoing funding from any source and as such relies on self-funding, through activities including raffles, street collections, and quiz nights (The Compassionate Friends, n.d.). As a result of the lack of external funding, TCF provides *Reflections* free for the first year, but after a year a $25 charge per year applies (The Compassionate Friends, 2003), despite the support being viewed as a lifeline.

> *"[TCF] is fantastic, absolutely fantastic. You can ring them up anytime. I guess that's what I did instead of talking to my friends… I never got to the meetings because they are in Perth, and I think at nighttime. I never ever went, I wanted to. I used to get their newsletters and I'd look forward to them so much, because you could do it in your own time and other people were going through what you were going through because they'd lost a child. Magic."* (Joan)

Despite the lack of funding and the small subscription charges, TCF remains inexpensive in comparison to other support services because they rely on low-cost helping strategies such as the printing of *Reflections* and brochures, telephone support, and the provision of two face-to-face meetings per month. In Chapter 6, I demonstrated that the costs of funerals can be difficult to meet, especially for those that are ineligible for reimbursement through the Fatal Accidents Act.

> *"…this is another reason why The Compassionate Friends is so important to people. The cost of funerals is phenomenal, and a lot of people have got to take out loans to bury their dead, and to know that help is there would help a hell of a lot. Because they've had that outlay [of the funeral], they can't afford to go get bereavement counselling, it's so expensive. And a lot of it, you don't get rebates on your medical insurance either."* (Sharon)

For many bereaved parents, TCF provides ways in which they can exercise control, power, decision-making, and are positioned as the experts in their situations rather than clients or patients. However, there were a number of bereaved informants who did not access support from the group. The most obvious reason was that they were

not bereaved parents. However, not all of the bereaved informants who had lost a child accessed support from TCF. Di stated that she felt she was listened to and understood within her natural support network. Despite knowledge of the group, Sylvia did not seek support from them because she felt that it did not suit her needs as she lost both her husband and a son. She feared the group would recognise and legitimise her experiences as a bereaved mother but not her experience as a bereaved wife.

Sometimes those that wanted to attend a TCF meeting could not do so because they required assistance to get to a meeting. Consequently, they could not make use of that support. Both Karen and Joan would have liked to go to a Friendship Night but the distances between their homes and West Perth was prohibitive (approximately 24 and 38 kilometres respectively), given it would require driving to and from the meetings alone, at night, and while potentially distressed.

> *"…[I] wanted to [go]… I knew if I had to go to meetings I would not be capable of driving home so I wasn't going to go on my own and my husband said an outright 'no, not doing that, not sharing my grief, …it's my grief, nothing anybody else can say, can do, is going to change [it]'…and I couldn't find a friend that was willing or prepared to come along so I couldn't make use of that sort of thing."* (Karen)

TCF also did not provide the type of support wanted by all informants. The match between the group and the needs of the bereaved appears to determine whether or not the group is considered to be beneficial (Rodger, 2005). Debra accessed the group via the telephone and also attended a Friendship Night, but felt that these supports did not meet her needs because *"…[at Friendship Nights] you sit in with groups where it could be a drug overdose, a suicide, death by cancer. So I found that it…probably wouldn't have been what I needed"*. She wanted to talk specifically to parents bereaved through crashes.

An additional barrier to accessing TCF is the courage required to attend the first meeting. Those that possessed the courage to attend a meeting recognised that the first time was the most difficult. They reported becoming comfortable quickly, and were exposed to an understanding and compassion that is more difficult to find outside of those that have experienced a similar loss.

> *"…the first time [you go to a meeting] is hard. You walk in and you start bawling because you're there and it's just an overwhelming emotion that you get*

> *but I feel comfortable going there now. I just like to be amongst people the same as myself… Just the talking I think, just the talking about everyday stuff as well, some days you'll go and you might not get a lot out of it because you might have a new person there and they might monopolise the evening, so you sit back and listen. I don't mind listening actually, I quite like sitting there listening, and you see the same faces and everyone's really nice and I just feel comfortable, it makes me feel comfortable being there…"* (Maggie)

In light of the legal, service, and road safety domains subscribing to the dominant discourse concerning grief (see Chapter 6), the bereaved informants actively sought support from people who had experienced a similar loss. Peer support follows a partnership model wherein power is shared and as such contrasts with bureaucratic and hierarchical organisations where help is professionalised (see Chapter 6) (Constantino & Nelson, 1995; Foote & Frank, 1999; Lieberman, 1993; Rock, 1998; Schiff & Bargal, 2000; Walter, 1999, 2000). The professionalisation of support (Albee, 1992; McKnight, 1977) renders personal experiences as 'baggage', thought to hinder or prevent the objectivity construed to be necessary in the provision of help, whereas personal experience is highly valued by bereaved informants and they actively sought it out. Through the access to and contact with peers, the private experience of grief becomes public. Peers allow experiences to be shared openly and unburdened instead of 'masking' the grief to fit a social norm. Thus, the experiences are considered authentic and valid rather than silenced.

Fighting the Silence: Entering the Political Realm

In Chapter 6, I demonstrated that the bereaved informants were largely rendered voiceless within the legal, service, and road safety domains. In the following section, I argue that their experiences of voicelessness continued in their attempts to create change. However, these attempts were often not supported by people in the legal, service, and road safety domains. One setting informant explained the bereaved informants' attempts to create change as stemming from paranoia (Road Safety Council informant), while another described it as a way of denying their grief and trying to assign blame to someone for the deaths of their loved ones.

> *"…the thing that binds all families in sudden death, be it road trauma or others, is simply the sheer horror and the initial denial that takes place, and intelligent people deny [their grief] by asking lots of questions without actually thinking through the relevance the answer is going to have, you know? …Really what it*

> *is, is the desire to purge their anger and their hurt on some poor unsuspecting bastard."* (Office of the State Coroner informant)

One role many bereaved informants saw as important was explicitly advocating the perspective of those bereaved through crashes. Those who had taken on political roles did so because they thought that someone had to make a stand in order to represent people bereaved through crashes, whose voices would otherwise remain silenced. They explained their actions as motivated by the principle of justice and also by the notion of honouring their deceased loved one and others so they did not die in vain. These reasons were also cited by parents fighting for justice following the deaths through accidents, 'disappearances', and murders of their children (Girasek, 2003; Holst-Warhaft, 2000; Rock, 1998). However, unlike that reported by Girasek, (2003), being successful in advocating changes was not viewed as therapeutic. Instead, the successes were usually bittersweet because of the difficulties in achieving them and because engagement in acts of advocacy did not bring their loved ones back. The bereaved informants emphasised that creating even small changes would be likely to help people bereaved through crashes in the future, but would not help them through their grief. For example, Sharon commented that she *"…fought desperately and got that changed [so people can touch their deceased loved ones at the mortuary instead of being separated by a glass window], thank goodness, but it doesn't help me now."*

Some attempted to voice their perspectives in a seemingly small manner. However, these small acts of resistance were a big deal because they were voicing their perspective. For example, despite being asked to alter her victim impact statement (see Chapter 6), Dawn explained that she left it the way she intended – *"…[the Victim Support Service] said I had to change a couple of things [I had written], but I didn't, I just left them (laughs)."* (Dawn)

Other examples included letting those in the service setting know when they have said or done something offensive rather than ignoring, justifying, or excusing it it. George, Debra, Natasha, Jim, Sharon, and Iris all reported participating in formal media interviews and presentations to hospitals and community groups. The presentations made by those who are bereaved through crashes focus on their personal experiences and the psychosocial outcomes of bereavement through crashes. They talked about their

deceased loved ones rather than referring to them as a number, which personalised the loss, and discussed the impact the death has had on the family. This approach is an alternative to the government's road safety education strategies, which do not emphasise the psychosocial consequences of crash fatalities (see Chapter 6). At other times, these acts were informal, as they occurred during their dealings with those in the service setting.

> *"…I went to this other doctor, because mine was on holidays, and I told him what was going on, that I was going to [the coronial] inquest*[1] *and I needed some [migraine medication] to get me through and he said 'oh you need counselling, I do a bit of counselling' so I thought okay, maybe I do, I'll give it a go. I was in there 15 minutes and he says to me 'you're so negative. What's the most positive thing you've gotten out of your son's death?' and I looked at him and I thought I don't believe I'm hearing this and I said 'what's positive about a 20-year-old healthy boy that's got his life ahead of him, wiped out by a car? Of course I'm bloody negative' and he said 'but there's got to be some positive thing, you know, you've got memories' and I thought 'ohhh!' and I said 'where did you get your degree, out of a Fruit Loop packet?' and with that I got up, I charged out, and I've got people running out of the surgery wanting me to sign the papers to pay…and I said 'I'm not paying for this!' and when I told the lady what happened she said 'don't worry love, you go ahead' and I said 'that man needs to see a psychiatrist! Fancy coming out with something stupid like that?' I couldn't believe it, …the idiocy, and he said 'oh I lost a friend on a motorbike, and three months later we were okay'. [And I said] 'Yeah, it wasn't your family. It wasn't your son. And you're a callous bastard!' (laughs)."* (Sharon)

Some of the bereaved informants were dissatisfied with the police investigation into their loved ones' deaths (see Chapter 6). As a result, some conducted their own investigations. For example, Pieter reported making numerous visits to the coroner's office to dictate the coronial report into a tape recorder in order to transcribe it at home, hiring a private automotive forensic analyst, attending other coronial inquests to familiarise himself with the process, and doorknocking to find four witnesses, only to have the police discredit them. He has also accessed research from a number of universities and organisations in order to reconstruct the crash. Pieter estimated having spent between $2000 to $2500 on the investigation as well as his weekends and annual leave. Pieter's request for an inquest into his son's death was initially denied, but was

[1] All non-natural or unexplained deaths are subject to a coronial inquiry. Some of these are then subject to an inquest. Death certificates are issued after the conclusion of the inquiry process, or for those deaths subject to an inquest, after that process.

later accepted after he prepared a document (approximately 40 pages) outlining the reasons for his request. At the time of their interview, Pieter was preparing to run the case at the inquest, because he was concerned about the legal representation assigned to them within the court and he and Di cannot afford independent counsel.

> *"…in the coroner's court they assign a police sergeant as like a prosecutor, so we went to a number of law firms, but…just for representation in the coroner's court for three days we were quoted by the person that we prefer to have done it at least $10,000 for three days and the cheapest one, which didn't seem to have all that much experience, that was about $8000 for two to three days."* (Pieter)

These investigations were not always successful. For example, evidence suggested that a taxi driver was the last person to see Sharon's son before a car hit him.

> *"I went around all the taxi ranks, at 2 o'clock in the morning, I went around with a poster [of a photo of her son] and said could the taxi driver please get in contact with me… I never found out from the taxi driver, the police didn't do enough enquiries…so to this day, I still don't know [what happened]."* (Sharon)

The government discourse positions road safety as a community responsibility, which is evident within its websites and road safety publications (e.g., Road Safety Council, n.d, 2000b, 2005). They emphasise that community ownership is the key to reducing deaths and serious injury on Western Australian roads and claim to consult with key road user groups. For example, the Office of Road Safety informant stated, *"…you need everyone working together basically because it's not this office (the Office of Road Safety) on its own that's gonna [sic] make the change, it's not the government on it's own that's gonna [sic] make the change…"*. The Royal Automobile Club (RAC) of WA, which represents approximately 440,000 of the state's motorists, has a representative on the Road Safety Council. Apart from this representation, there is no other formal and explicit mechanism for seeking feedback and involvement from the community. Some of the bereaved informants reported attempting to voice the psychosocial effects of crash fatalities and injuries to the government in order to create social and political change. By becoming involved in advocating for change, they position themselves as change agents and possess the belief that they can effect change.

> *"…until people like us start rattling chains it's not going to happen, and the more people we get on board to rattle more chains, to tell whoever's in power at the time, that there is a need that's not being supported, it won't happen."* (George)

Between them, the bereaved informants reported being involved in the Tissue and Transplant Act (1982) working party (Health Department of WA, 1997), the Coroners Act (1996) working party, the Pre-Driver and Youth Driver Road Safety working party, Australian College of Road Safety (Western Australian chapter), the Road Trauma Counselling Service steering committee, and the Main Roads' Roadside Memorial Policy and Guidelines committee (Main Roads WA, 2003)[2]. Most of those that had been involved in a government committee or working group thought that their role was intended to be tokenistic. They reported often being overwhelmed by jargon used by the 'professional' members of the committees, thought that their involvement was perceived as threatening and antagonistic, and were discouraged from voicing their opinions or were ignored outright. These experiences were also reported in other studies of advocacy attempts by bereaved parents (Girasek, 2003; Rock, 1998).

> *"…[many on the committee] were determined to exclude us… They did not want this written consent [for organ donation], they wanted oral consent. Now a lot of people are not mentally and emotionally fit to do that. They need to <u>see</u> it. When someone's talking to you, it's not sinking in. They need someone like family to read it through to them and then put it in front and say try and read that, and leave them for half an hour. I <u>know</u> time's precious, but what they don't realise is these people have got to live with [their decision] for the rest of their lives…"*
> (Sharon)

The bereaved informants' expertise and effort in being involved in the above committees was not always appreciated. However, Grigg (1999) reported that, although community involvement is essential to road safety strategies, authorities are often hesitant to share power with the community. For example, one setting informant expressed his disgust at the involvement of people bereaved through crashes in the following manner.

> *"During the late 80s and early 90s, there were a handful of families…who were highly vocal. They were constantly ringing [radio talkback]…saying 'they did this, they took my baby's brain, or they took my son and they got his liver' (sarcastic, cartoon-like tone). All this highly emotive stuff. Unfortunately there was a new government coming into power. The Coroners Act of 1996 was effectively written by those five families, <u>not</u> by coronial investigators, <u>not</u> by*

[2] Outlines the management of requests for, placement of, and removal of roadside memorials on Western Australian roads. Despite this policy, the Western Australian Local Government Association held discussions with Main Roads in an effort to ban roadside memorials (Paddenburg, 2006).

> *coronial officers, not by counselling staff, but by them… So this piece of legislation, really badly handled and thought out at that, it's a disgusting piece of populism, basically…"* (Office of the State Coroner informant)

Despite contributing their expertise, the bereaved informants received no payment or other remuneration, even when the commitment was considerable. For example, the Transplant and Tissue Act working party met once a fortnight for two years. Iris stated that it was unfair that some expertise was considered more important than others, especially as the doctors on the working party were getting paid whereas she and the other bereaved parents volunteered and were emotionally involved. In addition, although some had helped create legislative change, such as the passing of the Coroners Act in 1996, there were instances where the recommendations were disregarded. Thus, their contributions were often devalued and delegitimised and their experiences were silenced.

> *"…we worked on the working party for two years, and then it was just scrapped at the end of it. It was presented to [the Minister for Heath at the time], and it never got reintroduced to parliament, it just got scrapped and we considered [the whole process] was just to keep us quiet, because we were making too much noise."* (Iris)

George and Debra formed Australian Parents Against Road Trauma (APART) in 2000, after a meeting with the Chair of the Road Safety Council. The Chair asked them to consider working in the area of road trauma. As a result, they established APART. At the time of data collection, the group had approximately 20 members, many of whom were friends and relatives of Debra and George. Initially, the group sought out information on road safety in WA and met with people working in road safety such as representatives from the Office of Road Safety, the RAC, and the Police chaplain. APART's aims were to advocate for greater awareness of the psychosocial consequences of crashes, including bereavement; for changes in legislation pertaining to vehicle advertising and the enforcement of road rules; and for the development of a structured support service for people who have been affected by crashes.

APART's attempts to link with government have had limited success. They developed a working relationship with their local state Member of Parliament but found it difficult to have an open dialogue with other government representatives such and the Minister for Police and Emergency Services, Justice, and Community Safety, who

denied requests to meet with them. APART has received mixed messages from government bodies about providing a support to people bereaved via crashes. On one hand, they were invited by the Chair of the Road Safety Council to work towards road safety, yet on the other, inadvertently or deliberately, a representative from the Office of Road Safety discouraged them. Debra recalled, *"…one thing we've been told to be very careful is to not get into something too early, with emotional [elements], because they drain you at the same time. We've been told …to just be very careful of that…"*.

In addition, an employee of Roadwise suggested to Debra that APART should establish a support group for people bereaved though crashes. However, APART do not have capacity or infrastructure to provide such a service because of the emotional costs of providing such support, especially when bereaved, and the financial costs involved in gaining the required skills. As Debra explained, *"…while you are helping them, you're also reopening a lot of your own wounds …so I guess…you need to know how to handle those [situations]…[and] have to go to a course on [counselling]"*.

Despite the discouragement, a couple of members of APART have been able to provide peer support over the telephone to people bereaved through crashes. However, a primary aim was the development of a support service that would be provided and funded by the government. After considerable investigation, APART felt that the Road Trauma Support Team in Victoria and Tasmania (RTST) (Keir, 2000; Jeavons, 1997) provided the best model of support and could be adopted within WA. The RTST was established because existing services were not able to meet the needs of people affected by crashes (Willis et al., 1997) and provides support for those injured in and bereaved through crashes as well as motorists who have caused a crash (see Appendix N).

APART took the initiative and organised a meeting in 2001 between themselves, government road safety stakeholders, and a representative from RTST who was in Perth for a grief conference. The aim of the meeting was to raise awareness of the needs of people bereaved through crashes and to begin the process towards the establishment of a formal support service for people affected through crashes. However, George and Debra did not consider the meeting a success.

> *"We have come across a barrier. We did have a meeting last year with a lot of people…and had one of the people here from the eastern states [from the RTST] who ran through exactly how they operate, but at that time, Roadwise was*

> *working on the same thing, in a small way (sigh) with Lifeline, that's a 24-hour [telephone] counselling service (see Chapter 6), and one of [Roadwise's] representatives was there and said that [support for people bereaved through crashes] had already started. In a way, we think that put a halt to what we wanted to do…"* (Debra)

APART has developed links with the wider movement consisting of formalised groups in other Australian states and countries, such as the RTST and Mothers Against Drunk Driving (MADD) in the United States[3]. These links were useful in learning from them, as each organisation has existed for many years, and also were sources of emotional support and encouragement. Debra stated that she still hoped that a formalised support service would eventuate in WA because she knows the RTST took a number of years to evolve from an idea to reality.

With attempts to partner with government proving less successful than originally imagined, APART have broadened the strategy to include giving talks to upper high school students (aged 15-17 years) to educate young drivers about the psychosocial effects of losing a loved one in a crash, and increasing awareness of the psychosocial effects of crash fatalities via media outlets (radio, TV, paper). However, they characterised working with the media as emotionally draining, especially when previous experiences with them (e.g., attending funerals and legal trials) were difficult. An additional barrier to collaborating with the media was the notion that media are only interested when it suits their needs.

> *"We find that the television stations, radio stations and…newspapers, if they've got a particular bee in their bonnet, they want to make contact, but if you want to do something with them then well [they have the attitude that] we'll do it on our terms. An example was not this Easter just gone but the one before when we had a massive road toll in Western Australia… All of a sudden on Sunday morning, Debra and I were at the cemetery attending Kate's grave [and we] got a call on the mobile [telephone informing me that] Channel 10 or Channel 9…wanted to do an interview on our feelings on the road toll and we just had to say, 'sorry we're at the cemetery attending Kate's grave and we won't be available for comment till Wednesday or Thursday', by which it was too late [for the story]. And in respect, if we wanted to have a little more notoriety, …we probably should have jumped on the bandwagon, but it didn't suit us at the time. And*

[3] The road safety advocacy movement is evident in many countries throughout the world - see Browning (2002), M. Williams (1997), and the European Federation of Road Traffic victims' website http://www.fevr.org.

> *you'll find that with the media if they can use you to sell their product, they will, if you want to use them to sell your product, bow and scrape."* (George)

The setting informants appeared to hold a number of misunderstandings about APART. For example, despite some having met with APART members, often on a number of occasions, they did not know what APART was an acronym for. Others stated their government department or organisation would refer people bereaved through crashes to APART for support because they thought APART was a support group. Further, in the publication Victim Support Service (n.d.), under the subheading 'counselling' it is written, "APART (Australian Parents Against Road Trauma) is another support group of parents who have experienced bereavement due to a fatal motor vehicle crash" (p. 7). In addition, the Road Safety Council informant over-represented the amount of collaboration between APART and the government and misrepresented the members of APART (wittingly or unwittingly) in order support the government's emphasis on speed, alcohol, seatbelts, and fatigue.

> *"…there's a company, a group called APART, Parents Against whatever it is… We constantly, they work with the Office of Road Safety staff. They're aware of speed 'cause in most cases their losses have been through speed, alcohol, seatbelts, and fatigue. They're the four killers, we know that."*

The lack of funding means the bereaved informants must take time off work (and forgo wages/salary) in order to present to school and community groups, be interviewed by the media, and to join various government committees. George and Debra described feeling discouraged by the lack of financial assistance available that would enable them to meet their aims. They began planning but did not implement a memorial day for people bereaved through crashes, largely because of lack of financial support. APART have applied for grants (totalling approximately $15,000) through the Roadwise Community Grants Program, but none were successful because they were outside the scope of the state's road safety strategy that focuses solely on crash prevention (C. Parker, Roadwise, personal communication, 20 August 2002) (see Chapter 6).

> *"…it's usually platitudes and rhetoric that we hear and not enough gutsy stuff… When we tried to get a projector and laptop [for the school presentations] and we were told [by the Office of Road Safety] to <u>hire</u> them…even though we were asked initially by the Road Safety Council to do this. We've gone ahead and done it and we don't get support…"* (Debra)

Despite APART being unable to convince the government to fund a support service for people injured and bereaved through crashes, some post-crash issues have been able to access government funding. For example, the Office of Road Safety informant stated that the government funds emergency service personnel in regional areas. In addition, the Neurotrauma Research Program was initially granted core funding of two million dollars for three years by the Road Safety Council, a decision characterised by the Road Safety Council informant as a *"mistake"*. Despite the road safety strategy's concentration on crash prevention, the Minister for Police and Emergency Services, Justice, and Community Safety granted an additional $500,000 to the Program in 2003, directly contradicting the Road Safety Council's charter and recommendations (Gibson, 2003). The Road Safety Council informant described the grant in the following manner - *"What it was, was politics. The medical association and neurosurgeons are hugely powerful lobbyers, and they went in and got her (convinced the Minister to fund the program)"*.

According to George and Debra, attempts to access support from private companies proved considerably more successful than accessing assistance from the government. Roadcare 2000, which is a consortium comprised of Hyundai, *The West Australian*, Channel Nine, Pepsi, Chicken Treat, Waves Surfwear, Mix 94.5FM, Easifleet, and Drive Safe Australia, permanently loaned APART a laptop computer and data projector and paid for the production of APART's brochure (see Appendix O) which Hyundai included with the sale of all new and used Hyundai vehicles in WA. In addition, Eduka (a website company), helped APART establish and maintain their own website[4].

Worldwide, road safety advocate groups (such as APART) usually consists of volunteers that aim to fill the support, information, and legislation gaps evident in the provision of post-crash services and supports (Browning, 2002; FEVR, 1993, 1995; Haegi, 2002; Tehrani, 2004; Waller, 2001). However, the commitment and enthusiasm of advocacy and justice groups are difficult to maintain when gains are slow, when emotionally involved, and when trying to change complex and systemic systems

[4] APART has been defunct since 2003, primarily as a result of George and Debra moving to a town 366 kilometres south of Perth.

(Browning, 2002; Girasek, 2003; Haegi, 2002; Holst-Warhaft, 2000; Rock 1998). Some of the bereaved informants reported receiving abusive telephone calls and anonymous threats, and one received death threats. Advocating for changes was characterised by many of the bereaved informants as 'fighting'. They viewed their attempts to create change as battles that took their own toll, both physically and emotionally. The 'fights' were analogous to a boxing match where they either planted a punch or were knocked down. After taking some time out between 'rounds', they would go back into the 'ring' to fight another 'bout'.

> *"It's either fight to survive or just curl up and die. I know when I had a fight, I'd be good for two days but then I'd have three days when I wouldn't answer the phone, the door, anything, and I'd just be curled up in the foetal position, the pain was so intense, and I just didn't want to know anybody. I didn't eat, I didn't drink, didn't do anything, and then I'd come around for another bout, another week, and then I'd disappear again."* (Sharon)

Some of the bereaved informants have thought about advocating for change but have not yet been able to. They recognise the difficulties involved in fighting 'the system', especially when grieving. Consequently, some were pessimistic about the potential for change and thought that the small gains are not worth the energy and heartache. Others have not positioned themselves as change agents but either intend to do so in the future or support those who have done so.

> *"I thought yes, I'm going to find somewhere and do something and make a difference in some way… I thought I was going to make a difference but I never got that far somehow…[so] maybe I should still pursue that."* (Karen)

By positioning the responsibility for road safety within the community, the government is able to imply the existence of mutual obligation and bi-directional influence between the government and the community (Fisher, 2000; McMillan & Chavis, 1986). Despite the dominant definitions of community stressing relational ties, bonding, collaboration, and so on (McMillan & Chavis, 1986), the government's usage of the term does not borrow from affective definitions that emphasise partnership. Instead, the government's interpretation implies a definite hierarchy and is akin to being synonymous with the term 'society' (Tonnies, 1957). The appropriation and reinforcement of the discourse of community (e.g., community ownership) hides the economic rationalist ideals behind an emphasis on affective bonds (Fisher, 2000).

On the one hand, government rhetoric encourages community ownership of community problems, and on the other, acts to limit its effect (Hopton, 1995). By allowing some people bereaved through crashes to sit on committees, the government is able to regulate the extent of their engagement through determining who is involved, how often they are involved, and the roles of those involved. In effect, the rhetoric does not match the reality. Further, the appropriation of community discourses minimises the necessity of recognising and legitimising the consequences of crashes such as injury and bereavement. The net effect is the government benefits from the positive connotations of community, while at the same time their responsibility in providing support to those suffering the consequences of crashes is diminished.

Conclusion

The bereaved informants engaged in a number of thoughts and behaviours that are acts of resistance. As a result of finding the support from both their natural support systems and structured supports lacking (see Chapters 5 and 6), they tended to seek out alternative avenues, such as relying on themselves and/or others who share the experience. However, doing so unwittingly reinforces the 'silent' nature of grief resulting from crash fatalities.

The previous three results chapters demonstrated that throughout the grief experience following the death of a loved one in a crash, 'expert' knowledge and dominant discourses are privileged while the experiences of the bereaved are silenced. In this chapter I further demonstrated the existence of silencing processes surrounding attempts to create systemic change. The bereaved informants fought to be heard and for their needs to be recognised, but their attempts to politicise crash-related bereavement have been relatively unsuccessful. There remains a dearth of recognition concerning the experiences of those bereaved through crashes and their resulting support needs.

The bereaved informants were not complicit with the legal and medical conceptualisations of grief (see Chapter 6). Instead, they wanted assistance from a partnership model, where they are presented with alternatives and are involved in and control decision-making processes. They wanted to be listened to rather than being told what to do or what they need. Further, they wanted holistic rather than symptom-focussed care. Support from peers fulfils all these needs. Despite the bereaved

informants characterising peer support as extremely helpful, peer support is not recognised or legitimised and consequently remains under-funded. Despite the efforts of some of the bereaved informants, the government remains primarily accountable to votes and to budget concerns (see Chapter 6) rather than providing support for their constituents. The experiences of the bereaved informants are essentially rendered invalid and their critiques of current practices are largely silenced, ensuring their political voice is diminished.

Chapter 8
Overall Discussion and Conclusions

In this final chapter, I provide an overall discussion of the data and interpretations in light of the three key tensions in the grief literature highlighted in Chapter 2. I argue that the classic grief theories, and the dominant discourse that has emerged from them, do not adequately capture the grief experience following crash fatalities. Further, the medicalisation of grief has the potential to pathologise grief resulting from crash fatalities without regard to the possibility that an extreme response might be 'normal', given the context and circumstances of the grief experiences. As a result, service providers are likely to hold unrealistic expectations about crash-related bereavement, which likely exacerbates grief experiences. I position the research with the context of existing literature and frameworks and explicate the ways in which my study has made a substantial and novel contribution to both theory and practice concerning the experience of grief resulting from crashes in WA. In addition, I outline the strengths and limitations of the study, draw implications of and recommendations from the findings, and suggest avenues for future research.

This final chapter is divided into six sections. First I restate the aims of the research and the research questions. Second, I provide a summary of the data and interpretations, with a particular emphasis on the processes of 'silencing' experiences by the bereaved informants. Third, I discuss the data and interpretations in light of the three key tensions highlighted in Chapter 2 – the transferability of classic grief theories, the medicalisation of grief, and the efficacy of grief interventions. Next, I discuss the implications of the data for service delivery pertinent to bereavement following crash fatalities in WA. I then outline the strengths and limitations of the study. Finally, I suggest avenues for future research.

Aims and Research Questions

As stated in previous chapters, the aims of this research were to explore the experience of grief resulting from losing a loved one in a crash in WA and to describe the influence of the contextual factors on the grief experience, in order to develop a clearer picture of the role of contextual factors in supporting and hindering the experience of grief.

The research questions were as follows:

1. What is the experience of grief resulting from a crash?
2. What factors affect the experience of grief resulting from crashes? In what ways do they affect the grief experience?
3. Are there relationships between these factors? If so, what are they and how do they affect the grief experience resulting from crashes?
4. What are the implications for WA in terms of service delivery pertinent to crash-related bereavement?

Silenced Voices: Experiences of Grief Following Road Traffic Crashes in WA

In each results chapter (Chapters 4 to 7), the primary themes centred on sites of struggle, many of which resulted in the bereaved informants being 'silenced'. The bereaved informants were subjected to a number of silencing processes whereby their expression of grief is constrained - by themselves, their families and social networks, the legal and service systems, and the government road safety discourse. In Chapter 4, I discussed the bereaved informants' experience of grief and demonstrate that their experiences challenge the dominant discourse that constructs grief as a short-term,

stage/phase/task-based, finite, and meaningful phenomenon that culminates in the detachment from the deceased loved one. Instead, they described their grief as unique, long-lasting, and characterised by an oscillation of emotions. Further, their relationships with the deceased were likely to be maintained, and meaning in or positives from the deaths of loved ones were unlikely to be found. Despite the bereaved informants' grief experiences not readily matching the dominant grief discourse, the data also revealed that the bereaved informants may silence their own grief and that of others in their family.

In Chapter 5, I examined the bereaved informants' experiences within their families and social support networks. Although existing support networks were essential in providing support to the bereaved informants, the amount and quality of the support varied widely. However, for the most part, the bereaved informants reported that they could not always access the support they wanted or needed from their existing familial and social networks. Further, despite the limitations of the dominant discourse in capturing their experiences of grief following a crash (see Chapter 4), the bereaved informants' social networks often imposed and enforced the dominant grief narrative. Indeed, the bereaved informants reported being ignored, judged, and avoided by many in their networks. Although in some instances, the death of a loved one precipitated closer familial and social bonds, more commonly the relationships were irrevocably and negatively changed. Ultimately, the informants were shocked and angered at the lack of support they received from those closest to them, which led to the subsequent deterioration and collapse of many relationships in the bereaved informants' social support networks.

In Chapter 6, I outlined the bereaved informants' experiences of voicelessness within the legal, service, and road safety domains. The legal conceptualisation of crashes, as opposed to a health or social paradigm, means that the Western Australian legal system is unable to deal with the ongoing psychosocial effects resulting from crash fatalities. Not only is there the likelihood that the dominant narrative concerning grief will be enforced by family, friends, and colleagues (see Chapter 5), I demonstrated that the legal setting, service providers, media, and government departments also imposed it. The setting informants exhibited a superficial understanding of grief experiences

following crash fatalities. Further, the services available to the bereaved informants appear to be reactive and superficial, which in effect silenced their experiences of grief following crash fatalities. Additionally, the Western Australian government's sole emphasis on crash prevention, the use of advertisements that some of the bereaved informants characterised as insensitive, and the perception that revenue-raising and voter support are more important to the government than saving lives, further served to silence the psychosocial experience of bereavement following crashes.

As a consequence of being 'silenced', many of the bereaved informants reported engaging in a number of acts of resistance in order to reclaim their voices. In Chapter 7, I discussed the bereaved informants' attempts to 'break the silence' by resisting the dominant discourse concerning grief, its enforcement within their social support networks, and the conceptualisations of their experiences as held within the legal, service, and road safety domains. These attempts included self-reliance and support from others with a similar grief experience, such as via mutual help groups. However, learning when it is 'okay' to talk about their grief experiences and/or their deceased loved ones unwittingly reinforced the 'silent' nature of grief resulting from crash fatalities. In addition, some of the bereaved informants also discussed their active involvement in attempts to change government policies. However, doing so meant that they were exposed to further silencing processes**,** such as their perception that their involvement was considered threatening and antagonistic, their recommendations ignored, and a lack of remuneration for their time and expertise. Thus, the bereaved informants' critiques of current policies and practices were largely silenced, ensuring their political voice is diminished.

Three Key Tensions in the Thanatological Literature

In Chapter 2, I introduced and explored the three key tensions that exist in the thanatological literature. These tensions centre on the transferability of classic grief theories, the medicalisation of grief, and the efficacy of grief interventions. In the section below, I discuss each of these tensions in light of the data and interpretations reported in this thesis.

Transferability of Classic Grief Theories. It is clear from the data that grief includes, but is more than, a set of affective, cognitive, behavioural, and physiological

reactions or symptoms. For the bereaved informants in this study, losing a loved one in a crash was a life-changing experience characterised by upheavals in almost all facets of their lives – their roles, identities, priorities, assumptions, anticipated futures, spiritual/religious beliefs, family relationships, friendship networks, employment, financial states, beliefs concerning a 'just world' and faith regarding the legal, police, insurance, government, and service systems. These myriad of changes and losses were in addition to the death of their loved ones. However, although there were many shared experiences, the data revealed that grief following crash fatalities is primarily a unique and individual experience where no two experiences are exactly alike. Thus, while experiencing bereavement is universal; the experience of grief is not.

The data indicate that grief experiences following crashes are very much affected and impacted upon by the relationship with the deceased and method of death, as well as the context in which they occur, including familial, social, and employment contexts, together with the legal system, services, government, grief norms, culture, and the media. The notion that the experiences of grief are dependent on a number of factors is consistent with the notion of grief 'risk factors' in the literature (e.g., Center for the Advancement of Health, 2004; Parkes, 1972, 1986, 2002; Parkes & Weiss, 1983; Rando, 1984, 1993; Sanders, 1988, 1993; M. Stroebe & Schut, 2001; Worden, 1982, 1991, 2002; see also Chapter 2), but differs to the dominant grief narrative that specifies the emotions, stages, and timeframes of grief (e.g., Bowlby, 1961, 1980; Freud, 1915; R. D. Eliot, 1932; Fulconer, 1942, cited in Jacob, 1993; Hogan et al., 1996; Kübler-Ross, 1969; Lazare, 1979; Lindemann, 1944; Parkes, 1965a, 1972, 1986; Parkes & Weiss, 1983; Shuchter & Zisook, 1986, 1987a, 1993; Worden, 1982, 1991, 2002; Zisook, 1987; see Chapter 2).

The historical construction that portrays grief as a short-term process consisting of several stages, phases, or tasks, where the pattern comprises shock, yearning, and emerging from the grief, was not supported by the bereaved informants in this study. Instead, their experiences of grief following the death of a loved one in a crash in WA was characterised by a process of adaptation where, with time, they learn to live with, rather than recover from, their losses. In addition, rather than detaching from their relationship with their deceased loved ones, they actively seek to maintain relationships

with their deceased loved ones. Nor did they report being able to find meaning in the deaths of their loved ones. As such, neither the classic grief theories that were primarily constructed from data collected from North American, white, middle-class, middle-aged to elderly, widows grieving the loss of their husbands, generally after a long illness (see Chapter 2), nor the resulting dominant discourse, are easily transferable to grief following the sudden, unexpected, violent and preventable deaths of loved ones in crashes.

The circumstances of grief following crash fatalities likely explain the lack of transferability. As discussed in Chapters 1, 2, and 4, crash deaths are sudden, unexpected, violent, and usually preventable (Hobbs & Adshead, 1997; Sleet & Branche, 2004; Stewart, 1999; Stewart & Lord, 2002, 2003a; Waller, 2001; WHO, 2004; Zaza et al., 2001). The victims of crash fatalities are also significantly younger than those who die from natural causes (ABS, 2005; WHO, 2004). As a result, the characteristics of crash deaths differ from many other reasons for death, such as illness or old age. In addition, crash deaths are often 'hidden' or acceptable (e.g., Adshead, 1997; Browning, 2002; J. Clark, 2000; J. Clark & Franzmann, 2002; Di Gallo & Parry-Jones, 1996; R. J. Gregory, 1998; Mitchell, 1997a; Suchman, 1961; Tehrani, 2004; Vigilant & Williamson, 2003; WHO, 2004; M. Williams, 1997) and grief following sudden, violent, and preventable deaths, including crash fatalities, is further complicated by legal trials, insurance claims, financial stressors, police investigations, coronial processes, media reports, hospital and medical systems, a strong need to understand the circumstances of the death, thoughts of unfinished business with the deceased, and heightened feelings of unreality, guilt, blame, fear, vulnerability, anger, and helplessness (Currier et al., in press; Doka, 1996; Harwood et al., 2002; Keir, 2000; Kovarsky, 1989; Lord, 1996, 2000; Oliver & Fallat, 1995; Rando, 1993; Redmond, 1996; Riches & Dawson, 1998, 2000; Sprang, 1997; Tehrani, 2004; Volkan, 1970).

Medicalisation of Grief. The dominant portrayal of grief allows 'normal' and 'abnormal' constructions to be revealed. While 'abnormal' forms of grief are not (at least yet) legitimate mental disorders, the move to include 'complicated' grief in a subsequent edition of the DSM is rapidly gaining impetus (e.g., Chen et al., 1999; Goodkin et al., 2005-2006; Hartz, 1986; Horowitz et al., 1993, 1997; Horowitz, 2005-

2006; Kim & Jacobs, 1991; Jacobs, 1993, 1999; Jacobs et al., 2000; Jacobs & Prigerson, 2000; Marwit, 1991; Parkes, 2002, Parkes 2005-2006a, 2005-2006b; Prigerson et al., 1995; Prigerson et al., 1995, 1996, 1997, 1999; Prigerson & Jacobs, 2001; Prigerson & Maciejewski, 2005-2006; Prigerson & Vanderwerker, 2005-2006; Raphael & Middleton, 1990; G. K. Silverman et al., 2000; see also Chapter 2). Indeed, recent conceptualisations and definitions of complicated grief (or other 'abnormal' grief forms) appear to focus on intensity of grief and the length of time since bereavement, with some suggesting more than two months of 'symptoms' suggests the presence of pathology (e.g., APA, 2000). Others have suggested the presence of symptoms beyond six months as indicative of pathology (e.g., Prigerson & Maciejewski, 2005-2006), and yet another group proposed that the bereavement must have occurred at least 14 months previously (e.g., Horowitz et al., 1997). Based on the criteria proposed by Horowitz et al., probably none of the bereaved informants in this study would be diagnosed as having Complicated Grief Disorder. However, the majority, perhaps all, of the bereaved informants interviewed for this study would meet the Prigerson and Maciejewski's criteria for Complicated Grief, which appears to be preferred over the alternatives (see Chapter 2).

Given that an extreme grief reaction appears to be 'normal' for the bereaved informants in this study, perhaps we need to recognise that what might be an extreme reaction for some may in fact be 'normal' for someone else grieving the loss of a young loved one in a sudden, unanticipated, violent, and preventable crash. Although a vast body of literature recognises these characteristics as grief 'risk factors' (e.g., Bolye et al., 1996; Bugen, 1977; Center for the Advancement of Health, 2004; Christ et al., 2002; Currier et al., 2006, in press; Doka, 1996; A. Dyregrov & Dyregrov, 1999; Gamino et al., 1998; Gorer, 1965; J. E. Gregory & Gregory, 2004; Harwood et al., 2002; Hindmarch, 1993, 2000; Jacobs, 1999; Lehrman, 1956; Lev & McCorkle, 1998; Littlewood, 1992; Lofland, 1992; Lord, 1996, 2000; Marcey, 1996; T. Martin & Doka, 2000; McKissock & McKissock, 1991; S. A. Murphy et al., 1999, 2003; Oliver & Fallat, 1995; Parkes, 1972, 1986, 2002; Parkes & Weiss, 1983; Payne et al., 1999; Rando, 1984, 1993; Raphael & Middleton, 1987; Redmond, 1996; Riches & Dawson, 1998b; Rosenblatt, 2000; Rubin, 1993, 1999; Rubin & Malkinson, 2001; Sanders, 1988, 1993;

M. Stroebe & Schut, 2001; Volkan, 1970; Worden, 1982, 1991, 2002), whether or not such response should be pathologised remains heatedly debated. Parkes and Weiss (1983) referred to the interplay between 'pathological' forms of grief and the unique circumstances of the bereavement as a "paradox" (p. 170). They remarked, "it may well be that the pathological variations are no more than extreme forms that appear in response to particularly unfavourable circumstances" (pp. 15-16). Similarly, Rando (1993) defined complicated mourning as dependent on a number of factors. She wrote that, "reactions to loss can only be interpreted within the context of those factors that circumscribe the *particular* loss for the *particular* mourner in the *particular* circumstances in which the loss took place" (p. 12, italics in original). However, determining whether or not complicated grief exists is exceedingly difficult, given these imprecise caveats. Importantly, Rando (1993) listed the following behaviours as often being assumed to be indicators of complicated mourning, when she argued they are not – having a continued relationship with the deceased, maintaining aspects of environments in order to promote memories of the deceased, feelings other than sadness, behaviours that attempt to promote the memory of the deceased in others, experiencing some aspects of grief over many years/forever, or grief that does not decrease in a linear fashion over time. Thus, according to Rando's criteria, none of the bereaved informants in this study displayed pathological grief.

Despite the continuing debate concerning the definition of complicated grief, distinguishing it from other diagnostic categories such as depression, and the potential for all grief to become pathologised (e.g., Hogan et al., 2003-2004; M. Stroebe et al., 2001c; M. Stroebe & Schut, 2005-2006; M. Stroebe, Schut, & Finkenauer, 2001; M. Stroebe et al., 2000; Walter, 2005-2006), it appears more and more likely that complicated grief will be included in a future edition of the DSM. Based on my data, I join those who recommend that the inclusion of complicated grief in the DSM should be approached extremely cautiously, so that grief reactions such as those of the bereaved informants in this study, are not further medicalised and pathologised. As Sprang (1997) wrote in her analysis of families bereaved through crashes, what might be considered extreme in other circumstances of loss is in fact a "normal reaction to an abnormal event" (p. 634). Any grief experience following a crash fatality embodies many of the

risk factors known to be associated with more extreme grief reactions. However, if the experiences of the bereaved informants in this study typify the experience of grief following crash fatalities (and the small amount of literature on grief following crashes reviewed in Chapter 2 suggests this may be so) then the experiences are likely to be 'normal', given their context. How then can the experiences be constructed as aberrant? In posing this question, however, it is prudent to recognise the potentially vast services and support needs of people bereaved by crashes. Later in this chapter I address the issue of support for people bereaved through crashes.

Phenomena such as grief are constructions of the historical, political, social, and cultural setting (Foucault, 1961). Because dominant discourses are considered credible, legitimate, and 'true' forms of knowledge, less powerful discourses, and those who voice them, are marginalised. Thus, the possession of power is subject to and dependent upon the dominant discourses within a society. The possession of power influences our behaviour, our ability to claim resources, and our ability to exercise control (Albee, 1992; Brickman et al., 1982; Foucault, 1961; Gergen, 1999; Illich, 1977; McKnight, 1977; Newbrough, 1992). Similarly, Prilleltensky and Nelson (2002) stated that "theories serve constraining or emancipatory purposes" (p. 21). For example, grief experiences that closely match the dominant discourse concerning grief are likely to be validated, while those that challenge the hegemonic representation are silenced and potentially pathologised. Thus, the dominant discourse concerning grief influences the ways in which the bereaved and their experiences are constructed as either 'normal' or 'abnormal' via the legitimisation of certain experiences and the marginalisation of others. Ultimately, what we refer to as knowledge within a cultural context is particular constructions that are deemed credible and are thus given that stamp of 'truth'. When theories are scrutinized, practices based upon them "are easier to critique, resist, and alter" (Prilleltensky & Nelson, 2002, p. 23). By providing a challenge to the dominant discourse of grief, my research augments the growing body of knowledge that provides a 'normative narrative' (Rappaport, 2000, p. 14) of grief.

Efficacy of Grief Interventions. A third tension centres on the efficacy of grief interventions and service provision. One of the potentially immense barriers to effective grief intervention and service delivery is the general lack of understanding of grief in the

service professions. In light of the increasing trend towards medicalising/pathologising certain grief reactions, and the evidence that professional helpers and lay people often hold unrealistic expectations about grief (Center for the Advancement of Health, 2004; Foote & Frank, 1999; Lindstrøm, 2002; Murray, 2002; Parkes & Weiss, 1983; Payne et al., 2002; Rando, 1993; Riches & Dawson, 2000; Rosenblatt, 1996; Walter, 2000, 2005-2006; Winslade, 2001), my data are potentially revealing for those working in the area(s) of grief intervention and post-crash services and support (see next section).

To ensure that the bereaved are provided with appropriate support, it is imperative that grief following crashes is recognised and understood. Pilkington (1993) argued that it is via understanding grief that service providers, such as those employed in victims services, criminal justice system, insurance, government, and the mental health sector, are best able to effectively assist with the bereaved. However, despite the abundance of literature concerning grief, many areas remain under-researched, including grief resulting from crash fatalities. It is anticipated that the data reported in this thesis have provided a substantial contribution to the small body of literature focussing on the psychosocial consequences of crash fatalities (e.g., FEVR, 1993, 1995; Lehman et al., 1987; Lord, 1987, 1996, 2000; Shanfield & Swain, 1984; Sprang, 1997; Stewart, 1999; Tehrani, 2004). Implications for service delivery following crash fatalities in WA are discussed below.

Implications for Service Delivery Pertinent to Bereavement Following Crash Fatalities in WA

In light of the discord between current grief research and service provision (highlighted in Chapter 1), I have purposely presented this thesis in a format that is most likely to be used and incorporated by service providers; that is, it is 'natural', contextual, involved multiple stakeholders, is relevant to service provision, presented cases as examples with verbatim data from the informants, and incorporated the research literature (Bridging Work Group, 2005; Center for the Advancement of Health, 2004; Jordan, 2000). Thus, I hope that this thesis provides a useful foundation for the delivery of services and supports following crash fatalities in WA.

Crash deaths remain a major public health issue locally and worldwide. An analysis of the subjective experiences of grief following crashes in WA was required in

order to examine how services and supports might effectively meet the needs of those that have lost a loved one in a crash. In my analysis of the current service and support system for people bereaved through crashes in WA (see Chapter 6), I concluded that it is reactive and superficial and amounts to an abrogation of responsibility. I used terms such as moral exclusion (Opotow, 1990), post-crime victimisation (Reiff, 1979), and sanctuary trauma (Tehrani, 2004) to describe the system. The data revealed that, by and large, the needs of the bereaved are deflected; access to support, information, and compensation is poor; and the responsibility of the service setting is circumvented. Despite the expectation of being able to trust the legal and service settings, the reality suggests that the legal system, available support services, and the government together form a 'culture of neglect'. As such, the data clearly demonstrate a lack of adequate services and supports for people bereaved through crashes in WA.

It is clear from my data, as well as other research projects on the topic of crash-related bereavement (e.g., FEVR, 1993, 1995; Keir, 2000; Lehman et al., 1987; Lord, 1987, 1996, 2000; Shanfield & Swain, 1984; Sprang, 1997; Stewart, 1999; Tehrani, 2004; WHO, 2004; M. Williams, 1997), that there is a need for greater sensitivity to and recognition of the needs of those bereaved through crashes. Thus, the first recommendation emerging from the research concerns the provision of grief education. The dominant discourse of grief has pervaded lay and professional understandings and media representations of grief (e.g., Center for the Advancement of Health, 2004; Foote & Frank, 1999; Lindstrøm, 2002; Murray, 2002; Parkes & Weiss, 1983; Payne et al., 2002; Rando, 1993; Rosenblatt, 1996; Walter, 2000, 2005-2006; Winslade, 2001). In addition, the dominant discourse is somewhat endorsed by the service setting, in terms of the provision of short-term supports, the use of terms that reflect the dominant discourse (e.g., stages or phases of grief, process, recovery, closure), and the differentiation between 'normal' grief (reflecting the dominant discourse) and so-called aberrant forms that are medicalised (see Chapters 6 and 7). By echoing the dominant discourse, the setting informants demonstrated a superficial understanding of the experience of losing a loved one in a crash. However, the data clearly demonstrate that the dominant discourse is not reflected by the bereaved informants (see Chapter 4). In addition, service provision for the bereaved is complicated by a lack of grief education

and training provided to service providers; and associated with this dearth of grief education, the discomfort, insensitivity, and/or indifference in dealing with issues concerning grief, especially following sudden, unanticipated, violent, death of a young loved one (see Chapters 6 and 7).

Thus, there is a clear need for the grief education of service providers involved in post-crash services in WA (e.g., Victim Support Service, Insurance Commission of WA, Office of the State Coroner/Coronial Counselling Service, Police, Lifeline's Road Trauma Counselling Service, Major Crash investigators) in order to support them to understand and empathise more easily with the perspectives of the bereaved, and therefore provide better quality support. Similarly, the quality of support provided by other professionals likely to support those bereaved through crashes (e.g., general practitioners, psychologists, counsellors, psychiatrists) could also be improved via the provision of grief education. Although most bereaved people are thought to access support outside of structured support services, the Center for the Advancement of Health (2004) recommended that, "at a minimum, however, physicians and other health care providers should be capable of responding compassionately to bereaved persons" (p. 557). Likewise, providing the Road Safety Council and the Minster for Police and Emergency Services, Justice, and Community Safety with relevant information regarding grief following crash fatalities might better enable them to recognise the need to provide improved supports and services for those bereaved in this manner, a need which is currently not well-understood or appreciated (see Chapters 6 and 7).

Further, the data reveal that family, friends, and work colleagues also imposed the dominant discourse concerning grief and did not appear to understand the needs of the bereaved informants following the deaths of their loved ones in crashes. As a result, the social support networks of the bereaved informants were irrevocably changed, with many deteriorating and even collapsing, leading to experiences of social isolation (see Chapter 5). Given this lack of support, the presence of community-wide grief education would potentially increase awareness of, and support to, those bereaved through crashes (and possibly other types of sudden and violent deaths). Even if professional service providers offer effective and empathic support, they are not always accessed by the bereaved. One study demonstrated that those that met criteria for traumatic grief were

significantly less likely to access assistance (Prigerson et al., 2001). Murray (2002) recommended educating the community to provide the care required, while Hansson and M. Stroebe (2003) concluded that "helping professionals are likely to be most effective by providing support to natural helpers" (p. 519) such as the family, friends, and neighbours of the bereaved and the religious, social, and business groups they belong to. Importantly, community-wide grief education, and education/information aimed specifically for people bereaved through crashes (perhaps similar to the *Information and Support Pack for those Bereaved by Suicide or other Sudden Death*[1], by S. J. Clark, Hillman, and WA Youth Suicide Advisory Committee, 2001) would also lessen the likelihood of bereaved people internalising the dominant discourse, which may lead to less self-disenfranchisement (Kauffman (1989, 2002) and less policing of ones' grief (Walter, 1999) (see also Chapter 4). An example of community-wide education pertaining to crashes is the implementation and evaluation of a road trauma education and training program (Willis et al., 1997). The intervention, for service providers and volunteer community members, increased awareness about road trauma and those involved were more willing and better able to offer support to those in need.

The provision of grief education to these groups – services following crash fatalities, general practitioners, psychologists, counsellors, wider community, those bereaved through crashes, and the WA government – would likely shield the bereaved from the potential for subsequent exclusion, trauma, and victimisation (e.g., Opotow, 1990; Reiff, 1979; Tehrani, 2004) inflicted on them by the existing services, their social support networks, and themselves. The provision of relevant and sensitive grief education about the experiences of grief following crash fatalities in WA would mean that these experiences would not remain unrecognised, veiled, and silenced.

A second recommendation to emerge from the research concerns strengthening the current services available to Western Australians bereaved via crash fatalities. The current model of service provision following crash fatalities is based upon a number of potentially erroneous assumptions. First is the assumption that the bereaved next-of-kin

[1] Although the title of the information and support pack suggests it is relevant to all types of sudden death, it provides information primarily about suicide and is based on a study that investigated the information and support needs of Western Australians bereaved through suicide. As such, it is not particularly pertinent to grief following crash fatalities.

will keep the Office of the State Coroner pamphlet (Appendix L) for future reference, which is not always the case (see Chapter 6). Second, services that rely on self-referral (i.e., all of those currently available to people bereaved through crashes), assume that people who require help are aware they need help, are willing and able to seek help, and trust the services and are able to afford them, while those who do not ask for help do not need it (Parkes & Weiss, 1983). However, these assumptions fail to take into account the notion that the very experience of grief reduces the likelihood of recognising a need, asking for and receiving help, and being able to find right service (Prigerson et al., 2001). A third assumption concerns the dissemination of information via the next-of-kin, with the services appearing to assume that the provision of information to one member of a family will mean that all will then be informed by that person. In fact, many of the bereaved informants reported problems in family communication and difficulties in receiving information from the next-of-kin about coronial processes, the police investigation, the trial, victim support services, and compensation claims.

I demonstrated in Chapter 5 and elsewhere (Breen & O'Connor, in press) that the assumptions that families are inherently functional, remain functional following the significant and completely unexpected crisis that is a crash fatality, and are able to support each of its members, are not supported by the data. Therefore, there is a need for further contact beyond initial notification of the death and the distribution of the pamphlet. Follow up support was also recommended by Hillman et al. (1999) in their study of Western Australians bereaved via suicide, which resulted in the development and distribution of their information pack for families bereaved through suicide (S. J. Clark et al., 2001). The pack includes information on grief, practical matters, support services, and relevant books and websites. The development and structured dissemination of support materials specific to grief following crashes, would complement and expand upon the information contained in the Office of the State Coroner brochure and assist in the provision of support to those bereaved through crash fatalities. Similar materials exist elsewhere, such as *Coping with Grief when Someone You Love is Killed on the Road* in the United Kingdom (see M. Williams, 1997).

Additionally, the data reveal several issues regarding information about and access to current services. For example, the Coronial Counselling Service was

established in 1995, so the bereaved informants in this study, whose loved ones died prior to 1995, did not necessarily know of or have access to the service (see Chapter 6). Some of the informants also stated that the name of service was a barrier to them using it, either because or the word 'coronial' or because of the word 'counselling' (see Chapter 6). A common misconception reported by some of the bereaved informants, including those who had accessed the service, was that it provides a single counselling session only. As a result of this mistaken belief, some chose not to access the service because they did not see how one session could be helpful. Two bereaved informants spoke of their loved ones dying in crashes outside of WA. I had initially (and erroneously) assumed that the bereaved informants, being residents of WA, would be bereaved by deaths occurring here. I considered deleting their cases from the analysis but careful consideration led me to conclude that their experiences are no less representative of the experience of Western Australians bereaved via crash deaths. It is in fact quite plausible that there are many others who live in WA whose loved ones have been killed elsewhere. However, those living in WA grieving the loss of a loved one killed outside WA are not informed of the services here and, therefore, cannot access them. Perhaps the provision of support to this potentially disadvantaged subgroup needs to be considered.

Further, the services are, for the most part, centralised to the metropolitan area (specifically the central business district) of Perth. Although I did not access data from regional residents of WA, they account for just 27% of the state's population but 58% of the state's crash fatalities (Road Safety Council of WA, n.d.). Thus, it is possible that the centralised provision of services is likely to be problematic for them, especially given the large size of the WA (which occupies approximately one-third of Australia's total area) and the potential for significant geographical isolation from these services. The development and dissemination of support materials would assist these groups. Perhaps the placement of the support materials in public places such as general practitioners' surgeries would facilitate the dissemination of the information.

Some of the bereaved informants also reported issues with accessing the reimbursement of funeral costs through the Insurance Commission of WA.

Many informants were not even aware of the entitlement, and others described the difficulties they faced in accessing the funds (see Chapter 6). As the brochure from the Office of the State Coroner (Appendix L) is issued to every family/next-of-kin of the deceased, information regarding the reimbursement could be included in future prints of the brochure. Similarly, I identified that families/next-of-kin might experience a significant delay before being offered support from the Victim Support Service. The time lag is unique to those injured and bereaved through crashes, because of the potential for delay in determining whether or not an offence has been committed (see Chapter 6). As such, the provision of support through the Victim Support Service may be delayed for some people bereaved through crashes, regardless of whether or not the services are needed.

The third recommendation concerns the employment of 'liaison officers' for specific processes related to crash fatalities. As a result of the requirement that the Coroner must investigate all deaths that are not natural or where causes are unknown, the bodies of the deceased are housed at the mortuary before the funeral services, allowing the post-mortem examination to take place. As such, many identifications of the deceased occur there, and many family members take the opportunity to view their loved one's bodies prior to the transfer to a funeral parlour. Currently, technicians currently perform about 99% of the viewings, yet are not in the position to provide support and empathy for the newly bereaved because their duties include conducting the post-mortem examinations (see Chapter 6). Rather than training the technicians to be more sensitive and empathic, which may not fit their role because of their need to remain 'objective' and detached, a dedicated liaison officer could provide support to the bereaved without impeding the post-mortem process. This person or persons would also be useful, not just for crash fatalities, but for any mortuary viewing.

Similarly, the WA Police could benefit by employing a few dedicated liaison officers who could be present at crash scenes and during the death notification and body identification processes, so that the investigating police can continue with their investigative tasks. It is worth noting that most professionals in the position of delivering death notifications report that they have received no training in it (Stewart, Lord, & Mercer, 2000), despite inadequate death notification practices being implicated in the

later 'complicated' bereavement and/or PTSD (Stewart, 1999; Stewart & Lord, 2003b). Further, police officers attending fatal crashes do not readily attend to the psychosocial needs of bereaved family members (Hetherington et al., 1997). While Hetherington et al. (1997) suggested that police officers should be trained to enable them to address the psychosocial needs of family members adequately following fatal crashes, a separate liaison officer is preferable because police (and emergency service personnel) can be greatly and adversely affected by attending and investigating fatal crashes (Hetherington et al., 1997; Cowan 2005a, 2005b; see also Chapter 6), and the recognition by the bereaved informants that the primary role of the police should be to investigate the circumstances of the crash rather than to provide support and counselling to them. Further, some of the issues that some of the bereaved informants had regarding the police investigation, such as a lack of communication and poor access to information concerning the crash investigation (see Chapter 6), may be mitigated by the employment of liaison officers.

Potentially, there is also an option for providing a systematic support service for people affected through crash fatalities and injuries. In other Australian states (e.g., Victoria) the state government funds structured supports for those affected through crashes, including their psychological consequences (Keir, 2000). The Road Trauma Support Team (http://www.rtst.org.au) provides counselling, information about grief and trauma, newsletters, and links to related organisations. M. Williams (1997) recommended that counselling for people bereaved through crashes should be available, publicised, and government-funded. Given the intense and prolonged nature of grief following crashes, and the identified inadequacies of current support structures, Tehrani (2004) suggested the introduction of a national support programme to provide both initial assistance and ongoing support and resources to the bereaved families. Similarly, Adshead (1997) recommends greater acknowledgment and awareness of psychosocial needs of those affected by crashes, the employment of specialist staff to meet these needs, and more research/training in order to identify and meet these needs. In addition to the above support, there is room for greater recognition and funding of mutual help groups such as (but not limited to) The Compassionate Friends, especially as they provide support throughout WA, not just to those in the metropolitan area of Perth. It

would be beneficial if such a support programme was developed in consultation with those who are bereaved in crashes. This follows from the position that those who have experienced grief are best able to educate service providers to provide the best service (Hopton, 1995). This process would be empowering to the bereaved, because their voices would be heard, legitimised, and valued (see Chapter 7), but including them in the process would ensure that the program is relevant to those that would use it and would thus result in a better service.

The final recommendation concerns efforts to reduce and prevent crash fatalities from occurring. Road safety is a significant public health and social equity issue (WHO, 2004) and needs to be recognised and prioritised as such. I propose the WA government move beyond their focus on road-user education and enforcement to a more holistic program of road safety. In WA, the creation of the Road Safety Council, which coordinates multi-sectoral responses to eliminating road crashes as a major cause of death and injury, is to be commended, but requires two additional features. The first requirement is a strengthened focus. Rather than focussing on the *prevention* of crashes through attempts to alter human behaviour, WHO (2004) recommended the creation of a road traffic system that *absorbs* human error. WHO (2004) cited Sweden and the Netherlands as exemplars of comprehensive and holistic approaches to road safety that reduce road traffic fatalities and injuries. For example, in Sweden, human life is prioritised over mobility. As such, road safety is a responsibility of road users as well as providers of the road user system – government, vehicle manufacturers, police, and so on – rather than emphasising individual road user responsibility. The second requirement is more funding, so that the psychosocial outcomes resulting from crashes are also 'owned' and the responsibility for supporting them is shared. It is only then that appropriate support for those affected by the consequences of crash fatalities will be provided.

Strengths and Limitations of the Study

In this section I address the strengths and limitations of the study with a particular emphasis on the sampling techniques and methodology utilised in the study. The non-random sampling techniques used in this study yielded a predominantly white and middle class sample of bereaved informants. Nevertheless, given that the population

of WA is predominantly white and generally enjoys a comfortable standard of living, the sample is in the main typical of the population grieving the deaths of loved ones through crashes. However, the sample of bereaved informants was dominated by women, which is common to bereavement research generally (see Center for the Advancement of Health, 2004; Schlernitzauer et al., 1998; M. Stroebe, 1998; M. Stroebe et al., 2003) and research specifically on grief following crashes (e.g., Lehman et al., 1987; Lord, 1987; Spooren et al., 2000-2001; Tehrani, 2004). Further, those in the bereaved sample were either native English speakers or highly competent in English, meaning that the experiences of culturally and linguistically diverse people bereaved through crashes might not be characterised in the data. Similarly, the setting informants might not have been typical of all of those working in the wider context of crashes in WA. Despite these issues, the sampling techniques (as outlined in Chapter 3) were comprehensive and thus confidence in relatively characteristic samples of both bereaved and setting informants is high. Finally, samples of other research projects on the outcomes of crash fatalities have predominantly been drawn either from activist groups (e.g., FEVR, 1993, 1995; Lord, 1987; Sprang, 1997; Tehrani, 2004), mutual help groups (e.g., Spooren et al., 2000-2001; Sprang, 1997; Sprang & McNeil, 1998), or the wider community (e.g., Lehman et al., 1987, 1989; Shanfield & Swain, 1984), whereas the bereaved informants in this study were drawn from all three sources.

Just over half of all crash deaths in WA occur outside the Perth metropolitan area (Road Safety Council of WA, n.d.). Although I originally intended to sample bereaved informants throughout WA, budgetary and time constraints meant that I could not conduct interviews outside of Perth. I contemplated the use of technology such as telephone or video links but decided that the personal connection and rapport were of great importance in the interview process (Burgess-Limerick & Burgess-Limerick, 1998; Maykut & Morehouse, 1994; Minichiello et al., 1995; Patton, 2005; Smith, 1995), especially as interviews with bereaved individuals have the potential to elicit emotional responses (e.g., A. S. Cook, 1995, 2001; Cowles, 1988). As a consequence of my concern to maximise rapport, all informants were residents of the Perth metropolitan area and, as such, the findings from the study should not be uncritically applied beyond the metropolitan area. It is open to speculation whether or not the experience of

informants living in rural areas might be 'easier' given the potential for closer relational and community links in rural communities (Willis et al., 1997), or it might be 'worse', given the significantly higher rate of crash fatalities (Kirov et al., 2000; Legge et al., 2001; Road Safety Council of WA, n.d.), the potential for crash deaths to affect all members within small communities (Willis et al., 1997), and less support infrastructure in rural areas (see Chapter 6). Nevertheless, it would be expected that those in the Perth metropolitan area would have greater knowledge of and access to services and supports than those living in regional areas and thus the data are an indictment on the current provision of support available for people bereaved through crash fatalities.

The use of grounded theory methodology (Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin 1990, 1998) enabled the development of an original, systematic, sensitive, contextual, and data driven theory of grief following the deaths of loved ones in crashes in WA (Artinian, 1986; Chenitz & Swanson, 1986; Creswell, 1994; Denzin, 1972; Strauss, 1987; Strauss & Corbin, 1990, 1998). The use of qualitative methodology privileged the subjective experiences of both group of informants and enabled me to articulate the commonalties (intersubjectivities) and differences between both groups (Fischer, 1999). However, there are a number of issues that require discussion. First, the accuracy of data gathered through interviews has the potential to be distorted by the informants. For example, they might lie, have an aversion to or be suspicious of the researcher, feel embarrassed about sharing the truth, have difficulty in remembering, or even sabotage the research (Breakwell, 1995). Likewise, interviews are also susceptible to researcher effects and characteristics such as demeanour, sex, age, and so on (Breakwell, 1995). However, the same problems have the potential to be encountered in a number of techniques employed by social scientists, such as questionnaires, focus groups, psychometric tests, and even true experiments. Just like these methods, interviews can be rigorous, and all attempts were made to ensure the process was as rigorous as possible, including multiple sources of data and methods of data collection, the presence of an audit trail, checking interpretations with the informants to ensure accuracy, verifying or 'trialling' the interpretations by presenting it to different audiences for comment , conducting the research under the supervision of a team, and providing a detailed description of both the informants and the context of the research

(Berg, 2001; Breakwell, 1995; Burgess-Limerick & Burgess-Limerick, 1998; Creswell, 1994; Denzin & Lincoln, 1998; Lincoln & Guba, 1985; Maykut & Morehouse, 1994; Morse, 1994; Nagy & Viney, 1994; Patton, 1990, 2002; D. Silverman, 1993; Strauss, 1987; Strauss & Corbin, 1990, 1998).

The social, cultural, temporal, historical, and political contexts within which the bereavement experience is housed is of importance and, as such, I purposively limited the study to focus solely on the experience of bereavement following crash fatalities in WA. A thorough understanding of the grief experience resulting from crashes could only be articulated through understanding the wider context within which the grief occurs. As such, the use of a contextual framework that emphasises understanding individuals in their natural (non-manipulated) contexts (Dalton et al., 2001; Duffy & Wong, 2003; Lewin, 1951; Thomas & Veno, 1992) provided a framework for the contextual analysis of a psychosocial phenomenon such as grief following crash fatalities. As a result of focussing on the one substantive domain, the research yielded a rich and meaningful grounded theory of grief resulting from crash fatalities, and as such many implications for the provision of services and policy development were able to be drawn from the data (see previous section).

Finally, in embarking on an overall discussion of the data, it is important to address the knowledge claims that can be made. In Chapter 3, I stated that knowledge is not objective nor is it universal. Rather, knowledge of a phenomenon, including grief, is bound by the social, temporal, cultural, and political context within which it is housed, as well as the role and skills of the researcher. As a result, the findings I presented in this thesis were not an attempt to reveal a singular 'truth'. My findings are not 'the truth' but a summary of the multiple truths/perspectives. The findings also cannot be uncritically generalised beyond the temporal, cultural, and political boundaries outlined in the thesis. However, despite these limitations, the research provides a detailed grounded theory of the experience of grief resulting from crashes in WA.

Avenues for Future Research

In light of the strengths and limitations discussed above, I suggest a number of avenues for future research. Despite my recruitment strategies focusing on people who had lost a loved one in a crash (see Appendices A and B), all of the bereaved informants

interviewed had lost family members. Given the increasing importance of relationships with friends and colleagues in societies with increased mobility and industrialisation (Fowlkes 1991), investigating the grief experienced by friends and colleagues provides an area for future research, particularly as Deck and Folta (1989) regarded friends of the deceased as a potentially disenfranchised group. In addition, none of the bereaved informants were in other types of 'disenfranchised' relationships with the deceased, such as gay relationships, affairs, or former partners (Doka, 1989, 2002). Further, none were grieving the loss of their only child, which might be a particularly distressing bereavement (see Talbot, 1997; Wheeler, 1993-1994). Although parents bereaved by the death of their only child usually identify as parents, they are often not treated by society as parents. As McLaren (1998) stated, "this society has no name for parents who become childless" (p. 288). Moreover, given the considerably higher rate of crash fatalities (Road Safety Council of WA, n.d.) and less infrastructure in rural areas (see Chapter 6) of WA, the experience of the bereaved through crashes in rural areas provides another avenue for future research. While approximately 3% of Western Australians identify as Aboriginal, they are more likely to be involved in crashes and have higher fatality and hospitalisation rates than the rest of the population (Kirov et al., 1999; Legge et al., 2000). Finally, like a number of other studies (e.g., FEVR, 1993, 1995; Lehman et al., 1987; Lord, 1987; Tehrani, 2004), my sample reported that their loved ones died either because of the actions of another, or the causes of the crash were not clear (e.g., single vehicle crashes). Another avenue of investigation is the grief experiences of individuals whereby their loved ones caused the crash in which they died. Indeed, Shanfield and Swain's (1984) study revealed that parents of adult children who died in single-vehicle/single driver crashes were more likely to experience a more 'difficult' bereavement, perhaps because their children had 'caused' their own deaths, but this finding requires further study. Additional samples of interest include individuals who survived a crash wherein a loved one died, children bereaved through crashes, as children are likely to have grief experiences and needs that differ to that of adults (e.g., Christ, 2000; Raphael, 1984; Ward, 1996), and, in light of the gender-biased sample in this study, men bereaved through crashes. Investigating the experiences of the groups

identified above would also provide further insight into the experiences of grief following crash fatalities.

In addition to the above sampling suggestions, there is provision for a longitudinal study of grief following crash fatalities. While the 'scoping and profiling' process, document analysis, and interviews with the setting informants provided current information, the interviews with the bereaved informants were largely retrospective, with the exception of the discussion regarding their current experiences. Collecting data from the bereaved over many time points would ameliorate the reliance on retrospective data.

As stated earlier in this chapter, it is probable that many of the bereaved informants would meet the criteria for 'complicated' grief. The medicalisation (Zola, 1977) of grief, and specifically, the debate concerning the definition and criteria of complicated grief (see Chapters 1 and 2 provides a number of avenues for future research, such as the investigation of community and service providers' perceptions of what constitutes normal grief and when grief becomes 'complicated'. For example, could the important variable be the presence of certain thoughts and behaviours, a particular length of time, or the presence of 'symptoms', or a combination of these? Are the perceptions dependent on variables such as age of and relationship to the deceased? What are the likely consequences of the classification for complicated grief as a disorder in social, health, legal, and compensatory domains? In addition, it has been argued that "the pursuit of pathology tends to prevail" (Prilleltensky & Nelson, 2002, p. 113) when those experiencing a phenomenon are not included in the discussion. This raises the question of what the medicalisation of grief responses might mean for the bereaved. All these questions and issues provide fertile ground for further research.

Further, I did not use grief measures or psychometrics (e.g., depression, PTSD, complicated grief), nor am I a clinician, so I cannot say whether or not the bereaved informants would meet the criteria for complicated grief or other mental disorders. However, as discussed earlier in this chapter, it is evident that, given the intensity and duration of their grief, many would potentially meet the criteria for Major Depressive Disorder and/or PTSD (APA, 2000) and/or the proposed Complicated Grief Disorder (e.g., Prigerson & Maciejewski, 2005-2006). It would be pertinent in future studies to

ascertain whether or not, and the extent to which, the informants satisfy the criteria following a crash fatality. Further, any differences in the grief experiences of those who do meet the criteria for disorder and those who do not might be determined.

Given that the findings cannot be uncritically generalised beyond early 21st century WA, there is room for similar research to be conducted in other jurisdictions and at other times, especially as other contexts have different insurance and compensation schemes and support structures to those in WA. For example, I would expect that similar research in the state of Victoria would yield different results, given the different contexts. For example, Victoria has a no-fault system where WA has a fault-based system (Bureau of Transport Economics, 2000; see also Chapter 6) and Victoria has the Road Trauma Support Team (Keir, 2000), just to name two differences. Additionally, 85 to 90% of all traffic crash fatalities (and injuries) occur in low and middle-income countries (Nantulya & Reich, 2002; WHO, 2004). Factors that contribute to the disproportionate rate of death in low and middle-income countries include the exponential growth in the number of vehicles, the greater number of people killed per crash (due to the higher use of multi-passenger transport), poor traffic law and safety enforcement, insufficient health infrastructure, and inadequate access to health care (Nantulya & Reich, 2002). The economic cost alone due to crashes in many of these countries exceeds development assistance (WHO, 2004)! Furthermore, while the rates of crash fatalities and injuries in many high-income countries are slowly declining, they are growing rapidly in low and middle-income countries, where the rate of death from crashes is expected to rise up to 80% in coming years (Nantulya & Reich, 2002; WHO, 2004). As such, the experience of grief following crash fatalities as experienced in other countries would likely be very different to that reported here.

Finally, while the research provides a grounded theory of grief following crash fatalities in WA, the study was not action-oriented or based upon research partnerships with relevant stakeholders. Participatory action research would serve to make necessary changes with the participation of both the bereaved and setting informants. Participatory action research is gaining legitimacy as a powerful paradigm for the increasing understanding and resolution of social issues, and has been used in a number of domains, such as learning disabilities (e.g., Duckett & Fryer, 1998), women's health

(e.g., K. Johnson, Gridley, & Moore, 2003), and exposure of Indigenous people to environmental toxins (e.g., Santiago-Rivera, Morse, Hunt, & Lickers, 1998). This is an additional avenue for future research.

Conclusion

The broad aims of this research were to explore the experience of grief resulting from losing a loved one in a crash in WA and to describe the influence of the contextual factors on the grief experience, in order to develop a clearer picture of the role of contextual factors on supporting and inhibiting the experience of grief following crash fatalities. In essence, my thesis uncovered the multitude of factors that influence the grief experience following a crash fatality in WA and resulted in a number of recommendations for policy and the provision of supports for people bereaved through the death of a family member in a crash in WA.

References

Adshead, G. (1997). Psychological services for road accident victims and their relatives. In M. Mitchell (Ed). *The aftermath of road accidents: Psychosocial, social, and legal consequences of an everyday trauma* (pp. 217-223). London: Routledge.

Albee, G. W. (1992). Powerlessness, politics, and prevention: The community mental health approach. In S. Straub & P. Green (Eds.), *Psychology and social responsibility: Facing global challenges* (pp. 201-220). New York: New York University Press.

American Psychological Association. (1994). *Diagnostic and statistical manual of manual disorders* (4th ed.). Washington, DC: Author.

American Psychological Association. (2000). *Diagnostic and statistical manual of manual disorders text revision* (4th ed.). Washington, DC: Author.

Andersen, A. (2003, June). I am afraid if I stop hurting that I will forget. *Reflections, 22*(2), 3.

Anderson, C. (1949). Aspects of pathological grief and mourning. *International Journal of Psychoanalysis, 30*, 48-55.

Angell, G. B., Dennis, B. G., & Dumain, L. E. (1998). Spirituality, resilience, and narrative: Coping with parental death. *Families in Society, 79*, 615-630.

Artinian, B. (1986). The research process in grounded theory. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing theory* (pp. 16-23). Menlo Park, CA: Addison-Wesley.

Australian Bureau of Statistics. (2005). *Cause of death Australia 2003 (3303.0).* Canberra, Australian Capital Territory, Australia: Author.

Australian Transport Safety Bureau. (n.d.-a). *Australia's international road safety performance 1998 (Monograph 6)*. Retrieved February 2, 2004, from http://www.atsb.gov.au/road/mgraph/mgraph6/index.xfm

Australian Transport Safety Bureau. (n.d.-b). *Road safety 1997 (Monograph 2)*. Civic Square, Australian Capital Territory, Australia: Author.

Australian Transport Safety Bureau. (2003a). *Road crash data and rates: Australian states and territories 1925 to 2002*. Civic Square, Australian Capital Territory, Australia: Author.

Australian Transport Safety Bureau. (2003b). *Road fatalities Australia: 2002 statistical summary*. Civic Square, Australian Capital Territory, Australia: Author.

Baistow, K. (1995). Liberation and regulation? Some paradoxes of empowerment. *Critical Social Policy, 14*(3), 34-46.

Balk, D. E. (1999). Bereavement and spiritual change. *Death Studies, 23*, 485-493.

Ball-Rokeach, S. J., Hale, M., Scaffer, A., Porras, L., Harris, P., & Drayton, M. (1999). Changing the media production process: From aggressive to injury-sensitive traffic crash stories. In D. Demers & K. Viswanath (Eds.), *Mass media, social control, and social change: A macrosocial perspective* (pp. 229-262). Ames, IA: Iowa State University Press.

Bambauer, K. Z., & Prigerson, H. G. (2006). The stigma receptivity scale and its association with mental health service use among bereaved older adults. *Journal of Nervous and Mental Disease, 194*, 139-141.

Banks, D. A. (1998). The economics of death? A descriptive study of the impact of funeral and cremation costs of U.S. households. *Death Studies, 22*, 269-285.

Barclay, S., Wyatt, P. Shore, S., Finlay, I., Grande, G., Todd, C. (2003). Caring for the dying: Howe well prepared are general practitioners? A questionnaire study in Wales. *Palliative Medicine, 17*, 27-39.

Barry, C. A. (1998). Choosing qualitative data analysis software: Atlas/ti and Nudist compared [Electronic source]. *Sociological Research Online, 3*(3).

Barry, L. C., Kasl, S. V., & Prigerson, H. G. (2002). Psychiatric disorders among bereaved persons: The role of perceived circumstances of death and preparedness for death. *American Journal of Geriatric Psychiatry, 10*, 447-457.

Bartlett, D., & Payne, S. (1997). Grounded theory – its basis, rationale, and procedures. In G. McKenzie, J. Powell, & R. Usher (Eds.), *Understanding social research: Perspectives of methodology and practice* (pp. 173-195). London, Falmer Press.

Beem, E. E., Eurelings-Bontekoe, E. H. M., Cleiren, M. P. H. D., & Garssen, B. (1998). Workshops to support the bereavement process. *Patient Education and Counseling, 34*, 53-62.

Bellis, M. (2004). *The history of the automobile: Early steam powered cars.* Retrieved February 3, 2004, from http://inventors.about.com/

Bennett, K. M. (1998). Longitudinal changes in mental and physical health among elderly, recently widowed men. *Mortality, 3*, 265-273.

Berg, B. L. (2001). *Qualitative research methods for the social scientists*. Needham Heights, MA: Allyn & Bacon.

Bernardi, J. M., & Sanders, C. M. (1978). Self-help groups in illness and bereavement. *Death Education, 2*, 311-317.

Birtchnell, J. (1981). In search of correspondence between age at psychiatric breakdown and parental age of death: "Anniversary reactions". *British Journal of Medical Psychology, 54*, 111-120.

Blanchard, E. B., Hickling, E. J., & Kuhn, E. (2003). Of "crashes" and "accidents," a comment on Stewart and Lord. *Journal of Traumatic Stress, 16*, 527-528.

Bonanno, G. (1998). The concept of "working though" loss: A critical evaluation of the cultural, historical, and empirical evidence. In A. Maercker, M. Schuetzwohl, & Z. Solomon (Eds.), *Posttraumatic stress disorder: Vulnerability and resilience in the life-span* (pp. 221-247). Gottingen, Germany: Hogrethe & Huber.

Bonanno, G. A. (2001). Grief and emotion: A social-functional perspective. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 493-515). Washington, DC: American Psychological Association.

Bonanno, G. A. & Field, N. P. (2001). Examining the delayed grief hypothesis across 5 years of bereavement. *American Behavioral Scientist, 44*, 798-816.

Bonanno, G. A., & Kaltman, S. (1999). Towards an integrative perspective on bereavement. *Psychological Bulletin, 125*, 760-776.

Bonanno, G. A., & Kaltman, S. (2000). The assumed necessity of working through memories of traumatic experiences. In P. R. Duberstein & J. M. Masling (Eds.), *Psychodynamic perspectives on sickness and health* (pp. 165-200). Washington, DC: American Psychological Association.

Bowlby, J. (1961). Processes of mourning. *International Journal of Psychoanalysis, 42*, 317-340.

Bowlby, J. (1980). *Attachment and loss Vol. 3: Loss, sadness, and depression*. New York: Basic.

Bowlby-West, L. (1983). The impact of death on the family system. *Journal of Family Therapy, 5*, 279-294.

Bowman, T. (1997). Facing loss of dreams: A special kind of grief. *Journal of Palliative Nursing, 3*, 76-80.

Boyle, F. M., Vance, J. C., Najman, J. M., & Thearle, M. J. (1996). The mental health impact of stillbirth, neonatal death or SIDS: Prevalence and patterns of distress among mothers. *Social Science and Medicine, 43*, 1273-1282.

Braun, K. L., & Nichols, R. (1997). Death and dying in four Asian American cultures: A descriptive study. *Death Studies, 21*, 327-359.

Breakwell, G. M. (1995). Interviewing. In G. M. Breakwell, S. Hammond, & C. Fife-Shaw (Eds.), *Research methods in psychology* (pp. 230-242). London: Sage.

Breen, L. (2004, July). Doing grief research. *The Compassionate Friends Australian National Newsletter, 10*(2), 9-10.

Breen, L. & O'Connor, M. (in press). The role of the deceased in family disputes, dysfunction, and division: Case studies of road traffic crashes. In M. Mitchell (Ed.), *Remember me: Constructing immortality*. New York: Taylor & Francis.

Breslau, N., Davis, G. C., & Andrewski, P. (1998). Risk factors for PTSD-related traumatic events: A prospective analysis. *American Journal of Psychiatry, 152*, 529-535.

Brickman, P., Rabinowitz, V. C., Karuza, J., Jr., Coates, D., Cohen, E., & Kidder, L. (1982). Models of helping and coping. *American Psychologist, 37*, 368-384.

Bridging Work Group. (2005). Bridging the gap between research and practice in bereavement: Report from the Center for the Advancement of Health. *Death Studies, 29*, 93-122.

Broughton, J. (1997). Road accident statistics. In M. Mitchell (Ed). *The aftermath of road accidents: Psychosocial, social, and legal consequences of an everyday trauma* (pp. 15-32). London: Routledge.

Brown, G. (1972). Road trauma: A community crisis. *Medical Journal of Australia, 1*, 669-674.

Browning, R. (2002). Where are the protests? *British Medical Journal, 324*, 1165.

Bureau of Transport and Regional Economics. (2003). *State spending on roads (Working paper 56)*. Canberra, Australian Capital Territory, Australia: Author.

Bureau of Transport Economics. (2000). *Road crash costs in Australia (report 102).* Canberra, Australian Capital Territory, Australia: Author.

Bugen, L. A. (1977). Human grief: A model for prediction and prevention. *American Journal of Orthopsychiatry, 47*, 196-206.

Burgess-Limerick, T., & Burgess-Limerick, R. (1998). Conversational interviews and multiple-case research in psychology. *Australian Journal of Psychology, 50*(2), 63-70.

Calabrese, J. R., Kling, M. A., & Gold, P. W. (1987). Alterations in immunocompetence during stress, bereavement, and depression: Focus on neuroendocrine regulation. *American Journal of Psychiatry, 144*, 1123-1134.

Calhoun, L. G., & Tedeschi, R. G. (2001). Posttraumatic growth: The positive lessons of loss. In R. A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 157-172). Washington, DC: American Psychological Association.

Car death judge bags motor ads. (2003, March 12). *The West Australian*, p. 13.

Caserta, M. S., & Lund, D. A. (1996). Beyond bereavement support group meetings: Exploring outside social contacts among the members. *Death Studies, 20*, 537-556.

Cassem, N. H. (1975). Bereavement as indispensable for growth. In B. Schoenberg, I. Gerber, A. Weiner, A. H., Kutscher, D. Peretz, & A. C. Carr (Eds.), *Bereavement: Its psychosocial aspects* (pp. 9-17). New York: Columbia University Press.

Center for the Advancement of Health. (2004). Report on bereavement and grief research. *Death Studies, 28*, 491-575.

Cercarelli, L. R., & Guilfoyle, A. M. (2005). *Evaluating the Western Australian Railway Level Crossing Education Project* (No. RR162). Crawley, Western Australia, Australia: Injury Research Centre, University of Western Australia.

Charmatz, K. (2000). Grounded theory: Objectivist and constructivist methods. In. N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). Thousand Oaks, CA: Sage.

Chen, J. H., Bierhals, A. J., Prigerson, H. G., Kasl, S. V., Mazure, C. M., & Jacobs, S. (1999). Gender differences in the effects of bereavement-related psychological distress in health outcomes. *Psychological Medicine, 29*, 367-380.

Chenitz, W. C. (1986a). The informal interview. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing theory* (pp. 79-90). Menlo Park, CA: Addison-Wesley.

Chenitz, W. C. (1986b). Getting started: The research proposal for a grounded theory study. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing theory* (pp. 39-47). Menlo Park, CA: Addison-Wesley.

Chenitz, W. C., & Swanson, J. M. (1986). Qualitative research using grounded theory. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing* (pp. 3-15). Menlo Park, CA: Addison-Wesley.

Christ, G. H. (2000). *Healing children's grief: Surviving a parent's death from cancer*. New York: Oxford University Press.

Christ, G. H., Bonanno, G., Malkinson, R., & Rubin, S. (2002). Bereavement experiences after the death of a child. In M. J. Field, & R. E. Behrman (Eds.), *When children die: Improving palliative and end-of-life care for children and their families* (pp. 553-579). Washington, DC: National Academies Press.

Christiakis, N. A., & Iwashyna, T. J. (2003). The health impact of health care of families: A matched cohort study of hospice use by decedents and mortality outcomes in surviving, widowed spouses. *Social Science and Medicine, 57*, 465-475.

Clark, J. (1997), February), Wild behaviour: Infernal machines and serious accidents. *National Library of Australia News*, 3-5.

Clark, J. (1998). Moral motoring: Road safety for Christian gentlemen 1896-1970. *Roadwise, 10*(4), 4-11.

Clark, J. (2000). A short history of road safety. In G. Horne (Ed.), *Australian College of Road Safety yearbook* (pp. 3-5). Melbourne, Australia: Executive Media.

Clark, J. (2002). Road safety and the historical perspective: The example of women. *Roadwise, 13*(4), 19-22.

Clark, J. (2004). Deceased drivers: Memorialisation and road safety. *Roadwise, 15*(1), 11-13.

Clark, J. (Ed.). (1999a). Safe and mobile: Introductory studies in traffic safety. Armidale, New South Wales, Australia: Emu Press.

Clark, J. (Ed.). (1999b). The past: Hit and miss. In J. Clark (ed.), *Safe and mobile: Introductory studies in traffic safety* (pp. 1-20). Armidale, New South Wales, Australia: Emu Press.

Clark, J., & Cheshire, A. (2003-2004). RIP by the roadside: A comparative study of roadside memorials in New South Wales, Australia, and Texas, United States. *Omega: The Journal of Death and Dying, 43*, 203-222.

Clark, J. & Franzmann, M. (2002). "A father, a son, my only daughter": Memorialising road trauma. *Roadwise, 13*(3), 4-10.

Clark, J., & Franzmann, M. (2006). Authority form grief, presence and place in the making of roadside memorials. *Death Studies, 30*, 579-599.

Clark, S. J., Hillman, S. D., & Western Australian Youth Suicide Advisory Committee. (2001). *Information and support pack for those bereaved by suicide or other sudden death*. Perth, Western Australia, Australia: Western Australian Youth Suicide Advisory Committee.

Clarke, D. D., Ward, P., & Truman, W. (2005). Voluntary risk taking and skill deficits in young driver accidents in the UK. *Accident Analysis and Prevention, 37*, 523-529.

Cleiren, M. P. H. D., Dieskstra, R. F. W., Kerkof, A. J. F. M., & van den Wal, J. (1994). Mode of death and kinship in bereavement: Focusing on "who" rather than "how". *Crisis, 15*, 22-36.

Constantino, V., & Nelson, G. (1995). Changing relationships between self-help and mental health professionals: Shifting ideology and power. *Canadian Journal of Community Mental Health, 14*, 55-70.

Cook, A. S. (1995). Ethical issues in bereavement research: An overview. *Death Studies, 19*, 103-122.

Cook, A. S. (2001). The dynamics of ethical decision making in bereavement research. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 119-142). Washington, DC: American Psychological Association.

Cook, A. S. & Bosley, G. (1995). The experience of participating in bereavement research: Stressful or therapeutic? *Death Studies, 19*, 157-170.

Cook, D. White, D. K., & Ross-Russell, I. (2002). Bereavement support following sudden and unexpected dearth: Guidelines for care. *Archives for Disease in Childhood, 87*, 36-39.

Corr, C. A. (1993). Coping with dying: Lessons we should and should not learn from the work of Elisabeth Kübler-Ross. *Death Studies, 17*, 69-83.

Corruption and Crime Commission of Western Australia. (2006). *Report in the matter of an allegation of public sector misconduct concerning Mr John D'Orazio MLA*. Perth, Western Australia, Australia: Author.

Corwin, M. D. (1995). Cultural issues in bereavement therapy: The social construction of mourning. *In Session: Psychotherapy in Practice, 1*(4), 23-41.

Cowan, S. (2005a, November 16). Major crash officer wants trauma compo. *The West Australian*, p. 13.

Cowan, S. (2005b, November 19). Stressed out cops may have to leave force. *The West Australian*, p. 48.

Creswell, J. W., (1994). *Research design: Qualitative and quantitative approaches.* Thousand Oaks, CA: Sage.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, New South Wales, Australia: Allen & Unwin.

Currier, J. M., Holland, J. M., Coleman, R. A., & Neimeyer, R. A. (in press). Bereavement following violent death: An assault on life and meaning. In R. Stephenson & G. Cox (Eds.), *Perspectives on violence and violent death.* Amityville, NY: Baywood.

Currier, J. M., Holland, J. M., & Neimeyer, R. A. (2006). Sense-making, grief, and the experience of violent loss: Towards a mediational model. *Death Studies, 30*, 403-428.

Daggett, L. M. (1999). *Living with loss: The lived experience of spousal bereavement in men aged 40 to 60*. Unpublished doctoral thesis, University of Alabama, Birmingham, Alabama.

Dalton, J. H., Elias, M. J., & Wandersman, A. (2001). *Community psychology: Linking individuals and communities*. Stamford, CT: Wadsworth/Thomson Learning.

Darragh, D. (2005a, December 14). It's 45km over and you lose your car. *The West Australian*, p. 5.

Darragh, D. (2005b, May 7). Family anger as hit-run driver free. *The West Australian*, p. 5.

Davis, C. G. (2001). The tormented and the transformed: Understanding responses to loss and trauma. In R. A. Neimeyer (ed.), *Meaning reconstruction and the experience of loss* (pp. 137-155). Washington, DC: American Psychological Association.

Davis, C. G., & Nolen-Hoeksema, S. (2001). Loss and meaning: How do people make sense of loss? *American Behavioral Scientist, 44*, 726-741.

Davis, C. G., Nolen-Hoeksema, S., & Larson, J. (1998). Making sense of loss and benefiting from the experience: Two construals of meaning. *Journal of Personality and Social Psychology, 75*, 561-574.

Davis, C. G., Wortman, C. B., Lehman, D. R., & Silver, R. C. (2000). Searching for meaning in loss: Are clinical assumption correct? *Death Studies, 24*, 497-540.

Davis, M. Z. (1986). Observation in natural settings. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing* (pp. 48-65). Menlo Park, CA: Addison-Wesley.

Davison, K. P., Pennebaker, J. W., & Dickerson, S. S. (2000). Who talks? The social psychology of illness support groups. *American Psychologist, 55*, 205-217.

Deck, E. S., & Folta, J. R. (1989). The friend-griever. In. K. J. Doka (Ed.), Disenfranchised grief: Recognizing hidden sorrow (pp. 77-89). Lexington, MA: Lexington Books.

Delgado-Gaitan, C. (1993). Researching change and changing the researcher. *Harvard Educational Review, 63*, 389-411.

Denzin, N. K. (1972). The research act. In G. Manis & B. N. Meltzer (Eds.), *Symbolic interaction: A reader in social psychology* (2nd ed., pp. 897-922). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.) (1994). *Handbook of qualitative research.* Thousand Oaks, CA: Sage.

Denzin, N. Z., & Lincoln, Y. S. (Eds.) (1998). *The landscape of qualitative research: Theories and issues*. Thousand Oaks, CA: Sage.

Deutsch, H. (1937). Absence of grief. *Psychoanalytic Quarterly, 6*, 12-22.

Dickinson, G. E., & Field, D. (2002). Teaching end-of-life issues: Current status in United Kingdom and United States medical schools. *American Journal of Hospice and Palliative Care, 19*, 181-186.

Dickinson, G. E., Sumner, E. D., & Frederick, L. M. (1992). Death education in selected health professions. *Death Studies, 16*, 281-289.

Di Gallo, A., & Parry-Jones, W. (1996). Psychological sequelae of road traffic accidents: An inadequately addressed problem. *British Journal of Psychiatry, 169*, 405-407.

Dijkstra, I. C., & M. S. Stroebe (1998). The impact of a child's death on parents: A myth (not yet) disproved. *Journal of Family Studies, 4*, 159-185.

Doka, K. J. (Ed.). (1989a). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington, MA: Lexington Books.

Doka, K. J. (1989b). Disenfranchised grief. In K. J. Doka, (Ed.), *Disenfranchised grief: Recognizing hidden sorrow* (pp. 3-11). Lexington, MA: Lexington Books.

Doka, K. J. (1995). Recognizing hidden sorrow. In L. A. Despelder & A. L. Strickland (Eds.), *The path ahead: Readings in death and dying* (pp. 271-275). Mountain View, CA: Mayfield.

Doka, K. J. (1996). Sudden loss: The experience of bereavement. In K. J. Doka (Ed). *Living with grief after sudden loss: Suicide, homicide, accident, heart attack, stroke* (pp. 11-15). Bristol, PA: Taylor & Francis.

Doka, K. J. (Ed.) (2002a). *Disenfranchised grief: New directions, challenges, and strategies for practice*. Champaign, IL: Research Press.

Doka, K. J. (2002b). Introduction. In K. J. Doka (Ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice*. Champaign, IL: Research Press.

Doka, K. J. (2003). The death awareness movement: Description ,history, and analysis. In C. D. Bryant (Ed.), *Handbook of death and dying* (Vol. 1, pp. 50-56). Thousand Oaks, CA: Sage.

Dowdney, L. Wilson, R., Maughan, B., Allerton, M., Schofield, P., & Skuse, D. (1999). Psychological disturbance and service provision in parentally bereaved children: Prospective case-controlled study. *British Medical Journal, 319*, 354-357.

Downe-Wamboldt, B., & Tamlyn, D. (1997). An international survey of death education trends in faculties of nursing and medicine. *Death Studies, 21*, 177-188.

Duberstein, P. R. (2000). Death cannot keep us apart: Mortality following bereavement. In P. R. Duberstein & J. M. Masling (Eds.), *Psychodynamic perspectives on sickness and health* (pp. 250-331). Washington, DC: American Psychological Association.

Duckett, P. S., & Fryer, D. (1998). Developing empowering research practices with people who have learning disabilities. *Journal of Community and Applied Social Psychology, 8*, 57-65.

Duffy, K. G., & Wong, F. Y. (2003). *Community psychology* (3rd ed.). Boston: Allyn & Bacon.

Duperrex, O., Bunn, F., & Roberts, I. (2002). Safety education of pedestrians for injury prevention: A systematic review of randomized controlled trials. *British Medical Journal, 324*, 1129-1133.

Durkheim, E. (1897/1952). *Suicide: A study in sociology* (J. A. Spaulding & G. Simpson, Transl.). London: Routledge & Kegan Paul.

Dyregrov, A., & Dyregrov, K. (1999). Long-term impact of sudden infant death: A 12-to 15-year follow-up. *Death Studies, 23*, 635-661.

Dyregrov, K. (2003-2004). Micro-sociological analysis of social support following traumatic bereavement: Unhelpful and avoidant responses from the community. *Omega: The Journal of Death and Dying, 48*, 23-44.

Edmondson, S. (2001). *The context of recovery: Individual experience of recovery from work-related trauma*. Unpublished masters thesis, Edith Cowan University, Perth, Western Australia, Australia.

Elder, R. W., Shults, R. A., Sleet, D. A., Nichols, J. L., Thompson, R. S. Rajab, W., & the Task Force on Community Preventive Services. (2004). Effectiveness of mass media campaigns for reducing drinking and draining and alcohol-involved crashes: A systematic review. *American Journal of Preventive Medicine, 27*, 57-65.

Eliot, L. (2005, December 13). Driver clocked at 209kmh. *The West Australian*, p. 12.

Eliot, R. D. (1932). The bereaved family. *Annals of the American Academy of Political and Social Science, 160*, 184-190.

Emery, R. (2005, October 2). Hoon flips car in pub burnout. *The Sunday Times*, p. 9.

Engel, G. L. (1961). Is grief a disease? A challenge for medical research. *Psychosomatic Medicine, 23*, 18-22.

Engel, G. L. (1964). Grief and grieving. *American Journal of Nursing, 64*, 93-98.

Etherington, K. (2004). *Becoming a reflexive researcher: Using our selves in research*. London: Jessica Kinglsey.

Eyetsemitan, F. (1998). Stifled grief in the workplace. *Death Studies, 22*, 469-479.

Farnsworth, E. B., & Allen, K. R. (1996). Mothers' bereavement: Experiences of marginalisation ,stories of change. *Family Relations, 45*, 360-367.

Federal Office of Road Safety. (1998). *The history of road fatalities in Australia (Monograph 23)*. Retrieved February 2, 2004, from http://www.atsb.gov.au/road/pubs.cfm

Federal Office of Road Safety. (1999). *Australia's international road safety performance 1996 (Monograph 28)*. Retrieved February 2, 2004, from http://www.atsb.gov.au/road/pubs.cfm

Federation of European Road Traffic Victims. (1993). *Study of the physical, psychological, and material secondary damage inflicted on the victims and their families by road crashes*. Geneva: Author.

Federation of European Road Traffic Victims. (1995). *Impact of road death and injury: research into the principal causes of the decline in quality of life and living standard suffered by road crash victims and victim families: Proposal for improvements*. Geneva: Author.

Fischer, C. T. (1999). Designing qualitative research reports for publication. In M. Korpala & L. A. Suzuki (Eds.), *Using qualitative methods in psychology* (pp. 105-119). Thousand Oaks, CA: Sage.

Fisher, C. (2000). *Silent voices: Domestic violence in Western Australia*. Unpublished doctoral thesis, Curtin University of Technology, Perth, Western Australia, Australia.

Fisher, C. (2003). The invisible dimension: Abuse in palliative care families: A review. *Journal of Palliative Care Medicine, 6*, 257-264.

Fisher, C. (in press). 'I guess it happens but…': Palliative care nurses' perceptions of abusive relationships within palliative care. *Journal of Palliative Medicine*.

Flannery, R. B., Jr. (1990). Social support and psychological trauma: A methodological review. *Journal of Traumatic Stress, 3*, 593-611.

Foliart, D. E., Clausen, M., & Siljestrom, C. (2001). Bereavement practices among Californian hospices: Results of a statewide survey. *Death Studies, 25*, 461-467.

Foote, C., & Frank, A. (1999). Foucault and therapy: The disciplining of grief. In A. S. Chambon, A. Irving, & L. Epstein (eds.), *Reading Foucault for social work* (pp. 157-187). New York: Columbia University Press.

Foucault, M. (1961). *Madness and civilization: A history of insanity in the age of reason* (R. Howard, Trans.). London: Routledge Classics.

Fox, D. R., & Prilleltensky, I. (2003, June). *Socialize or social lies?: Psychopolitical validity literacy for wellness and justice*. Paper presented at the 9th Biennial Conference of the Society for Community Research and Action, Las Vegas, New Mexico, United States.

Fowlkes, M. R. (1990). The social regulation of grief. *Sociological Forum, 5*, 635-652.

Fowlkes, M. R. (1991). The morality of loss: The social construction of mourning and melancholia. *Contemporary Psychoanalysis, 27*, 529-551.

Frantz, T. T., Farrell, M. M., & Trolley, B. C. (2001). Positive outcomes of losing a loved one. In. R. A. Neimeyer (ed.), *Meaning reconstruction and the experience of loss* (pp. 191-209). Washington, DC: American Psychological Association.

Frantz, T. T., Trolley, B. C., & Johll, M. P. (1996). Religious aspects of bereavement. *Pastoral Psychology, 44*(3), 151-163.

Freire, P. (1972). *Pedagogy of the oppressed*. Harmondsworth, England: Penguin.

Freud, S. (1917/1957). Mourning and melancholia. In J. Stachey (Ed.), *Standard edition of the complete works of Sigmund Freud*. London: Hogarth Press.

Friedlos, D. (2004, July 4). P-plater dies in pole crash. *The Sunday Times*, p. 13.

Fulton, G. (1999-2000). Anticipating death: Challenges for health care practitioners. *Clinical Psychologist, 4*(2), 43-51.

Fulton, G., Madden, C., & Minichiello, C. (1996). The social construction of anticipatory grief. *Social Science and Medicine, 43*, 1349-1358.

Gamino, L. A., & Sewell, K. W. (2004). Meaning constructs as predictors of bereavement adjustment: A report from the Scott and White Grief Study. *Death Studies, 28*, 397-421.

Gamino, L. A., Sewell, K. W., & Easterling, L. W. (1998). Scott & White grief study: An empirical test of predictors of intensified mourning. *Death Studies, 22*, 333-355.

Gamino, L. A., Sewell, K. W., & Easterling, L. W. (2000). Scott and White grief study – phase 2: Toward an adaptive model of grief. *Death Studies, 24*, 633-660.

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*, 266-275.

Gergen, K. J. (1999). *An invitation to social construction*. London: Sage.

Gergen, K. J., & Gergen, M. M. (1991). Toward reflexive methodologies. In F. Steier (Ed.), *Research and reflexivity* (pp. 76-95). London: Sage.

Gerrard, I. (2002). Disenfranchised grief in stepfamilies. *Grief Matters, 5*(1), 11-14.
Gibson, D. (2003, August 2). Fight over spinal research finding. *The West Australian* [On-line]. Available: http://library.ecu.edu.au/search/tTHe+West+Australian/twest+australian/1,43,50,B/l856~1459749&FF=&1,0,,1,0
Giles, M. (2001). Data for the study of road crashes in Australia. *Australian Economic Review, 34*, 222-230.
Giles, M. (2003a). The cost of road crashes: A comparison of method and recent Australian estimates. *Journal of Transport Economics and Policy, 37*, 95-110.
Giles, M. (2003b). Correcting for selectivity bias in the estimation of road crash costs. *Applied Economics, 35*, 1291-1301.
Girasek, D. C. (2003). Parents of fatally injured children discuss taking part in prevention campaigns: An exploratory study. *Death Studies, 27*, 929-937.
Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.
Glaser, B. G. (2002, September). Constructivist grounded theory? *Forum: Qualitative Social Research [on-line journal], 3*(3), Available at http://www.qualitative-research.net/fqs/fqs-eng.htm [Date of access: February 14, 2006].
Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.
Glass, T. A., Prigerson, H., Kasl, S. & Mendes de Leon, C. F. (1995). The effects of negative life events on alcohol consumption among older men and women. *Journal of Gerontology: Social Sciences, 50B*(4), s205-s216.
Gooch, J. (2000). Trauma doesn't get much worse than losing a child. *Nursing Standard, 14*(26), 27.
Goodkin, K., O'Mellan, S., Lee, D., Asthana, D., Molina, R., Shapshak, P., Zheng, W., Khamis, I., & Frasca, A. (2005-2006). Complicated bereavement: Disease state or state of being? *Omega: The Journal of Death and Dying, 52*, 21-36.
Gorer, G. (1965). *Death, grief, and mourning*. New York: Doubleday.
Grad, O. T., Zavasnik, A. (1999). Phenomenology of bereavement process after suicide, traffic accident and terminal illness (in spouses). *Archives of Suicide Research, 5*, 157-172.
Green, B. L., Krupnick, J. L., Stockton, P., Goodman, L., Corcoran, C., & Petty, R. (2001). Psychological outcomes associated with traumatic loss in a sample of young women. *American Behavioral Scientist, 44*, 817-837.
Gregory, D., & Longman, A. (1992). Mothers' suffering: Sons who died of AIDS. *Qualitative Health Research, 2*, 334-357.
Gregory, J. E., & Gregory, R. J. (1994). The spirit feather: An ecological based celebration of life. *Journal of Palliative Medicine, 7*, 297-300.
Gregory, R. J. (1994). Grief and loss among Eskimos attempting suicide in Western Alaska. *American Journal of Psychiatry, 151*, 1815-1816.
Gregory, R. J. (1998). Attitudes to death and the future changing our thinking. *Futures, 30*, 75-81.
Grigg, C. (1999). The future: Whither traffic safety? In J. Clark (Ed.), *Safe and mobile: Introductory studies in traffic safety* (pp. 161-196). Armidale New South Wales, Australia. Emu Press.
Haegi, M. (2002). A new deal for road crash victims. *British Medical Journal, 324*, 1110.

Hagman, G. (1996). Bereavement and neurosis. *Journal of the Academy of Psychoanalysis, 23*, 635-653.

Hallgrimsdottir, E. M. (2000). Accident and emergency nurses' perceptions and experiences of caring for families. *Journal of Clinical Nursing, 9*, 611-619.

Haney, C. A. Leimer, C., & Lowery, J. (1997). Spontaneous memorialization: Violent death and emerging mourning ritual. *Omega: The Journal of Death and Dying, 35*, 159-171.

Hansson, R. O., & Stroebe, M. S. (2003). Grief, older adulthood. In M. Bloom & T. P. Gullotta (Eds.), *Encyclopedia of primary prevention and health promotion* (pp. 515-521). New York: Kluwer Academic.

Hartz, G. (1986). Adult grief and its interface with mood disorder: Proposal for a new diagnosis of complicated bereavement. *Comprehensive Psychiatry, 27*, 60-64.

Harwood, D., Hawton, K., Hope, T., & Jacoby, R. (2002). The grief experiences and needs of bereaved relatives and friends of older people dying through suicide: A descriptive and case-controlled study. *Journal of Affective Disorders, 72*, 185-194.

Hayslip, B., Jr., Allen. S. E., & McCoy-Roberts, L. (2001). The role of gender in a three-year longitudinal study of bereavement: A test of the experienced competence model. In D. A. Lund (Ed.), *Men coping with grief: Death, value, and meaning series* (pp. 121-146). Amityville, NY: Baywood.

Hayward, C., & Madill, A. (2003). The meanings of organ donation: Muslims of Pakistani origin and white English nationals living in North England. *Social Science and Medicine, 57*, 389-401.

Haywood, M. (1998). Road trauma: Dealing with loss and grief. *Journal of Family Studies, 4*, 228-229.

Health Department of Western Australia. (1997). *Human tissue and transplant act 1982: Codes of practice working party*. Perth, Western Australia: Author.

Hetherington, A., Munro, A., & Mitchell, M. (1997). At the scene: Road accidents and the police. In M. Mitchell (Ed). *The aftermath of road accidents: Psychosocial, social, and legal consequences of an everyday trauma* (pp. 113-122). London: Routledge.

Hillman, S., Green, A., & Silburn, S. (1999). *A study of families bereaved by suicide*. Perth, Western Australia: TVW Institute of Child Health Research and the Youth Suicide Advisory Committee.

Hindmarch, C. (2000). *On the death of a child* (2nd ed.). Abingdon: Radcliff Medical Press.

Hobbs, M., & Adshead, G., (1997). Preventative psychological intervention for road crash survivors. In M. Mitchell (Ed). *The aftermath of road accidents: Psychosocial, social, and legal consequences of an everyday trauma* (pp. 159-171). London: Routledge.

Hogan, N., Morse, J. M., & Tason, M. C. (1996). Towards an experiential theory of bereavement. *Omega: The Journal of Death and Dying, 33*, 43-65.

Hogan, N. S., Worden, J. W., & Schmidt, L. A. (2003-2004). An empirical study of the proposed complicated grief disorder criteria. *Omega: The Journal of Death and Dying, 48*, 263-277.

Hogan, N. S., Worden, J. W., & Schmidt, L. A. (2005-2006). Considerations on conceptualizing complicated grief. *Omega: The Journal of Death and Dying, 52*, 81-85.

Holst-Warhaft, G. (2000). *The cue for passion: Grief and its political uses*. Cambridge, MA: Harvard University Press.

Hopton, J. (1995). User involvement in the education of mental health nurses: An evaluation of possibilities. *Critical Social Policy, 14*(3), 47-60.

Horowitz, M. (2005-2006). Meditating on complicated grief disorder as a diagnosis. *Omega: The Journal of Death and Dying, 52*, 87-89.

Horowitz, M., Bonanno, G., & Holen, A. (1993). Pathological grief: Diagnosis and explanation. *Psychosomatic Medicine, 55*, 260-273.

Horowitz, M., Siegel, B., Holen, A., Bonanno, G. A., Milbrath, C., & Stinson, C. H. (1997). Diagnostic criteria for complicated grief disorder. *American Journal of Psychiatry, 154*, 904-910.

Horowitz, M. J., Wilber, N., Marmar, C., & Krupnick, J. (1980). Pathological grief and the activation of latent self-images. *American Journal of Psychiatry, 137*, 1157-1162.

Horswill, M. S., Waylen, A. E., & Tofield, M. J. (2004). Drivers' ratings of difficult components of their own driving skill: A greater illusion of superiority for skills that relate to accident involvement. *Journal of Applied Social Psychology, 34*, 177-195.

Howarth, G. (1997). Death on the road: The role of the English coroner's court on the social construction of an accident. In M. Mitchell (Ed). *The aftermath of road accidents: Psychosocial, social, and legal consequences of an everyday trauma* (pp. 15-32). London: Routledge.

Illich, I. (1977). Disabling professions. In I. Illich, I. K. Zola, J. McKnight, J. Caplan, & H. Shaiken (Eds.), *Disabling professions* (pp. 11-39). New York: Marion Byers.

Irwin, M., Daniels, M., & Weiner, H. (1987). Immune and neuroendocrine changes during bereavement. *Grief and Bereavement, 10*, 449-465.

Jacob, S. R. (1993). An analysis of the concept of grief. *Journal of Advanced Nursing, 18*, 1787-1794.

Jacobs, S. (1993). *Pathologic grief: Maladaptations to loss*. Washington, DC: American Psychiatric Press.

Jacobs, S. (1999). *Traumatic grief: Diagnosis, treatment, and prevention*. Castleton, NJ: Brunner/Mazel.

Jacobs, S., Mazure, C., & Prigerson, H. (2000). Diagnostic criteria for traumatic grief. *Death Studies, 24*, 185-199.

Jacobs, S., & Prigerson, H. (2000). Psychotherapy of traumatic grief: A review of evidence for psychotherapeutic treatments. *Death Studies, 24*, 497-495.

Jacobson, D. E., (1986). Types and timing of social support. *Journal of Health and Social Behaviour, 27*, 250-264.

Janoff-Bulman, R (1992). *Shattered assumptions: Towards a new psychology and trauma*. New York: Free Press.

Jeavons, S. (1997). Voluntary organisations and their role in providing support in the aftermath of accidents. In M. Mitchell (Ed.), *The aftermath of road accidents: Psychological, social, and legal consequences of an everyday trauma* (pp. 205-216). London: Routledge.

Job, R. F. S. (1999). The road user: The psychology of road safety. In J. Clark (Ed.), *Safe and mobile: Introductory studies in traffic safety* (pp. 21-55). Armidale New South Wales, Australia. Emu Press.

Johnson, K., Gridley, H., & Moore, S. (2003). Tensions and dilemmas in feminist research on sensitive issues: The case of Project Hippocrates. *Network, 14*(1), 45-52.

Johnston, I. R. (1992). Traffic safety education. Panacea, prophylactic, or placebo? *World Journal of Surgery, 16*, 374-378.

Jordan, J. R. (2000). Research that matters: Bridging the gap between research and practice. *Death Studies, 24*, 457-467.

Jordan, J. R., & Neimeyer, R. A. (2003). Does grief counseling work? *Death Studies, 27*, 765-786.

Kastenbaum, R. J. (2001). *Death, society, and human experience* (7th ed.). Boston: Allyn & Bacon.

Kauffman, J. (1989). Intrapsychic dimensions of disenfranchised grief. In K. J. Doka (Ed.), *Disenfranchised grief: Recognizing hidden sorrow* (pp. 25-29). Lexington, MA: Lexington Books.

Kauffman, J. (2002). The psychology of disenfranchised grief: Liberation, shame, and self-disenfranchisement. In K. J. Doka (ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice* (pp. 61-77). Champaign, IL: Research Press.

Kaunonen, M. Tarkka, M.-T., Laippala, P., & Paunonen-Ilmonen, M. (2000). The impact of supportive telephone call intervention on grief after the death of a family member. *Cancer Nursing, 23*, 483-491.

Keir, J. (2000). The Road Trauma Support Team Victoria: How we can help you. *In-Psych, 22*(4), 25.

Kellehear, A. (2001). *Grief and remembering: 25 Australians tell it like it is*. Melbourne, Australia: Rivoli.

Kelly, J. (2005a, January 16). Serial drink-driver: 17th conviction for biggest dope in WA. *The Sunday Times*, p. 4.

Kelly, J. (2005b, February 13). Court again for five time life-ban driver. *The Sunday Times*, p. 18.

Kelly, J. (2005c, December 18). Drunken Clause. *The Sunday Times*, p. 26.

Kelly, J. (2004d, September 19). Target young drivers: Plan calls for curfews and zero alcohol. *The Sunday Times*, p. 21.

Kelly, J. (2005e, March 6). Zero alcohol limit. *The Sunday Times*, p. 1.

Kim, K., & Jacobs, S. C. (1991). Pathologic grief and its relationship to other psychiatric disorders. *Journal of Affective Disorders, 21*, 257-263.

King, R. (2005, August 20). Banned motorists quick to flout law. *The West Australian*, p. 5.

Kirchberg, T. M., & Neimeyer, R. A. (1991). Reactions of beginning counselors to situations involving death and dying. *Death Studies, 15*, 603-610.

Kirchberg, T. M., Neimeyer, R. A., & James, R. K. (1998). Beginning counselors' death concerns and empathic responses to client situations involving death and grief. *Death Studies, 22*, 99-120.

Kirov, C., Legge, M., & Rosman, D. L. (2000). *Reported road crashes in Western Australia 1999*. Perth, Western Australia, Australia: Road Safety Council of Western Australia.

Kissane, D. W., & Bloch, S. (1994). Family grief. *British Journal of Psychiatry, 164*, 728-740.

Kissane, D. W., Bloch, S., Dowe, D. L. Snyder, R. D., Onghena, P., McKenzie, P., & Wallace, C. S. (1996). The Melbourne Family Grief Study, I: Perceptions of

family functioning in bereavement. *American Journal of Psychiatry, 153*, 650-658.

Klass, D. (1995). Solace and immortality: Bereaved parents' continuing bonds with their children. In. L. A. Despelder & A. L. Strickland (eds.), *The path ahead: Readings in death and dying* (pp. 246-259). Mountain View, CA: Mayfield.

Klass, D. (1996a). The deceased child in the psychic and social worlds of bereaved parents during the resolution of grief. In D. Klass, P. R. Silverman, & S. L. Nickman (Eds.), *Continuing bonds: New understandings of grief* (pp. 199-215). Philadelphia, PA: Taylor & Francis.

Klass, D. (1996b). Grief in an Eastern culture: Japanese ancestor worship. In D. Klass, P. R. Silverman, & S. L. Nickman (Eds.), *Continuing bonds: New understandings of grief* (pp. 59-70). Philadelphia, PA: Taylor & Francis.

Klass, D. (2001). Continuing bonds in the resolution of grief in Japan and North America. *American Behavioral Scientist, 44*, 742-763.

Klass, D., & Goss, R. (1999). Spiritual bonds to the dead in cross-cultural and historical perspective: Comparative religion and modern grief. *Death Studies, 23*, 547-567.

Klass, D., Silverman, P. R., & Nickman, S. L. (Eds.). (1996). *Continuing bonds: New understandings of grief*. Philadelphia, PA: Taylor & Francis.

Klass, D. & Walter, T. (2001). Processes of grieving: How bonds are continued. In. M. S., Stroebe, R. O. Hannson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 431-448), Washington, DC: American Psychological Press.

Klein, M. (1940). Mourning and its relation to manic-depressive states. *International Journal of Psychoanalysis, 21*, 125-153.

Kojlak, J., Keenan, S. P., Plotkin, D., Giles-Fysh, N., & Sibbald, W. J. (1998). Determining the potential need for a bereavement follow-up program: How well are family and health care workers' needs currently being met? *Official Journal of the Canadian Association of Critical Care Nursing, 8*, 16-21.

Kovarsky, R. S. (1989). Loneliness and disturbed grief: A comparison of parents who lost a child to suicide or accidental death. *Archives of Psychiatric Nursing, 3*, 86-96.

Kristjanson, L., Lobb, E., Aoun, S., & Monterosso, L. (2006). *A systematic review of the literature on complicated grief*. Churchlands, Western Australia: West Australian Centre for Cancer and Palliative Care.

Krupp, G. (1972). Maladaptive reactions to the death of a family member. *Social Casework, 53*, 425-434.

Kübler-Ross, E. (1969). *On death and dying*. New York: Tavistock.

Kugelmann, R. (1992). Stress: The nature and history of engineered grief. Westport, CT: Praeger.

Lampathakis, P. (2005, June 5). Night drive curfew. *The Sunday Times*, p. 1.

Lattanzi-Licht, M. (2002). Grief and the workplace: Positive approaches. In K. J. Doka (ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice* (pp. 167-180). Champaign, IL: Research Press.

Law, P. (2004, August 1). Memorial for murder victims. *The Sunday Times*, p. 29.

Lawley, J. (2006). Reflections on the founding of TCF from Joe Lawley co-founder. *The Compassionate Friends Australian National Newsletter, 12*(2), 9-10.

Lazare, A. (1979). Unresolved grief. In A. Lazare (Ed.), *Outpatient psychiatry: Diagnosis and treatment* (pp. 498-512). Baltimore, MD: Williams & Wilkins.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Lehman, D. R., Ellard, J. H., Wortman, C. B. (1986). Social support for the bereaved: Recipients' and providers' perspectives on what is helpful. *Journal of Consulting and Clinical Psychology, 54*, 438-446.

Lehman, D. R., Lang, E. L., Wortman, C. B., & Sorenson, S. B. (1989). Long-term effects of sudden bereavement: Marital and parent-child relationships and children's reaction. *Journal of Family Psychology, 2*, 344-367.

Lehman, D. R., Wortman, C. B., & Williams, A. F., (1987). Long-term effects of losing a spouse or child in a motor vehicle crash. *Journal of Personality and Social Psychology, 52*, 218-231.

Lehrman, S. (1956). Reactions to untimely death. *Psychiatric Quarterly, 30*, 564-578.

Lepore, S. J., Silver, R. C., Wortman, C. B., & Wayment, H. A. (1996). Social constraints, intrusive thoughts, and depressive symptoms among bereaved mothers. *Journal of Personality and Social Psychology, 70*, 271-282.

Lev, E. L., & McCorkle, R. (1998). Loss, grief, and bereavement in family members of cancer patients. *Seminars in Oncology Nursing, 14*, 145-151.

Lewin, K. (1951). *Field theory in social science*. New York: Harper.

Lieberman, M. A. (1993). Bereavement self-help groups: A review of conceptual and methodological issues. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 411-426). Cambridge: Cambridge University Press.

Lincoln, Y. S., & Guba. E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lincoln, Y. S., & Guba. E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.) *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Lindemann, E. (1944). Symtomatology and management of acute grief. *American Journal of Psychiatry, 101*, 141-148.

Lindstrøm, T. C. (1997). Immunity and health after bereavement in relation to coping. *Scandinavian Journal of Psychology, 38*, 253-259.

Lindstrøm, T. C. (2002). "It ain't necessarily so…" Challenging mainstream thinking about bereavement. *Family and Community Health, 25*, 11-21.

Lister, E. (1998). Comments on diagnosis including symptoms of turbulent grief. *American Journal of Psychiatry, 155*, 1305-1306.

Littlewood, J. (1992). *Aspects of grief: Bereavement in adult life*. New York: Routledge.

Lloyd-Bostock, S. (1997). The natural history of claims for compensation after an accident. In M. Mitchell (Ed.), *The aftermath of road accidents: Psychological, social, and legal consequences of an everyday trauma* (pp. 135-144). London: Routledge.

Lofland, L. H. (1992). The social shaping of emotion: The case of grief. In H. A. Farberman, G. A. Fine, & J. Johnson (Eds.), *Social psychological foundations: Readings from the interactionist perspective* (pp. 181-198). Greenwich, CT: Jai Press. (Reprinted from Symbolic Interaction, 8, 171-190).

Loimer, H., & Guarnieri, M. (1996). Accidents and acts of God: A history of the terms. *American Journal of Public Health, 86*, 101-107.

Lord, J. H. (1987). Survivor grief following a drunk-driving crash. *Death Studies, 11*, 413-435.

Lord, J. H. (1996). America's number one killer: Vehicular crashes. In K. J. Doka (Ed.), *Living with grief after sudden loss: Suicide, homicide, accident, heart attack, stroke* (pp. 25-39). Bristol, PA: Taylor & Francis.

Lord, J. H. (2000). *No time for goodbyes: Coping with sorrow, anger and injustice after a tragic death* (5th ed.). Oxnard, CA: Pathfinder.

Lorenz, L. (1998). Selecting and implementing support groups for bereaved adults. *Cancer Practice, 6*, 161-166.

Lyhne, N. (1999, November). *New directions for road safety in Western Australia 2000-2005*. Paper presented at the Insurance Commission of Western Australia conference on Road Safety, Perth, Western Australia, Australia.

Lyons, J. (1991). Strategies for assessing the potential for positive adjustment following trauma. *Journal of Traumatic Stress, 4*, 93-111.

Madden, C. (2005, May 8). Our miracle girl. *The Sunday Times*, p. 11.

Main Roads Western Australia. (2003). *Roadside memorials policy and guidelines*. Perth, Western Australia: Author.

Malkinson, R., & Bar-Tur, L. (1999). The aging of grief in Israel: A perspective of bereaved parents. *Death Studies, 23*, 413-431.

Marcey, M. M. (1996). A comparison of the long-term effects of bereavement after four types of death: Anticipated death, sudden death, drunk driver crash, and homicide. *Dissertation Abstracts International, 11B*, 6399.

Marris, P. (1958). *Widows and their families*. London: Routledge.

Martin, J., & Sugarman, J. (1997). The social-cognitive construction of psychotherapeutic change: Bridging social constructionism and cognitive constructionism. *Review of General Psychology, 1*, 375-388.

Martin, T., & Doka, K. J. (1996). Masculine grief. In K. J. Doka (Ed.), *Living with grief after sudden loss: Suicide, homicide, accident, heart attack, stroke* (pp. 161-171). Bristol, PA: Taylor & Francis.

Martin, T. L. & Doka, K. J. (2000). *Men don't cry… women do: Transcending gender stereotypes of grief*. Philadelphia: Brunner/Mazel.

Martikainen, P., & Valkonen, T. (1996). Mortality after death of spouse in relation to duration of bereavement in Finland. *Journal of Epidemiology and Community Health, 50*, 264-268.

Marwit, S. J. (1991). DSM-III-R, grief reactions, and a call for revision. *Professional Psychology: Research and Practice, 22*, 75-79.

Maton, K. I. (2000). Making a difference: The social ecology of social transformation. *American Journal of Community Psychology, 28*, 25-57.

May, K. A. (1986). Writing and evaluating the grounded theory report. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing* (pp. 146-154). Menlo Park, CA: Addison-Wesley.

Maykut, P., & Morehouse, R. (1994). *Beginning qualitative research: A philosophic and practical guide*. London: Falmer Press.

McGrath, J. (2000). The changing patterns of injuries in road traffic crashes. In G. Horne (Ed.), *Australian College of Road Safety yearbook* (pp. 6). Melbourne, Australia: Executive Media.

McGuire, W. J. (1983). A contextualist theory of knowledge: Its implications for innovation and reform in psychological research. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 16, pp. 1-47). Orlando, FL: Academic Press.

McKissock, M. A., & McKissock, D. R. (1991). Bereavement: A "natural disaster" responses and adaptations. *Medical Journal of Australia, 154*, 677-681.

McKnight, J. (1977). Professionalised service and disabling help. In I. Illich, I. K. Zola, J. McKnight, J. Caplan, & H. Shaiken (Eds.), *Disabling professions* (pp. 69-91). New York: Marion Byers.

McLaren, J. (1998). A new understanding of grief: A counsellor's perspective. *Mortality, 3*, 275-290.

McMillan, D. W., & Chavis, D. M. (1986). Sense of community: A definition and theory. *Journal of Community Psychology, 14*, 6-23.

McSherry, B. (1995). Research involving interviews with individuals who have experience traumatic events: Some guidelines. *Psychiatry, Psychology, and Law, 2*, 155-164.

Merrin, W. (1999). Crash, bang, wallop! What a picture! The death of Diana and the media. *Mortality, 4*, 41-62.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1995). *In-depth interviewing*. Melbourne, Victoria, Australia: Longman.

Miraudo, N. (2004, November 28). 100 hoons take a walk. *The Sunday Times*, p. 18.

Mitchell, M. (1997a). Death and injury on the road. In M. Mitchell (Ed). *The aftermath of road accidents: Psychosocial, social, and legal consequences of an everyday trauma* (pp. 3-14). London: Routledge.

Mitchell, M. (Ed). (1997b). *The aftermath of road accidents: Psychosocial, social, and legal consequences of an everyday trauma*. London: Routledge.

Moos, R. H., & Schaefer, J. A. (1986). Life transitions and crises: A conceptual overview. In R. H. Moos (ed.), *Coping with life crises: An integrated approach* (pp.3-28). New York: Plenum.

Morgan, D., Carder, P., & Neal, M. (1997). Are some relationships more useful than others? The value of similar others in the networks of recent widows. *Journal of Social and Personal Relationships, 14*, 745-759.

Morse, J. M. (1994). Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks, CA: Sage.

Morton, T. A., & Duck, J. M. (2001). Communication and health beliefs: Mass and interpersonal influences on perception of risk to self and others. *Communication Research, 28*, 602-626.

Moss, M. S., Braunschwieg, H., & Rubinstein, R. L. (2002). Terminal care for nursing home residents with dementia. *Alzheimer's Care Quarterly, 3*, 233-246.

Moustakas, C. E. (1990). *Heuristic research: Design, methodology, and applications*. Newbury Park, CA: Sage.

Murphy, G. E., Armstrong, J. W., Hermele, S. L. Fischer, J. R., & Clendenin, W. W. (1979). Suicide and alcoholism: Interpersonal loss confirmed as a predictor. *Archives of General Psychiatry, 36*, 65-69.

Murphy, S. A., Johnson, L. C., Chung, I.-J., & Beaton, R. D .(2003). The prevalence of PTSD following the violent death of a child and predictors of change 5 years later. *Journal of Traumatic Stress, 16*, 17-25.

Murphy, S. A., Johnson, L. C., Wu, L., Fan, J. J., & Lohan, J. (2003). Bereaved parents' outcomes 4 to 60 months after their children's deaths by accident, suicide, or homicide: A comparative study demonstrating differences. *Death Studies, 27*, 39-61.

Murphy, S. A., Lohan, J., Braun, T., Johnson, L. C., Cain, K. C., Beaton, R. D., & Baugher, R. (1999). Parents' health, health care utilization, and health behaviours following the violent deaths of their 12- to 28-year-old children: A prospective longitudinal analysis. *Death Studies, 23*, 589-616.

Murray, J. A. (2002). Communicating with the community about grieving: A description and review of the foundations of a broken leg analogy of grieving. *Journal of Loss and Trauma, 7*, 47-69.

Murray, J. A., & Terry, D. J. (1999). Parentals reactions to infant death: The Effects of resources and coping strategies. *Journal of Social and Clinical Psychology, 18*, 341-369.

Murray, J. A., Terry, D. J., Vance, J. C., Battistutta, D., & Connolly, Y. (2000). Effects of a program of intervention on parental distress following infant death. *Death Studies, 24*, 275-305.

Nadeau, J. W. (2001). Meaning making in family bereavement: A family systems approach. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 329-347). Washington, DC: American Psychological Association.

Nader, R. (1965). *Unsafe at any speed: The designed-in dangers of the American automobile*. New York: Grossman.

Nagy, S., & Viney, L. (1994, September). *The rigorous application of qualitative methods to constructivist research*. Paper presented at the Australian Psychological Society Conference, Wollongong, Australia.

Nantulya, V. M., & Reich, M. R. (2002). The neglected epidemic: rod traffic injuries in developing countries. *British Medical Journal, 324*, 1139-1141.

Neimeyer, R. A. (2000a). Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death Studies, 24*, 541-558.

Neimeyer, R. A. (2000b). Grief therapy and research as essential tensions: Prescriptions for a progressive partnership. *Death Studies, 24*, 603-610.

Neimeyer, R. A. (Ed.). (2001). *Meaning reconstruction and the experience of loss*. Washington, DC: American Psychological Association.

Neimeyer, R. A. (2005-2006a). Complicated grief and the quest for meaning: A constructivist contribution. *Omega: The Journal of Death and Dying, 52*, 37-52.

Neimeyer, R. A. (2005-2006b). Defining the new abnormal: Scientific and social construction of complicated grief. *Omega: The Journal of Death and Dying, 52*, 95-97.

Neimeyer, R. A., & Gamino, L. A. (2003). The experience of grief and bereavement. In C. D. Bryant (Ed.), *Handbook of death and dying* (Vol. 2, pp. 847-854). Thousand Oaks, CA: Sage.

Neimeyer, R. A., & Hogan, N. S. (2001). Quantitative or qualitative? Measurement issues in the study of grief. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping,*

and care (pp. 89-118). Washington, DC: American Psychological Association.

Neimeyer, R. A., & Jordan, J. R. (2002). Disenfranchisement as empathic failure: Grief therapy and co-construction of meaning. In K. J. Doka (Ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice* (pp. 95-117). Champaign, IL: Research Press.

Neimeyer, R. A., Prigerson, H. G., & Davies, B. (2002). Mourning and meaning: *American Behavioral Scientist, 46*, 235-251.

Nesbit, M. J., Hill, M., & Peterson, N. (1997). A comprehensive pediatric bereavement program: The Patterns of Your Life. *Critical Care Nursing Quarterly, 20*(2), 48-62.

Newbrough, J. R. (1992). Community psychology in the postmodern world. *Journal of Community Psychology, 20*, 10-24.

Nixon, J., & Pearn, J. (1977). Emotional sequelae of parents and sibs following the drowning or near-drowning of a child. *Australian and New Zealand Journal of Psychiatry, 11*, 265-268.

Nolen-Hoeksema, S. (2000). Growth and resilience among bereaved people. In J. E. Gillham (Ed.), *The science of optimism and hope: Research essays in honor of Martin E. P. Seligman* (pp. 107-127). London: Templeton Foundation Press.

Oliver, R. C., & Fallat, M. E. (1995). Traumatic childhood death. How well do parents cope? *Journal of Trauma: Injury, Infection, and Critical Care, 39*, 303-308.

Opotow, S. (1990). Moral exclusion and injustice: An introduction. *Journal of Social Issues, 46*(1), 1-20.

Opotow, S. (1996). Affirmative action, fairness, and the scope of justice. *Journal of Social Issues, 52*(4), 19-24.

Ott, C. H. (2003). The impact of complicated grief on mental and physical health at various points in the bereavement process. *Death Studies, 27*, 249-272.

Paddenburg, T. (2006, June 11). Ban bid on road crosses. *The Sunday Times*, p. 3.

Parkes, C. M. (1965a). Bereavement and mental illness: Part 1. A clinical study of the grief of bereaved psychiatric patients. *British Journal of Medical Psychology, 38*, 1-12.

Parkes, C. M. (1965b). Bereavement and mental illness: Part 2. A classification of bereavement reactions. *British Journal of Medical Psychology, 38*, 13-26.

Parkes, C. M. (1972). *Bereavement: Studies of grief in adult life*. New York: International Universities Press.

Parkes, C. M. (1986). *Bereavement: Studies of grief in adult life* (2nd ed.). New York: Tavistock.

Parkes, C. M. (1992). Grief: Lessons from the past, visions for the future. *Death Studies, 26*, 367-385.

Parkes, C. M. (1995). Guidelines for conducting ethical bereavement research. *Death Studies, 19*, 171-181.

Parkes, C. M. (2001). A historical overview of the scientific study of bereavement. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping, and care* (pp. 25-45). Washington, DC: American Psychological Association.

Parkes, C. M. (2002). Grief: Lessons from the past, visions for the future. *Death Studies, 26*, 367-385.

Parkes, C. M. (2005-2006a). Guest editor's conclusions. *Omega: The Journal of Death and Dying, 52*, 107-113.

Parkes, C. M. (2005-2006b). Symposium on complicated grief. *Omega: The Journal of Death and Dying, 52*, 1-7.

Parkes, C. M., & Weiss, R. S. (1983). *Recovery from bereavement*. New York: Basic Books.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Payne, S., Horne, S., & Relf, M. (1999). *Loss and bereavement*. Philadelphia, PA: Open University Press.

Payne, S., Jarrett, N., Wiles, R., & Field, D. (2002). Counselling strategies for bereaved people offered in primary care. *Counselling Psychology Quarterly, 15*, 161-177.

Pilkington, F. B. (1993). The lived experience of grieving the loss of an important other. *Nursing Science Quarterly, 6*, 130-139.

Polatinksy, S., & Esprey, Y. (2000). An assessment of gender differences in the perception of benefit resulting from the loss of a child. *Journal of Traumatic Stress, 13*, 709-718.

Prigerson, H. G., Bierhals, A. J., Kasl, S. V., Reynolds, C. F., III, Shear, M. K., Newsom, J. T., & Jacobs, S. (1996). Complicated grief as a disorder distinct from bereavement-related depression and anxiety: A replicated study. *American Journal of Psychiatry, 153*, 1484-1486.

Prigerson, H. G., Bierhals, A. J., Kasl, S. V., Reynolds, C. F., III, Shear, M K., Day, N., Beery, L. C., Newsom, J. T., & Jacobs, S. (1997). Traumatic grief as a risk factor for mental and physical morbidity. *American Journal of Psychiatry, 154*, 616-623.

Prigerson, H. G., Bridge, J., Maciejewski, P. K., Beery, L. C., Rosenheck, R. A., Jacobs, S. C., Bierhals, A. J., Kupfer, D. J., & Brent, D. A. (1999). Influence of traumatic grief on suicidal ideation among young adults. *American Journal of Psychiatry, 156*, 1994-1995.

Prigerson, H. G., & Jacobs, S. C. (2001). Traumatic grief as a distinct disorder: A rationale, consensus criteria, and a preliminary empirical test. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 613-637). Washington, DC: American Psychological Association.

Prigerson, H. G., & Maciejewski, P. K. (2005-2006). A call for sound empirical testing and evaluation of criteria of complicated grief proposed for DSM-V. *Omega: The Journal of Death and Dying, 52*, 9-19.

Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., III, Beirhals, A. J., Newsom, J. T., Fasiczka, A., Frank, E., Doman, J., & Miller, M. (1995). Inventory of complicated grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research, 59*, 65-79.

Prigerson, H. G., Silverman, G. K. Jacobs, S. C., Maciejewski, P. K., Kasl, S. V., & Rosenheck, R. A. (2001). Disability, traumatic grief, and the underutilization of health services: A preliminary examination. *Primary Psychiatry, 8*, 61-69.

Prigerson, H. G., & Vanderwerker, L. C. (2005-2006). Final remarks. *Omega: The Journal of Death and Dying, 52*, 91-94.

Prilleltensky, I. (1997). Values, assumptions, and practices: Assessing the moral implications of psychological discourse and action. *American Psychologist, 52*, 517-535.

Prilleltensky, I. (2003). Critical health psychology needs psychopolitical validity. *Health Psychology Update, 12*(3), 2-11.

Prilleltensky, I., & Nelson, G. (2002). *Doing psychology critically: Making a difference in diverse settings*. New York: Palgrave MacMillan.

Provini, C., Everett, J. E., & Pfeffer, C. R. (2000). Adults mourning suicide: Self-reported concerns about bereavement, needs for assistance, and help-seeking behavior. *Death Studies, 24*, 1-19.

Quartermaine, B. (2005, July 3). Ricardo lives for challenge. *The Sunday Times*, p. 20.

Quartermaine, B., & Kelly, J. (2005, March 13). Death drag-race: Father killed in Mandurah horror crash. *The Sunday Times*, p. 9.

Rando, T. A. (1984). *Grief, dying, and death: Clinical interventions for caregivers*. Champaign, IL: Research Press.

Rando, T. A. (1993). *Treatment of complicated mourning*. Champaign, IL: Research Press.

Raphael, B. (1984). *The anatomy of bereavement: A handbook for the caring professions*. London: Hutchinson.

Raphael, B., & Middleton, W. (1987). Current state of research in the field of bereavement. *Israel Journal of Psychiatry and Related Sciences, 24*, 5-32.

Raphael, B., & Middleton, W. (1990). What is pathologic grief? *Psychiatric Annals, 20*, 304-307.

Rappaport, J. (2000). Community narratives: Tales of terror and joy. *American Journal of Community Psychology, 28*, 1-24.

Redmond, L. M. (1996). Sudden violent death. In K. J. Doka (Ed.), *Living with grief after sudden loss: Suicide, homicide, accident, heart attack, stroke* (pp. 53-71). Bristol, PA: Taylor & Francis.

Reid, J. K. (2003). Impromptu memorials to the dead. In C. D. Bryant (ed.), *Handbook of death and dying* (Vol. 2, pp. 712-720). Thousand Oaks: Sage.

Reid, J. K, & Reid, C. L. (2001). A cross marks the spot. A study of roadside death memorials in Texas and Oklahoma. *Death Studies, 25*, 341-356.

Reiff, R. (1968). Social intervention and the problem of psychological analysis. *American Psychologist, 23*, 524-531.

Reiff, R. (1979). *The invisible victim: The criminal justice system's forgotten responsibility*. New York: Basic.

Reilly, D. M. (1978). Death propensity, dying, and bereavement: A family systems perspective. *Family Therapy, 5*, 35-55.

Reilly-Smorawski, B., Armstrong, A. V., & Catlin, E. A. (2002). Bereavement support for couples following death of a baby: Program development and 14-year exit analysis. *Death Studies, 26*, 21-37.

Reisman, A. S. (2001). Death of a spouse: Illusory basic assumptions and continuation of bonds. *Death Studies, 25*, 445-460.

Reynolds, J. J. (2002). Disenfranchised grief ad the politics of helping: Social policy and its clinical implications. In .K. J. Doka (Ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice* (pp. 351-387). Champaign, IL: Research Press.

Richards, T. A., Acree, M., & Folkman, S. (1999). Spiritual aspects of loss among partners of men with AIDS: Postbereavement follow-up. *Death Studies, 23*, 105-127.

Richards, T. A., & Folkman. S. (1997). Spiritual aspects of loss at the time of a partner's death from AIDS. *Death Studies, 21*, 527-552.

Riches, G. (2005). Intimacy in couple relationships following the death of a child. *Grief Matters, 8*(3), 54-57.

Riches, G., & Dawson, P. (1996a). Communities of feeling: The culture of bereaved parents. *Mortality, 1*, 143-161.

Riches, G., & Dawson, P. (1996b). 'An intimate loneliness': Evaluating the impact of a child's death on parental self-identity and marital relationships. *Journal of Family Therapy, 18*, 1-22.

Riches, G., & Dawson, P. (1996c). Making stories and taking stories: Methodological reflections on researching grief and marital tension following the death of a child. *British Journal of Guidance and Counselling, 24*, 257-365.

Riches, G., & Dawson, P. (1997). 'Shoring up the walls of heartache': Parental responses to the death of a child. In D. Field, J. Hockey, & N. Small (Eds.), *Death, gender and ethnicity* (pp. 52-75). London: Routledge.

Riches, G., & Dawson, P. (1998a). Spoiled memories: Problems of grief resolution in families bereaved through murder. *Mortality, 3*, 143-159.

Riches, G., & Dawson, P. (1998b). Lost children, living memories: The role of photographs in processes of grief and adjustment among bereaved parents. *Death Studies, 22*, 121-140.

Riches, G., & Dawson, P. (2000). *An intimate loneliness: Supportive bereaved parents and siblings*. Buckingham, UK: Open University Press.

Riches, G., & Dawson, P. (2002). Shoestrings and bricolage: Some notes on researching the impact of a child's death on family relations. *Death Studies: 26*, 209-222.

Riseborough, J. (2004, April 4). Man walks from wreck. *The Sunday Times*, p. 20.

Road death. (2005, November 18). *The West Australian*, p. 40.

Road Safety Council of Western Australia. (n.d.). *Arriving safely: Road safety strategy for Western Australia 2003-2007*. Perth, Western Australia, Australia: Author.

Road Safety Council of Western Australia. (2000a). *Achieving safer Western Australian roads*. Perth, Western Australia, Australia: Author.

Road Safety Council of Western Australia. (2000b). *Analysis of road crash statistics Western Australia 1999-1999*. Perth, Western Australia, Australia: Author.

Road Safety Council of Western Australia. (2005). *2004 annual review of Arriving Safely – Road safety strategy for Western Australia, 2003-2007*. Perth, Australia, Author.

Robb, T. (2001a, February 24). More money, safer roads. *The West Australian*, p. 3.

Robb, T. (2001b, August 11). Road groups want brakes for car ads. *The West Australian*, p. 58.

Roberts, I., Mohan, D., & Abbasi, K. (2002). War on the roads. The public health community must intervene. *British Medical Journal, 324*, 1107-1108.

Robson, C. (2002). *Real word research* (2nd ed.). Oxford: Blackwell.

Rock, P. (1998). *After homicide: Practical and political responses to bereavement*. Oxford: Clarendon Press.

Rodabough, T. (2003). The evolution of the legal definition of death. In C. D. Bryant (Ed.), *Handbook of death and dying* (Vol. 1, pp. 284-291). Thousand Oaks, CA: Sage.

Rodger, M. L. (2005). *Living beyond the unanticipated sudden death of a partner: A phenomenological study*. Unpublished doctoral thesis, Edith Cowan University Bunbury, Western Australia, Australia.

Romanoff, B. D. (2001). Research as therapy: The power of narrative to effect change. In R. A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 245-257). Washington, DC: American Psychological Association.

Romanoff, B. D., & Terenzio, M. (1998). Rituals and the grieving process. *Death Studies, 22*, 697-711.

Rose, K., & Webb, C. (1998). Analyzing data: Maintaining rigor in a qualitative study. *Qualitative Health Research, 8*, 556-562.

Rosenblatt, P. C. (1996). Grief that does not end. In D. Klass, P. R. Silverman, & S. Nickman (Eds.), *Continuing bonds: New understandings of grief* (pp. 45-58). Philadelphia, PA: Taylor & Francis.

Rosenblatt, P. C. (2000). *Parent grief: Narratives of loss and relationship.* Philadelphia, PA: Brunner/Mazel.

Rosenblatt, P. C. (2001). A social constructionist perspective on cultural differences in grief. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut, (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 285-300). Washington, DC: American Psychological Association.

Rosenblatt, P. C. (2003). Bereavement in cross-cultural perspective. In C. D. Bryant (Ed.), *Handbook of death and dying* (Vol. 2, pp. 855-861). Thousand Oaks, CA: Sage.

Rosenwieg, A., Prigerson, H., Miller, M. D., & Reynolds, C. F., III. (1997). Bereavement and late-life depression: grief and its complication in the elderly. *Annual Review of Medicine, 48*, 421-428.

Ross, H. L. (1961). Traffic law violation: A folk crime. *Social Problems, 8*, 231-241.

Rubin, S. S. (1993). The death of a child is forever: The life course impact of child loss. In M. S. Stroebe, W. Stroebe, & R. O. Hansson, (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 285-299). Cambridge: Cambridge University Press.

Rubin, S. S. (1999). The two-track model of bereavement: Overview, retrospect, and prospect. *Death Studies, 23*, 681-714.

Rubin, S. S., & Malkinson, R. (2001). Parental response to child loss across the life cycle: Clinical and research perspective. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut, (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 219-240). Washington, DC: American Psychological Association.

Sanders, C. M. (1988). Risk factors in bereavement outcome. *Journal of Social Issues, 44*(3), 97-111.

Sanders, C. M. (1993). Risk factors in bereavement outcome. In M. S. Stroebe, W. Stroebe, & R. O. Hansson, (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 255-267). Cambridge: Cambridge University Press.

Santiago-Rivera, A. L., Morse, G. S. Hunt, A., & Lickers, H. (1998). Building a community-based partnership: Lesson from the Mohawk nation of Akwesasne. *Journal of Community Psychology, 26*, 163-174.

Saunders, C. (2006). Dealing with death. *The West Australian (Mind and Body liftout)*, 21st February, pp. 2-3.

Saunders, J. M. (1981). A process of bereavement resolution: Uncoupled identity. *Western Journal of Nursing Research, 3*, 319-336.

Schaefer, J. A., & Moos, R. H. (2001). Bereavement experiences and personal growth. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut, (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 145-167). Washington, DC: American Psychological Association.

Schiff, M., & Bargal, D. (2000). Helping characteristics of self-help and support groups: Their contributions to participants' subjective well-being. *Small Group Research, 31*, 275-304.

Schlernitzhauer, M., Bierhals, A. J., Geary, M. D., Prigerson, H. G., Stack, J. A., Miller, M. D., Pasternak, R. E., & Reynolds, C. F., III. (1998). Recruitments methods for intervention research in bereavement-related depression. *American Journal of Geriatric Psychiatry, 6*, 67-74.

Schor, E. (1994). *Bearing the dead: The British culture of mourning from the enlightenment to Victoria*. Princeton, NJ: Princeton University Press.

Schut, H., Stroebe, M. S., van den Bout, J., & Terheggen, M. (2001). The efficacy of bereavement interventions: Determining who benefits. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 705-727). Washington, DC: American Psychological Association.

Schwab, R. (1998). A child's death and divorce: Dispelling the myth. *Death Studies, 22*, 445-468.

Seale, C. (1998). *Constructing death: The sociology of dying and bereavement*. Cambridge: Cambridge University Press.

Shanfield, S. B. (1987). The prediction of outcome in bereavement. In S. Zisook (Ed.), *Biopsychosocial aspects of bereavement* (pp. 97-108). Washington, DC: American Psychiatric Press.

Shanfield, S. B., & Swain, B. J. (1984). Death of adult children in traffic accidents. *Journal of Nervous and Mental Disease, 172*, 533-553.

Shapiro, E. R. (1996). Family bereavement and cultural diversity: A social developmental perspective. *Family Process, 35*, 313-332.

Shotter, J. (1993). *Conversational realities: constructing life through language*. London: Sage.

Shuchter, S. R., & Zisook, S. (1986). Treatment of spousal bereavement: A multidimensional approach. *Psychiatric Annals, 16*, 295, 298-305.

Shuchter, S. R., & Zisook, S. (1987). The therapeutic tasks of grief. In S. Zisook (Ed.), *Biopsychosocial aspects of bereavement* (pp. 177-189). Washington, DC: American Psychiatric Press.

Shuchter, S. R., & Zisook, S. (1993). The course of normal grief. In M. S. Stroebe, W. Stroebe, & R. O. Hansson, (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 23-43). Cambridge: Cambridge University Press.

Silver, R. C., Wortman, C. B., & Crofton, C. (1990). The role of coping in support provision: The self-presentational dilemma of victims of life crises. In. B. R. Sarason, I. G. Sarason, & G. R .Pierce (Eds.), *Social support: An interactional view* (pp. 357-426). New York: John Wiley & Sons.

Silverman, D. (1993). *Interpreting qualitative data: Methods for analysing talk, text, and interaction.* London: Sage.

Silverman, P. R. (2000). Research, clinical practice, and the human experience: Putting the pieces together. *Death Studies, 24*, 469-478.

Silverman, P. R., & Klass, D. (1996). Introduction: What's the problem? In D. Klass, P. R. Silverman, & S. L. Nickman (Eds.), *Continuing bonds: New understanding of grief* (pp. 3-27). Philadelphia, PA: Taylor & Francis.

Silverman, G. K., Jacobs, S. C., Kasl, S. V., Shear, M. K., Maciejewski, P. K., Noahiul, F. S., & Prigerson, H. G. (2000). Quality of life impairments associated with diagnostic criteria for traumatic grief. *Psychological Medicine, 30*, 857-862.

Sixth ban for drink driver. (2006, January 28). *The West Australian*, p. 34.

Sleet, D. A., & Branche, C. M. (2004). Road safety is no accident. *Journal of Safety Research, 35*, 1731-74.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. Smith, R. Harré, & L. van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 9-26). London: Sage.

Spagnolo, J. (2005, August 28). Legacy of the Collie classmates. *The Sunday Times*, p. 7.

Spooren, D. J., Henderick, H., & Jannes, C. (2000-2001). Survey description of stress of parents bereaved from a child killed in a traffic accident: A retrospective study of a victim support group. *Omega: The Journal of Death and Dying, 42*, 171-185.

Sprang, G. (1997). PTSD in surviving family members of drunk driving episodes: Victim and crime related factors. *Families in Society, 78*, 632-641.

Sprang, G., & McNeil, J. (1998). Post-homicide reactions: Grief ,mourning and post-traumatic stress disorder following a drunk driving fatality. *Omega: The Journal of Death and Dying, 37*, 41-58.

Sque, M., Payne, S., & Clark, J. M. (2006). Gift of life or sacrifice? Key discourses for understanding of organ donors' decision-making by families. *Mortality, 11*, 117-132.

Stein, A. J., & Winokuer, H. R. (1989). Monday mourning: Managing employee grief. In. J. K. Doka (Ed.), *Disenfranchised grief: Recognizing hidden sorrow* (pp. 91-102). Lexington, MA: Lexington Books.

Stewart, A. E. (1999). Complicated bereavement and posttraumatic stress disorder following fatal car crashes: Recommendations for death notification practice. *Death Studies, 23*, 289-321.

Stewart, A. E., & Lord, J. H. (2002). Motor vehicle crash versus accident: A change of terminology in necessary. *Journal of Traumatic Stress, 15,* 333-335.

Stewart, A. E., & Lord, J. H. (2003a). Some crashes are more unintentional than others: A reply to Blanchard, Hickling, & Kuhn. *Journal of Traumatic Stress, 16,* 529-530.

Stewart, A. E., & Lord, J. H. (2003b). The death notification process: Recommendations for practice, training, and research. In C. D. Bryant (ed.), *Handbook of death and dying* (Vol. 2, pp. 513-522). Thousand Oaks, CA: Sage.

Strauss, A. (1987). *Qualitative analysis for social scientists*. New York: Cambridge University Press.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Stroebe, M. (1998). New directions in bereavement research: Exploration of gender differences. *Palliative Medicine, 12*, 5-12.

Stroebe, M. (2001). Bereavement research and theory. *American Behavioral Scientist, 44*, 854-865.

Stroebe, M., Gergen, M., Gergen, K., & Stroebe, W. (1996). Broken hearts or broken bonds? In D. Klass, P. R. Silverman, & S. L. Nickman (Eds.), *Continuing bonds: New understandings of grief* (pp. 31-44). Washington, DC: Taylor & Francis.

Stroebe, M., Gergen, M. M., Gergen, K. J, & Stroebe, W. (1992). Broken hearts of broken bonds: Love and death in historical perspective. *American Psychologist, 47*, 1205-1212.

Stroebe, M., Gergen, M. M., Gergen, K. J, & Stroebe, W. (1993). Hearts and bonds: Resisting classification and closure. *American Psychologist, 48*, 991-992.

Stroebe, M. S., Hansson, R. O. Stroebe, W., & Schut, H. (2001a). Introduction: Concepts and issues in contemporary research on bereavement. In. M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 3-22). Washington, DC: American Psychological Association.

Stroebe, M. S., Hansson, R. O. Stroebe, W., & Schut, H. (Eds.) (2001b). *Handbook of bereavement research: Consequences, coping, and care*. Washington, DC: American Psychological Association.

Stroebe, M. S., Hansson, R. O. Stroebe, W., & Schut, H. (2001c). Future directions for bereavement research. *Handbook of bereavement research: Consequences, coping, and care* (pp. 741-766). Washington, DC: American Psychological Association.

Stroebe, M., & Schut, H. (1999). The dual process model of grief: Rationale and description. *Death Studies, 23*, 197-224.

Stroebe, M., & Schut, H. (2005). To continue or relinquish bonds: A review of consequences for the bereaved. *Death Studies, 29*, 477-494.

Stroebe, M., & Schut, H. (2005-2006). Complicated grief: A conceptual analysis of the field. *Omega: The Journal of Death and Dying, 52*, 53-70.

Stroebe, M., Schut, H., & Finkenhauer, C. (2001). The traumatisation of grief? A conceptual framework for understanding the trauma-bereavement interface. *Israel Journal of Psychiatry and Related Sciences, 38*, 185-201.

Stroebe, M., Stroebe, W., & Schut, H. (2001). Gender differences in adjustment to bereavement: An empirical and theoretical review. *Review of General Psychiatry, 5*, 62-83.

Stroebe, M., Stroebe, W., & Schut, H. (2003). Bereavement research: Methodological issues and ethical concerns. *Palliative Medicine, 17*, 235-240.

Stroebe, M., Stroebe, W., Schut, H., Zech, E., & van den Bout, J. (2002). Does disclosure of emotions facilitate recovery from bereavement? Evidence from two prospective studies. *Journal of Consulting and Clinical Psychology, 70*, 169-178.

Stroebe, M., van den Bout, J., & Schut, H. (1994). Myths and misconceptions about bereavement: The opening of a debate. *Omega: The Journal of Death and Dying, 29*, 187-203.

Stroebe, M., van Son, M., Stroebe, W., Kleber, R., Schut, H., van den Bout, J. (2000). On the classification and diagnosis of pathological grief. *Clinical Psychology Review, 20*, 57-75.

Stroebe, M. S., Stroebe, W., & Hansson, R. O. (1988). Bereavement research: An introduction. *Journal of Social Issues, 44*(3), 1-18.

Stroebe, M. S., Stroebe, W., & Hansson, R. O. (1993a). Bereavement research and theory: An introduction to the handbook. In. M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 3-19). Cambridge: Cambridge University Press.

Stroebe, M. S., Stroebe, W., & Hansson, R. O. (Eds.). (1993b). *Handbook of bereavement: Theory, research, and intervention*. Cambridge: Cambridge University Press.

Stroebe, M. S., Stroebe, W., & Hansson, R. O. (1993c). Future directions for bereavement research. In. M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 741-766). Cambridge: Cambridge University Press.

Stroebe, M. S., & Schut, H. (2001). Models of coping with bereavement: A review. In. M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 375-403). Cambridge: Cambridge University Press.

Stroebe, W., & Schut, H. (2001). Risk factors in bereavement outcome: A methodological and empirical review. In. M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 349-371). Cambridge: Cambridge University Press.

Stroebe, W., Stroebe, M., Abakoumkin, G., & Schut, H. (1996). The role of loneliness and social support in adjustment to loss: A test of attachment versus stress theory. *Journal of Personality and Social Psychology, 70*, 1241-1249.

Stylianos, S. K., & Vachon, M. L. S. (1993). The role of social support in bereavement. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 397-410). Cambridge: Cambridge University Press.

Suchman, E. A. (1961). A conceptual analysis of the accident phenomenon. *Social Problems, 9*, 241-253.

Sullivan, K. (1998). Managing the 'sensitive' interview: A personal account. *Nurse Researcher, 6*(2), 72-85.

Swanson, J. M. (1986a). The formal qualitative interview for grounded theory. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing theory* (pp. 66-78). Menlo Park, CA: Addison-Wesley.

Swanson, J. M. (1986b). Analyzing data for categories and description. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing theory* (pp. 121-132). Menlo Park, CA: Addison-Wesley.

Talbot, K. (1997). Mothers now childless: Structures of the life-world. *Omega: The Journal of Death and Dying, 36*, 45-62.

Taylor, N. (2005a, June 12). Our worst P-plater. *The Sunday Times*, p. 7.

Taylor, N. (2005b, October 16). Cops out of school: Road safety roles cut. *The Sunday Times*, p. 32.

Taylor, S. E., & Brown, J. D. (1988). Illusion and well-being: A social psychological perspective on mental health. *Psychological Bulletin, 103*, 193-210.
Tedeschi, R. G., & Calhoun, L. G. (1995). Trauma and transformation: Growing in the aftermath of suffering. Thousand Oaks, CA; Sage.
Tehrani, N. (2004). Road victim trauma: An investigation of the impact on the injured and bereaved. *Counselling Psychology Quarterly, 17*, 361-373.
The Compassionate Friends. (2003, June). *Reflections, 22*(2).
The Compassionate Friends, (n.d.). Information pamphlet [Brochure].
Thomas, D., & Veno, A. (Eds.) (1992). *Psychology and social change: Creating an international agenda*. Palmerston North, New Zealand: Dunmore Press.
Thompson, K. E., & Range, L. M. (1992-1993). Bereavement following suicide and other deaths: Why Support attempts fail. *Omega: The Journal of Death and Dying, 26*, 61-70.
Thorson, J. A. (1996). Qualitative thanatology. *Mortality, 1*, 177-190.
Tonnies, F. (1957). *Community and society (Gemeinschaft and gessellschaft)*. East Lansing, MI: Michigan State University Press.
Tye, C. (1993). Qualified nurses' perceptions of the needs of suddenly bereaved family members in the accident and emergency department. *Journal of Advanced Nursing, 18*, 948-956.
Unger, R. M. (1975). *Knowledge and politics*. New York: Free Press.
Vachon, M. L. S., & Stylianos, S. K. (1988). The role of social support in bereavement. *Journal of Social Issues, 11*(2), 65-73.
Van, P. (2001). Breaking the silence of African American women: Healing after pregnancy loss: *Health Care for Women International, 22*, 229-243.
Vernick, J. S., Li, G., Ogaitis, S., MacKenzie, E. J., Baker, S. P., & Gielen, A. C. (1998). Effects of high school driver education on motor vehicle crashes, violations, and licensure. *American Journal of Preventive Medicine, 16*, 40-46.
Vickio, C. J. (1999). Together in spirit: Keeping our relationships alive when loved ones die. *Death Studies, 23*, 161-175.
Vickio, C. J. (2000). Developing beefs that are compatible with death: Revising our assumptions about predictability, control, and continuity. *Death Studies, 24*, 739-758.
Victim Support Service. (n.d.). *What do I do now? Assistance for families dealing with the unlawful death of a family member*. Perth, Western Australia: Author.
Vigilant, L. G., & Williamson, J. B. (2003). To die, by mistake: Accidental deaths. In C. D. Bryant (ed.), *Handbook of death and dying* (Vol. 1, pp. 211-222). Thousand Oaks: Sage.
Vivid crash images to drive message home. (2005, August 20). *The West Australian*, p. 8.
Volkan, V. (1970). Typical findings in pathological grief. *Psychiatric Quarterly, 44*, 231-250.
Volkan, V. D., (1972). The linking objects of pathological mourners. *Archives of General Psychiatry, 27*, 215-221.
Vulcan, P., Cameron, M., & Newstead, S. (1995). *Road trauma in perspective*. Retrieved December 17, 2000, from http://www.genereal.monash.edu.muarc
Wahl, C. W. (1970). The differential diagnosis of normal and neurotic grief following bereavement. *Psychosomatics, 11*, 104-106.

Waller, P. F., (2001). Public health's contribution to motor vehicle injury prevention. *American Journal of Preventive Medicine, 21* (4 Supplement), 3-4.

Walsh, K., King, M., Jones, L., Tookman, A., & Blizard, R. (2002). Spiritual beliefs may affect outcome of bereavement: Prospective study. *British Medical Journal, 324*, 1551-1554.

Walter, T. (1996). A new model of grief. Bereavement and biography. *Mortality, 1*, 7-25.

Walter, T. (1999). *On bereavement: The culture of grief*. Buckingham, UK: Open University Press.

Walter, T. (2000). Grief narratives: The roles of medicine in the policing of grief. *Anthropology and Medicine, 7*, 97-114.

Walter, T. (2005-2006). What is complicated grief? A social constructionist perspective. *Omega: The Journal of Death and Dying, 52*, 71-99.

Walter, T., Littlewood, J., & Pickering, M. (1995). Death in the news: The public invigilation of private emotion. *Sociology, 29*, 579-696.

Ward, B. (1996). *Good grief: Exploring feelings, loss, and death with under elevens: A holistic approach*. London: Jessica Kingsley.

Wass, H. (2004). A perspective on the current state of death education. *Death Studies, 28*, 289-308.

Weber, M. (1921/1968). *Economy and society* (Vols. 1, 2, & 3). Totowa, NJ: Bedminster Press.

Weinstein, N. (1980). Unrealistic optimism about future life events. *Journal of Personality and Social Psychology, 39*, 806-820.

Weiss, R. S. (1988). Loss and recovery. *Journal of Social Issues, 44*(3), 37-52.

Western Australian Police Service. (n.d.). *When someone dies in a road fatality in Western Australia: Things you need to know*. Perth, Australia: Author.

Western Institute of Self Help. (2001). *Directory: Self-help and support groups*. Perth, Western Australia: Author.

Wheat, K., & Napier, M. (1997). Claiming damages for psychiatric injury following a road accident, In. M. Mitchell (ed.), *The aftermath of road accidents: Psychological, social, and legal consequences of an everyday trauma* (pp. 124-134). London: Routledge.

Wheeler, I. (1993-1994). The role of meaning and purpose in life of bereaved parents associated with a self-help group: Compassionate Friends. *Omega: The Journal of Death and Dying, 28*, 261-271.

Wheeler, I. (2001). Parental bereavement: The crisis of meaning. *Death Studies, 25*, 51-66.

White, K. (2000). *Maintaining meaning in life: The central challenge for palliative care practice*. Unpublished doctoral thesis, University of Sydney, Sydney, Australia.

White, M. (1989). Saying hullo again: The incorporation of the lost relationship on the resolution of grief. In M. White (ed.), *Selected papers* (pp. 29-36). Adelaide, Australia: Dulwich Centre Publications.

Wickie, S. K., & Marwit, S. J. (2000-2001). Assumptive world views and the grief reactions of parents of murdered children. *Omega: The Journal of Death and Dying, 42*, 101-113.

Wikan, U. (1998). Bereavement and loss in two Muslim communities: Egypt and Bali compared. *Social Science and Medicine, 27*, 451-460.

Wiles, R., Jarrett, N., Payne, S., & Field, D. (2002). Referrals for bereavement counselling in primary care: A qualitative study. *Patient Education and Counseling, 48*, 79-85.

Williams, A. F., Paek, N. N., & Lund, A. K. (1995). Factors that drivers say motivate safe driving practices. *Journal of Safety Research, 26*, 119-124.

Williams, M. (1997). The other victims. *Nursing Standard, 11*(46), 18.

Willis, K., Cameron, P, & Igoe, P. (1997). Building community networks: A road trauma education and training program for rural areas. *Australian Journal of Rural Health, 5*, 6-10.

Winslade, J. (2001). Putting stories to work. *Forum, 27*(2), 1-4.

Wolfe, B., & Jordan, J. R. (2000). Ramblings from the trenches: A clinical perspective on thanatological research. *Death Studies, 24*, 569-584.

Worden, J. W. (1982). *Grief counselling and grief therapy: A handbook for the mental health practitioner*. New York: Springer.

Worden, J. W. (1991). *Grief counselling and grief therapy: A handbook for the mental health practitioner* (2nd ed.). New York: Springer.

Worden, J. W. (2002). *Grief counselling and grief therapy: A handbook for the mental health practitioner* (3rd ed.). New York: Springer.

World Health Organization. (2004). *World report on road traffic injury prevention*. Geneva: Author.

Wortman, C. B., & Silver, R. C. (1989). The myths of coping with loss. *Journal of Consulting and Clinical Psychology, 57*, 349-357.

Wortman, C. B., & Silver, R. C. (2001). The myths of coping with loss revisited. In. M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 405-429). Cambridge: Cambridge University Press.

Wretmark, G. (1959). A study in grief reactions. *Acta Psychiatrica et Neurologic Scandinavia, Suppl. 136*, 292-299.

Zaza, S., Carande-Kulis, V. G., Sleet, D. A., Sosin, D. M., Elder, R. W., Shults, R. A., Dinh-Zarr, T. B., Nichols, J. L., Thompson, R. S., the Task Force of Community Preventions Services. (2001). Methods for conducting systematic reviews of the evidence of effectiveness and economic efficiency of interventions to reduce injuries to motor vehicle occupants. *American Journal of Preventive Medicine, 21*(4 Supplement), 23-30.

Zisook, S. (1987). Unresolved grief. In S. Zisook (Ed.), *Biopsychosocial aspects of bereavement* (pp. 23-34). Washington, DC: American Psychiatric Press.

Zisook, S., Shuchter, S. R., & Lyons, L. E. (1987). Adjustment to widowhood. In S. Zisook (Ed.), *Biopsychosocial aspects of bereavement* (pp. 51-74). Washington, DC: American Psychiatric Press.

Zola, I. K. (1977). Healthism and disabling medication. In I. Illich, I. K. Zola, J. McKnight, J. Caplan, & H. Shaiken, (Eds.), *Disabling professions* (pp. 41-67). New York: Marion Byers.

Appendix A

Information Letter

[Date]

To whom it may concern,

My name is Lauren Breen and I am completing a PhD in psychology at Edith Cowan University. The aim of my study is to explore people's experiences of bereavement through crashes. The research has the approval of the Edith Cowan University Ethics Committee.

In order to do this, I am hoping to interview people who have experienced the loss of a loved one through a crash in Western Australia. By talking with people, I hope to gain an understanding of people's experiences of grief resulting from crashes. I hope that my findings will support others that may face a similar situation in the future.

I understand that your self-help group possibly includes people who might like to participate in my study, and I was wondering if you could pass on the following information to your group.

Participating in the research involves an interview lasting up to 2 hours and participants remain anonymous. Participants must be at least 18 years of age, English-speaking, and it must be at least a year since their loved one's death.

The information provided by respondents will be used in my PhD thesis. The final report will be based on the responses of the group as a whole. It will not identify any individual by name nor will it include any identifying information. All information collected will be treated in the strictest confidence.

If you have any questions please do not hesitate to contact me on (08) 9400 5543 or my supervisor, Dr Moira O'Connor on (08) 9400 5593 during working hours. If you would like to talk to someone independent of the research, you may contact Professor Alison Garton on (08) 9400 5110.

Yours sincerely,

Lauren Breen
PhD student

Appendix B

Media Release

[Date] For Immediate Release

Grief and Road Trauma Study

Edith Cowan University psychology lecturer Lauren Breen is seeking people who have lost a loved one through a crash to participate in research for her Doctor of Philosophy degree.

“Coping with the death of a loved one is very difficult. I hope that the findings will be used to help provide more appropriate supports to people the loss of a loved one through a crash,” said Lauren.

Participants must be at least 18 years of age, English-speaking, and it must be at least a year since their loved one’s death.

Participating involves an interview lasting up to 2 hours and participants remain anonymous.

For information telephone Lauren on 9400 5543.

Appendix C

Demographics of Bereaved Informants

Table 2

Demographic Data: Bereaved Informants

Informant	Age (years)	Occupation	Relationship and age of loved one(s)	Time since death(s)	Household members now	Circumstances of death
Sylvia	66	Retiree/ Volunteer	Husband Keith (68); Son Ian (32)	1 year 8 months	Lives alone	Passenger and driver in a single car crash in Melbourne
Patrick	42	Homemaker/ Odd jobs	Father Keith (68); Brother Ian (32)	1 year and 10 months	Wife and 2 children	Passenger and driver in a single car crash in Melbourne
Joan	63	Retiree	Son Craig (19)	11 years	Partner	Motorcycle rider hit by a car
Kelly	39	Small business owner	Mother (39)	23 years	Husband and 2 sons	Driver in a single car crash in Busselton
Nicola	40	Respite worker	Brother Tom (36)	2 years 2 months	Lives alone	Pedestrian killed by truck in Northern Territory
George	54	Self-employed builder	Daughter Kate (17)	3 years 5 months	Wife	Driver in a two car crash in Perth metropolitan area; a passenger was also killed
Debra	53	Teachers' assistant	Daughter Kate (17)	3 years 5 months	Husband	Driver in a two car crash in Perth metropolitan area; a passenger was also killed
Nick	24	Disability pensioner	Sister Kate (17)	3 years 5 months	Partner, her parents, and her sister	Driver in a two car crash in Perth metropolitan area; a passenger was also killed
Lorraine	46	Homemaker	Father (70)	1 year 10 months	Teenage daughter	Driver in a two car crash in South Africa; mother seriously injured
Heather	48	Homemaker	Sister Melanie (42)	1 year 11 months	Husband	Pedestrian killed by motorcyclist in Perth metropolitan area; another sister seriously injured

Informant	Age (years)	Occupation	Relationship and age of loved one(s)	Time since death(s)	Household members now	Circumstances of death
Sharon	51	Bank officer	Son Alex (20)	9 years 9 months	Husband	Pedestrian hit by car in Perth metropolitan area
Pieter	46	Technical officer	Son Chris (19)	1 year 1 month	Wife and 2 teenage sons	Passenger in a single car crash in Perth metropolitan area
Di	45	Homemaker	Son Chris (19)	1 year 1 month	Husband and 2 teenage sons	Passenger in a single car crash in Perth metropolitan area
Maggie	50	Bank officer	Daughter Sally (21)	3 years 11 months	Husband	Driver in a single car crash southwest of Perth
Natasha	57	Homemaker	Daughter Jess (18)	11 years 4 months	Husband and 2 grandchildren	Pedestrian hit by car in New Zealand; another pedestrian also killed
Jim	56	Truck driver	Daughter Jess (18)	11 years 4 months	Wife and 2 grandchildren	Pedestrian hit by car in New Zealand; another pedestrian also killed
Brooke	33	Retail assistant	Grandmother (74)	8 years	Teenage son	Driver in a two car crash in Perth metropolitan area
Iris	71	Retiree	Daughter Mary-Anne (10)	23 years	Lives alone	Pedestrian hit by car in Perth metropolitan area
Dawn	43	Student	Daughter Claire (17)	3 years 4 months	Husband and teenage son	Passenger in a two car crash in Perth metropolitan area; the driver was also killed
Karen	43	Teachers' assistant	Son Mikey (6)	4 years 1 month	Husband and 2 teenage sons	Pedestrian hit by car in Perth metropolitan area
Jelena	37	Part-time student/ homemaker	Brother Sasha (25)	13 years	Husband and 2 children	Single motorcycle crash in Perth metropolitan area

Note. The bereaved informants are listed by their pseudonyms.

Appendix D

Road Safety Co-ordination in Western Australia

Road Safety Coordination in Western Australia

Ministerial Council on Road Safety									
Minister for Police and Emergency Services (Chair)		Minister for Health		Minister for Education		Minister for Local Government and Regional Development		Minister for Planning and Infrastructure	
Road Safety Council									
Independent Chairperson	Assistant Commissioner, WA Police Service	Director General, Department of Health	Executive Director, Office of Road Safety	Executive Director Road Network Services, Main Roads WA	Department of Education Representative	Managing Director, Insurance Commission of Western Australia	Local Government Representative	Divisional Manager Public Policy, Traffic and Safety, RAC of WA	Executive Director Integrated Planning and Policy, Department of Planning and Infrastructure
Road Safety Council Officers Support Group									
WA Police Service	Main Roads WA	Office of Road Safety (Chair)	Local Government	Education	Health	Insurance Commission of WA	RAC	Department of Planning and Infrastructure	
Taskforces									
Speed Management	Vulnerable Road Users	Fatigue	Drink/Drug Driving	Occupant Safety	Driver Training and Licensing	Young Road Users	Workplace Road Safety	Aboriginal Road Safety	Road Safety Around Schools

Note: Table correct as at November 11, 2002.

Source: Office of Road Safety.

Appendix E

Information Documents

Bereaved Informants

[Date]

Dear Potential Participant,

My name is Lauren Breen and I am completing a PhD in psychology at Edith Cowan University. The aim of my study is to explore people's experiences of bereavement through crashes.

In order to do this, I am hoping to interview people who have experienced the loss of a loved one through a crash in Western Australia. Interviews usually last up to 2 hours, but may take longer. If this is the case, I would like to come back at another time to finish the interview. By talking with people, I hope to gain an understanding of people's experiences of grief resulting from crashes. I hope that my findings will support others that may face a similar situation in the future.

The research has the approval of the Edith Cowan University Ethics Committee. The information provided by respondents will be used in my PhD thesis. The final report will be based on the responses of the group as a whole. It will not identify any individual by name nor will it include any identifying information. All information collected will be treated in the strictest confidence.

It is possible that discussing the death of your loved one may be upsetting and could result in emotional distress. You may choose to not answer specific questions during the interview and are free to withdraw your consent and terminate your participation at any time without penalty. I am happy to provide all participants with a summary of the final results.

If you have any questions please do not hesitate to contact me on (08) 9400 5543 or my supervisor, Dr Moira O'Connor on (08) 9400 5593 during working hours. If you would like to talk to someone independent of the research, you may contact Professor Alison Garton on (08) 9400 5110. Should you wish to discuss any personal issues or concerns about the loss of your loved one, please contact me and I will directly refer you to the Edith Cowan University Psychological Services Centre on (08) 9301 0011 or another appropriate service.

Yours sincerely,

Lauren Breen
PhD student

Setting Informants

[Date]

Dear Potential Participant,

My name is Lauren Breen and I am completing a PhD in psychology at Edith Cowan University. In order to learn more about the experiences of people bereaved through crashes, I would like to invite you to participate in an interview.

I appreciate the demands on your time and would be happy to arrange the interview at a time and place convenient for you. The interview is likely to last no more than 1 hour.

The research has the approval of the Edith Cowan University Ethics Committee. The information provided by respondents will be used in my PhD thesis. The final report will be based on the responses of the group as a whole. It will not identify any individual by name nor will it include any identifying information. All information collected will be treated in the strictest confidence.

If you have any questions or would like to make an interview time please contact me on (08) 9400 5543 or my supervisor, Dr Moira O'Connor on (08) 9400 5593 during working hours. If you would like to talk to someone independent of the research, you may contact Professor Alison Garton on (08) 9400 5110.

I would be very grateful for your assistance and I look forward to hearing from you.

Yours sincerely,

Lauren Breen
PhD student
Tel: 9400 5543
Fax: 9400 5834
Email: l.breen@ecu.edu.au

Appendix F

Consent Form

Please read the following statements before proceeding any further.

I _____ (insert your name) have read the information letter. Any questions I have asked have been answered to my satisfaction. I agree to participate in the interview. I realise that I may withdraw at any time. I realise that my interview may be taped with my permission. I understand that a third party, who will be bound by confidentiality, may transcribe my interview. I understand that the tapes will be locked in a secure cabinet and erased as soon as they are transcribed. I agree that the research data gathered for the study may be published providing I am not identifiable.

_____/___/____

Your Signature and date

_____/___/____

Investigator and date

Appendix G

Interview Guide – Bereaved Informants

I'm here to find out about your experiences from your point of view about losing your loved one in a crash. I hope that this information will assist in developing effective supports for those grieving the death of a loved one in a crash. I would like to spend our time together talking about your thoughts and feelings in relation to your loss, life at the moment, and to discuss the supports you've received during this time.

Firstly, I have some background questions –
Age _____
Sex □ Female □ Male
Time since bereavement _____
Name of deceased loved one _____
Age of deceased loved one _____ □ Female □ Male
Household members
(now?)_____
_____
_
Occupation
_____
Postcode _____

Now I would like to ask you more detailed questions about your experiences -
Tell me something about you experience since the death of your loved one?
- Finding out about (your loved one's) death.
- Description of the days that immediately followed (your loved one's) death.

Issues or problems you faced in the first few weeks or months after the death.
- Description.
- Problem solving.
- Examples.

Current issues.
- Changes over time.

Help/support over the time.
- Form of support/help.
- Who helped/supported and how.
- Examples.

Reactions of people around you (family/friends) to your loss.
- Helpful/unhelpful things they did.
- Your reactions to their reactions.
- What you actually wanted.
- Anything else that could have helped.

Employment/work.
- Reaction of boss/colleagues.
- Helpful things they did.
- Unhelpful things they did.
- What you actually wanted.
- Anything else that could have helped.

Reactions from the community.
- Where/who from.
- Examples.

Support services.
- Why access them/Why not?
- What were they?
- Were they helpful or unhelpful?
- In what way(s)?
- Examples.
- What else could they have done?

Experience of:
- Coroner's office?
- Police?
- Medical professionals?
- Coronial Counselling Service?
- Psychologists/counsellors?
- Insurance companies?
- Victim Support Service?
- Road safety organisations?
- Clergy/chaplains?
- Lawyers/legal system/courts?
- Any others?

Any other supports.
- Ideal support.
- Advice for the bereaved.

Positive things that come out of experiencing hard times.
- Growth and/or changes since you lost your loved one?
- Future?

Remembering (loved one's name)?

Are there other questions you wished I had asked you?

We've come to the end of my questions. Thank you for your time. How are you feeling?
I have some information and pamphlets of people who are able to talk further with you about any feelings that may have arisen.

Appendix H

Interview Guide – Setting Informants

I'm here to find out about the context surrounding the loss of a loved one in a crash. I hope that this information will assist in developing effective supports for those grieving the loss of a loved one in a crash. I am interested in your thoughts and opinions so please answer each question in your own words.

Firstly, I would like to ask you a few questions about you -
Age _____
Sex □ Female □ Male
Organisation _____
Occupation/Job Title _____

Tell me about your organisation?
- When was it formed?
- Your job and duties.
- Length of time in field.
- Qualifications and experience.
- Entering the field.

Supports for people who are grieving the loss of a loved one through road death.
- Efficacy.
- Other supports.
- What else could they do?

Could you tell me what you know about each of the following -
- Coroner's office?
- Police?
- Medical professionals?
- Coronial Counselling Service?
- Psychologists/counsellors?
- Insurance companies?
- Victim Support Service?
- Road safety organisations?
- Clergy/chaplains?
- Legal system?
- Who are they for? What is their role? Could each be improved? How?

Factors that might prevent you or your organisation from providing a better service to people bereaved through road death.

In your own words, tell what you know about the experience of grief
- Duration
- Effects
- Thoughts and feelings.
- Support that might be needed.
- Are the supports that you have just mentioned readily available?

From who/where?
Why/why not?

What do you think would be the ideal in terms of support for people that have lost a loved one in a road death?
Can you give me an example?

Advice for people bereaved in road crashes.

Are there other questions you wished I had asked you?

We've come to the end of my questions. Thank you for your time. I have some information and pamphlets of people who are able to talk further with you about any feelings that may have arisen.

Appendix I

Letter from Edith Cowan University Psychological Services Centre

Edith Cowan University Psychological Services Centre
8 Davidson Tce
Joondalup 6027

Tel: 9301 0011

Marilyn Beresford
Research Ethics Officer
Phone 9273 8170
Fax 9273 8661
E-mail m.beresford@ecu.edu.au

Dear Marilyn,

I understand that Lauren Breen, a PhD (Psychology) student, is conducting research in the area of grief following crashes. I further understand that she would like to inform her interviewees about the services we offer.

As Lauren is interviewing a relatively small number of people, I anticipate that Edith Cowan University Psychological Services Centre has the capacity to meet the needs of the participants in Lauren's research.

Yours sincerely,

Clare Wilson
Director
Edith Cowan University Psychological Services Centre

Appendix J

Confidentiality Agreement for Transcriptionists

Please read the following statement.

Confidentiality of information is vitally important to protect the interest of research participants. As a transcriptionist of audiotaped data, you must maintain the confidentiality of all information gained in the course of your employment.

It is a term and condition of your employment that you:

> Keep the information confidential and will not disclose or permit disclosure of the information to any person; and
> Will not use or permit the use of the information for any purpose whatsoever other than that for which it is intended.

These obligations apply for the period of your employment and continue without limitation of time after the date of termination of your employment to all information.

I _____ (insert your name) agree to transcribe the audiotapes for Lauren Breen's Doctor of Philosophy research on grief experiences resulting from crashes. I understand the information above. I will not breach confidentiality.

_____/___/____

Your Signature and date

_____/___/____

Investigator and date

Appendix K

Summary of Results for Informants

[Date]

Dear [Name]

I spoke to you a while ago for my research on the experiences of grief following a road crash and I indicated then that I would send you a summary of my research.

I would like to first apologise for the delay in providing you with a summary of the findings. I underestimated the time required to compile the data. A big concern for me throughout this process was the thought that I might misrepresent what each of you said so I took a long time to immerse myself in this aspect of my work. Hopefully the extra time taken will mean a better thesis in the end and one that represents your experiences and feelings in a meaningful way.

In all, I interviewed 21 people who had lost at least one loved one in a crash. The loved ones were children, siblings, parents, spouses, and grandparents. I also interviewed 10 people representing such agencies and departments as the Office of Road Safety, Office of the Coroner, Police Service, Lifeline, Insurance Commission of Western Australia, and so on in order to get a better understanding of the context of road crashes in Western Australia.

Please find enclosed a summary of my findings. I have included only a summary, as the section in my thesis devoted to reporting the findings is over 100 pages in length. However, please feel free to contact me if you have queries or comments. My contact details are provided below.

It was a privilege to meet all of you and to listen to the stories you told. I would like to once again thank you for your time, effort, wisdom, and candour.

Lauren Breen
PhD Student
Edith Cowan University
Tel: [redacted]
Email: l.breen@ecu.edu.au

The Experience of Grief Following the Death of a Loved One in a Crash in Perth, Western Australia: A Critical Contextual Analysis
by
Lauren Breen

Summary of Findings

In my thesis, I discuss the findings in four chapters. As a result, I've provided a brief summary of each chapter for you.

First Results Chapter
Historically, grief researchers and theorists have suggested that grief is a temporary condition consisting of stages leading to recovery. There are many assumptions about the experience of grief contained in these theories including;

Grief follows a relatively distinct pattern;
Grief is short-term;
Grief is a process characterised by linear stages that include shock, yearning, and emerging from the grief;
Detachment from the deceased loved one is necessary for recovery, and the continued attachment to the deceased loved one is abnormal, even pathological.
Grief needs to be 'worked through'; and
There is meaning in the death that should be found.

Despite these assumptions, almost all of the bereaved people I spoke to did not talk about their grief in this way. Instead, they talked about grief as an individual experience, where the experience of grief differed greatly between spouses, family members, and friends. They spoke about learning to live with the loss rather than recovering from it. They also reported oscillating between feelings rather than experiencing a progression through clear-cut stages of emotion. They stated that they were usually not able to find meaning in their loss and finally, they spoke about having a continued attachment to their deceased loved one.

Second Results Chapter
In the second chapter, I focused on the ways in which family, friends, work colleagues, and acquaintances reacted to the death of a loved one in a crash. The bereaved participants stated that many assumptions were 'enforced' onto them by those around them. Sometimes the enforcement was overt, such as when people ask, "Haven't you gotten over that yet?" At other times, the enforcement was covert, such as ignoring or minimising the bereaved person's feelings.

Further, the bereaved respondents often experienced consequences of the enforcement of these assumptions about grief and some of these outcomes could be potentially harmful. One example is when bereaved people start to believe that something is wrong with them because their experience doesn't fit the grief assumptions. For example, many respondents reported feeling as though they were going mad, or thinking they had failed because they were still grieving after a year.

Third Results Chapter
In this chapter, I focused on the bereaved respondents' experiences in the legal, service, and road safety domains. Overwhelmingly, the experiences within these domains were characterised by a feeling of 'voicelessness'. For example, the legal conceptualisation of road crashes serves to minimise the psychosocial experiences of losing a loved one in a crash. In addition, although conceptualised within the legal domain, crash fatalities are distinct from criminal deaths and the participants felt that they are often considered by the legal system to be more acceptable and 'less criminal' than are other deaths.

It also appears that they consider the services available for people bereaved through crashes as largely reactive and superficial. Finally, I discuss the Western Australian government's road safety policies and practices and argue that the emphasis of preventing crashes further serves to minimise participants' experience of grief following crashes.

Fourth Results Chapter
Many of the bereaved respondents engaged in what I have termed acts of resistance, where they resisted the enforcement of the common assumptions around grief. Examples of this are when people connected with others with a similar experience, ignored hurtful comments from others, and accepted their grief experience as normal. I also discuss the experience of the bereaved informants who have voiced their experiences in order to advocate for greater awareness of the psychosocial experiences that result from crashes. For example, some of the bereaved informants spoke to the media or were involved on government committees.

Implications of the Results
Despite crashes being a common cause of death, there is very little research on the grief experience that results from crashes. As a result, the findings have implications in a number of areas. For example, they challenge the common grief assumptions and they will be able to inform policy and planning for service delivery and will give information for improving grief supports in a number of areas, such as grief education for the general public and for service providers.

Appendix L

Office of the State Coroner Pamphlet

Appendix M

Road Trauma Counselling Service Card

Appendix N

Road Trauma Support Team (RTST) Victoria Inc. Pamphlet

Appendix O

Australian Parents Against Road Trauma (APART) Inc. Pamphlet