Article

Bereavement Adaptation as Deflection Reduction: Bereaved Caregivers Define the Event of Dying

Linda E. Francis[1] and Malissa Alinor[2]

Abstract

Affect control theory (ACT) has the potential to extend dominant understandings of adaptation to bereavement. Using narratives from bereaved caregivers, we assessed attributions they made about the death of a loved one from cancer. We transformed these attributions into actor-behavior-object events along the evaluation, potency, and activity dimensions of ACT. After creating hypothetical baseline deflections for events, we simulated the attributions as events in INTERACT. We found eight emergent categories of resolutions that caregivers used to make sense of the death: caregivers redefined the event to align with their sentiments about the deceased or the death. We also found racial differences in the attributions. White caregivers were more likely to blame themselves or others for the death of their loved one, while black caregivers were more willing to admit their deceased loved one's faults. These findings demonstrate how caregivers make sense of their grief in a framework of cultural sentiments and underscore the utility of affect control theory in qualitative and theory-generating research.

Keywords

affect control theory, cancer caregiving, bereavement, grief

[1]Cleveland State University, Cleveland, OH, USA
[2]Stanford University, Stanford, CA, USA

Corresponding Author:
Linda E. Francis, Department of Criminology, Anthropology and Sociology, Cleveland State University, 1736 Rhodes Tower, 2121 Euclid Avenue, Cleveland, OH 44115, USA.
Email: l.e.francis@csuohio.edu

Grief and bereavement are understudied issues in sociology (Charmaz & Milligan, 2006; Walter, 1996). Some sociologists study grief and bereavement as a matter of wellbeing, such as the concept of a "good death," (Carr, 2003), as recovery from the trauma of the death of a loved one (Carr & Boerner, 2009) or as the medicalized conflation of grief and depression (Horwitz & Wakefield, 2007; Francis et al., 2015). Beginning with Lofland's (1985) argument that grief is deeply socially shaped, a key interactionist concern has been the context in which the individual tries to make sense of their loss (Charmaz & Milligan, 2006). Whether the emphasis is on relationships (Rosenblatt, 1988), defining recovery (Francis, 1997a, 1997b), reactions of others (Clark, 1997), or labels given to the emotion (Horwitz & Wakefield, 2007; Walter, 1996), grief is embedded in interactions which give it meaning. Common to all sociological understandings, however, is that grief and mourning are social, not just psychological processes.

The current study builds on interactionist ideas about grief and emotion. We explore how bereaved caregivers make sense of a family member's death from cancer through a qualitative analysis of caregivers' statements about that death. Specifically, we code these statements as attributions of meaning in the form of the actor-behavior-object (ABO) events used in affect control theory. These attribution events define actors and behaviors in ways that agree with established sentiments about a loved one, and thus make more sense than an event where their loved one engaged in the very bad, weak, and inactive behavior of dying. We argue that bereaved caregivers manage their painful emotions by altering the meaning of the event of death. This analysis, therefore, contributes both to the literature on grief, and the methodological application of affect control theory to qualitative interviews.

Meaning and Grief

Much of the clinically oriented literature captures the importance of meaning in grief with the concepts of sense-making or meaning-making. This literature emphasizes *bereavement adaptation*, underscoring that one does not recover from the death of a loved one, but adapts to the loss over time (Holland & Neimeyer, 2010). Accordingly, adapted mourners are those able to construe meaning from the death in a way that fits their understanding of the world (Davis & Nolen-Hoeksema, 2001). Meaning-making allows the mourner to "assimilate the loss into their existing self-narratives" (Neimeyer et al., 2002). Despite an explicit rejection of the medicalization of grief (Maciejewski et al., 2007; Neimeyer, 2019; Stroebe et al., 2010), the emphasis of this work remains on the clinical aspects of pathological, prolonged, or complicated grief (Rozalski et al., 2017). While a major step forward from older stage-based models of grief (Bowlby, 1980; Kübler-Ross, 1969), such work still individualizes grief and locates it in the person alone (Hibberd, 2013; Bonanno et al., 2002). Most meaning-making models focus tightly on the individual's cognitive processes with little acknowledgement of the role of non-clinicians (Park, 2010).

From a sociological perspective, an individualized focus on grief omits half the story. In her classic work on grief, Lofland (1985) underscores that grief is shaped by the survivors' definitions of the situation developed in the context of their social environment and culture. Both expression and experience of grief vary across cultures (Rosenblatt, 1988) and even across time within our own (Steams & Stearns, 1986). Doka (1989) recognizes this social shaping in the disenfranchised grief of people not socially approved to grieve a particular death. Walter (1996, 2007) argues for the inherently social process of grieving in the collaborative work of recreating the person as a permanent fixture in one's memory. Others have extended such ideas to relate grief to deviance (Kalich & Brabant, 2006), narratives of interactional ordering (Sawicka, 2017), and to embed grief in social structure (Jakoby, 2015).

From the perspective of the literature above, making sense of grief and loss should situate adaptation within culturally approved ways of mourning. Loss events only take on meaning in relation to the settings, people, objects, actions, and history surrounding them (Charmaz, 1980; Charmaz & Milligan, 2006; Lofland, 1985; Walter, 1996). Thus, while meaning-making may be a universal process, the experience of it can vary dramatically depending not only on the intimacy of the relationship and the temperament of the mourner, but on the social elements that are accorded significance by the group or culture defining appropriate responses.

Affect Control Theory and Cancer Bereavement

Building on this culturally grounded view, this exploration of caregiver narratives of bereavement applies concepts of affect control theory (ACT) (Heise, 2012) to illustrate how individuals make sense of bereavement. ACT reflects Osgood et al.'s (1975) cross-cultural work inferring meaning from three dimensions: evaluation (good–bad), potency (strong–weak) and activity (lively quiet). According to ACT, actors have culturally rooted fundamental sentiments regarding identities, objects, and actions. As a result, they are motivated to maintain transient feelings (impressions) that confirm those fundamental sentiments. When their sentiments are not confirmed in the interaction, individuals experience the discomfort of inconsistency, called "deflection." Actors then perform identity-restoring behaviors; when deflection is extreme, however, they may resort to attributing new meanings to the actor, behavior, recipient, or setting (Nelson, 2006).

Based on the symbolic interactionist premise of language as the social basis for identity, ACT provides a powerful theoretical and methodological schema for identifying cultural meaning. For bereaved caregivers, the death of their loved one is likely to produce an enormous deflection between established sentiments about the deceased and the event of death. The extremely bad, weak, and inactive act of dying violates our sentiments for someone we view as good and strong (e.g., a *beloved mother*). This explains why denial is often the first reaction to news of the death of a valued person—it seems impossible to believe. Reflecting this, denial, disbelief, and yearning are common foci in both bereavement scales and clinical treatment (Boerner & Schulz, 2009;

Guarnaccia & Hayslip, 1998). The likely outcome of such deflection is grief—a complex emotion comprised of multiple and sometimes conflicting emotions (Charmaz & Milligan, 2006). The deflection and resulting painful emotions motivate the caregiver to reinterpret the event to something more comprehensible and less discrepant from the caregiver's sentiments about their deceased loved one. Reducing deflection is therefore a means of making sense of the death and an example of redefining the situation for a new meaning. Thus, ACT enables a theoretically based qualitative analysis of how individuals make sense of loss within their cultural context.

The Case of Caregivers

This study used in-depth interviews of bereaved caregivers to elicit descriptions about the death of their loved one from cancer. With end-of-life caregiving shifting increasingly into the home, the heavy burden of end-of-life care now falls on such family caregivers (Williams & McCorkle, 2011). The resulting grief reflects not only attachment to their loved one, but caregiving experiences and the sociocultural expectations in which their mourning is embedded.

Caregivers defined actors, behaviors, and/or objects in ways that made the event consistent with the caregivers' understandings of their social worlds. We found that redefinitions occurred along the ACT dimensions of evaluation, potency, and activity, reducing deflection and turning the death into a comprehensible event that the survivors could "live with." Such narratives of grief, therefore, became mechanisms for making meaning by applying cultural understandings to a personal context of loss. These examples of sense-making validate using affect control theory as a framework to understand how family caregivers make attributions of meaning regarding death.

Data and Methods

Data

This project is a qualitative extension of a larger, longitudinal study on late-stage "terminal" cancer (Bowman et al., 2009) with over 400 patient–caregiver pairs recruited from two urban cancer clinics caring for underserved patients. To be eligible, patients had to have a prognosis of approximately 1 year to live, 40+ years old, cognitively intact, and English-speaking. Patients designated the person most involved in daily care and decision-making as their family caregiver. These caregivers—usually spouses/partners, children, or siblings—bore the brunt of the difficult care of a dying person, including medication regimens, appointments, surgical wound care, emotional support, and in the end stages, often intimate physical and personal care. The current study is comprised of follow-up qualitative interviews with 50 of these caregivers 12–24 months after the patient's death. Although "normal" grieving times are debated (Horwitz & Wakefield, 2007), a 12–24-month window shifts respondent focus from personal distress to culturally acceptable sense-making narratives. Of 54 caregivers

contacted, four refused to participate. The recorded interviews were semi-structured, face-to-face, and one to three hours long. The transcriptions were checked for accuracy by the research team staff.

Coding Procedures

Caregivers attributed causal meanings to the patient's death. We define an attribution, therefore, as *a statement from the caregiver describing the cause, timing, or nature of the death as being due to a specific actor, rather than just a result of the progression of disease*. We coded these attributions about death using a combination of in vivo and protocol coding (Miles et al., 2014). We copied coded attributions from the interviews to an Excel spreadsheet along with each participant's demographics from the parent survey study and EPA ratings from INTERACT[1] (Heise, 2013) (see supplemental appendix). Similar to earlier work by Boyle and McKinzie (2015), we sought emergent themes congruent with ACT's EPA dimensions. Therefore, we only included attributions where the caregiver was discussing an actor doing some action to an object, coding each individual attribution as a unique ABO (action-behavior-object) event.

Of 50 cases, 38 contained attributions about the patient's death, and 16 cases had two or more attributions, for a total of 67 "death attributions" in the sample. The 12 cases without death attributions did not differ demographically from the other 38, so are not reported separately in Table 1. We coded death attribution(s) by summarizing them as ABO events using best approximations from the existing dictionaries. To capture the EPA dimensions, we added modifiers to identities to capture the tone of the surrounding text (e.g., apathetic, reckless, trusting, affectionate, etc.) and summarized action sentences with a behavior verb reflecting similar dimensions. Sample ABO statements are: "considerate father protects grief-stricken daughter," or "careless doctor neglects trusting patient." We verified our events by modeling them as closely as possible in the simulation program INTERACT and assessing whether the resulting emotions, behaviors, and/or labels corresponded to the respondents' own reports. This resulted in an iterative process where emerging themes led to reassessing attributions, leading to refinements of both coding and themes. The process was an effective check on both validity and reliability, as the simulations triangulated meaning and often resolved interrater disagreement. This inductive use of INTERACT to simulate naturally occurring events reported by respondents helped to distill layers of meaning. Once all attributions were characterized as ABO events, we categorized them according to qualitative differences in types of attributions.

Quantitative Measures

Demographic variables were drawn from the quantitative parent dataset (Table 1). Age was measured as numeric age of the caregiver (M = 52.6 years). Gender was measured dichotomously as male–female (80% female). Race was a binary variable comprising of white and black racial groups (64% white, 32% black, 2% mixed-race w/black).

Table 1. Description of sample.

Respondent characteristics	N	%
Caregiver age		
18–40	9	18%
41–60	26	52%
61+	15	30%
Caregiver gender		
Female	40	80%
Male	10	20
Caregiver race		
White	32	64%
African American/Black	16	32%
Mixed race (White/Hispanic w/Black)	2	4%
Caregiver relationship to deceased		
Wife	13	26%
Husband/Male partner	5	10%
Daughter/Stepdaughter	13	26%
Son/Stepson	4	8%
Sister	10	20%
Brother	1	2%
Sister-in-Law	1	2%
Brother-in-law	1	2%
Niece or cousin	2	4%
Boyfriend	1	2%
Caregiver education		
Less than HS	6	12%
HS Diploma	17	34%
Some college	16	32%
College graduate	6	12%
Graduate degree	4	8%
Missing	1	2%
Caregiver income		
Less than HS	3	6%
$ 0–9999	6	12%
$ 10,000–19,999	12	24%
$ 20,000–29,999	9	18%
$ 30,000–$39,000	4	8%
$ 50,000+	14	28%
Missing	2	4%
Attributions by case		
Cases w/o attributions	12	24%
Cases w/attributions	38	76%
Total attributions coded	67	—

Education (less than high school to graduate degree) and income (six categories from US$ 0 to US$ 50,000+) were treated as continuous variables. Relationship to the deceased was coded nominally with the majority of caregivers being wives (26%), sisters (20%), or daughters (26%) of the deceased.

Analytic Strategy

This study contains two analyses. In the first analysis, we assessed all attributions (statements attributing meaning) regarding the event of dying. In the second, we analyzed patterns of attributions by race. Both analyses used individual attributions as the units of analysis, rather than individual cases. Of the 38 bereaved caregivers with attributions, 22 caregivers made one attribution, 11 caregivers made two attributions, three caregivers made three attributions, and two caregivers made four attributions. On six occasions two attributions from the same caregiver had similar meanings, though we excluded identical attributions. On 10 occasions, caregivers made multiple attributions that were quite different from one another. For multiple attributions from one individual, we counted all attributions in the total but only included one attribution from any respondent as an exemplar of a category. We also included the median redefined ABO and hypothetical baseline deflection scores for each category (discussed below). While such scores are numeric, we treat them qualitatively as additional triangulation, interpreting them ordinally in terms of more-less/higher–lower. See the supplemental appendix for full coding.

Results

Simulating Grief

Cancer bereavement literature (Boerner & Schulz, 2009; Francis et al., 2015; Williams & McCorkle, 2011) supports the assumption that a loved one's terminal illness and death cause very large deflections from the survivor's usual sentiments, resulting in painful, negative, emotions. Unfortunately, we lacked a measure of the original deflection caused by the death to get a baseline by which to measure resolution. Nor could we simulate the expected deflection precisely, as INTERACT does not include the verb "to die." As a proxy, we simulated the act of death using the INTERACT "Find Concepts" function, seeking behaviors that were bad, weak, and inactive. Three behaviors emerged from this search: leave (EPA: −.69, .67, .02), abandon (EPA: −1.94, −.05, −.14), and desert (EPA: −2.01, −.70, .08). "Desert" and "abandon" produced highly similar deflections, so we only report "leave" and "abandon" as hypothetical baselines.[2]

To generate a baseline for deflection, we simulated ABO events in INTERACT using the most common family identities and the modifiers "loved" or "affectionate" to indicate caring relationships (within the setting of a hospital room). Such simulations are hypothetical but have some grounding in real cultural practices: while not all family relationships are affectionate, it is unlikely that people who are indifferent would take

on the caregiving role, and while many cancer patients do not die in a hospital, this setting proxied a death by illness. We ran simulations for the behaviors of leaves and abandons based on the relationship of the caregiver to the deceased. Deflections for the affectionate mother-loved daughter pair were leaves = 37.7 and abandons = 43.8. Deflections for the loved brother-affectionate sister pair were leaves = 23.0, and abandons = 42.1. Deflections for the loved husband-loved wife pair were leaves = 24.4, and abandons = 45.1. All deflections produced negative emotions with hopelessness being the most common. Interestingly, INTERACT indicated that the deceased who left or abandoned, the caregiver would have had to feel outraged, spiteful, humiliated, or similar emotions in order to engage in such a dreadful act against the caregiver. Clearly that is untrue when cancer is the culprit, underscoring the importance of making sense of the death of a loved one.

Evaluation-Potency-Activity Attributions of Meaning

Of 50 respondents, 12 made no causal attributions about death. Most such caregivers described the cancer death as uncontrollable or unpredictable, such as genetic (runs in the family) or random (anyone can get it). These individuals also scored higher than average on a general distress measure, though not on grief—providing some indirect support for our argument that deflection-reducing attributions are an effective form of making meaning of death.

We coded caregiver (FCG) attributions about the deceased (DCD) in terms of actors, behaviors, and object persons (ABO events). Based on this coding, the attributions of meaning fell into the eight categories shown in Table 2.

The underlying commonality of these categories is that they all alter situational meaning to make it more congruent with sentiments about the deceased or about death. For example, the act of dying is redefined as good, powerful, and/or active, or the deceased's identity is downrated to be more similar to the negatively rated act of dying, or someone else is identified as somehow controlling the circumstances of death. Interestingly, most such strategies resulted in low deflections and positive emotions, with two notable exceptions (#3 & #8) to be discussed below (Table 3)

Deceased-as-Actor Resolutions

The deceased-as-actor attribution type is the largest of the three types of resolutions, and in some ways, the most interesting. In these attributions, the deceased person was described as having power over the timing or cause of their death and using that power (or not) to help or hurt the self or others.

Good, Active Deceased Does Good Act to Good Caregiver/Other. In the three representative examples below, the deceased person is described as choosing his or her time of death in order to make their dying better for the caregiver. To reduce their deflection of loss,

Table 2. Attribution categories with reduced (ABO) and baseline median deflections.

Attribution category[a]	No. & % of Attributions		Median deflections	Baseline	
	N	%	ABO	Leaves	Abandons
Deceased-as-Actor resolutions					
Good, active DCD does good act to good FCG/other	9	13	4.1	9.4	16.2
Good, active, DCD does good act to/for self	10	15	4.4	11.3	21.5
Bad, active, DCD does bad act to good FCG/other	3	4	12.5	23.6	43.5
Bad, active, DCD does bad act to self	19	28	5.3	12.6	20.4
Other as Actor resolutions					
Good, powerful, other does good act to good, weak, inactive DCD	4	6	3.6	9.25	21.7
Bad, powerful, other does bad act to good, weak, inactive DCD	12	18	3.0	12.9	21.7
FCG as Actor resolutions					
Good FCG does good act to DCD	5	8	3.4	13.4	24.6
Bad, weak, FCG does bad, weak act to DCD	5	8	10.4	8.6	14.7
Total	67	100			

[a]Categories were distinguished primarily by evaluation and secondarily by potency. Activity was ambiguous and least represented; this reflects the naturally occurring nature of attributions, as this study did not probe for EPA dimension information.

Table 3. Attribution Categories by Race of Caregiver.

	Race				Total	
	White Attributions (N = 42)		Black Attributions (N = 25)		All Attributions (N = 67)	
Attribution Category	N	%	N	%	N	%
Deceased-as-actor resolutions						
Good, active DCD does good act to good FCG/other	6	14	3	12	9	13
Good, active, DCD does good act to/for self	10	24	0	0	10	15
Bad, active, DCD does bad act to good FCG/other	0	0	3	12	3	4
Bad, active, DCD does bad act to self	9	21	10	40	19	28
Other as actor resolutions						
Good, powerful, other does good act to good, weak, inactive DCD	1	2	3	12	4	6
Bad, powerful, other does bad, weak act to good, weak, inactive DCD	9	21	3	12	12	18
FCG as actor resolutions						
Good FCG does good act to DCD	2	5	3	12	5	8
Bad, weak, FCG does bad, weak act to DCD	5	12	0	0	5	8
Total Attributions	42	63	25	37	67	100

caregivers redefined the event to make death a more beneficent, powerful, active behavior to correspond with the identity sentiments of the deceased.

> He died right after I left. To be honest with you, I really don't think I could have watched him die. I think he was waiting for me to leave. (47-year-old, white, daughter)

> He always told me when I was growing up, when the day comes when you have to start wiping my butt—I don't want to be here anymore. And that's exactly what started to happen, that last ten days you know he couldn't handle himself. I think he was keeping to his promise. (39-year-old, white, son)

> I went in to see her and I was talking to her… I was touching her, but she wasn't responsive…. She was still warm, but I couldn't detect any breathing, so I called the nurse in….and they checked her, and she was gone. It was like she waited for me to get there <crying> and she was gone. (64-year-old, white, husband)

Deflections in this category were fairly low, ranging from 2.1 for "considerate brother-in-law protects compassionate brother-in-law," to 6.1 for "considerate father protects disappointed daughter." Caregivers in the simulation were consistently either good (e.g., compassionate) or weak (grief-stricken). The resultant emotions in INTERACT for the caregiver were all positive (even those with no exact matches for emotions) and similar across all deflections: sentimental, reverent, humble, and serene.

Interestingly, the hypothetical baselines differed for good and weak caregivers. For good caregivers, scores for "leave" were mostly 17.6–20.6, and for "abandon" they were in the upper 30s (hopeless). For weak caregivers, "leave" ranged from 5.1–10.2, and "abandon" from 9.8–17.3 (apprehensive, shocked, and overwhelmed).

Good, Active, DCD Does Good Act to/for Self. The category of attributions where the good, active deceased does a good act to or for themselves also show the deceased in a positive, active light. However, these attributions were lower potency self-directed events (Britt & Heise, 1992), depicting the deceased acting on herself.

> The day I had her anointed and they prayed on her, and the Pastor asked her where she was going and she said she was going home to be with her family. So that's when I knew that it wasn't long after that. (36-year-old, white, daughter).

> This woman, the tenacity of this woman was amazing. They gave me a year when she was diagnosed at the most. We went two and a half. I mean, the tenacity! (49-year-old, white, sister-in-law)

> All her kids finally were all together at once with her at the hospice. They all went up there, and they were laughing and joking and having fun. I think that was her closure. I think she felt she got what she needed, and she was you know settled and she was done. You know she was tired. (51-year-old, white, sister)

In the first of these quotes, the deceased takes herself home to Heaven, in the second the deceased holds on to her life against the odds, and in the third, the deceased chooses her time of death for her own needs. Deflections in this category were mostly relatively low ranging from 4.1 to 5.1, except for two people going to Heaven (9.3 and 9.8); emotions of both actor and observer were positive: reverent, awe-struck, appreciative, and grateful. Hypothetical baseline deflections of the DCD leaving/abandoning the FCG were all much higher: "leaves" 9.1–20.2, and "abandons" 16.2–39.7, with emotions such as hopeless, desperate, melancholy, or apprehensive. The one low baseline case had "felt better off dead," which might be giving up on himself instead of releasing himself.

Bad, Active, Deceased Does Bad Act to Good Family Caregiver/other. In contrast to the above attributions, the second two categories in Table 2 show the DCD doing bad active things to self or other. The first category of three individual attributions depicts the deceased doing something bad to the caregiver or some other good person.

> Sometimes I get mad at him for leaving you know when he did. I just, I really, really wanted him to see our son graduate from high school. (46-year-old, black, wife)

> …my brother called and told me that my brother was gone, and you know I was preparing to go and stay the night with him, it was in the evening, and it was the strangest thing. It's the thought of 'Why couldn't he wait? I wanted to say some more things to him. (46-year-old, black, sister)

> I'm not as angry anymore, so I know I'm doing better, but.... [Interviewer: Why were you angry?] Because she left. She left. And I say all the time, I say 'God, she didn't even think enough to say, 'If I can just smoke one less cigarette today, maybe tomorrow or next week I can smoke two less,' or maybe three or four less. (57-year-old, black, sister)

All three caregivers described themselves as upset at the deceased for being inconsiderate in the timing or cause of their deaths. This implies that the deceased persons had power over their deaths and actively chose poorly. Deflections from the simulations of events in this category were substantially higher than in previous categories with three of four ABO events producing deflections of 10.3–13.8, and with INTERACT providing no words for the bad, powerful, weak emotions produced; most caregivers claimed anger. Hypothetical baseline deflections based on a good DCD identity were much worse, however: 19.6–47.4, with all "abandon" deflections at the upper end, "hopeless" being the common result.

Bad, Active, DCD Does Bad Act to Self. The category of the bad, active deceased doing a bad act to themselves was the largest in the sample: 19 attributions across 14 respondents. Here, the identity of the deceased was defined either by alternate terms (smoker, braggadocio) or modifiers (depressed, tired) to make them weaker and/or more negative and more consonant with the act of dying. Many attributions focused on the deceased's

risky behavior or poor self-care, but others emphasized the DCD finding life or treatment too burdensome and giving up.

> It made me appreciate life, and you know he brought a lot of what happened to him on himself by ignoring and being afraid. (69-year-old, white, brother-in-law)

> He was braggadocio in the fact that he had cancer and no medication and no this, that and the other, but he never ever changed his bad habits of a heavy smoker and heavy drinker. (67-year-old, black, wife)

> My sister was going through depression. Her oldest, her daughter had got murdered, and after her daughter had got murdered, she just like gave up. She didn't really care about life. She was just like, she was here, but she wasn't here, and I think sometimes she willed herself to die 'cause she didn't want to be around, you know. (49-year-old, black, sister)

> I got to thinking - Dog- gone it, he wouldn't be dead if he would have gotten a colonoscopy like I told him to…dog gone him! I came in here and I cracked him on the back of the head, and he said, "what was that for?" I said "that's because you didn't get a colonoscopy! He laughed and laughed. He said, "no you know, they told me that it wouldn't have made a difference." Because it was on the outside of the colon, but I think that if he had gone to the doctors more. He was one of these - well I feel fine, why should I go? And he didn't have a thing wrong with him, ever! But I think if he had gone for a colonoscopy and had the blood work that went along with it, they may have found an inconsistency. (61–year-old, white, wife)

Deflections in this category ranged from 2.5 for the brother-in-law who ignored his health to a high of 7.0 for a mother who gave up, showing that variation in deflections were based on different identities, but INTERACT does not report observer emotions for self-directed events. Hypothetical baseline deflections were also relatively low ("leaves" 6.2–15.6; "abandons" 10.1–25.4) and the brother-in-law whose baseline was the same as the resolution (2.5). Downgrading the deceased's identity makes it more consonant with dying and directing the bad act to the self reduces deflection more.

Other-as-Actor Resolutions

The two subcategories of other-as-actor resolutions were the smallest and one of the largest categories of attributions. The good, powerful other helps good, weak, inactive deceased had four attributions, while the bad, powerful other does bad, weak act to good, weak, inactive deceased had 12 attributions.

Good, Powerful, Other Helps Good, Weak, Inactive DCD. Two of the four positive attributions of a strong, good other helping the deceased were references to God taking care of them, and two were to doctors keeping a patient alive against the odds.

Deflections from these events were low (2.4–4.1) but all resulted in positive emotions of peacefulness, satisfaction, or serenity. Baseline deflections varied widely ("leaves" 4.8–15.3; "abandons" 8.0–21.2), possibly indicating lower deflections for male FCGs that might be teased out in a larger sample. The most significant things to note about this category is that attributions tended to be ambiguous or overlap with other categories (discussed later), and how few attributions fell in this category, compared to the relative plethora in the other-as-bad-actor resolutions below.

Bad, Powerful, Other Does Bad, Weak Act to Good, Weak, Inactive DCD. Of the 12 attributions in the second subcategory of other-as-actor resolutions, five of them identify medical providers as harming or neglecting the deceased, and the rest are divided between unethical employers and miscellaneous others.

> Yeah, he had melanoma, but he didn't die of melanoma. His melanoma was in remission. What he died of was one of these super-bugs…. [The doctor] didn't know what he was doing…he didn't even know what he was prescribing… and of course it's no good fighting doctors because they're all together. (74-year-old, white, wife)

> [[H]e retired [from working in the steel mill] … they say they knew back in 1929 that the asbestos was bad, … and they just now a few years ago took the last of the asbestos out, all that time. He said 'We used to test tablecloths where we ate lunch. They had it hanging on walls. People would …lean against it and sleep,' and he was in contact with it because he was all over the mill. He …was in contact with it probably the whole 40 years he worked there. We do have a class action lawsuit going on…but I feel anger, you know dislike of what they did to the men, 'cause there's so many people who have asbestosis [and] Mesothelioma, and they don't have a cure for it. (74-year-old, white, wife)

> I think it was about a day or two away, and then I had tried calling her, but her caregiver refused to let me talk to her. So, you know I found a lot of proof that her death was not natural, but unfortunately, she was cremated before I could do anything. (44-year-old, white, niece)

Despite these harsh accusations of causing the death, the deflections for these attributions are pretty low. The attributions were among the easiest to simulate (e.g., immoral employer harms naïve husband) but the deflections of the 12 attributions in this category ranged from 2.2 to 6.5. INTERACT provides emotions only for interactants, not observers (such as the family caregiver), but the deceased would have felt anguished, worried, or overwhelmed. To approximate baseline deflections, we had to model the deceased leaving/abandoning the family caregiver; the weak modifiers for the identities of the deceased resulted in variable deflections ("leaves" 5.3–13.9; "abandons" 8.9–25.5), with male caregivers far lower than females, regardless of gender of the deceased.

Caregiver-as-Actor Resolutions

Good FCG Does Good Act to DCD. The final two categories describe the caregiver as taking an active role in the deceased person's death. The five good-actor resolutions are particularly interesting because of the power they ascribe to the caregiver.

> I was holding on to her hand and I was just talking to her, and I told her, 'cause she was still fighting, 'cause I noticed her breathing changed, like she was…like gasping for air like fish breathing, and I told her, I said 'Mommy,' and she squeezed my hand. I said 'Mom, <crying>, me and the baby gon' be okay, 'cause I don't want you to suffer. This not you. You were such a vibrant person,' and she went on. (23-year-old, black, daughter)

> I felt that I could have asked God to take him even before that, but I waited until Christmas to give him to God. So, I was upset with myself for holding on to him for as long as I did. But as long as he wasn't in pain, it was okay. (75-year-old, white, wife)

> I told [hospice] to give her as much morphine [as she wanted]. I know a little bit about morphine, so I already know that morphine, if you're terminally ill, it relaxes you and relaxes and relaxes you…. So, I basically knew what the morphine was going to do, but I also didn't want my mother in pain…. (58-year-old, black, daughter)

In these attributions, the caregivers' actions in some way released the dying from their suffering. The deflections ranged from 2.7–4.3, leaving the caregiver feeling awe-struck and emotional, while approximate baseline deflections were high, despite the weak status of the deceased ("leaves" 5.0–15.3; "abandons" 8.1–26.2), with abandoned FCGs feeling hopeless and desperate.

Bad, Weak, FCG Does Bad, Weak Act to DCD. The final category of resolutions—bad, weak, family caregiver does bad, weak act to deceased—also only had five attributions, but with very a different emotional result. In all cases, the caregiver let down the deceased who trusted or depended on them. These attributions have the feel of un-resolved deflections that continue to intrude on the caregiver's mourning progress.

> It's hard to put into words. I guess I feel guilt. I feel like even though I know I personally couldn't have done anything to change the outcome, I feel like I could've done more. (35-year-old, white, son)

> … I picked up the book and I says [to my husband] 'You really have to give me inspiration to work on this. I promised you that I was going to work on this class and get the degree. I have to keep one of my promises because I broke the promise to you that I wasn't going to let you die in a hospital,' and I just broke down after that and I just cried so hard…I felt so bad and it still bothers me and I mean it's going to be two years next month and it's still you know where it'll hit me 'What did I do to you? Why was I so rotten?' And I go 'He hates me. I know he hates me for this.' (59-year-old, white, wife)

Deflections in this category ranged from 7.8-16.4, with resultant emotions all negative, including troubled, shaken, angry, sorry, panicked, and apprehensive. Baselines were similar to—and often lower than—ABO deflections ("leaves" 4.4–9.6; "abandons" 6.9–17.5), showing that the FCG had not reduced their distress much, if at all.

Caregivers with Multi-Category Resolutions

There were eight clear cases of disagreeing multiple attributions and two ambiguous ones; the remaining six cases of multiple attributions were all in the same category. The caregivers quoted below were reported earlier in one category, but also made attributions in another. The most common was to both blame the deceased person and then to make a positive statement about them. For example, this 69-year-old white man made two attributions speaking about his brother-in-law:

> And I checked his pulse, but he was already gone. And I think the way he arranged it was so I would be away from him. I guess he knew or something.

> It made me appreciate life, and you know he brought a lot of what happened to him on himself by ignoring and being afraid.

Here, the deceased both controlled the timing of his own death in a way that seemed to protect his brother-in-law (a very common attribution), but the respondent also blamed the deceased's weakness and irresponsibility. Thus, one attribution falls in the category of good, active deceased does good act to good family caregiver, and the second falls under bad deceased does bad, weak act to self.

Below, a 57-year-old black woman both blames her sister for smoking and attributes her death to God's benevolent plan:

> I'm not as angry anymore, so I know I'm doing better, but… [Interviewer: Why were you angry?] Because she left. She left. And I say all the time, I say 'God, she didn't even think enough to say 'If I can just smoke one less cigarette today, maybe tomorrow or next week I can smoke two less, or maybe three or four less.

(and)

> [T]hat's my time to talk to God about her because that's usually when I talk to him, Sunday morning. I'm on the road to church and I usually have a little cry in the morning and talk about her and how I miss her and how I would like for her to be here without the pain. I said, 'But I know you had something better in mind for her, so you took her away from us, and so we're learning how to get along with each other now a little bit better.'"

These attributions fall under the categorizations of bad deceased does bad, weak act to self and good, powerful, other helps good, weak, inactive deceased. There were even

occasions where such double attributions occurred in the same statement, such as this by a 43-year-old black daughter:

> He lived eleven months after that. And deep down inside of me, I believed that my dad had beat it. But he was just tired, he was tired 'cause he didn't want to be a burden to nobody. And to me he just gave up.

Here, the father both unburdens his loved ones and gives up on himself. With two different ABO events, resulting deflections of these conflicting attributions were not really comparable, so they are not reported here. However, their existence indicates that in complex emotional situations individuals have conflicting deflections and may engage in serial resolutions of each. While we have insufficient data to pursue the possibility here, a future question is whether a resolution that creates a negative identity for a loved one creates its own deflection which in turn must be resolved.

Race and Meaning

The second analysis in this study assessed whether the categories of attributions were patterned by characteristics of the caregivers (e.g., race, gender, education). Most showed no qualitative relationship and associations were nonsignificant, possibly due to sample size. For example, one would expect gender differences and deflection patterns showed hints of that, but caregivers are mostly women (National Alliance for Caregiving, 2020), and we lacked enough male caregivers to show statistically significant effects. The sole caregiver characteristic that showed a clear relationship to categories of attributions was caregiver race ($x^2 = 22.12$, df = 8, $p = .005$).[3] Some characteristics (education, patient age) showed slight patterns, but were associated with (and better accounted for) by race.

While this study has a high proportion of black or mixed race-black individuals, black caregivers comprised only 18 of 50 respondents (36%) and 25 of 67 attributions (37%), making it hard to compare directly across racial groups in a small sample. Only three categories of attributions show a lopsided enough distribution to be potentially meaningful. White caregivers made 10 attributions (24% of their total) of the good deceased doing a good act to themselves with the death, such as waiting to have closure with loved ones. Black caregivers made no attributions at all in this category. Second, white caregivers blamed the bad acts of powerful others, with nine attributions (21%). Only three (12%) came from two black caregivers, one lamented getting insufficient information from hospice, and another caregiver made mild condemnations ("she couldn't get anyone to pay attention") and described doctors as mistaken. Third, only white caregivers claimed to have done something bad to the deceased. However, with only five attributions (12%) from four caregivers, this may not be meaningful.

By contrast, within groups there is a much clearer pattern. White caregivers concentrated their attributions in categories where the deceased was evaluated positively—sometimes seeming to stretch to do so. This includes the deceased actively (and mildly

powerfully even in death) doing a beneficent act toward others (14%), the good, active deceased acting in good ways toward the self (21%), and a bad, powerful other doing a bad, weak act toward a weak or inactive deceased (24%), for a total of 59% of the attributions identifying the deceased as being a good actor/object person, though power and activity varied.

Black caregivers, however, often viewed the deceased as having faults and as playing a role in their own illness. No black caregivers reported the deceased doing something good for the self, nor did any see the deceased as victimized by the caregiver and seldom perceived the deceased to be victimized by powerful others (12%). Lack of blame directed at health care is surprising given research on medical distrust among African Americans (Shoff & Yang, 2012) and merits future exploration. Black caregiver attributions were concentrated in the categories of a bad, active deceased doing something bad to self or others (10 total attributions or 40%). This included neglecting or risking their health, being depressed or afraid, or being selfish towards loved ones. In most attributions where the deceased people were not at fault, they were weak objects of good acts from either powerful others or the caregiver (six total attributions, or 24%).

The only negative category with representation from both races was blaming the deceased for their own bad or weak behavior: nine attributions by white caregivers and 10 by black caregivers. This is a common trend in our society overall and reflects the dominance of sick role beliefs in U.S. culture more broadly (Horwitz & Wakefield, 2007). It is worth noting, nonetheless, that it is the single largest category of black caregiver attributions, in keeping with an overall trend toward viewing the deceased in a less determinedly positive light than white caregivers.

Finally, in Table 2 there are two categories where the ABO-redefined deflection remains relatively high with negative emotions. The first, blaming the deceased for acting badly toward the caregiver is only expressed by black caregivers, while the second, the caregiver self-blaming for acting badly toward the deceased is expressed only by whites. Both are congruent with above-described trends, and both are small categories, perhaps because of the lack of sufficient reduction of negative-emotion-producing deflection. More refined analysis in the future may find more significance in the differences between these two categories—and perhaps their relationships to ongoing distress.

Discussion

ACT in Grief Resolution

There are several take-aways from these findings. When faced with large deflections, most people will try first to redefine the actors' behaviors to reduce deflection (Nelson, 2006). It is evident that caregivers redefine dying as a beneficent, active, and slightly powerful act by the deceased or caregiver, which accords with good, strong, active identities for the actors. Such acts include the deceased controlling the timing of their

death to protect the caregiver, the caregiver giving permission to die, or even relieving one's own pain by dying.

However, when actions are intransigent and difficult to redefine away (Francis, 1997a) (such as dying), actors may modify identities. Many attributions modified the actor to match the negative action of dying, emphasizing the deceased's faults (smoking or self-neglect) or attributing bad actions to powerful others (incompetent doctors). Such attributions produced deflections lower than the simulated baselines, indicating that the alternative definition of the event made more sense. The only ABO events that continued to cause notable deflections and negative emotion were the caregiver and deceased directing bad actions towards one another. For the caregiver, such actions were usually letting down the deceased. For the deceased, such actions were similar to the baseline simulations: the deceased left or deserted the caregiver or other good person. While the simulated baselines are both imprecise and hypothetical, they provide a benchmark against which to assess deflections for a distressing event.

These strategies of meaning-making were also patterned by race, with black caregivers making sense of death by admitting the deceased's faults, while white caregivers either blamed others or defined some aspect of the death as beneficence by the deceased. While the meaning literature argues that finding benefit in the event is better for bereavement adjustment (Park, 2010), the pattern here raises some questions. For example, the seemingly determined efforts to find good in the deceased (e.g., beneficent timing of dying) may reflect not a preference but a culturally enforced expectation among white caregivers. That some white caregivers resorted to self-blame shows a potential dark side of that norm. We found no cases of black caregivers describing themselves in a negative light, supported by findings of higher average self-esteem among black people than white people (Erol & Orth, 2011). However, given wide racial disparities in cancer mortality, the tendency to give the deceased some responsibility for the death may also be a protective element for black caregivers. Furthermore, little work in the meaning-making literature focuses on race. Our findings give evidence that there are racial differences in bereavement and support the inter-actionist claim that grief is socially and culturally shaped (Charmaz & Milligan, 2006; Horwitz & Wakefield, 2007; Lofland, 1985). Future research should explore this further.

The above insights build on, rather than conflict with most psychological literature on grief. Our results both inform and are informed by the current dominant model of grief adaptation. The Dual Process Model (Stroebe & Schut, 2010) postulates a process of adaptation that oscillates between loss-oriented and restoration-oriented coping strategies in grief. Loss-oriented coping includes clinically defined "grief work," the tightly focused mental and emotional processing of the death. Restoration-oriented activities emphasize rebuilding and moving on. The attributions in this study could be viewed through a Dual Process lens, with the very act of redefining itself being a form of restoration.

The psychological literature on meaning is also congruent with our findings. According to Park's (2010) comprehensive review, people possess orienting systems they use to appraise stressful situations and assign meaning to them. The degree to which

meanings are discrepant with global meanings determines distress, and distress initiates more meaning-making as individuals attempt to restore a sense of meaning and worth to their lives (pp. 257–258). ACT argues similarly that individuals compare their transient impressions of events to established cultural sentiments, and resulting deflections produce emotion and motivate restorative actions, including redefining events. ACT adds to this, moreover, by basing action in language, tying it to both social structure and culture and thereby enabling predictions from both local institutional and culturally comparative perspectives (MacKinnon & Heise, 2010). This approach offers a pathway for resolving tensions persisting in the meaning-making literature, including global versus situational, cognitive versus affective, subjective versus objective, and universal versus culturally specific meaning (Park, 2017). An ACT-based model of meaning-making ties the psychological literature to interactionist understandings, showing how Lofland's "threads of connectedness" between individuals shape the experience of grief (1985).

Finally, our methodological approach outlines a means of using the theoretical elements of ACT as a powerful qualitative coding tool. Beginning with qualitative interview data, we summarized text as ABO events based on the EPA dimensions of ACT. We simulated those events as closely as possible with INTERACT, using the simulations as triangulation to support coding reliability and validity. Emergent themes were iteratively assessed against the data, inductively developing categories of resolutions for grief. This analysis procedure has broad potential for qualitative data and should be used more widely.

This exploratory study has several important limitations. The respondents were caregivers for a loved one with a terminal cancer diagnosis, so findings may not apply to other kinds of deaths or to more distant relationships. Additionally, the study is retrospective, concerning deaths 12–24 months previously. Because of this, we simulated a hypothetical baseline, so all reported deflection reductions are also hypothetical. Finally, our simulations with INTERACT were imperfect as existing dictionaries lacked death/dying terminology, leaving us to rely on proxy behaviors.

While obtaining baseline grief measures immediately after bereavement is difficult, even for anticipated deaths, in future research, longitudinal interviews beginning during active grieving would provide more accurate baseline information. Including different circumstances of death and types of relationships would also expand the typology begun here. Finally, future ACT dictionaries could address the issue of objectless verbs and their place in human interaction.

Conclusion

Drawing on affect control theory, this study adds a sociological perspective to the literature on bereavement adaptation and meaning-making. We argued that a grieving person redefines circumstances of the death in order to make the event fit their established sentiments about the deceased person. By explaining qualitative attributions about death as ABO events formulated in terms of evaluation, potency, and activity, we

showed how they appeared to reduce deflections, enabling caregivers to make sense of their loss. Moreover, from patterns of individual resolutions, ABO-based categories emerged with the deceased, the caregiver, or other as primary actor. These categories and subcategories form the basis of a new analytical typology of meaning-making in grief. This application demonstrates the potential of affect control theory to reach across both disciplines and methodologies and inductively generate new theoretical models based in human interaction.

Acknowledgments

Declaration of Conflicting Interests

Funding

Supplemental Material

Supplemental material for this article is available online.

Notes

1. The Ontario Canada 2001 in INTERACT v.2 dictionary provided the best selection of ABO elements for this analysis. Simulations run in the 2015 US dictionary produced similar rating patterns with higher deflections (e.g., 4.3 rather than 2.8). "Leave" and "abandon" deflections were very high (e.g., 45–50) and regularly indicated "no words in range"; the Ontario 2001 dictionary identified hypothetical baseline emotions for corresponding deflections (e.g., 25–35).
2. Other common proxies were "weak" for sick/dying, "compassionate" for caring, and "affectionate" for loving.
3. Potentially unstable coefficient from small cell frequencies.

References

Boerner, K., & Schulz, R. (2009). Caregiving, bereavement, and complicated grief. *Bereavement Care*, *28*(3), 10–13. https://doi.org/10.1080/02682620903355382.

Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., Carr, D., & Nesse, R. M. (2002). Resilience to loss and chronic grief: a prospective study from preloss

to 18-months postloss. *Journal of Personality and Social Psychology*, *83*(5), 1150–1164. https://doi.org/10.1037/0022-3514.83.5.1150.

Bowlby, J. (1980). *Attachment and loss: Vol. 3: Loss, sadness, and depression*. Hogarth Press and the Institute of Psycho-Analysis.

Bowman, K. F., Rose, J. H., Radziewicz, R. M., O'Toole, E. E., & Berila, R. (2009). Family caregiver engagement in a coping and communication support intervention tailored to advanced cancer patients and families. *Cancer Nursing*, *32*(1), 73–81. https://doi.org/10.1097/01.NCC.0000343367.98623.83.

Boyle, K. M., & McKinzie, A. E. (2015). Resolving negative affect and restoring meaning: Responses to deflection produced by unwanted sexual experiences. *Social Psychology Quarterly*, *78*(2), 151–172. https://doi.org/10.1177/0190272514564073.

Britt, L., & Heise, D. R. (1992). Impressions of self-directed action. *Social Psychology Quarterly*, *55*(4), 335–350. https://doi.org/10.2307/2786951.

Carr, D. S (2003). A "good death" for whom? Quality of spouse's death and psychological distress among older widowed persons. *Journal of Health and Social Behavior*, *44*(2), 215–232. https://doi.org/10.2307/1519809.

Carr, D., & Boerner, K. (2009). Do spousal discrepancies in marital quality assessments affect psychological adjustment to widowhood? *Journal of Marriage and Family*, *71*(3), 495–509. https://doi.org/10.1111/j.1741-3737.2009.00615.x.

Charmaz, K. (1980). *The social reality of death: Death in contemporary America*. Addison-Wesley.

Charmaz, K., & Milligan, M. J. (2006). Grief. In J. Stets, & J. Turner (Eds.), *Handbook of the sociology of emotions* (pp. 517–543). Springer.

Clark, C. (1997). *Misery and company*. University of Chicago Press.

Davis, C. G., & Nolen-Hoeksema, S. (2001). Loss and meaning: How do people make sense of loss? *American Behavioral Scientist*, *44*(5), 726–741. https://doi.org/10.1177/0002764201044005003.

Doka, K. J. (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington Books.

Erol, R. Y., & Orth, U. (2011). Self-esteem development from age 14 to 30 years: A longitudinal study. *Journal of Personality and Social Psychology*, *101*(3), 607–619. https://doi.org/10.1037/a0024299.

Francis, L. E. (1997a). Emotion, coping, and therapeutic ideologies. In D. Franks, R. Erikson, & B. Cuthbertson-Johnson (Eds.), *The sociology of emotions: Real life applications* (pp. 71–101). JAI Press.

Francis, L. E. (1997b). Ideology and interpersonal emotion management: Redefining identity in two support groups. *Social Psychology Quarterly*, *60*(2), 153–171. https://doi.org/10.2307/2787102.

Francis, L. E., Kypriotakis, G., O'Toole, E. E., Bowman, K. F., & Rose, J. H. (2015). Grief and risk of depression in context: Emotional outcomes of bereaved cancer caregivers. *Omega: The Journal of Death and Dying*, *70*(4), 351–379. https://doi.org/10.1177/0030222815573720.

Guarnaccia, C. A., & Hayslip, B. Jr. (1998). Factor structure of the bereavement experience questionnaire: The BEQ-24, a revised shortform. *Omega*, *37*(4), 303–316. https://doi.org/10.2190/L6HW-VGKF-KNPT-VT3F.

Heise, D. R. (2012). *Expressive order*. Springer.

Heise, D. R. (2013). *INTERACT, version 2*. New York: Springer Publishers. https://cs.uwaterloo.ca/~jhoey/research/ACTBackup/ACT/interact.htm. May 27th, 2019.

Hibberd, R. (2013). Meaning reconstruction in bereavement: Sense and significance. *Death Studies*, *37*(7), 670–692. https://doi.org/10.1080/07481187.2012.692453.

Holland, J. M., & Neimeyer, R. A. (2010). An examination of stage theory of grief among individuals bereaved by natural and violent causes: A meaning-oriented contribution. *OMEGA-Journal of Death and Dying*, *61*(2), 103–120. https://doi.org/10.2190/OM.61.2.b.

Horwitz, A., & Wakefield, J. (2007). *The Loss of sadness*. Oxford University Press.

Jakoby, Nina, R (2015). The Self and Significant Others: Toward a Sociology of Loss. *Illness, Crisis & Loss*, *23*(1), 129–174. https://doi.org/10.1177/1054137315575843.

Kalich, D., & Brabant, S. (2006). A continued look at Doka's grieving rules: Deviance and anomie as clinical tools. *OMEGA-Journal of Death and Dying*, *53*(3), 227–241. https://doi.org/10.2190/FVTR-T8EV-3TQ6-QAJC.

Kübler-Ross, E. (1969). *On death and dying: What the dying have to teach doctors, nurses, clergy and their own families*.

Lofland, L. (1985). The social shaping of emotion: The case of grief. *Symbolic Interaction*, *8*(2), 171–190. https://doi.org/10.1525/si.1985.8.2.171.

Maciejewski, P. K., Zhang, B., Block, S. D., & Prigerson, H. G. (2007). An empirical examination of the stage theory of grief. *Jama*, *297*(7), 716–723. https://doi.org/10.1001/jama.297.7.716.

MacKinnon, N. J., & Heise, D. R. (2010). *Self, identity, and social institutions*. Palgrave.

Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative analysis*. Sage.

National Alliance for Caregiving (2020). *Caregiving in the U.S. 2020*. https://www.caregiving.org/caregiving-in-the-us-2020/.

Neimeyer, R. A. (2019). Meaning reconstruction in bereavement: Development of a research program. *Death Studies*, *43*(2), 79–91. https://doi.org/10.1080/07481187.2018.1456620.

Neimeyer, Robert, A, Prigerson, Holly, G, & Davies, Betty (2002). Mourning and meaning. *American Behavioral Scientist*, *46*(1), 235–251. https://doi.org/10.1177/000276402236676.

Nelson, S. M. (2006). Redefining a bizarre situation: Relative concept stability in affect control theory. *Social Psychology Quarterly*, *69*(3), 215–234. https://doi.org/10.1177/019027250606900301.

Osgood, C. E., May, W., & Miron, M. S. (1975). *Cross-cultural universals of affective meaning*. University of Illinois Press.

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin*, *136*(2), 257–301. https://doi.org/10.1037/a0018301.

Park, C. L. (2017). Unresolved tensions in the study of meaning in life. *Journal of Constructivist Psychology*, *30*(1), 69–73. https://doi.org/10.1080/10720537.2015.1119083.

Rosenblatt, P. C. (1988). Grief: The social context of private feelings. *Journal of Social Issues*, *44*(3), 67–78. https://doi.org/10.1111/j.1540-4560.1988.tb02077.x.

Rozalski, V., Holland, J. M., & Neimeyer, R. A. (2017). Circumstances of death and complicated grief: Indirect associations through meaning made of loss. *Journal of Loss and Trauma*, *22*(1), 11–23. https://doi.org/10.1080/15325024.2016.1161426.

Sawicka, M. (2017). Searching for a narrative of loss: Interactional ordering of ambiguous grief. *Symbolic Interaction*, *40*(2), 229–246. https://doi.org/10.1002/symb.270.

Shoff, C., & Yang, T. C. (2012). Untangling the associations among distrust, race, and neighborhood social environment: A social disorganization perspective. *Social Science & Medicine*, *74*(9), 1342–1352. https://doi.org/10.1016/j.socscimed.2012.01.012.

Steams, C. Z., & Stearns, P. N. (1986). *Anger: The struggle for emotional control in America's history*. University of Chicago Press.

Stroebe, M., & Schut, H. (2010). The dual process model of coping with bereavement: A decade on. *OMEGA*, *61*(4), 273–289. https://doi.org/10.2190/OM.61.4.b.

Stroebe, M., Schut, H., & Boerner, K. (2010). Continuing bonds in adaptation to bereavement: Toward theoretical integration. *Clinical Psychology Review*, *30*(2), 259–268. https://doi.org/10.1016/j.cpr.2009.11.007.

Walter, T. (1996). A new model of grief: Bereavement and biography. *Mortality*, *1*(1), 7–25. https://doi.org/10.1080/713685822.

Williams, A., & McCorkle, R. (2011). Cancer family caregivers during the palliative, hospice, and bereavement phases: A review of the descriptive psychosocial literature. *Palliative Support Care*, *9*(3), 315–325. https://doi.org/10.1017/S1478951511000265.

Author Biographies

Linda Francis is a professor of sociology at Cleveland State University. She has received funding from the Alzheimer's Association and the National Cancer Institute to study patient-provider interaction, self, and grief. Her work has appeared in Social Psychology Quarterly, Symbolic Interaction, Social Forces, and medical and interdisciplinary journals and edited volumes.

Malissa Alinor is a postdoctoral fellow in the VMware Women's Leadership Innovation Lab at Stanford University. She is a mixed methodologist who researches racial and gender discrimination, emotion, and health. Her work has appeared in the Du Bois Review and the Journal of Interpersonal Violence.