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Bereavement and Mortality: A Methodology for Assessing Capacity and Functioning Following the Loss of a Spouse

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Abstract:

Bereavement and mortality are major issues and concerns for the surviving spouse of a husband or wife. Information is presented on the grieving process, models for assessing mortality, factors than may impinge upon the well-being and/or the mortality of the surviving spouse, and a model for addressing the issue of damages. In terms of evaluating these issues in a forensic context, several approaches are discussed, including a review of selected court cases related to admissibility. A revised model for the over-all assessment and decision-making process is presented with regard to the impact of bereavement on future functioning.

Background

The loss of a spouse results in several risk factors which include bereavement, mortality, grief, and health issues both physical and emotional, all of which are related to such demographic factors as age, gender, socioeconomic status and mortality. Related to these considerations is conjugal loss, emotional sequelae, (i.e., depression), and pleasure issues as discussed in some of the literature pertaining to hedonics. Finally, in cases involving liability of the loss of a spouse, the value of the loss may be reasonable to evaluate in terms of financial compensation for the surviving spouse. For those who are deprived of a companion there may be a significant increase in several risk factors associated with the surviving spouse that will have obvious implications for the months and years ahead. Several different risk areas will be discussed along with a method or approach of assessing the degree of difficulty the surviving spouse may have in the future, including a review of the research and theory related to bereavement and the grieving process.

Bereavement, Grieving and Mortality

The loss of a loved one or a significant other, and/or any related crisis event usually results in immediate responses of bereavement, depression and grieving, depending upon the severity of the event. There are several demographic and social variables, such as age, gender, sudden vs. long-term death, and socioeconomic status of the survivor that also have direct bearing on the bereavement process. This section will discuss a few general theories of the response to death by the surviving person.

Kübler-Ross (1969) developed what is commonly referred to as the stage theory involving a pattern, or stages, that a person progresses through following the event of death, or other significant loss, including divorce or a catastrophic event (i.e., losing one's house and a lifetime of possessions due to fire). Kübler-Ross presents five distinct stages that a person experiences that can help the person (survivors as well as victims) understand and eventually

accept the reality of death, dying and loss. The stages are:

Denial and Isolation: This response is common when first learning the news of a death, impeding death, or catastrophic event. The shock results in a denial of the facts – not really believing that a negative experience is happening. Anger: Upon receiving the bad news, anger can give rise to acting outward toward some other person (the doctor or nurse), family, or God. This stage is the beginning of passing through the denial stage and angrily acknowledging what might be true.

Bargaining: An attempt to "bargain" for the event not to have occurred or for the event not to occur in the future (i.e., news of cancer). An attempt to reverse the event by promising "to do better." Sometimes the bargaining is often between the aggrieved or victim and God.

Depression: This stage is moving into grieving, mourning and bereavement and is usually marked by a loss of interest in activities/work, and a dependence on family.

Acceptance: This stage is one of the most difficult. It is the acceptance that the event cannot be reversed, and that some degree of accommodation will be required in the months and years ahead.

A limitation of a stage theory such as this is that it implies people will move through these stages and then all will be well. The reality is that some stages are not relevant to some people, or that some might move back and forth between the stages before there is a final accommodation (assuming final accommodation can be achieved permanently).

Individualized coping is an approach that was developed by Corr, Nabe, and Corr (2002) who emphasized that death and dying is a highly individual process and could not always be consistent with the stage theory of grief. Acknowledging that several personal, psychological, and socioeconomic factors are very relevant to the individual's journey, and understanding the process of loss for an individual is predicated on the understanding of the individual him or herself (the N of 1). This holistic approach to understanding bereavement is supported by the work of Stroebe and Associates (1993), again in some divergence to the stage theory of Kübler-Ross. In Stroebe, contributors address issues related to physiology and medicine, various sources of grief and bereavement, vulnerability to related illness and complications resulting from different types of loss.

Smith and Zick (1996) discuss four different theoretical models as a framework for investigating and understanding the risk of mortality to the surviving spouse.

Psychiatric Models: Following the death of a spouse, there could be a loss of social support and positive reinforcement similar to the social learning theory of Bandura (1977). Psychoanalytic theory suggests that guilt of the surviving spouse can be debilitating due to feelings of "why not me" and the lack of opportunity to make restitutions. Finally, a person with over-dependence or learned helplessness of with the departed spouse only compounds the feelings of helplessness for the weeks and months ahead during the grieving process.

Role Theory: In cases of sudden death, the risk of mortality is increased due to issues of dependence, especially in cases of an elderly surviving spouse. Having relied on the departed spouse for care, companionship, and activities of all sorts, the surviving spouse may be at a complete loss and fall into despair and further helplessness.

Social Support Theory: The notion has particular significance to situations involving the

sudden death. A couple that evolved a lifestyle of mutual activities, interests, and co-dependency, along with other social support and activities (shopping, recreation, friends), is significantly affected by the suddenness of the unexpected loss making the surviving spouse particularly vulnerable to health issues and related complications.

Caregiver Burden: The long-term care of the "care provider" creates considerable stress over time.

Following the death of the spouse, health issues and mortality risk factors could become more pronounced and would require a longer period of time for recovery. Any of the models may apply, but they become relevant in light of the observation by Corr et al. that individual differences will prevail, and each case involving mortality must be understood on a case-by-case basis (N of 1).

To summarize the theoretical models and the estimated impact of death or loss on the mortality of the surviving spouse, see Table 1 (adapted from Smith & Zick, 1996, p. 61). Conclusions reached by the authors include: "(a) nonelderly (25-64 years old) widowers have the highest risk or mortality when their wives die suddenly; (b) the risk diminishes substantially for older widowers, and (c) the relative risks are lower for widows than for widowers, except when the elderly spouse dies from a prolonged illness" (p. 69).

Table 1: Understanding mortality in the context of type of death, gender factor, sex factor, and type of effect within theoretical models

Model	Type of Effect	Gender Factor	Age Factor
Psychiatric	Sudden deaths should elevate the risk of mortality for the surviving spouse following a prolonged illness.	No Prediction	No prediction
Role Theory	Same as above	No Prediction	Older widowers at greater risk; younger widows at greater risk
Social Theory	Same as above	Widowers at greater risk	Elderly widowers at greater risk
Caregiver	Deaths following a prolonged illness elevate the risk for the surviving spouse.	Widows at greater risk	Younger widows/ widowers at greater risk

Source: Woof & Carter (1997)

Factors Impacting Loss

In any assessment the consequences of bereavement and grief, it is important to consider several of the more salient factors that are germane to the process. The following sections both identify these factors and provide an operational definition and discussion of each of the factors.

Bereavement/grief: Bereavement is a universal experience of which almost nobody is immune. Bereavement and grief (used interchangeably) is viewed as one of life's most stressful events. In the view of the research and writings of Kübler-Ross and others, bereavement for the surviving spouse is a time of difficult transitions, and very contingent upon a variety of factors. An example of understanding bereavement is also provided by Bowlby's research on

the topic and is presented in Table 2. In Table 3, Bowlby offers a phase model for the process of bereavement which is somewhat similar to Kübler-Ross' stage model for grieving. The information provided in both Tables 2 and 3 provide an excellent orientation to the process that a person may encounter during a period of bereavement.

Table 2: Examples of bereavement disorders

Reaction Description	Absent Individuals show no evidence of the emotions of grief developing, in spite of the reality of the death. This can appear as an automatic reaction or as the result of active blocking.
Delayed	This initially presents in a similar way to absent grief. However, this avoidance is always a conscious effort and the full emotions of grief are eventually expressed after a particular trigger. This may be seen in more compulsively self-reliant individuals.
Chronic depression	The normal emotions of grief persist without any depression diminution over time. It is postulated that this is most often seen in relationships that were particularly dependent.

Source: Woof & Carter (1997)

Table 3. Bowlby's phase model for bereavement

Phase of numbing	The immediate reaction to the loss of a loved one tends to be a stunned disbelief. Feelings of anxiety and anger can also predominate.
Phase of yearning	Over a matter of days or weeks the and searching bereaved has pangs of intense pining and distress. There is also restlessness and a preoccupation with thoughts of the deceased. It is at this time that cues can be misperceived and interpreted as the actual presence of the deceased. Anger is often more intense in this phase.
Phase of disorganization	The feelings of pining, searching and despair anger are complicated by the failure of old patterns of behaviour to serve the new existence. The enormity of the necessary transformation can lead to despair and depression.

Source: Woof & Carter (1997)

Another perspective on the consequences and nature of grief is explained by the section below (End of Life Online Curriculum, 2009):

> *Although human beings, along with other social animals, tend to cry and to search when separated from those they love, the expression of grief following a permanent loss is very variable being influenced by learning from early childhood. Hence there is no blueprint for grief and the concept of "normal grief" needs to be considered in the light of demographic and cultural variables.*
>
> *Most bereaved people oscillate between episodes of intense pining for the lost person (loss orientation) and relatively calm periods during which they can plan and carry out forward-looking activities (restoration orientation). Problems arise if either of these activities is carried year of bereavement the intensity of distress usually declines steadily but thereafter*

any further decline is much more gradual. It is difficult to estimate time range of bereavement symptoms because there are so many aspects to grief, some of which are "permanent" (e.g. "He lives on in my memory") and others less so. Thus, following the death of a spouse, the loss of appetite seldom lasts more than a month and, by the end of the first year, weight gain is more likely to be a problem than weight loss. The first year is usually the worst and there are likely to be several "turning points" in the course of the second, when people realize that new directions are emerging and they can relish life again.

Most often the experience of bereavement eventually leaves people more mature, confident and sympathetic to the suffering of others. Many bereaved people cherish their memories of the dead person who is often felt to be near at hand and may even be perceived as a transient ("hypnagogic") hallucination or illusion. These phenomena usually provide comfort and should not be seen as "denial" or indicating a need for psychiatric help. The hypnagogic hallucinations may persist indefinitely. They are distinguished from psychotic hallucinations by their transience, they disappear when people "wake up".

Depression: Depression is a common occurrence of a person losing a spouse (Rosenzweig, Progerson, Miller, & Reynolds, 1997). Following the early phases or stages after spousal loss, depression is one of the behaviors that settles on the surviving spouse. As noted by Holley and Mast (2007), spousal loss is a significant predictor of depression at six months following the loss of a spouse. In addition to reduced activities and social involvements, "it seems that widowhood brings on depression characterized by poor health, poor habits of eating and drinking, and contributes to the increased mortality rates of recent widows" (p. 2). The incidence of "syndromal depression in newly bereaved was nearly nine times as high as the rate for married individuals (Turvey, Carney, Arndt, Wallace, & Herzog, 1999), and "women who were not depressed pre-bereavement were most vulnerable to depression after the loss of a spouse during the first year of widowhood" (Carnelley, Wortman, & Kessler, 1999). However, the "similarities between bereavement-related depression and depression related to other stressful life events substantially outweigh their differences" (Kendler, Myers, & Zisook, 2008).

Gender: There are significant differences between men and women relative to the loss of a spouse. First, the average length of widowhood for men is generally shorter for men than women (Lee, Willetts, & Secombe, 1998) due primarily to either remarriage or mortality (Peters & Liefbroer, 1997). "Men are approximately five times more likely to remarry after widowhood rather than women" (Mastekaasa, 1994). Men also appear to suffer more stress from the loss of a spouse, who provided most of the domestic tasks (Arber & Ginn, 1991) resulting in more health problems and issues following the loss of the spouse (Stroebe & Stroebe, 1987).

Psychological Health: According to Lee and DeMaris (2007), widowhood is psychologically a much more difficult experience for men than for women. Research has also shown that widows were found to have lower self-efficacy and higher levels of depression (Arbuckle & de Vries, 1995). Maciejewski, Prigerson, and Rosenbeck (2000) found that widows suffered more problems with depression, chronic illness, and functional abilities than did people who were married. Wells and Kendig (1997) in an earlier study found that widows showed poorer

appetite, more smoking, more loneliness and boredom, and generally poorer health, including depression. With regard to the marital status of psychological adjustment following widowhood, the following findings were observed by Carr, House, Kessler, Nesse, Sonnega, and Wortman (2000): (1) for widows there may be a high risk for anxiety which will vary depending on how much one depended on the spouse for "male related" tasks such as lawn and garden work, or managing finances; (2) widowhood was a very significant predictor of depression, and usually unrelated to any other factor; and (3) grief, or yearning, is strongly affected by the quality of marriage. Widows suffered the greater amount of grief and depression when their relationship was warm, supportive and mutually dependent.

Physical Health and Mortality: The loss of a spouse increases the risk of death for the surviving spouse, but the "results are inconsistent for differential gender effects, the time course of risk and whether risk is affected by spousal health" (Ahern, 2004; see also Elwert & Christakis, 2008). Persons who are widowed also have a higher mortality rate than married persons (Kaprio, Koskenvuo, & Rita, 1987). Even though the risk was increased for widows, the effect was not significantly greater for widowers. On the other hand, Helsing, Szklo, and Comstock (1981) found that the mortality rate for the widowed male was significantly higher than for married males. Also, for widows, having a spouse in poor or fair health had a "protective effect" on one's own survival. These findings were supported by work completed by Elwert & Christakis (2008) that revealed that the effect of widowhood on mortality varies substantially by the cause of death of a spouse, suggesting that widowhood effect is not restricted to any one particular cause of death, i.e., cancers, infections, and cardiovascular diseases. Lichtenstein, Gatz, and Berg, (1998) found that spousal bereavement was a risk factor for both men and women with the mortality risk factor being higher for the recently widowed than for the long-term widow, but the risk factor was markedly decreased if the widow survived four years following bereavement.

Economic/Wealth: Early widowhood comprises the greater risk of poverty than does the occurrence of widowhood after the social security age of retirement. Early poverty rates for the early widowed also tend to increase with age and especially for poorer households following the death of the husband (Weir, Willis, & Sevak, 2000; Ho, 1986; Hurd & Wise, 1989). Relying on data from the Survey of Income and Program Participation (SIPP), Zick and Holden (2000) found that "couples who are about to experience widowhood have somewhat lower wealth holding than do couples who remain intact . . . , but there appears to be a further decline in wealth when the husband dies" (p.21; also supported by the research of Hurd & Wise, 1989). Zick and Smith (1991) were able to show, based on research on four different widowed groups, that each group had fewer economic resources after five years after the death of the husband compared to married groups. Wealthier households also tend to plan for sustained income after the death on the husband which insures a minimal decline in resources and income. However, Holden and Zick (1997) concluded in their survey research that "upon their husband's death widows on average see a decline in virtually every income source – including that from social security, pensions, assets, and income sources designed to cushion the loss of the husband's earnings and retirement benefits. Furthermore, both economic wealth and marriage have a significant and positive effect and correlation on the length of a person's life, including the spouse of the deceased partner (Gardner, Oswald, & Wyatt, 2004).

Methodologies for Evaluating Functioning and Capacity

In the forensic setting, experts may be called to assist the trier of fact in evaluating the

impact of the loss of a spouse upon the surviving spouse's capacity to function following such a loss. Brookshire (1990) has suggested that there will be a loss of pleasure for which compensation is justified. This approach, referred to as hedonics, takes into account the value (and loss thereof) such factors as relationships, support activities, pleasure, emotional well-being, and personal, social and occupational functioning. The issue of "loss of pleasure" (sometimes referred to as consortium) has been a point of contention in areas of special or general damages. An alternate and more global approach is suggested that emphasizes the development of all relevant data and information about the surviving spouses, including evaluations and assessments of functioning, and the utilization of professional clinical judgment on the part of the professional in developing an opinion regarding future functioning, needs, loss, and worth. When utilizing clinical judgment in the consideration of general data sources which are deemed relevant, it is important to apply the client to the data, not the data to the client.

Hedonic, Consortium, General and Special Damages

Hedonic Damages: According to Berla, Brookshire, and Smith (1990), hedonics is "a conceptual approach for applying estimates of the loss of the pleasure of life to personal injury cases" (p. 1).The authors suggest that the loss of pleasure can be quantified in four different functional areas – practical, emotional/psychological, social, and occupational – by utilizing the Lost Pleasure of Life Scale (LPL). Along with the LPL Scale, "through the use of psychological tests, questionnaires and interviews, a judgment can be made concerning the degree of an individual's hedonic loss" in the four functioning areas (p. 3). The practitioner would then apply a percentage loss of pleasure to a person's life which can be translated in a dollar value of the loss. The authors also suggest that the probative value is every bit as traditional as testimony presented by forensic economists regarding lost earning capacity (p. 8). The hedonic damages approach presented by Smith and Brookshire (1990), Franz (1996) and Smith (1990) has been aggressively challenged in federal and state courts for failing to meet standards such as those set forth by Daubert (1993) with such testimony being disallowed in several courts. The academic article at issue included an analysis of 88 studies by Miller (1990) that reviewed the "willingness-to-pay" and "wage-risk" approaches often used by hedonic experts. Miller suggested that the value of life's enjoyment ranged between $1.5 and $3.5 million dollars. Comprehensive surveys of legal decisions (Ireland, Johnson, & Taylor, 1997; Ireland, 2000) conclude that the courts "generally do not look with favor on the hedonic damages concept." In a federal appeals court (Baron v. Sayre Memorial Hospital, cited in Ireland, 2000, p. 1994) commented that "federal courts which have considered expert testimony on hedonic damages in the wake of Daubert have unanimously held quantifications of such damages inadmissible." By way of example, Staller and Gibson (2008) cite the Ayers v. Robinson case which, according to them, "eloquently discredits the proffered testimony of the [hedonic expert], and takes special exception to Miller's plausible range theory . . . the court notes that the results achieved by Miller are obtained by very subjective adjustments and manipulation of data." (p. 3). Another concern the Ayers' court had was that the average statistical life was not specific enough to the claimant's personal circumstances . . . and that various estimates of the value of the 'average' life fell between $500,000 and $9 million, a range much too wide to assist the jury (p 3)." Posner and Sunstein (2006) point out the problems associated with the administrative regulatory policies that "rely on a fixed value of a statistical life (VSL) representing the hedonic loss from death" (p. 537). In contrast, "tort law excludes hedonic loss from the calculations of damages" (p. 537) in most states. The authors

contend that both areas of assessment (regulatory and tort) should adopt approaches from each other; namely, that tort laws should address the VSL in terms of hedonics, and that regulatory policies should be more mindful of the individualized approach to valuing loss from death. Viscusi (2007) asserts that

> *The hedonic damages approach proposed by Posner and Sunstein (2005) seeks to breathe new life into the increasingly moribund hedonic damages approach by adding hedonic damages on top of conventional economic damages. The result of their proposal will be an unprecedented level of excessive compensation from the standpoint of both deterrence and insurance. As plaintiffs seek to boost the damage awards, it is likely that they will continue to introduce ways in which the VSL estimates can be linked to the damages in a particular case. (p. 134).*

Staller goes on to identify other cases involving hedonics where the testimony was "severely wanting" (p. 3), (see Anderson v. Nebraska Department of Social Services, Hein v. Merck & Co., Kurncz v. Honda North America, Montalvo v. Lopez, Sullivan v. U.S. Gypsum Co., and Wilt v. Buracker). The hedonic approach is much too subjective, resulting in a wide range of the estimated dollar value of loss with sometimes an exorbitant estimate of dollar value. The hedonic methodology has received much scrutiny and a lack of acceptance by the courts generally. Accepted methodological approaches must be utilized to assess any consequences of bereavement and loss.

Consortium: To add to the confusion regarding hedonics, several other notions are also entertained (Ireland, 2000), such as loss of society, enjoyment of life, pain and suffering (i.e., loss of pleasure), and loss of consortium. Different states or jurisdictions may treat these concepts differently, but a growing number of attempts to discuss hedonics in the context of a "loss of pleasure" are being rejected by the courts (Albrecht, 1994; Ireland, 2000; Viscusi, 1990; Havrilesky, 1990). Perhaps in the consideration of hedonics there needs to be a distinction between the loss of pleasure issues and loss of consortium. Metcalf (1992) identified several strategies that can be employed to address issues related to the "loss of enjoyment," which included the passage of time, medical treatment, physical therapy, psychotherapy, family therapy, vocational rehabilitation, education programs, and ergonomic interventions. All of these strategies are quantifiable and can be expensed in terms of special damages. The strategies, however, do not address the consortium issue. Consortium, according to Black's Dictionary (2002) is:

> *Benefit that one person, esp. a spouse, is entitled to receive from another, including companionship, cooperation, affection, aid, and sexual relations . . . . a spouse's society, affection, and companionship given to the other spouse.*

Consortium, or the valuing of consortium, is the central issue in hedonics, and that is what most courts are disallowing in terms of testimony and damages. For example, in the State of Washington (WPI 31.02.01, Measure of Damages), marital consortium means:

> *the fellowship of husband and wife and the right of one spouse to the company, cooperation, and aid of the other in the matrimonial. It includes emotional support, love, affection, care, services, companionship, including sexual companionship, as well as assistance from one spouse to the other.*

In making a determination on special damages, the WPI rules emphasize that such factors as

age, health, life expectancy, occupation, habits, earning capacity, past, actual and future earnings should be considered. Each of the factors can be measured and quantified. Unlike the notice of the value of a statistical life (as discussed by Albrecht, 1994), special damage awards fall within measurable guidelines.

General and Special Damages: According to Black's Law Dictionary (2000), general damages "are presumed to follow from the type of wrong complained of [and] do not need to be specifically claimed or proved to have been sustained." Special damages "are alleged to have been sustained in the circumstances of a particular wrong [and] must be specifically claimed and proved."Based upon this discussion, general damages do not apply in terms of hedonics, and special damages equally do not apply when it is broadly assumed that anything that falls under the umbrella of "loss of pleasure" is generally inadmissible in federal courts. An alternative is the Washington Model where "marital consortium" is defined by a number of measurable factors that can be translated, with reliable methodology and approach, into a dollar value. Finally, Ireland (2000), in a review of over 50 cases adjudicated in federal and state courts, revealed that hedonics has frequently been ruled inadmissible due to a lack of scientific rigor demanded by the Daubert ruling. On the other hand, testimony in this area of expertise should be considered non-scientific and allowed with proper methodology.

Professional Clinical Judgment

For purposes of this discussion, professional clinical judgment is defined as follows by the New American Heritage Dictionary (1953):

> ***clinical:*** *involving direct observation of the patient, diagnosable by, or based on clinical observation, coolly dispassionate, analytical . . . .*
>
> ***judgment:*** *authoritative opinion, the process of forming an opinion or evaluation by discerning and comparing: the capacity for judging, a proposition stating something believed or asserted.*

Consider that the following expands upon the dual concept with relevant language drawn primarily from Federal Rules of Evidence 702 (Choppa et al., 2004).

> *Clinical judgment requires that the final opinion be predicated on valid, reliable and relevant foundation information and data that are scientifically established through theory and technique building which has been tested, peer reviewed, and published, with known error rates, and is generally accepted within the professional community. In cases where any of the above factors do not apply, but other factors have greater relevance, the expert will rely on these other factors within a methodological approach, based on the expert's knowledge, skill, experience, training, or education in order to assist the trier of fact to reach a conclusion. Therefore, clinical judgment, which is the extension of the credentialing factors of the expert, encompasses all relevant factors germane to the weight of the case while discarding those factors which are not relevant, and which are allowed by the court.*

Clinical judgment may incorporate such activities as direct observation, diagnosis (vocational evaluation and assessment), dispassionate (objective) and analytical observations, discerning and comparing (evaluating and synthesizing varieties of information), in order to assert a proposition (opinion) about the client. This model is really not unlike a medical model, which requires much of the same experience, and knowledge based activities requiring judgment,

albeit based on as many objective findings as reasonable.

Using this model, a reasonable method of evaluating all relevant information can be achieved (Choppa, et al., 2004; Choppa, Field & Johnson, 2005; Field & Choppa, 2005). Furthermore, this model is defensible as a method for presenting the facts of a case and developing opinion in judicial settings (Field, 2002; Field & Stein, 2002).

Utilizing a holistic clinical approach, a sequence of steps would be followed with the objective being to reach conclusions that are founded in all relevant data and information, assessing and evaluating the myriad list of factors that would apply to the person being studied, and then developing judgment and opinion consistent with the parameters as identified in the professional clinical model. Reference to Table 4 will identify the possible factors that would be taken into consideration with this method. While all factors may not apply to any single individual, this comprehensive approach for gathering information and data is very opened-ended as the professional begins the process of assessment and evaluation and then moves to focus on only those factors that are relevant to the person (N of 1).

Table 4: Factors relevant to the assessment of a surviving spouse

Factor	Evaluation/Assessment	Procedures/Data
Personal/Social Information	Relevant background information	Clinical interview Review of reliable sources (i.e., depositions)
Physical Health/Medical	General medical or specialist evaluation	Reports and/or consultation with medical providers/ therapists
Psychological Evaluation	Psychological/behavioral assessment and evaluation	Reports and/or consultation with medical providers/ therapists

Source: Woof & Carter (1997)

The Clinical Model

In the assessment of damages related to bereavement cases, the following five step method is recommended. The vocational rehabilitation process is well-founded in a tradition of professional excellence from the 1950's (McGowan & Porter, 1967) and beyond. Founders and leaders of the profession have been diligent in developing standards of practice, ethics standards, certification programs, graduate level education and training, and several professional associations that provide on-going training of activities, methods and support for individual practitioners (Weed & Field, 2001). Furthermore, both state and federal courts have allowed, with very few exceptions, testimony developed by the forensic rehabilitation consultant (Field & Choppa, 2005). Each of the five steps identified below are consistent with and reflect upon the best practices of professionals in the rehabilitation field and would meet the general acceptance and peer reviewed standards for admissibility in state and federal courts (Field, el al., 2006).

Step 1: Gathering Information and Data: Obtaining all relevant information is perhaps the most critical phase of the decision-making process (Choppa et al., 1992; Field, Johnson, Schmidt, and Van de Bittner, 2006). While the information gathering is essential to the process, relying on the most relevant data and information serves as the foundation for findings and opinions at Step 5.

Step 2: Solicit Additional Information and Data (as needed): It is not uncommon for client information to be incomplete. In such a situation, the professional identifies those areas that need to be addressed and consults with the appropriate professionals (i.e., physician, psychologist, physical therapist, etc.) to clarify the issue(s). The rehabilitation professional may well evaluate areas within their own areas of training and expertise as part of this process, such as vocational interests and functioning, educational and academic achievement levels, employment history, residual job skills, and household services. Once all needed and necessary information is received, the professional proceeds to the next step of analysis and synthesis of the information and data.

Step 3: Identify Differences between Pre-Death and Post-Death Functioning: The surviving spouse, possessed a certain level of functioning in a variety of areas of their life. These areas may include personal and social activities, employment, and economic information (earnings and earnings potential), and independent functioning in the home and community. Following the predeath assessment of function, the professional would then assess the functional capacities in the same dimensions following the death of a spouse (see Field, Grimes, & Havranek, 2001, for a summary of the methodology of pre-to-post analysis format). An analysis and comparison of both the pre and post-death functioning serves as a foundation for decision-making in Steps 4 and 5.

Step 4: Identify the Impact of the Post-Death Functioning and Need: Based on the analysis of all relevant data and information, a summary and/or plan will be developed which identifies areas where assistance or remediation is required, including time and costs for specific services and programs (see Forman, Caruthers & Londer, 2006; Garland & Andersen, 2008; Weed, 2007; Weed & Johnson, 2006). At this step, a definitive and specific presentation is made in terms of the future interests, needs, and support sources required for the surviving spouse. Time lines and cost factors should be identified.

Step 5: Findings and Opinion: Ultimately, in court settings involving liability and death, the issues of economic damages are assessed. The identification of special as opposed to general damages require that a dollar amount be assigned to changes in life due to predeath versus postdeath circumstances. Consequently, the professional, based on relevant supporting foundation data and information developed through Steps 1 - 4, opines concerning the loss or impact for the surviving (see Chaps. 10 & 11, in Weed

& Field, 2001; and Deutsch & Sawyer, 1986). Services, support, rehabilitation and other needs are identified including costs, frequency and duration over the survivor's life. In the event occupational loss is an issue opinions concerning work capacity and earnings are rendered utilizing accepted methodology for those processes (see Dillman, Field, Horner, Slesnick, & Weed, 2002; Field, 2008; and Field & Jayne, 2008).

Summary

In cases involving bereavement and related factors of a surviving spouse, a professional clinical model is proposed for addressing issues related to damages. Based on a complete, if not rigorous gathering, analyzing and synthesizing of all relevant data and information, the qualified professional, consistent with the federal Rules of Evidence, offers an opinion related to the future costs and services for the person. When appropriate, the professional will defer to other professionals when information or opinion is needed in an area for which the professional is not qualified. Following the proposed format and methodology is consistent with the determinations and requirements set forth by federal courts in the admissibility of expert testimony.

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Disclaimer: Terms in this article are not to be construed as strict legal definitions. In other words, we are speaking in this article as rehabilitation professionals who work directly with the consequences of death and the human response to suffering. Our terminology reflects our professional context while legal terminology reflects the context of the legislature and the courts. Although our work overlaps, our very raison d'etre as rehabilitation professionals is to provide an understanding of the human dilemma that is helpful to those unfamiliar with our specialized knowledge and training.