Grief and bereavement theories

Buglass E (2010) Grief and bereavement theories. Nursing Standard. 24, 41, 44-47.
Date of acceptance: January 4 2010.

Summary

This article explores the main theories of grief and bereavement. It is important that nurses have a good knowledge and understanding of the processes and stages involved so that they can support individuals who are bereaved. The terms grief, mourning and bereavement are defined and the unique experience of loss is emphasised, acknowledging the importance of person-centred care.

Author

Edith Buglass, Macmillan head and neck clinical nurse specialist, Maxillofacial Unit, Queen Elizabeth Hospital, Birmingham.
Email: edith.buglass@uhb.nhs.uk

Keywords

Bereavement, end of life care, grief, mourning, theories

These keywords are based on subject headings from the British Nursing Index. All articles are subject to external double-blind peer review and checked for plagiarism using automated software. For author and research article guidelines visit the Nursing Standard home page at **www.nursing-standard.co.uk**. For related articles visit our online archive and search using the keywords.

DEATH IS A SITUATION that is frequently encountered by nurses and other healthcare professionals in the course of their work. It is important that nurses have a good understanding of the reactions and responses to grief and bereavement so that they are in a better position to support patients, family members and relatives during the grieving process.

Grief is a natural human response to separation, bereavement or loss, in particular the loss of a loved one. The terms grief, mourning and bereavement are often used interchangeably, however they have different meanings. Grief describes an individual's personal response to loss and has emotional, physical, behavioural, cognitive, social and spiritual dimensions (Greenstreet 2004). Mourning is the outward and active expression of that grief. It is through the process of mourning that grief is resolved. Bereavement refers to the period after loss during which grief and mourning occur. It is the state of having experienced a loss. Bereavement is a form of depression, which usually resolves spontaneously over time. The person who is bereaved may experience anxiety, insomnia, inertia, hyperactivity or a feeling of helplessness.

Grief, mourning and bereavement may be affected by personality, culture, religion, the nature of the relationship with the deceased person and the way in which he or she died. Stroebe *et al* (1993) defined bereavement as a state of loss, triggering a grief reaction that manifests in a set of behaviours known as mourning.

Theories and frameworks

Many theories or models of grief have common themes or stages (Lindemann 1944, Kübler-Ross 1969, Parkes 1975, Bowlby 1980, Worden 1991). Diagrammatic representations such as the 'grief wheel' are often used to describe the process and stages involved in grief, suggesting that it is rarely a static process. However, other models, for example the dual process model of coping with bereavement (Stroebe and Schut 1999), provide a more flexible approach to the interpretation and management of grief. It describes how a bereaved person copes with the experience of loss in everyday life, along with other lifestyle changes that develop as a result of that loss. The dual process model is based on the principle that when people are grieving, the manner of coping is a two-way process: 'The person moves between grieving and trying to come to terms with the loss' (Dunne 2004).

Freud (1961) viewed grief as a solitary process, whereby mourners withdrew from the world so that detachment from the deceased could be a gradual process. The psychological function of grief was thought to release the individual from his or her bond with the deceased. This was achieved by looking back at the past and reliving memories of the deceased person. Detaching from the deceased involved working through the loss so that the grief could be overcome. This was often termed 'grief work'. This focus on letting go of, or detaching from, the deceased to accommodate grief is still debated among theorists (Payne *et al* 1999). Freud's (1961) theories about grief were based on clinical experience with people who were depressed. Therefore his understanding of grief and loss may be limited to this specific group and may not be applicable to the general population. However, Freud's (1961) ideas about grief and, more importantly, the need to confront grief to allow

detachment have remained a feature of subsequent theory and practice.

Lindemann (1944) identified parameters for 'normal' and 'pathological' grief, such as duration, intensity and changes in social functioning. However, many of the pathological factors identified are now known to be relatively common and are accepted as 'normal' reactions to grief. Based on his clinical experience focusing on people who have been bereaved as a result of disasters, Lindemann (1944) developed a theory of grief with five distinct phases, including:

- Somatic disturbance, for example, tightness in the throat, shortness of breath or choking.
- Preoccupation with the image of the deceased.
- Guilt, for example, reviewing behaviour that occurred before the death for evidence of negligence and/or failure.
- Feelings of hostility or anger.
- Difficulty in carrying out everyday routines.

Lindemann (1944) suggested that grief work, the psychological process of coping with a significant loss, required the bereaved person to become emotionally detached from the deceased person and adapt to a new environment in which the deceased was not included. Subsequent studies have confirmed these findings (Parkes 1964, Bowlby 1980).

Kübler-Ross (1969) identified five stages of grief, including:

- Denial.
- Anger.
- Bargaining.
- Depression.
- Acceptance.

The model was devised as a means of understanding and coping with dying and was based on Kübler-Ross' work as a psychiatrist with dying patients. Although the model has been used widely it has also received some criticism. One limitation of stage or phase models is that they follow a fairly set pattern whereas, in reality the stages or phases often overlap or occur non-sequentially. Corr (1993) stated that Kübler-Ross' (1969) work was organised around clinical impressions, not empirical data. Corr (1993) argued that the five stages resemble defence mechanisms and are too linear, rigid and passive to be used in the complex processes of grief and bereavement. In addition, Kübler-Ross' (1969) model of grief in the individual with life-limiting illness is often misinterpreted and applied to bereavement. While the person who is dying may grieve for the loss of his or her future and a shortened lifespan, the bereaved person mourns the death of the deceased and the life shared with that person.

Bowlby's (1973) theory of attachment emphasises the importance of human attachments and bonds that are developed early in life. Grief evolves through a sequence of four overlapping, flexible phases. These are:

- Shock.
- Yearning and protest.
- Despair.
- Recovery.

It provides an explanation for the common human need to form strong affectional bonds with other people and the emotional distress or reactions caused by the involuntary severing of these bonds and loss of attachments. Bowlby (1973) relied on childhood experiences to explain bereavement reactions in adulthood. He viewed attachment as a mutual relationship, occurring as a result of long-term interactions, which starts in infancy between a child and his or her parents and later between adults. These bonds and attachments remain active throughout the life cycle.

In psychoanalytic theory, grief work relates to the struggle to sever ties and detach energy invested in the deceased person, whereas attachment theory is characterised by a response that many individuals experience when strong affectional bonds are disrupted, for example attempting to regain a feeling of closeness (Stroebe *et al* 2004). When death occurs, that closeness cannot be regained leading to protest and despair.

Stroebe (1992) discussed some of the shortcomings associated with the grief work hypothesis, such as the notion that one has to confront the experience of bereavement to come to terms with death and avoid detrimental health consequences, such as sleep disturbance, loss of appetite, absent mindedness and social withdrawal.

Parkes' (1998) theory of grieving is similar to that described by Bowlby (1973) and identifies four phases of bereavement. These are:

- Shock or numbness.
- Yearning and pining.
- Disorganisation and despair.
- Recovery.

Grief is described as the transition of the bereaved person from 'incomprehension and denial, through a distressed state of confrontation with

reality and finally to some form of resolution' (Parkes 1998). It was noted that these phases were not always linear, but could be experienced several times as a result of reminders of the loss or a trigger such as an anniversary. Parkes (1996) suggested that grief is not a state, but a process that does not involve symptoms that begin after a death and then fade away, but rather a succession of phases that merge into and replace each other. Parkes (1986) focused on the emotional and physical responses to a death, emphasising the prevalence of anxiety, searching behaviour, anger and guilt, and the necessity of working through those feelings to adapt to the death.

Worden (1991) adopts a different approach to loss by setting tasks that have to be worked through if grief is to be resolved. In Worden's (1991) model the emphasis moves from passive phases of grief to active tasks of mourning. These tasks include:

- Task one – to accept the reality of loss.
- Task two – to work through and experience the pain of grief.
- Task three – to adjust to an environment without the deceased person. The bereaved person must embrace new roles and adjust to the changing dynamics of his or her environment. Often the full extent of what this involves, and what has been lost, is not realised until some time after the loss.
- Task four – to withdraw emotionally from or relocate the deceased and move on. Relocation requires that the bereaved person forms an ongoing relationship with his or her memories of the deceased in such a way that he or she is able to continue with his or her life.

Advantages and disadvantages of stage and phase models

Stroebe *et al* (2004) suggested that the stage or phase models are more about the dynamic process of coping. The grieving person works through his or her grief actively, rather than experiencing it in a passive way, which represents the reality for most individuals who grieve. Although the shift in emphasis is from passive to active in these models, in some respects the grieving process draws on attachment theory, recognising the way in which people make strong affectional bonds with each other and acknowledging the emotional reactions that may take place when these bonds are broken, such as sadness, helplessness, loneliness, numbness and self-reproach. However, not everyone will undertake Worden's (1991) tasks in the order mentioned. Stroebe *et al* (2004) suggested that completion of each task should assist adaptation to death or loss and includes an implied time limit. Other tasks also need to be carried out, such as working towards acceptance of the changes that occur, not only accepting the reality of death. The person who is bereaved needs to take time out to grieve and should work towards developing new roles, identities and relationships (Stroebe *et al* 2004).

Stage or phase models attempt to find patterns and similarities in human behaviour. This may help those who grieve to gain comfort from knowing that their experiences are shared by others and that their feelings and responses do not only apply to themselves. However, grief is a complicated process and alluding to patterns of 'normal' behaviour, does not account for the uniqueness of each individual's bereavement. One limitation of these models is that they explain grief in a linear fashion. Stroebe *et al* (1993) argued that such prescriptive models do not allow for any variations, leading to judgements about what is the right or wrong way to grieve. In addition, stage or phase models were developed within western culture and may not be appropriate for bereaved people from other cultures.

Dual process model

The dual process model of coping with bereavement (Table 1) represents the integration of existing ideas, drawing on traditional models, while introducing a new concept, that of oscillation between coping behaviours (Strobe and Shut 1999). This model describes how a bereaved individual has to cope with the experience of death as well as the lifestyle changes that result from it. The person has to cope with both loss and restoration-oriented factors.

Loss-oriented factors relate specifically to the death experience. This encompasses grief work,

TABLE 1

Dual process model of coping with bereavement

Loss-oriented processes	Restoration-oriented processes
Grief work	Attending to life changes
Intrusion of grief	Distraction from grief
Denial/avoidance of restoration changes	Doing new things
Breaking bonds/ties	Establishing new roles/ identities/relationships

(Adapted from Stroebe 1998)

including being preoccupied with the death, ruminating and yearning for the deceased person and associated behaviours, such as visiting places or listening to music that triggers sorrow. Restoration-orientated factors relate to making lifestyle changes, coping with everyday life, and building new roles and relationships as a result of the death. The dual process model is more flexible and more sensitive to cultural differences. The model suggests that most bereaved people will need to move back and forth between the loss-oriented and restoration-oriented domains, addressing emotional issues, then practical issues and vice versa. Both loss-oriented and restoration-orientated processes are necessary for adjustment, although the degree and emphasis on each approach varies for each individual, depending on the circumstances of the death, personality factors, gender and cultural background.

The dual process model of coping with bereavement recognises that both expressing and controlling feelings are important and implies that judgements about the way a bereaved individual is coping should not be made too hastily (Stroebe and Schut 1999). However, the scope of oscillation remains open to debate. The model may be criticised for placing too much emphasis on the individual's ability to cope and suggesting that by not coping he or she is abnormal. Furthermore, there does not appear to be any scope for the role of interpersonal relationships in helping people cope with death. Family members may each have their own interpretation of the death and interact with each other to determine the course of grief within the family. They may use different strategies, creating new ways of relating, communicating, and adapting in coping with stress and difficult emotions. However, a major advantage of this model is that it takes into account the effect of cultural and religious beliefs on the grieving process thus emphasising the individuality of the experience of loss and grief.

Conclusion

Healthcare professionals are often present at the time of bereavement and although they may be familiar with the variety of emotional and behavioural responses, they do not necessarily have the knowledge, expertise or confidence to cope with bereaved individuals. Grief is a unique experience and theories of grief and bereavement can help to consolidate the many ideas about how people deal with the death of a loved one. Healthcare professionals need to ensure that they respect the individuality of the bereaved person and offer appropriate person-centred care and support.

The dual process model of coping with bereavement focuses on grieving processes and acknowledges the uniqueness of each individual, and the way in which culture and gender may affect how a person grieves. Healthcare professionals need to have an awareness and understanding of the different factors that can influence the grieving process to be able to offer sensitive support to individuals who are bereaved at this difficult time **NS**

References

Bowlby J (1973) *Attachment and Loss: Separation, Anxiety and Anger*. Volume II. Hogarth Press, London.

Bowlby J (1980) *Attachment and Loss: Sadness and Depression*. Volume III. Hogarth Press, London.

Corr CA (1993) Coping with dying: lessons that we should and should not learn from the work of Elisabeth Kübler-Ross. *Death Studies*. 17, 1, 69-83.

Dunne K (2004) Grief and its manifestations. *Nursing Standard*. 18, 45, 45-51.

Freud S (1961) Mourning and melancholia. In Strachy J (Ed) *The Complete Psychological Works*. Standard edition. Hogarth Press, London.

Greenstreet W (2004) Why nurses need to understand the principles of bereavement theory. *British Journal of Nursing*. 13, 10, 590-593.

Kübler-Ross E (1969) *On Death and Dying*. Macmillan, New York NY.

Lindemann E (1944) Symptomatology and management of acute grief. *American Journal of Psychiatry*. 101, 3, 141-149.

Parkes CM (1964) Effects of bereavement on physical and mental health. A study of the case records of widows. *British Medical Journal*. 2, 5404, 274-279.

Parkes CM (1975) Determinants of outcome following bereavement. *Omega*. 61, 303-323.

Parkes CM (1996) *Bereavement: Studies of Grief in Adult Life*. Penguin Books, London.

Parkes CM (1998) Bereavement in adult life. *British Medical Journal*. 316, 7134, 856-859.

Payne S, Horn S, Relf M (1999) *Loss and Bereavement*. Open University Press, Buckingham.

Stroebe M (1992) Coping with bereavement: a review of the grief work hypothesis. *Journal of Death and Dying*. 26, 1, 19-42.

Stroebe MS, Stroebe W, Hansson RO (Eds) (1993) *Handbook of Bereavement: Theory, Research, and Intervention*. Cambridge University Press, New York NY.

Stroebe MS (1998) New directions in bereavement research: exploration of gender differences. *Palliative Medicine*. 12, 1, 5-12.

Stroebe M, Schut H (1999) The dual process model of coping with bereavement: rationale and description. *Death Studies*. 23, 3, 197-224.

Stroebe MS, Hansonn RO, Stroebe W, Schut H (Eds) (2004) *Handbook of Bereavement Research. Consequences, Coping, and Care*. Fourth edition. American Psychological Association, Washington DC.

Worden JW (1991) *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner*. Second edition. Routledge, London.