Grief

Lessons from the past, visions for the future

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Over the last millennium patterns of mortality have changed and have determined who grieves and how. At all times grief has been recognised as a threat to physical and mental health but, more recently, the scientific study of bereavement has enabled us to quantify such effects and to develop theoretical explanations for them. This paper reviews our evolving understanding of grief, focusing especially on the developments in research, theory and practice that have taken place during the 20th century.

Written over a millenium ago, the poem *Beowulf*[1] records the reaction of his subjects to the death of the hero king, Beowulf, who died of wounds after slaying the Firedrake, a dragon 50 feet long. It seems that in the late eighth century even warriors could cry when their great chief died and that it was seen as right and proper for them to talk of him and praise his great deeds.

We tend to think of it as normal to die in old age, but the first millenium was a time of strife and early death. Few people survived to old age and the greatest mortality was in the first year of life. This melancholy fact remained true until the last hundred years in the West and is still the case in the so-called Third World. During most of the millennium many deaths took place in infancy and it was sometimes said that you were not a woman until you had lost your first child. Today the death of a child is recognised as one of the most traumatic experiences and we all view the very thought with horror.

Were our predecessors psychologically scarred by all these horrors? I think not. Very little was written about the death of children and essayists, such as Montaigne, in 1580, can write 'I have lost two or three children in their infancy, not without regret, but without great sorrow'[2]. More recently Nancy Sheper-Hughes[3], working among the poor people of North-East Brazil where the infant mortality rate is still very high, records her own sense of shock when, in great distress, she told a mother that her baby had died. The mother, surprised at her distress, reassured her 'It's only a baby!' In such cases there is no funeral. The baby is entrusted to a procession of children who carry the body to the cemetery for burial. It is believed that the souls of dead babies are immediately promoted to become cherubs in heaven and it is they who welcome their mother when she comes to join them. Some mothers boast of the number of cherubs they have contributed.

But we would be wrong to assume that the deaths of infants inoculated people against the effects of other griefs. There is plenty of evidence that other types of bereavement, including the death of older children, could have devastating effects. Montaigne[2] also describes the reaction of John, King of Hungaria, to the death of his son: 'He only, without framing word or closing his eyes, but earnestly viewing the dead body of his son, stood still upright, till the vehemence of his sad sorrow, having suppressed and choaked his vital spirits, fell'd him stark dead to the ground.'

EDITOR'S NOTE

Patterns of bereavement and loss have changed over the years, and vary from culture to culture. The terminology has also varied, but common themes emerge. In this article, Dr Parkes reviews how our understanding of responses to bereavement, grieving and loss have developed over the past millennium, and draws attention to recent important and influential developments. It is hoped that new forms of communication and transport will help all members of the 'global village' access information, advice and support when needed. *MN*

PATTERNS OF MOURNING

The idea that you can die of a broken heart goes back to Biblical times and we find 'griefe' listed as a cause of death in Heberden's statistics[4] of causes of death for the city of London in 1657. But it was not until my own statistical study with Benjamin and Fitzgerald[5] was published in 1969 that clear evidence of an increased mortality rate from heart disease was found among widowers during the first year of bereavement. Since then several other studies have confirmed the finding and indicate that men are more likely than women to die of a 'broken heart'.

In 1621, when Robert Burton published his influential *Anatomy of Melancholy*[6], he adopted the classical humoral system which attributed depression or 'melancholy' to an excess of 'black bile'. But the flow of bile could also be caused by grief and Burton describes grief or sorrow as 'the epitome, symptome and chief cause of melancholy'. In this he preceded Freud and Lindemann by 200 years.

Coming closer to the present day, in 1835 we find the American physician Benjamin Rush[7], one of the signatories to the Declaration of Independence, describing dissection of the body of persons who had died of grief. He found 'inflammation of the heart, with rupture of its auricles and ventricles'. This alarming finding caused him to recommend that 'Persons afflicted with grief should be carried from the room in which their relatives have died, nor should they ever see their bodies afterwards.' He went on to prescribe 'liberal doses of opium'.

Rush's recommendations do not seem to have deterred bereaved people from adopting ever more flamboyant customs of mourning during Queen Victoria's reign. In 1853 there were no less than four 'mourning warehouses' in London's Regent Street[8]. Victoria's own grief for the death of her husband Prince Albert was severe and protracted.

According to Geoffrey Gorer[9], it was the rising death rate in the trenches during the first World War that put paid to shows of mourning. By the time the war ended the 'stiff upper lip' had become the ideal and grief was under firm control. Repression of grief is not uncommon among warriors and other people at time of war.

THE PIONEERS

And so we come to Sigmund Freud, whose classical paper, 'Mourning and melancholia'[10], written in 1917, proposed that grieving or 'mourning', as it was inaccurately translated, is a job of work in the course of which emotional energy, or libido, is withdrawn from a loved person before it can be re-directed elsewhere. He also compared grief to clinical depression, or 'melancholia', and suggested that, although depression resembles grief its causes are symbolic rather than real losses and that their roots are to be found in earlier traumatic experiences.

Freud's paper had much influence on the psychoanalytic theory of depression but it was not until the end of the Second World War that its relevance for bereavement was given further attention. At this time two important papers were written. The first, in 1944 by Eric Lindemann[11], described 'the symptomatology and management of acute grief' and provided a clear account of the reaction to bereavement, its short-term course and the treatment of the problems which arise when it is delayed or distorted. Lindemann was a psychoanalyst and he found confirmation in his work with bereaved people for Freud's theory of repression. In his view 'The essential task of the psychiatrist is that of sharing the patient's grief work.' This, he claimed could be done in 8-10 interviews. He also acknowledged the possibility that this work could be done by non-psychiatrists and, in doing so, sowed the seeds of bereavement counselling.

Lindemann's paper was a great success. Before long his recommendations were being followed widely and applied to many kinds of loss. At last we had a simple, short-term psychotherapy for grief. But there were limitations to this theory. In 1949 Anderson[12], in the UK, published an account of the psychiatric consequences of bereavement in which he described a type of problem which had not been given weight by Lindemann and which was not so easily explained. This was the chronic grief syndrome. People with chronic grief did not show any signs of repressing their grief, rather they grieved intensely from the start and continued to do so long after they were expected to stop. Anderson's work did not have the same impact as Lindemann's perhaps because it did not come up with a simple solution to the problem.

THE FIELD DEVELOPS

In 1952 Bowlby and Robertson[13] had observed that young children separated from their mothers expressed a distinctive pattern of grieving. They moved in sequence from a phase of acute separation anxiety, in which they cried a great deal, to a period of disorganisation and despair, to a final phase of recovery in which they began to reach out to others and make new relationships. In the 1960s I found a similar response in my own study of young widows, the only difference being that many reported an initial phase of blunting or numbness. From the start Bowlby and I recognised that there was a great deal of individual variation in the response to bereavement and that not everybody went through these phases in the same way or at the same speed[14, 15]. At this time, Elizabeth Kubler Ross working in the USA adapted the phases of grief to describe phases of dying[16]. Subsequently, the concepts of the phases of both grief and dying have given rise to a fair amount of controversy and several alternative models have been described.

Later work, including a study I directed in the USA with Gerald Caplan (the Harvard Bereavement Project[17]), enabled us to indentify factors which can be used to recognise bereaved people who are at risk of problems later (see table below). Of particular note is Doka's category, 'disenfranchised grief'[18]. This arises in situations in which, for various reasons, grief is discouraged and social supports are absent.

In 1966 I was delighted to be invited by Cecily Saunders to join her in setting up support services for the families of patients at the new St Christopher's Hospice in south London. I was able to make use of the findings from the Harvard study to identify family members at risk and to offer them the help of a carefully trained and selected volunteer counsellor. At that time, the idea of sending volunteers into the homes of newly-bereaved people proved controversial. However, the study confirmed that such interventions could be helpful[19].

RISK FACTORS IN BEREAVEMENT

Mode of loss

Sudden or unexpected losses for which people are unprepared
Multiple losses
Violent or horrific losses
Losses for which the person feels responsible
Losses for which others are seen as responsible
Disenfranchised losses (ie losses that cannot be mourned)

Personal vulnerability

Dependent on deceased person (or *vice versa*)
Ambivalence to deceased person
Persons lacking in self-esteem and/or trust in others
Persons with previous history of psychological vulnerability

Lack of social support

Family absent or seen as unsupportive
Social isolation

Elsewhere, other researchers were also undertaking important work. In Australia, David Maddison[20, 21] studied high risk factors in bereavement and Beverley Raphael[22] looked at the effects of interventions in high-risk bereaved people, with similar results to my own. Under Raphael's influence, the Australian National Association for Loss and Grief developed training courses for professionals who provide a high standard of care for bereaved people.

In the UK, it is voluntary services, like Cruse Bereavement Care, that have flourished. Some services are based in the community, whilst others are linked with hospices. In the USA, death education has come to play a major part in the training of the caring professions under the aegis of the Association for Death Education and Counselling (ADEC). Mutual help groups have come to dominate the scene. These owe much to Phyllis Silverman, who has devoted her life to developing Widow-to-Widow and other projects aimed at bringing bereaved people together[23]. Unfortunately, there have been few attempts to demonstrate, by scientific means, the value of this work and those that have been carried out have not shown clear benefits[24]. Another development, by Bill Worden, was the development of a list of the tasks of mourning[25], which has been found very helpful by counsellors.

While these approaches were being developed other research was taking place in stress studies. This, although not primarily focused on bereavement, has come to overlap with this field and has triggered important developments more fully described by Newman on p27 of this issue. A landmark event whose influence is still not fully appreciated was the inclusion of post-traumatic stress disorder (PTSD) in the third and subsequent editions of the Diagnostic Statistical Manual of Psychiatric Disorders[26]. This is the Bible of psychiatric diagnosis and the inclusion of PTSD acknowledged that a particular psychiatric disorder could follow a particular life event. This has opened the door to the possibility that other life events will be recognised as

causes of other syndromes.

Raphael and Martinel[27] and Horowitz and his colleagues[28, 29, 30] have tried to formulate criteria for the diagnosis of pathological grief but the most impressive work in this field stems from Holly Prigerson and her colleagues whose recent systematic studies have established clear diagnostic criteria for what they are calling 'traumatic grief'[31]. This should not be confused with bereavement by traumatic death and it includes most of the disorders that have previously been categorised as chronic grief, delayed grief, morbid grief etcetera. The distinctive feature of 'traumatic grief', which distinguishes it from most other disorders, is pining for a person who is lost. This places it in the category of separation disorders, a concept which owes much to attachment theory.

ATTACHMENT THEORY

Attachment theory stems from the seminal work of John Bowlby whose magnum opus *Attachment and Loss* was published in three volumes[32, 33, 34]. Bowlby formulated the concept of the 'secure base' which should be provided by a good relationship with one or both parents, and by the familiar home in which a child grows up. Given a secure base children learn to explore their world and cope with its challenges. Lack of a secure base, however, can give rise to serious problems which interfere with cognitive and emotional development. Bowlby went on to show how therapists and counsellors can provide a secure base within the therapeutic relationship[35].

The American psychologist, Mary Ainsworth, developed a systematic way of studying the attachments between parent and child[36]. With colleagues, notably Mary Main[37, 38], she identified three main types of insecure attachment patterns which she called anxious/ambivalent, avoidant and disorganised/disoriented.

My own work in recent years has included an attempt to map out the attachment patterns of people who seek psychiatric help after a bereavement. I have developed a retrospective questionnaire which confirms that people who report having had secure attachments to their parents show less grief and have lower scores on distress than those who have had insecure attachments. (Some prelimary results of this have been published[39].)

To summarise a large number of statistical correlations:

- Adults who had anxious, overprotective parents, insensitive to their needs for autonomy, became **anxious/ambivalent** children who tended to be nervous and clinging. In later life, they often have conflicted relationships with their partners. in bereavement they suffer protracted grief and a continued tendency to cling.
- Adults who had parents who were intolerant of closeness, learned to inhibit attachment, but their apparent independence masks underlying anxiety. These **avoidant** children learned to avoid attachments and remain aggressive and assertive in adult life. They have difficulty in expressing both affection and grief.
- Adults with parents who were unpredictable and inconsistent in their parenting may have experienced family rejection, violence, danger and depression and grow up unhappy and helpless. They exemplify Main's **disorganised/disoriented** pattern of attachment. As adults they lack trust in themselves and others. Under stress they turn in on themselves and may even harm themselves. Following bereavement they become anxious, panicky and/or depressed. They may turn to alcohol for escape.

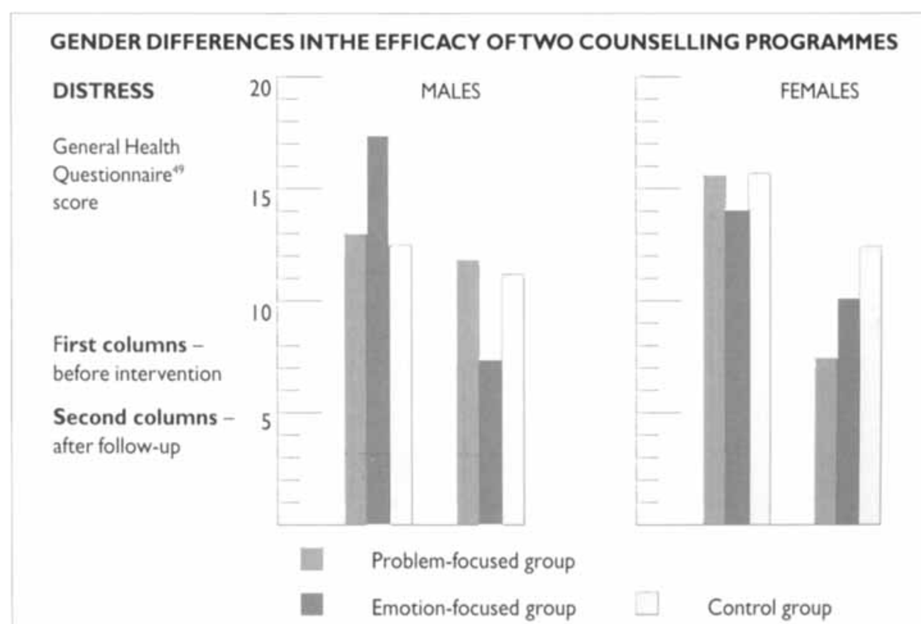
I have dwelt on these findings because I believe that they reconcile some of the arguments that have arisen in recent years between exponents of various approaches to bereavement care.

NEW IDEAS

More recently psychologists and sociologists have challenged several of the assumptions made by the pioneers. Freud's concept of grief work has been questioned by Wortman and Silver[40] and by the Stroebes[41]. More constructive than Worman's approach is the dual process model of bereavement put forward by the Margaret Stroebe and Henk Schut at the University of Utrecht[42]. They point out that, in the acute phase of grief, people tend to oscillate between the so-called 'pangs' of grief, when they are focused on thoughts of loss and pining for the dead person, and periods when they put their grief aside, are less distressed and able to begin to look forward and make plans. They term these 'loss orientation' and 'restoration orientation'. Both facing loss and turning away are appropriate responses so long as they do not last too long. Some people, however, become preoccupied with the loss orientation, others with restoration. The former equates with chronic grief, the latter with avoided grief.

This model seems to correspond reasonably well with the observed evidence and with my own research which, as we have seen, explains why it is that some people find it hard to stop grieving, while others avoid it. In both cases it would seem likely that it is important for people to have a secure base in which they can feel safe enough either to let go of the person 'out there' and move into the restoration mode, or to relinquish avoidance and begin to face the pain of loss orientation.

The dual process model also conforms with the findings of another study by the Utrecht group[43]. They assigned people with problematic bereavements, at random, to one of three groups, an emotion-focused group which employed Lindemann's traditional method of helping people to express grief, a problem-focused group who adopted a more cognitive, forward-looking approach and a third waiting-list control group. When all three groups were followed up 11 months after bereavement they found that both of the counselled groups did rather better than the control group. Looking more closely they found that men, who in most societies are more inclined to avoidance of grief, had responded best to emotion-focused help while women did best with problem-focused help. It is worth



noting that, if they had been given a free choice, the men would probably have chosen the problem focus and the women the emotion focus. What our clients want is not necessarily what they need.

Another sacred cow that has come under attack is the concept of stages of grief[40].

I am inclined to agree that the phases have been misused, but I think they served their purpose in providing us with the idea of grief as a process of change

Several studies have failed to replicate earlier work and critics have suggested that it is inappropriate for counsellors to attempt to impose this model on their clients. Each person will grieve in their own way and their own time. I am inclined to agree that the phases have been misused but I think that they served their purpose in providing us with the idea of grief as a process of change through which we need to pass on the way to a new view of the world.

My own studies of the reaction to amputation of a limb[44] and Fitzgerald's studies of blindness[45] gave rise to the concept of psycho-social transitions[15]. They showed how people faced with change need to let go of redundant assumptions about the world if they are to learn to live as an amputee or a blind person. The same applies to bereaved people. Many habits of thought and behaviour which depended on the presence of the person now lost have to be given up if we are to find new ways of living in a world without the person who has died.

But letting go does not mean forgetting the dead. In fact there are many people who find that they feel closer to the dead person when they give up trying to force them to return 'out there'. Only then do they realise that there is a literal truth in the saying, 'He (or she) lives on in my memory'. The concept of continuing bonds is a useful one which has been explored by Denis Klass and his colleagues in the book of that name[46].

Another contribution to our understanding of psycho-social transitions comes from Jannoff-Bulman who points out that the assumptive world includes basic assumptions regarding our security, worth and the protection of others. In her book *Shattered Assumptions*[47] she described how traumatic life events can easily shatter these assumptions and leave us feeling insecure, unworthy and unprotected.

Most of those who work with bereaved people prefer to reserve the term 'pathological' for the minority of bereaved people whose grief fails to follow the course which, in Western society, is regarded as 'normal'. They see it as unfair to bereaved people to stigmatise them with a psychiatric diagnosis and they see no reason to believe that doctors are the best people to treat grief.

Perhaps the problem lies in our prejudice about mental illness. By excluding grief from our diagnostic categories we may collude with those who see all mental illness as permanent and shameful and, in doing so, we may perpetuate the prejudice. Yet, if we are honest, we should admit that there are times when most of us need to be relieved of our responsibilities, to take a break, unload our problems on to others and even take a drug (such as alcohol) which will relieve some of our feelings of distress.

THE FUTURE

In a world in which many people can no longer rely on their own families to provide them with emotional support, non-judgemental acceptance and tolerance, there will continue to be a need for counsellors, and trained volunteers who understand grief, to do just that. Recent years have seen a steady increase in the numbers of such bereavement workers and a similar increase in the willingness of bereaved people to seek their help. The internet enables those who prefer to remain anonymous to do so and must create its own safeguards against the unscrupulous minority who abuse it. Help is needed by people of all races and status but especially by those who are at the bottom of the pile, who are likely to be most at risk and least likely to afford to pay for therapy. Sadly the 'inverse care' law currently implies that those in most need of support are least likely to get it.

Paradoxically this also applies to those at the top of the hierarchy. Most support systems work downwards. That is to say, the people at the top of the hierarchy are expected to support those below them. But who supports the people at the top? Anger, we know, is a part of grieving. It can also bring about a cycle of violence which can become self-perpetuating. How many times in history have terrible deeds been done because people in power were overwhelmed with grief and acted out their rage? How easily a delicate political balance can be destroyed by an act of violence. I have a dream of a cadre of specially-trained 'counsellors' whose role would be to monitor the needs of people in positions of leadership, to ensure that they are supported as they struggle to fulfil their roles as leaders at times of crisis. Such counsellors would themselves carry great responsibility and would need to be incorruptible and properly supported.

Perhaps my most heartening experience was in Rwanda. Visiting that poor country a year after the genocidal killings that devastated that land I had little hope that the small group of psychologists and social workers employed by UNICEF under the leadership of the American psychologist, Leila Gupta, would achieve anything worthwhile. Yet, over the months that followed, that little group recruited and trained groups of volunteer counsellors, those volunteers each went out and trained another group until they had 21,156 teachers, caregivers, social workers, community and religious leaders, health workers and local associations who reached out and supported over 200,000 children and surviving families[48]. If anything can break the cycle of violence and restore peace in Rwanda and elsewhere it must be ventures of this kind.

So my vision for the future is of a world where Beowulf's dragons are extinct: no-one needs to resort to terrorism or violence to assuage their grief. The global village, with all its soap operas and other trivia, brings everyone who needs it within reach of proper and effective help. Parents as well as children, leaders as well as followers, receive the cherishing and support that they need and the griefs that are a necessary part of life are recognised as such and those who suffer them receive understanding and wise counsel. BC

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BOOK REVIEW

LOSS AND BEREAVEMENT

Sheila Payne, Sandra Horn, Marilyn Relf

Buckingham, UK: Open University Press, 1999, 144pp. £17.99 pb. ISBN 0 335 20105 9

The varied backgrounds of the authors, who work in both research and service provision, have clearly benefited this book which manages to bridge the gap between a heavy academic tome, and a practice manual, providing a good introduction to the fields.

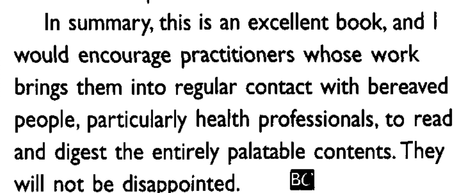
Bereavement and Loss opens with a fascinating account of the 'why' of bereavement, the fact that, historically, human societies have always had death and grief rituals and that, though these may have changed over the millennia, the need for them remains to the present day.

There follows an interesting exploration of the various theoretical models that have informed our thinking over the past 50 years, particularly the work of Bowlby and Parkes, whose thinking remains so influential even now. However, the authors are also rightly critical of these models and the more recent thinking from within the stress and coping literature, but the work of Stroebe and her colleagues, in particular, gets good coverage. The reader is left in no doubt that the state of the 'art' within the 'science' is far from clear.

I was particularly pleased to see a chapter on 'Theoretical perspectives: life span development'. This is often a neglected area in the bereavement literature, but one that is essential. If the adage 'to live and learn' is to be truly tested, then developmental models of adaptation, particularly to life events such as bereavement, have to be incorporated into our thinking. It is not enough to assume that early attachment is a necessary and sufficient explanation for success or failure in adaptation over the life course. These complex issues are clearly laid out for the reader.

The final chapter is on integration of theory and practice, and here again, while not offering a 'how to do it' approach, the reader is given the opportunity to think about the difficulties of putting theory into practice. This is timely, because, in a world in which we are increasingly expected to use evidence-based practice, we need to attend to the messages contained within the chapter.

In summary, this is an excellent book, and I would encourage practitioners whose work brings them into regular contact with bereaved people, particularly health professionals, to read and digest the entirely palatable contents. They will not be disappointed. BC



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FORTHCOMING EVENTS

7th international conference on grief and bereavement in contemporary society. 25-28 August 2003. Belfast, UK. Contact Patrick Shannon: ☎ 02890 792419; patrick@crusebereavementcare.org.uk

Children's grief. Manchester Bereavement Forum 9th annual international conference. 5 September, 2002. Manchester, UK. ☎ 0161 371 8860; grief@mabf.org,uk

The changing face of funerals. Cruse Bereavement Care Cymru conference. Speaker, Douglas Davies. 25 October 2002. Cardiff, UK. ☎ 029 2088 6913; cruse.cymru@care4free.net

The culture of grief . London Bereavement Network annual lecture. Speaker, Tony Walter. 11 November 2002. London. ☎ 020 7700 8134; info:bereavement.org.uk

Understanding bereavement by suicide. Child Bereavement Trust workshop. 29 October 2002. High Wycombe, UK. ☎ 01494 446648; enquiries@childbereavemement.org.uk

Working with disastrous events. Workshop with Bob Wright, Marjorie Ashdown. 17 October 2002. Cambridge, UK. ☎ 0113 3926498