Bereavement theory: Recent developments in our understanding of grief and bereavement

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Abstract: In recent decades research evidence on the experience of grief has led to a broadening of attention from the traditional focus on an emotional journey from distress to 'recovery'. This article looks at how early stage theories of grief came to be rejected and examines more recent theories which also consider the cognitive, social, cultural and spiritual dimensions of grief and loss. It goes on to highlight emerging trends in bereavement theory, potential complications of grief, and the evidence for the efficacy of grief interventions.

Keywords: bereavement theory, stages of grief, complicated grief, grief interventions

Introduction

The field of grief and bereavement has undergone a transformational change in terms of how the human experience of loss is understood and how the goals and outcomes of grief therapy are conceptualised. Long-held views about the grief experience have been discarded, with research evidence failing to support popular notions which construe grief as the navigation of a predictable emotional trajectory, leading from distress to 'recovery'. We have also witnessed a shift away from the idea that successful grieving requires 'letting go' of the deceased, and a move towards a recognition of the potentially healthy role of maintaining continued bonds with the deceased. Recent research evidence has also failed to support popular notions that grieving is necessarily associated with depression, anxiety and PTSD or that a complex process of 'working through' or engagement with 'grief work' is critical to recovery. The absence of grief is no longer seen, by definition, as pathological.

Loss and grief are fundamental to human life. Grief can be defined as the response to the loss in all of its totality – including its physical, emotional, cognitive, behavioural and spiritual manifestations – and as a natural and normal reaction to loss. Put simply, grief is the price we pay for love, and a natural consequence of forming emotional bonds to people, projects and possessions. All that we value we will someday lose. Life's most grievous losses disconnect us from our sense of who we are and can set in train an effortful process of not only re-learning ourselves but also the world. For many the desire to 'make sense' and 'find meaning' in the wake of loss is central. Neimeyer and Sands (2011) have emphasised that the reconstruction of meaning represents a critical issue, if not the critical issue in grief. In recent decades we have seen a broadening of attention from a traditional focus on emotional consequences, to one that also considers cognitive, social, cultural and spiritual dimensions to the study of grief. There is also a growing awareness that losses can also provide the possibility of life-enhancing 'post-traumatic growth' as one integrates the lessons of loss and resilience. Personal growth following even seismic experiences of loss is common.

How we adapt to these deprivations shapes who we become. While recognising that grief reactions are

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universal, they are shaped by the reciprocal impact of loss on families, organisations and broader cultural groups. This article examines a number of elements common to a new approach to our understanding of grief and loss and highlights emerging trends.

The rejection of stages and phases of grief

The first major theoretical contribution on grief was provided by Freud in his paper *Mourning and melancholia* (1917/1957), and profoundly shaped professional intervention for nearly half a century. For Freud, 'grief work' involved a process of breaking the ties that bound the survivor to the deceased. This psychic rearrangement involved three elements: (1) freeing the bereaved from bondage to the deceased; (2) readjustment to new life circumstances without the deceased; and (3) building of new relationships. Freud believed that this separation required the energetic process of acknowledging and expressing painful emotions such as guilt and anger. The view was held that if the bereaved failed to engage with or complete their grief work, the grief process would become complicated and increase the risk of mental and physical illness and compromise recovery. The grief work model stresses the importance of 'moving on' as quickly as possible to return to a 'normal' level of functioning. It is ironic that Freud maintained that mourning ends within a relatively short time; however, as a bereaved father he wrote about his strong attachment to his daughter some 30 years after her death. In his private correspondence he was acutely aware of the long-term nature of grief and a parent's ongoing connection to the dead child (Shapiro, 2001).

Put simply, grief is the price we pay for love

Several later grief theorists conceptualised grief as proceeding along a series of predictable stages, phases and tasks (Kübler-Ross, 1969; Bowlby, 1980; Parkes & Weiss, 1983). Perhaps the best-known model is that postulated by Kübler-Ross in her text *On death and dying*. Based upon her clinical work with the dying, her model was one of anticipatory grief; how an individual responds to a terminal diagnosis. Over time this model transformed into the five stages of grief – (1) shock and denial; (2) anger, resentment and guilt; (3) bargaining; (4) depression; and (5) acceptance – and was subsequently applied to both the bereavement experience and many other forms of change. The model implied that failure to complete any of these stages would result in a variety of complications. Kübler-Ross's perspective, although capturing the imagination of both lay and professional communities, has been widely criticised for suggesting that individuals must move through these stages, and has been empirically rejected.

Stage theories have a certain seductive appeal – they bring a sense of conceptual order to a complex process and offer the emotional promised land of 'recovery' and 'closure'. However they are incapable of capturing the complexity, diversity and idiosyncratic quality of the grieving experience. Stage models do not address the multiplicity of physical, psychological, social and spiritual needs experienced by bereaved people, their families and intimate networks. Since the birth of these theories, the notion of stages of grief has become deeply ingrained in our cultural and professional beliefs about loss. These models of grieving, albeit without any credible evidence base, have been routinely taught as part of the curriculum in medical schools and nursing programs (Downe-Wamboldt & Tamlyn, 1997).

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Multiple trajectories through grief

A more recent prospective study of spousal bereavement identified the most common trajectories of adjustment to loss (Bonanno *et al*, 2002) and made the compelling finding that resilience is the most common pattern and that delayed grief reactions are rare. Five distinct trajectories covered the outcome patterns of most participants: (1) common grief or recovery (11%); (2) stable low distress or resilience (46%); (3) depression followed by improvement (10%); (4) chronic grief (16%); and (5) chronic depression (8%). Bonanno identified, within the 'depression followed by improvement' group, individuals who improved in functioning after the death of their spouse. This was most prevalent in those who experienced relief following a period of considerable caregiver burden or who suffered oppressive relationships (Bonanno *et al*, 2004).

In Bonanno's research, those who experienced the highest levels of distress tended to exhibit high levels of personal dependency prior to the death of their spouse. For those not depressed before the loss, dependency was an important predictor of grief reactions. A lack of expectation or psychological preparation for the loss also contributed strongly to increased distress. The distinction between chronic grief and chronic depression, which this study illuminates, is of critical importance. Relationship conflict was predictive of chronic depression but not chronic grief. Chronic grievers reported greater processing of the loss and searching for meaning compared to chronically depressed

individuals. Both groups evidenced elevated pre-loss dependency. What is clear is that there is no single set of stages or tasks in adapting to loss, but instead qualitatively distinct paths through bereavement, which calls for a closer understanding of both patterns of complication and resilience.

The early stage theories of grief became unpopular because they were considered to be too rigid. There are, however, new models that succeed in identifying definite patterns and relations in the complex and idiosyncratic grief experience. Phasal conceptualisations have been enormously influential. Two of the most comprehensive and influential grief theories are the Dual-Process Model of Stroebe and Schut (1999) and the Task-Based Model developed by Worden (2008). These models serve both counsellors and clients by offering frameworks that guide interventions and enhance clients' self-awareness and self-efficacy.

The Dual Process Model of Grief (Stroebe & Schut, 1999), developed from a cognitive stress perspective, describes grief as a process of oscillation between two contrasting modes of functioning. In the 'loss orientation' the griever engages in emotion-focussed coping, exploring and expressing the range of emotional responses associated with the loss. At other times, in the 'restoration orientation', the griever engages with problem-focussed coping and is required to focus on the many external adjustments required by the loss, including diversion from it and attention to ongoing life demands. The model suggests that the focus of coping may differ from one moment to another, from one individual to another, and from one cultural group to another.

Worden (2008) suggests that grieving should be considered as an active process that involves engagement wwith four tasks: (1) to accept the reality of the loss; (2) to process the pain of grief; (3) to adjust to a world without the deceased (including both internal, external and spiritual adjustments); and (4) to find an enduring connection with the deceased in the midst of embarking on a new life.

Worden also identifies seven determining factors that are critical to appreciate in order to understand the client's experience. These include: (1) who the person who died was; (2) the nature of the attachment to the deceased; (3) how the person died; (4) historical antecedents; (5) personality variables; (6) social mediators; and (7) concurrent stressors. These determinants include many of the risk and protective factors identified by the research literature and provide an important context for appreciating the idiosyncratic nature of the grief experience. Issues such as the strength and nature of the attachment to the deceased, the survivor's attachment style and the degree of conflict and ambivalence with the deceased are important considerations. Death-related factors, such as physical proximity, levels of violence or trauma, or a death where a body is not recovered, all can pose significant challenges for the bereaved.

A stigmatising death, such as that by suicide or as a result of autoerotic asphyxiation, can 'disenfranchise' the griever (Doka, 2002) and complicate the bereavement experience. Disenfranchised grief refers to grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned or socially supported. The concept of disenfranchised grief recognises that societies have sets of norms – in effect, 'grieving rules' – that attempt to specify who, when, where, how, how long and for whom people should grieve. Disenfranchised grief can be a result of the circumstances of the death, but can also extend to the relationship not being socially recognised, the griever being excluded (such as a child), or the way the individual expresses their grief, particularly with regard to the level of emotional distress which is publicly displayed.

Those who help bereaved people must recognise the unique reactions, needs and challenges as individuals and their families cope with loss. Subscription to a stage theory can lead to a failure of empathy, where we fail to listen to and address the needs of bereaved people.

Continuing bonds

There has been a movement away from the idea that successful grieving requires 'letting go', with writers such as Klass, Silverman and Nickman (1996) offering an alternate approach where they argue that after a death bonds with the deceased do not necessarily have to be severed, and that there is a potentially healthy role for maintaining continuing bonds with the deceased. This idea represents recognition that death ends a life, not necessarily a relationship. Rather than 'saying goodbye' or seeking closure, there exists the possibility of the deceased being both present and absent.

There has been a movement away from the idea that successful grieving requires 'letting go'

The development of this bond is conscious, dynamic and changing. The expression of this continuing bond can be found in a variety of forms. The deceased may be seen as a role model and the bereaved may turn to the deceased for guidance or to assist them in clarifying values. The relationship with the deceased may be developed by talking to the deceased or by re-locating the deceased in heaven, inside themselves or joined with others whom they pre-deceased. The bereaved may experience the deceased in their dreams, by visiting the grave, feeling the presence of the deceased or through participating in rituals or linking objects. Many people build the connection out of the fabric

of daily life. Frequently this continuing bond can be co-created with others. A number of studies have found that approximately half of the bereaved population experience the sense of presence of the deceased (Datson & Marwit, 1997) although the true incidence is thought to be much higher, given a great reluctance among the bereaved to disclose its occurrence to clinicians for fear of ridicule or being thought of as 'mad or stupid'.

Ongoing research is still examining when continuing bonds are helpful, and when they are not. Continuing bonds must always be considered within a cultural context and there needs to be assessment of the ways the bond influences adaptation to the loss. Recent literature has attempted to distinguish the conditions under which it is adaptive from those where it is maladaptive. Field (2006) identifies a type of continuing bonds expression that represents failure to integrate the loss due to extreme avoidance in processing the implications of the loss. In keeping with Bowlby's (1980) early work, growing evidence suggests that individuals who experience insecure styles of attachment are more prone to chronic grief trajectories (Bonanno, Wortman & Nesse, 2004), contributing to maladaptive rather than adaptive forms of continuing bonds with the deceased.

In essence, continuing bonds expressions that are indicative of unresolved loss imply disbelief that the other is dead. An important factor distinguishing adaptive versus maladaptive continuing bonds expression is whether the given expression reflects an attempt to maintain a more concrete tie that entails failure to relinquish the goal to regain physical proximity to the deceased. This can be compared to a more internalised, symbolically-based connection, which suggests a greater acceptance of the death.

Meaning reconstruction following loss

In stark contrast to earlier modernist or positivist views which focus on breaking bonds and universal symptoms and stages of adaptation to loss, the postmodern social constructionist approach views continuing bonds as resources for enriched functioning and the oscillation between avoiding and engaging with grief work as fundamental to grieving (Neimeyer, 2001). These later models see grieving as a process of reconstructing a world of meaning that has been challenged by loss. The experience of loss, particularly if it is sudden and unexpected, can interfere with a bereaved person's ability to rebuild his or her assumptive world, particularly when the death assaults the survivor's notion world that life is predictable or that the universe is benign. A bereaved individual may have no mental constructions to help them with the meaning-making process to incorporate the loss into a new worldview. When people indicated that they could not make sense of the loss they often indicated that the death seemed unfair, unjust or random. If the loss is consistent with existing worldviews then making sense does not appear to represent a significant coping issue.

Across a variety of different losses, a body of research indicates that the failure to find meaning following the loss, especially in terms of 'making sense' of the death itself, is associated with higher levels of complicated grief symptoms. An intense and protracted search for meaning is likely to accompany losses that are unexpected and premature, as in the death of a child, and that a ruminative preoccupation with the loss is an indicator of long-term depression, anxiety, anger and grief. A failure to find spiritual or secular meaning in the loss accounts for nearly all of the heightened symptoms of complicated grief following suicide, homicide and fatal accident, as opposed to natural anticipated deaths (eg. cancer) and even natural sudden deaths (eg. heart attack).

Most definitions of meaning encompass two concepts: (1) making sense of the loss (eg. the death had been predictable in some way; it was consistent with the caregiver's perspective on life; or religious or spiritual beliefs provide meaning); and (2) finding benefits from the loss (eg. it led to a growth in character, a gain in perspective and strengthening of relationships). Data suggests that sense-making and benefit-finding are two distinct processes and represent two distinguishable psychological issues for the bereaved person. It is not so much making sense of the loss that alleviates distress, as it is becoming less interested in the issue. The finding of benefit on the other hand grows stronger with time (Davis, Nolen-Hoeksema & Larson, 1998).

Meaning-making is a highly iterative and interactive process and the significance of a loss can be affirmed or disconfirmed, congruent or discrepant, and supported or contested within families and other reference groups (Nadeau, 1998).

Complications of bereavement

Nearly a century ago, Freud (1917/1957) wrote:

> Although mourning involves grave departures from the normal attitude toward life, it never occurs to us to regard it as a pathological condition and to refer it to a medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (p 243)

Research has proved Freud largely correct, although not completely. It is now clear that grief, at least for a subset of 10 to 15% of bereaved people, can be intense and chronic for many months or years. Individuals bereaved as a result of deaths that are unexpected, violent or untimely

(eg. the death of a child) tend to be over-represented in this cohort. This condition, termed complicated grief (CG) or more recently prolonged grief disorder (PGD), has received increasing attention in both the psychiatric and psychological literatures over the past decade.

Most people ultimately adapt well to bereavement, typically regaining their psychological equilibrium after some weeks or months of acute mourning, although they frequently will continue to miss their loved one for a considerably longer period of time (Bonanno *et al*, 2002). Studies show that for most people grief intensity is fairly low after a period of about six months. This does not imply that grief is completed or resolved, but rather that it has become better integrated, and no longer stands in the way of ongoing life. Acute grief is a normal response to loss, with symptoms that should not be pathologised.

Prolonged grief disorder and the DSM-V

In the late 1990s two research teams independently published a set of diagnostic criteria to assess CG (Horowitz *et al*, 1997; Prigerson *et al*, 1999). Recently, these two diagnostic entities were integrated and the concept of CG was renamed as prolonged grief disorder (PGD). This incapacitating disorder is defined as a combination of separation distress and cognitive, emotional and behavioural symptoms that can develop after the death of a significant other. The symptoms must last for at least six months and cause significant impairment in social, occupational and other important areas of functioning.

There was significant support for including the disorder of complicated grief or prolonged grief disorder in the fifth edition of The *Diagnostic and Statistical Manual of Mental Disorders,* the American Psychiatric Association's (APA) classification and diagnostic tool (widely referred to as an authority for psychiatric diagnosis) (APA, 2013). Recent findings confirm the proposition that professional assistance is indicated for only this subgroup of the bereaved – those who show CG or PGD reactions. PGD symptoms have been shown to be different from other symptoms and disorders, such as normal grief reactions, mood disorders, and anxiety disorders including posttraumatic stress disorder. PGD is associated with several mental and physical health problems, such as sleep disruption, substance abuse, depression, compromised immune function, hypertension, cardiac problems, cancer, suicide, and work and social impairment. Bereaved individuals in this cohort report higher utilisation of medical services and more frequent hospitalisation than people with similar losses whose grief is less profound and extended, and these effects have been observed for as long as four to nine years after the death. These negative outcomes emerge even when levels of depression and anxiety are taken into account, and support the distinctiveness of a prolonged grief diagnosis.

Although prolonged grief disorder failed to be included in the DSM-5 the most recent edition has included Persistent Complex Bereavement Disorder (PCBD) as a condition that merits further study. The criteria for PCBD has been established to encourage future research and is not designed for clinical use.

It is essential that we do not consider bereavement complications simply as a re-labelling of conventional psychiatric conditions. Bereavement is a severe stressor that can trigger the onset of both physical and mental disorders such as major depression, posttraumatic stress disorder, anxiety and sleep disorders. These co-morbidities require identification, clinical attention and treatment.

Grief interventions

There is sufficient evidence to show that intervention is not effective for the bereaved in general, but is effective for those at high risk or for those who are already experiencing complications in their grief. Unsolicited help based on routine referral and delivered shortly after loss is not likely to be effective. Schut and Stroebe (2005) summarise their review of the literature with the conclusion that:

> Routine intervention for bereavement has not received support from quantitative evaluations of its effectiveness and is therefore not empirically based. Outreach strategies are not advised, and even provision of intervention for those who believe that they need it and who request it should be carefully evaluated. Intervention soon after bereavement may interfere with 'natural' grieving processes. Intervention is more effective for those with more complicated forms of grief. (p. 140)

The general pattern emerging from this, and other reviews, is that the more complicated the grief process, the better the chances of bereavement interventions leading to positive results.

Recent research indicates that a specially designed complicated grief therapy outperformed a more general psychotherapy for carefully diagnosed bereaved people, and was particularly helpful for those whose losses were traumatic (Shear, 2006). Another study found that a series of tailored writing assignments delivered over the internet that helped people express and explore their stories of loss significantly reduced symptoms of complicated grief relative to a no-treatment control group (Wagner, Knaevelsrud & Maercker, 2006). On the other hand, it appears that antidepressant medication does little to address the core symptoms of bereavement complication, even when it usefully reduces symptoms of depression (Pasternak *et al*, 1991). Recent treatment interventions for CG have been designed more adequately and have proved to be efficacious.

A large body of research has supported the value of grief counselling as long as clinicians undertake careful assessment and interventions are carefully tailored. Because grief is a highly individualised experience, the most effective grief support offers a range of options including online support, bibliotherapy, individual counselling, group support, community support, rituals and psycho-educational programs. There are a wide range of publications which provide detailed information on clinical interventions from constructivist (Neimeyer, 2001), cognitive (Malkinson, 2007) and family systems perspectives (Nadeau, 1998; Kissane & Bloch, 2002 Kissane & Parnes, 2014). Neimeyer (2013) provides comprehensive details on a range of bereavement interventions that are drawn from a range of theoretical perspectives.

Conclusion

It is clear that clinical research has expanded our understanding of the distinctive symptoms, risk factors, psychological processes and outcomes of bereavement, which has contributed to more appropriate interventions for the bereaved. No 'one-size-fits-all' model or approach to grief is justifiable. Any interventions must be tailored to the uniqueness of the person, relationship and circumstances that characterise a client at a particular point in time as they grieve a specific loss. If we define grief in a broader perspective, and move beyond the experience of death, it is clear that grief is the substrate for much of what confronts practitioners in the field of the helping professions. ■

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