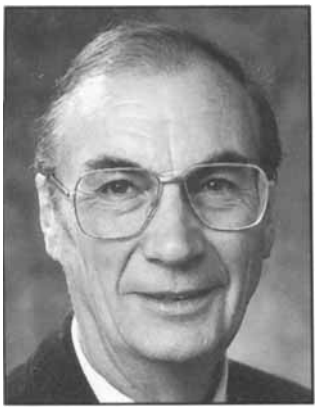
Traditional models and theories of grief



Colin Murray Parkes OBE MD DPM FRCPsych
Consultant Psychiatrist, St Christopher's and St Joseph's Hospices, London, UK

Human beings are complex creatures who can be viewed in many ways. This article take a bird's eye view of grief and of the various models and theories that have been developed to help us to think more clearly about this process. Each of the contributors included here focuses on different ways of viewing grief but I believe that each of these viewpoints is valid and each has its usefulness.

We first need to distinguish models from theories. A model is a way of describing and categorising phenomena, it does not explain them; a theory on the other hand implies explanation and, to some extent, causation. Both have been found useful in our attempts to think about grief but each has its advantages and disadvantages and we need to be clear about these if we are not to misuse these models and theories.

It is often assumed that people who use different theories must disagree. While this is sometimes the case it is not necessarily so. Some theories conflict with others, some do not. Thus, depression can be seen as having both psychological and chemical causes. Each causal system can be used to provide treatment to people who are suffering from depression and each method of treatment works. The important issue is to decide which theory works best for which person and when.

THREE MODELS OF GRIEF

The phase model

This has proved to be a controversial topic. It was originated by James Robertson and John Bowlby[1] as a way of describing the reactions of young children separated from their mothers. They described three phases beginning with 'angry pining', followed by 'depression and despair', which finally led to 'detachment'. Bowlby and Parkes[2] subsequently applied the model to bereaved adults and added a first phase of 'numbness or blunting'. The model was then taken up, further elaborated and applied to dying people by Elizabeth Kubler Ross[3]. Other researchers have produced their own variants of the model and Marrone[4] has recently reviewed eight different phase or task models.

It is important to recognise that the phase model was not an explanation for anything, it was simply an attempt to describe empirically and to classify the process of grieving through which most bereaved people go. It was never intended to be a prescription for grief and it was recognised from the start that people went back and forth across these phases many times in the course of grieving. Only gradually, over time, was it possible to discern a transition.

Objections to the phase model have come from two main sources, cross-cultural studies which have shown great variation in the expression of grief from one culture to another and research attempts to measure these phenomena which showed no neat progression from one phase to another. Certainly the phases have been misused by therapists who have applied them in a rule-of-thumb way which fails to take account of this human variation. This said, I think there is still some value in recognising that grief is not a state but a process through which we pass and that, in the course of that process, people commonly move from incomprehension and denial, through a distressed state of confrontation with reality and, finally, to some form of resolution.

The medical model

There are two versions of this. Engel[5] first pointed out that all major grief has the defining characteristics of an illness – it causes pain and disturbs physical and mental functions, concentration and memory are impaired, judgement may be poor and, for a time, people may need to take a break from their normal responsibilities. Others have found it offensive to suggest that all people who are grieving are suffering from a mental illness and have preferred to reserve medical diagnosis for a minority of people whose grief is abnormal or 'pathological'. Across the world there are many societies which make this distinction and have special terms for individuals whose grief is seen as a sickness. The problem is that what is seen as normal in one society may be abnormal in another.

This brings home the nub of the problem. Illness and health are socially not causally defined. We can decide where we draw the line between health and illness but we should not imagine that these lines are anything more than social conventions. They tell us nothing about causation.

Of course these social structures have important social implications. If we define a person as 'sick' this may entitle them to certain benefits such as treatment under health insurance packages but it may also cause them to incur penalties, they may be

EDITOR'S NOTE

Dr Parkes gave this paper at a meeting last year at the Bereavement Research Forum – a valuable forum called into existence with the aim of enabling researchers in the field to meet and exchange views and information. Other speakers were Tony Walters, whose paper we published in the Winter 1997 issue of *Bereavement Care* and Margaret Stroebe, whose paper, written with Henk Schut, we published in the Spring 1998 issue. Here Parkes, helpfully and with his customary clarity, reviews the models and theories of grief with which most counsellors are familiar and puts them in their historical context, in the certainty that they will in time be superseded by others as we continue to study and deepen our understanding of human responses to loss.

forbidden to work and stigmatised in various ways. From a purely pragmatic point of view we may be wiser to follow the example of the popular song and reassure people that, `You're not sick, you're just in love'.

The grief work model

This is another descriptive model which tells us little about causation. It arose from Freud's observation that it takes time and painful effort for bereaved people to make real the fact of loss, in his terms, to 'test reality'. The struggle appears similar to a job of work which we neglect at our peril. My own empirical observations certainly confirmed the accuracy of his claim. These showed that London widows who grieved openly during the first two weeks after bereavement came through the grieving process more rapidly and with less lasting depression than those who did not. Others have challenged these claims but, rather than refuting these in detail, suffice to say that the crucial time when failure to grieve predisposes to later emotional distress seems to be the immediate aftermath of the loss.

So much is observable and supported by evidence. When we come to explain these phenomena in theoretical terms a new crop of problems begins to emerge.

THEORIES OF GRIEF

This is not intended as a comprehensive list, but it does cover the main traditional theories.

Stress and crisis theory

Stress theory is rooted in Cannon's observation[6] that whenever an animal becomes aware of a situation of danger it reacts in a characteristic physiological and psychological way regardless of the nature of the threat. This reaction is biologically determined and has the function of increasing the individual's chances of survival in a potentially hostile world. The fact that most of the dangers which face us in the world today are very different from those that existed in the environment of evolution means that many of the physiological and psychological responses are now inappropriate and may even create fresh problems for us. One example of this which has received much attention in recent years is post-traumatic stress disorder (PTSD) in which people who have experienced a major, life-threatening event remain hypersensitive to any reminder of that event. There is now an enormous body of knowledge about the physiology of stress which continues to grow along with our understanding of such things as the endocrine and immune response systems.

Caplan[7] recognised that stress seldom occurs in isolation. He showed how family and wider groups can act together to support each other through situations of danger and worked out the implications of this in crisis theory. Concepts of 'emotional inoculation' by which people can be prepared for a traumatic event and 'mutual support' by which people who have experienced such an event can support each other are practical applications of crisis theory.

The main criticism of stress and crisis theory is that it is simplistic and does not go far enough. No distinction is made between losses and other life events and these theories only cover one type of problem area. Much of the literature on disaster and critical incident management only focuses on this area despite the fact that PTSD is relatively uncommon.

Psychoanalysis and the theory of repression.

While the grief work model was essentially descriptive it fitted rather neatly with Freud's theory of repression. Freud developed the theory that psychiatric illnesses are caused by the avoidance of intolerable mental pain by consigning the memories and other thoughts that cause the pain to the unconscious mind. Here the memories do not fade away but remain in 'the unconscious' and liable to re-emerge into consciousness in partial or distorted form at any time. It is the emergence of these memories and the ideas that go with them that were said to cause most psychiatric symptoms. Psychoanalysis, then, was a method of treatment for mental illness which helped the patient to recover repressed memories, to make the unconscious conscious and, in the process, to remove the root cause of the mental illness.

Despite Freud's interest in mourning[8] it was many years before psychoanalysts took a serious interest in bereavement. The first to do this was Eric Lindemann whose classical paper, 'The symptomatology and management of acute grief'[9], described the reactions of survivors of a disastrous fire. Delayed and distorted reactions, he claimed, could be treated in eight to ten interviews by `sharing the grief work', helping the patient to express his sorrow and sense of loss and `finding new patterns of rewarding interaction'.

Lindemann's method was taken up with enthusiasm by proponents of the new mental health movement and continues to influence counsellors to this day. It works best as a means of helping people who find it hard to grieve and remains an effective way of treating delayed and avoided grief. Unfortunately the very success of this approach has led some to think that repression and its consequences are the only or at least the principal cause of pathological grief and that all that a bereavement counsellor needs to do is to facilitate the expression of grief. This conclusion is not borne out by clinical studies which show that delayed and avoided grief are relatively uncommon problems today and that Lindemann's method is of limited value.

Psychoanalytic theory has other shortcomings, but this is not the place to undertake a detailed critique of it.

Attachment theory.

This was originated by another psychoanalyst, John Bowlby, who parted company with Freud and many of his followers to develop his own theory of grief[10-12]. His studies of children separated from their mothers led him to conclude that the urge to cry aloud and to search is part of the repertoire of behaviours which develop in the first year of life and facilitate the attachment between mother and child. Hence it has important survival value. He saw attachment behaviour as having a strong innate component but, like all instinctual behaviour, being subject to modification by learning from the moment of its inception.

It was his student, Mary Ainsworth, who developed a scientific way of studying attachment behaviour, the 'strange situation' test[13]. This has now been used to show how the patterns of attachment established in the first two years of life influence the security or insecurity of future attachments and much of my own recent work has focused on exploring how these predict the way in which people respond to bereavement in adult life. One type of insecure attachment causes the child to cling to the mother. This tendency is likely to persist and to affect other relationships which, when they come to an end, give rise to severe and often chronic grief, the commonest type of pathological grief. Similarly, other patterns of attachment can be shown to explain a great deal of the reaction to loss.

Psycho-social transition theory

If attachment theory explains the immediate reaction to separation and loss (seen most obviously in the 'pang' of grief), it contributes little to our understanding of the ways in which people emerge from grief and develop a new identity. Peter Marris[14] speaks of the 'structures of meaning' by which we make sense of the world around us and of ourselves within it. Bereavements are one

of many types of life event which create a major discrepancy between our assumptive world, the world which we assume to exist on the basis of our experience, and the real world with which we are now confronted. Countless habits of thought and behaviour which involve the person we love must be identified and their continued relevance examined. Memories, ideas and plans which have continued relevance may take on added value now that the person we love is gone. Those which are now irrelevant, painful or misleading must be recognised and tagged as danger areas to be avoided when possible. It is this process that I have termed psycho-social transition[15]. Viewed in this way, 'grief work' is the process by which we slowly and painfully construct a new relationship with the dead and a new view of ourselves and our world. We do this, not by forgetting the past but by reconstructing it. This is the focus of Klass, Silverman and Nickman's recent book *Continuing Bonds*[16].

Problems emerge when bereaved people cling to the past, continuing to utilise models of the world that are obsolete. Conversely they may also arise when people bury their treasure, turning their back on the past in an attempt to avoid the pain of remembrance. In either case they may need help and encouragement to review what has happened and discover new perspectives. These approaches will be familiar to people trained in cognitive therapies.

WORKING WITH NEW IDEAS

Metals are refined by heating them in the fire and beating them and it is often hard for the researchers who have rough-hewn theories out of the bare rock to see them hammered into shape by others. This said, we still have much to learn and it is encouraging to see others emerging whose ideas add to our understanding. Some ideas from the past will, no doubt, have to go by the board, but I am confident that the basic foundation is secure and that new thinkers such as Margaret Stroebe and Tony Walter will continue the process of refinement. **BC**

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NEWS AND VIEWS

OPINION

Expression or repression?

Emotional reserve and the English way of grief

In *The Unknown Country: Death in Australia, Britain and the USA**, Tony Walter describes English people as reserved, and expected to conceal their emotions. Traditional rituals following death once provided a framework within which it was acceptable for the English to express emotions openly but, now these traditions have weakened, the result is confusion among the bereaved who find that the expectation of emotional reserve forbids any public display of grief.

This attitude is now being revised in some quarters, in the belief that the expression of grief is a healthier reaction. But, Walters contends, this has also left people confused: expressivists see displaying feelings of grief as natural and the repression of tears as harmful, yet public situations are not natural but are governed by social rules. As a result many people find it difficult to know how to grieve in a way that is socially acceptable.

Sheila Hodges and John Bush

* Charmaz K, Howarth G, Kellehear A (eds). The Unknown Country: Death in Australia, Britain and the USA. London, UK: Macmillan, 1997.

FORTHCOMING EVENTS

Aspects of Family Grief. 26 September 1998. Manchester Area Bereavement Forum Fifth Annual Conference; keynote speaker, Kevin Kendrick. Denton, Tameside, UK. Enquiries ☎ 0161 371 8860.

A Child's Grief – Someone Has Died. 9 October 1998 in London; 12 October 1998 in Edinburgh, UK. One-day conferences held by The Child Bereavement Trust and Winston's Wish; speakers, William Worden, Julie Stokes, Jenni Thomas. For further information contact Woods Ruinard, 71 Cambridge Road, London SW20 0PX. ☎ 0181 879 7688.

Mental Health Afternoon Seminars convened by Mole Conferences. 16 October 1998, Dealing with Grief and Anger in Grief; speaker, Lyn Franchino. 20 November 1998, Counselling the Difficult Patient (includes pathological grief); speaker, Gillian McGauley. 5 March 1999, Youth Suicide; speaker, Simon Armson. 16 March 1999, Children, the Family and Grief; speaker, Atle Dyregrov. London, UK. Details from: Philippa Weitz, Mole House, 47 Tidy Street, Brighton BN1 4EL. ☎ 01273 24 26 34.

New Horizons in Hospice Care. 2-4 June 1999. Asia Pacific Hospice Conference. Hong Kong. Contact the Society for the Promotion of Hospice Care Ltd. GPO Box 13772, Hong Kong. ☎ (852) 2868 1211.

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