Challenging the Paradigm: New Understandings of Grief

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In 1989, Wortman and Silver published a controversial yet influential article entitled “The Myths of Coping With Loss,” in which they identified five “myths” that were widely accepted by professionals treating bereavement:

- Depression and distress are inevitable in grief.
- Distress is necessary, and its absence is problematic.
- Survivors must “work through” a loss.
- Survivors can expect to recover from a loss.
- Survivors can reach a state of resolution.

The research, in Wortman and Silver’s evaluation, did not support the widespread acceptance of these propositions.

Wortman and Silver’s article crystallized a challenge to what might be called the grief work hypothesis. This hypothesis was really a conceptual belief that one must work through powerful feelings in order to detach from the deceased, reinvest in life, and recover from and resolve the loss.
Originally derived from Freud’s seminal 1917 article “Mourning and Melancholia” (Freud, 1917) the concept is pervasive in self-help books. Staudacher (1991), for example, expresses this notion:

Simply put, there is only one way to grieve [emphasis in original]. That way is to go through the core of grief. Only by experiencing the necessary emotional effects of your loved one’s death is it possible for you to eventually resolve the loss. (p. 3)

Although the grief work hypothesis was evident in much work in the field, especially in trade and self-help literature, it was not universally accepted. In the professional literature, the hypothesis was continually challenged in one way or another and coexisted with other ideas and approaches. In many ways, Wortman and Silver had oversimplified some very subtle and nuanced approaches to the understanding of grief and loss, but their article had great heuristic value, bringing forth many modifications and challenges to these early and popular understandings of grief.

The past 15 years have seen an increasing number of challenges to the early paradigms. In this chapter, I will describe five significant ways in which earlier understandings or paradigms of grief have been challenged. I will also discuss three current challenges to the field and two others that are likely to occur in the not-too-distant future.

FIVE NEW UNDERSTANDINGS OF GRIEF

1. Extending the definition of grief.

One of the basic questions in the field relates to the definition of grief. Is grief a reaction to the death of a significant person, or can it be more broadly understood as a reaction to loss? Freud’s illustration of grief in “Mourning and Melancholia” is a bride left standing at the altar. Most contemporary work emphasizes grief as a reaction to death. Yet confusion over the issue still remains. The major death-related professional organization founded in the United States (though international in membership) was called the Association for Death Education and Counseling (ADEC). The Australian counterpart is called NALAG, the National Association for Loss and Grief. Yet, it remains unclear if the differences between these organizations, in terms of focus or mission, are, in fact, significant.
However, recent work has begun to emphasize grief as a more widespread reaction to loss. Some of this loss is certainly related to dying or death. For example, there has been long-standing recognition that people grieve secondary losses; that is, losses that follow a primary loss and engender additional grief. For example, a parent who has experienced the death of a child may mourn not only the loss of the child but also the absence of the child’s friends, who were often present in the home. Rando’s (1986, 2000) work on anticipatory mourning further develops the idea that losses other than death can generate grief. The original concept of anticipatory grief was that at the onset of a life-limiting disease, a person anticipated a future death and mourned that expected loss. Rando considerably expanded the concept to include anticipatory mourning, which she defined as a response to all the losses encountered—past, present, and future—in the course of an illness. For example, both patient and family may mourn the progressive disabilities and role losses that accompany the disease, as well as the loss of dreams, such as for an idyllic retirement, that now seem unlikely to be fulfilled. Rando’s sensitivity to the myriad forms of loss is illustrated in The Treatment of Complicated Mourning (1993), in which she discusses tangible losses, such as an object that is stolen or a fire that destroys one’s home, and intangible or symbolic losses, such as a divorce.

My work on disenfranchised grief (Doka, 1989, 2002) also addresses the wide range of losses that engender grief, stressing that the very lack of recognition of the grief experienced in such losses complicates grief. Some of these losses involved deaths that were unacknowledged by others—such as the deaths of former spouses, lovers, friends, and even animal companions. The work also emphasized the effects of other types of losses—such as incarceration, divorce, or infertility—that can generate significant grief. The concept of disenfranchised grief emphasizes that every society has “grieving rules” that determine a socially conferred “right to grieve.” Generally, for example, these rules give family members the right to grieve the deaths of other family members. But in many situations—including non-death-related losses—a person might experience a significant loss but be deprived of the opportunity to publicly acknowledge the loss, openly mourn, and receive social support. This is disenfranchised grieving.
Harvey (1998) also notes the pervasiveness of loss and suggests the need for a larger psychology of loss that would complement and move beyond the study of dying and death. This shift is a critical one, as it allows the application of the study of grief to areas such as divorce and job loss, and allows the study to draw from the considerable literature around stress, coping, and adaptation (i.e., seeing grief as a type of stress reaction and mourning as a form of coping or adaptation).

However, the danger exists that grief will be trivialized. If every loss evokes “grief,” the word becomes less important and signifies little. The antidote is to support research that clarifies the grief reactions and outcomes in a wide array of losses, allowing comparisons between grief reactions and outcomes from a death with those from other losses.

2. The application of new models.
Most of the early models of grief were drawn from the work of Kubler-Ross (1969) and emphasized that people were likely to experience grief by going through a series of predictable reactions, or stages. Kubler-Ross originally studied the ways adults with life-threatening illness coped with impending death, but her work quickly was applied to the process of grief, in which a person was expected to experience a relatively linear movement through denial, bargaining, anger, and depression to reach a state of acceptance. This understanding of grief has become widespread.

Despite the popular embrace of these stages, most of the newer models have avoided the language and assumptions of stage theories. Worden (1982) broke new ground in his book *Grief Counseling and Grief Therapy* by conceptualizing mourning as a series of four tasks:

1. To accept the reality of the loss
2. To work through the pain of grief
3. To adjust to an environment where the deceased is missing
4. To withdraw emotional energy and invest it in another relationship

(In the second and third editions (1991, 2002), this task was revised to read “To emotionally relocate the deceased and move on with life,” a modification that is discussed later in this chapter.)

While Worden’s tasks clearly identified grief and mourning with death, they represented a significant paradigm shift from the predominant
stage theories. Worden’s task model was not linear; people worked on whatever issues arose in the process of mourning. The model stressed individuality (different survivors completed the tasks differently) and autonomy (survivors could choose when they were ready to tackle any task).

I recognized the value of Worden’s approach and suggested a fifth task: to rebuild spiritual systems challenged by the loss (Doka, 1993). This task recognizes that some losses challenge personal spiritual belief systems, causing individuals to question and possibly redefine their faith.

After Worden, other models appeared. Rando (1993), for example, proposed the “R” processes of mourning: recognizing the loss; reacting to the separation; recollecting and reexperiencing the deceased and the relationship; relinquishing the old attachments to the deceased and the old assumptive world; readjusting to move adaptively into the new world without forgetting the old; and reinvesting. Stroebe and Schut (1999) offered a dual-process model, suggesting that successful coping in bereavement means oscillating between loss-oriented and restoration-oriented processes.

Both these models, along with Worden’s task model, reaffirmed that mourning was more than simply a series of affective responses to loss. In addition, the new models asserted that mourning involved not only a response to the loss of another but also an effort to manage life in a world altered by significant loss.

All these new models offer value to counselors in assisting bereaved persons. Stage models suggested a limited role for counselors: interpreting the reactions of bereaved persons and helping them move through the stages. The newer models allow a more significant role, in which the counselor helps the bereaved person understand what factors are complicating the completion of certain tasks or processes and develops interventions that can help the person adapt to loss.

The models also have implications for group programs. One way to evaluate a program is to determine the underlying model. Programs based on newer models should do more than simply allow participants to express affect. They should reflect the variety of tasks and processes that are part of the experience of grief and mourning.
3. Beyond affect.
While research from Lindemann (1944) on has emphasized that grief is manifested in many ways—including cognitive, physical, emotional, behavioral, and spiritual reactions—much attention has been placed on affect, to the exclusion of other responses. This focus reflects a general Western preoccupation with affect in counseling and therapy (see Sue & Sue, 2003). A number of writers have stressed reactions to loss other than affect; two will serve as examples.

Neimeyer (2001) emphasizes that the reconstruction of meaning is a critical issue—if not the critical issue—in grief, adding strong cognitive and spiritual components to the study of grief. Neimeyer's “narrative” approach to therapy helps people “reweave” the narrative of their lives, which has been torn apart by significant loss.

Martin and Doka (2000) suggest a continuum of grieving styles ranging from the intuitive to the instrumental. Intuitive grievers experience, express, and adapt to grief in strongly affective ways. Instrumental grievers, on the other hand, are likely to experience muted affective reactions. Their experience is more likely to be cognitive and behavioral, and they will favor such strategies for expression and adaptation to loss. Martin and Doka's work strongly challenges the notion that expressing feelings is the most effective way to adapt to loss. The work began as an attempt to understand the grieving patterns of males; the authors now see these patterns as related to, but not determined by, gender.

Other researchers have strongly challenged the idea that expression of feelings and emotions in grief should be encouraged and that a lack of open affect suggests difficulty. In his social-functioning approach, Bonanno (2004) suggests that adaptation to loss is facilitated when grief-related distress is minimized and positive affect is accentuated. Similarly, Nolen-Hoeksema, McBride, and Larson (1997) suggest that excessive rumination might not be helpful and, in fact, is associated with poor outcomes. The excessive processing of loss can exacerbate distress. Resilient individuals minimize rumination by distraction—shifting their attention in a positive direction. However, Nolen-Hoeksema and her associates also found that deliberate avoidance and suppression of grief were maladaptive.
These insights have important implications for grief counselors, grief groups, and grief curricula. The ideas reflected in the newer models reaffirm that grief is more than emotion. They suggest that leaders should try to move their groups beyond shared anguish to discussions of effective ways to cope with grief and should encourage the recognition of positive memories and experiences, even within a state of grief. These concepts reaffirm the individuality of the grief experience and discourage dogmatic, one-size-fits-all strategies.

4. Beyond coping.

Early work in the field tended to emphasize the difficulty of coping with loss and focused on restoring a sense of equilibrium while slowly and painfully withdrawing emotional energy from the deceased. The perception of the survivor was primarily passive, besieged to cope with changes out of his or her control.

This concept was strongly challenged in the work of Catherine Sanders (1989). In her phase model of grief, Sanders suggested that the process of grieving involves a series of phases, and most people follow a common sequence. The first phase is shock, as the person begins to feel the impact of the death. In each phase, Sanders related the psychological, cognitive, and physical sequelae of grief. For example, in the shock phase, physical symptoms may include weeping, tremors, and loss of appetite. Bereaved persons may experience psychological distancing, egocentric phenomena, or preoccupation with thoughts of the deceased. Cognitive manifestations at this phase may include disbelief, restlessness, and a heightened state of alarm or a sense of unreality or helplessness. In each of the phases, Sanders recognized both the individuality and the multiplicity of grief reactions—a significant advance over the stage theory (Kubler-Ross, 1969).

The second phase, Sanders said, is awareness of loss. Here the funeral rituals are over and support has ebbed. Until now, shock and support have acted as a buffer. Now, as the shock recedes and family and friends withdraw, the primary grievors experience the full force of their loss. This is a period of high emotional and cognitive arousal; separation anxiety is intense and stress is prolonged. Grief is both raw and deeply painful. The bereaved person becomes exhausted and needs to withdraw from others to conserve limited energy.
Sanders proposed conservation-withdrawal as the third phase of bereavement. This is a long (possibly endless) phase of grief. The grieving person seems to be functioning, and pain is more chronic than acute. But the person feels physically weak and helpless—going through the motions rather than actively living life. Bereaved persons in this phase often express a belief that they are in state of hibernation, a sort of holding pattern as they struggle to adapt to the loss.

Sanders said that in the first and second phases, people are motivated largely by unconscious or biological factors. In this phase, she suggested that people have three choices. In the face of extreme physical and psychological stress, some may consciously or unconsciously seek their own death rather than live without the person who died. Others may assume that the necessary major life adjustments require more strength and power than they possess. They may choose the status quo, living the rest of their lives in a diminished state of chronic grief. Still others may decide to move forward and adjust to their loss.

According to Sanders, bereaved persons who choose to move forward often experience a fourth phase: healing/the turning point. In her research, many persons could point to a moment when they consciously decided that their lives needed to change. In one vignette, a widow recalled hearing her young granddaughter ask her mother, “Why does Grandma always cry?” The widow resolved then and there that she would not be remembered as “the grandma who always cried.” In this phase, people reconstruct their identities and lives, and enjoy restored physical health, increased energy, and psychological vigor.

Finally, those who experience the turning point move to a fifth phase that Sanders called renewal. While they still experience occasional bad days and episodic moments of grief, they experience a new level of functioning characterized by enhanced self-awareness, increased levels of energy, personal revitalization, and the renewal of social ties. At this phase, the bereaved person has learned to live without the physical presence of the loved one, while retaining an internal sense of the deceased person's presence. Sanders noted that in this phase, people could often process and even enjoy memories of the deceased without the high emotional arousal experienced earlier in the grieving process.
Later, Sanders began to develop the notion of a sixth phase: fulfillment. In this phase, the grieving person can look back on his or her own life in a way that integrates the loss into the fabric of that life. While the loss was neither expected nor welcomed, the person can no longer imagine what life would be like without the loss (Doka, 2006).

Sanders was one of the first theorists to affirm that people had choices in the mourning process. Her writing emphasized that bereaved persons were active participants in the mourning process rather than passive copers with little control. Her renewal phase presaged such trends in contemporary bereavement theory as grief as a transformative experience (Neimeyer, 2001; Prend, 1997; Schneider, 1994), in which loss can lead to significant personal growth as the bereaved person struggles to adapt to life without the deceased. These concepts are supported in the research of Calhoun and Tedeschi (2004), which emphasizes the human capacity for resilience and notes that loss may trigger growth and change.

This work emphasizes that the point of therapy is not to “recover” from the loss. Rather, it suggests therapists can pose a larger question: “How will this loss change you?” The question implies an active response. Grieving persons are not passive: While they might have no choice about grief, they do have choices about what they will do with their loss.

5. Continuing bonds.

The Freudian notion that the work of grief is to detach from the deceased and reinvest in other relationships has been strongly challenged. In 1987, Attig compared “letting go” in grief to letting go of an adult child. By that Attig meant that even though there may be less physical presence, the connective bonds and sense of presence remain strong. Synthesizing other work, I suggested in the Encyclopedia of Death (Doka, 1984) that rather than emotionally withdraw, survivors might find ways to creatively retain their attachments to the loss object. Using his own research, Worden (1991) revised the wording of his fourth task from the Freudian concept of withdrawing emotional energy from the deceased to relocating the deceased, emphasizing that the bond between the deceased and the survivor continues, albeit in a different form.

In other work, LaGrand (1999) described a connection he labeled “extraordinary experiences,” in which bereaved persons recounted dreams,
sense experiences, and other phenomena after the death of someone they loved. Often these experiences were therapeutic—reaffirming a bond and offering comfort. Such experiences are so common that I suggest counselors routinely ask bereaved persons about them—they may be comforted by the experiences but reluctant to bring them up.

The challenge to the idea of withdrawal received its fullest treatment in the groundbreaking book *Continuing Bonds: New Understandings of Grief*, edited by Klass, Silverman, and Nickman (1996). The editors emphasize that throughout history and across cultures, bereaved persons have maintained bonds with their deceased. The research in this book deeply challenges the idea that emotional withdrawal is essential or even desirable.

Counselors should assure clients that the goal of grief therapy is not to abolish memories of the deceased. The amelioration of grief means that over time the intensity of the grief experience lessens and the bereaved person functions as well as (or perhaps even better than) before the loss, although surges of grief may occur even years later, brought on by significant transitions or other experiences. The point is that relationships continue even beyond death, and the grief process has no final end point.

However, not all bonds with the deceased are helpful. Some persons may retain connections to a loved one who has died that impair relationships with others or adaptation to the loss. Recent research described by Stroebe (2006) suggests that bonds may be supportive for some persons but maladaptive for others. The therapeutic challenge is to recognize that not all attachments are positive.

**CURRENT CHALLENGES**

These new understandings have received considerable attention and widespread acceptance. Three current challenges may further modify the way we understand grief.

1. **Increasing diversity: The challenge of culture.**

The United States and many other nations are becoming increasingly racially and ethnically diverse. Much of the research has been based on white, middle-class samples, so it may not be possible to generalize our understanding of grief. A more diverse society will cause us to rethink basic
questions. For example, what does loss actually mean? Different societies, with different patterns of attachment and different expectations about life and death, may respond to a loss quite differently. What, for example, is the impact of a child’s death in a society with high levels of infant and child mortality?

A more diverse society may challenge what we believe we know about grief. Different cultures may have distinct ways of describing the experience of grief, as well as their own modes of expressing grief and adapting to loss. It may be that the only thing all cultures share is that each one responds and adapts to loss. We may be able to learn from other cultures—their rituals and methods of expression and adaptation may teach us effective strategies and offer insights on different approaches to dealing with loss.

The issue of diversity also has programmatic implications for hospices and bereavement programs. How sensitive are programs to ethnic and cultural differences? Are there significant differences in participation or withdrawal from grief programs or bereavement groups? Do other programs such as memorial services and other forms of community outreach reflect sensitivity to diversity? Do “interfaith services” truly reflect religious and cultural diversity? As Islam and other nonwestern faiths grow in the United States and many other western nations, is this growth reflected in the religious affiliations of chaplains and the nature of spiritual care? Are resources on grief—such as books or brochures—available in all the languages spoken in our communities?

Social class is another aspect of diversity, and strategies and programs need to acknowledge the differences. Are fees for services based on a sliding scale? Social class also encompasses differences in life style. For example, for many lower income families, photographs are a luxury. A common activity in children’s groups involves creating photographic montages and picture boxes. Such exercises may isolate lower income children or expend a precious and not easily replaced resource.

Sexual orientation is yet another source of diversity. How inclusive are groups and materials? Are bereavement groups solely for widows and widowers or also for partners? Would bereaved unmarried partners—either gay or straight—be comfortable in the grief groups offered, or is it clear that the groups are meant to serve heterosexual widowed spouses?
Sue and Sue (2003) remind us that counseling is a culture itself, with its own distinct values. How well do these values match the values and approaches of the cultures being served?

2. **The challenge of research and evidence-based practice.**

As Neimeyer (2000) notes, little research has been done on the actual methods of grief counseling and grief therapy. In the past, we simply assumed that these methods worked. Grief counseling requires the integration of theory, practice, and research. Interventions need to be theoretically grounded and empirically assessed. Evidence-based practice is becoming the standard.

This standard has implications for practitioners, including the need for constant evaluation of grief programs. How can we be sure that the programs we offer are effective? On what evidence do we base programs? More integration is needed between clinical practice and research. This integration is facilitated when researchers and theoreticians explore the practice applications of their work and when clinicians take an empirical approach to therapy—constantly assessing how well their therapy is helping the client adapt to loss. Research on the link between theory and practice will likely cause us to reassess and reevaluate the concepts and models that underlie the study of grief and grief therapy.

3. **The challenge of technology.**

The challenge to research and evaluate is especially clear with regard to the many resources offered through the Internet. Online resources include grief information, grief groups, chat rooms, counseling, and opportunities for memorialization. Yet there has been little evaluation of these resources and little study of their efficacy.

The Internet may offer support for bereaved persons, but it may itself be a source of grief. The exponential increase in cyberspace relationships raises questions for the study of attachment and loss. If close relationships can form online, will these people constitute a future class of disenfranchised griever? Will these relationships raise new questions regarding the processes of death notification?
ON THE HORIZON

Two additional issues are likely to affect future understanding of grief. The first one is the move to add a “grief” category to the forthcoming DSM-V. One of the proposals before the American Psychiatric Association is on complicated grief (formerly called traumatic grief). Jacobs and Prigerson and others (see Jacobs & Prigerson, 2000; Prigerson & Maciejewski, 2006) suggest that certain symptoms evident early in the process of grieving predict problematic outcomes, and they recommend early intervention. For years, the field has eschewed a medical model of grief and avoided using terms like “symptoms.” Grief, it is argued, is a normal part of the life cycle, not an illness. These proposals challenge that notion, asserting that at least some experiences of grief show evidence of psychiatric illness. The proposals are a sign of increasing recognition that there is a need for correction, that the emphasis on the normalcy of loss and grief has led to the neglect of problematic variants. Receptiveness to these proposals is probably also fueled by the growth of managed care in the United States and the need to have a clear grief-related diagnostic code. Regardless of the motivation, adding a diagnostic category for grief will constitute a paradigm shift.

The second issue is the demographic change as the Baby Boomers age. Many of them are experiencing the loss of their parents; in a few decades, they will face their own deaths. Also, each generation develops unique forms of attachment; many boomers have developed extremely close attachments to their children, so their deaths may create different problems for their offspring than in previous generations. This is a generation that has challenged and changed every institution it has experienced in its collective journey through the life cycle. Boomers demand choices in programs and avoid programs that ignore individual differences. They tend to trust individuals rather than institutions. They want to be active participants in programs rather than passive recipients. The Baby Boomers will surely change the ways we encounter loss, death, and grief.

Over the past 15 years, our understanding of grief has experienced major modifications. Changes and challenges are likely to continue to
affect how we think about and respond to loss. As a popular baby
boom song, Dylan's "The World It Is a Changin" put it "the wheel is still
in spin."


