

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. 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 twentieth century. Wars and similar conflicts are associated with repression of grief but methods of helping by facilitating its expression, which were introduced during the two World Wars are less needed and effective at other times. In recent years more attention has been paid to the social context in which grief arises and, particularly, to the nature of the attachments which precede and influence the reaction to bereavement and to other traumatic life events. At the same time a range of caring resources have become available and acceptable to bereaved people and the results of scientific evaluation of these give promise that we are moving towards an era in which more sensitive and appropriate care will be provided to the bereaved by both voluntary and professional caregivers.

Grief in the last millennium

Written over a millennium ago, the poem 'Beowulf' 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.

"The people of the Geats then made ready for him on the ground, a firm-built funeral pyre, hung round with helmets, battle shields, bright corselets as he had bid them do. Then mighty men, lamenting, laid in its midst the famous prince, their beloved lord. ...the roaring flame mingled with the sound of weeping. Depressed in soul, they uttered forth their misery, and mourned their lord's death... Heaven swallowed up the smoke.

Then the people of the Geats raised a mound upon the cliff, which was high and broad and visible from far by voyagers on sea... the warriors, brave in battle, ...rode round the barrow; they would lament their loss, mourn for their king, utter a dirge and speak about their hero. They revered his man-

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liness, extolled highly his deeds of valour – so it is meet that man should praise his friend and lord in words, and cherish him in heart when he must needs be led forth from the body” (Hall, 1950).

It seems that, in the late 8th 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. Many barrows were raised in Britain above the dead to ensure that they were not forgotten.

Of course, this was the privilege of the great and important dead. Humble folk had humble graves then, as they do now. We tend to think of it as normal to die in old age, but the first millennium 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. In this day and age 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 (1603), in 1580, can write “I have lost two or three children in their infancy, not without regret, but without great sorrow”. One is reminded of the recent research of Nancy Sheper-Hughes (1992) among the poor people of North-East Brazil, where the infant mortality rate is still very high. She entitles her book *Death Without Weeping* and records her own sense of shock when, in great distress, she told a mother that the baby she had been taking to hospital 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 (1603) 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”.

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 (1657) statistics of

causes of death for the city of London in 1657. But it was not until my own statistical study with Benjamin and Fitzgerald 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 (Parkes, Benjamin, & Fitzgerald, 1969). 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*, 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 (1621) describes grief or sorrow as "The epitome, symptome and chief cause of melancholy". In this he preceded Freud and Lindemann by 200 years.

Vogther in Altdorf (1703) published a Ph D thesis entitled *De Morbis Moeventium*, which translates as 'The Illnesses of Grief' or, to use modern language, 'Pathological Grief Reactions'. He lists a number of prescriptions for grief. It seems that the idea that bereavement can cause mental illness goes back a long way.

Coming closer to the present day, in 1835 we find the American physician Benjamin Rush, 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" (Rush, 1835). 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 (Morley, 1971, p. 73). Victoria's own grief for the death of her husband Prince Albert was severe and protracted.

Grief in the twentieth century

According to Geoffrey Gorer (1965), 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.

And so we come to Sigmund Freud, whose classical paper, 'Mourning and Melancholia', written in 1917, proposed that grieving or 'mourning', as it was inaccurately translated, is a job of work in the course of which emotional en-

ergy, or libido, is withdrawn from a loved person before it can be re-directed elsewhere. "When the work of mourning is completed," he wrote, "the ego can become free and uninhibited again." 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, 1953).

Freud's paper had much influence on the psycho-analytic 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, 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 that arise when it is delayed or distorted. Lindemann was a psycho-analyst 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, 1944).

Lindemann's approach led to great enthusiasm for Bereavement Counselling, most of it based on the naïve assumption that all the counsellor needed to do was to encourage the bereaved person to express grief, or 'do the grief work'. In recent years, however, a number of random allocation studies have shown that most bereaved people do not need and will not benefit from such counselling (Currier, Holland, & Neimeyer, 2007; Forte, Hill, Pazder, & Feudtner, 2004; Schut, Stroebe, van den Bout, & Terheggen, 2001). Fortunately they also show that, for the minority who are at special risk, appropriate interventions can be successful.

From the outset it was apparent that there were limitations to Lindemann's theory. In 1949 Anderson, in the UK, published an account of the psychiatric consequences of bereavement in which he described a type of problem that had not been given weight by Lindemann and which was not so easily explained. This was the Prolonged Grief Disorder (PGD) and it was, and remains, the most frequent diagnosis among people seeking psychiatric help. People with PGD do not show any signs of repressing their grief, rather they grieve intensely from the start and continued to do so long after they are expected to stop grieving. 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.

Lindemann's work triggered a great deal of interest in the topic of bereavement, which has continued to this day. Any attempt to summarise the research that has followed must pick and choose between a large number of

contenders and I apologise if my own review is highly selective and misses out your favourite paper.

My own interest in the subject arose when, as a trainee psychiatrist, I met two people who had been admitted to the Maudsley Hospital for treatment of depression following bereavement. Reading what literature there was on the subject alerted me to the possibility that the study of bereavement might make a useful contribution, not only to our understanding of bereavement but of the many other stresses that contribute to cause mental illness.

My first study was focused on people seeking psychiatric help after bereavement and was published in 1965. It showed that bereavement could trigger a wide range of psychiatric disorders, of which affective disorders were the most frequent. It also showed that a minority of these patients were suffering from the forms of pathological grief which had been described by Lindemann and by Anderson. It confirmed Anderson's claim that PGD was more frequent than delayed grief.

Part of the problem faced by researchers at this time was the absence of any systematic studies of normal or uncomplicated grief. What was the range of normality, how long did grief last, was there a pattern to it? In 1962 John Bowlby, who was studying the reactions of small children to the experience of separation from their mothers, invited me to join his unit at the Tavistock Institute of Human Relations. Here I was able to study a relatively unselected sample of young women who had lost their husbands through the course of their first year of bereavement.

Robertson and Bowlby (1952) had observed that young children separated from their mothers expressed a distinctive pattern of grieving moving 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. I found something very similar in my own study of young widows, the only difference being that many widows reported an initial phase of Blunting or Numbness which preceded the phase of crying and yearning. 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 (Bowlby & Parkes, 1970).

It was in 1964 that I visited the United States for the first time. I had read a paper on 'The Dying Patient's Grief' by Prof. Knight Aldrich (1963) in Chicago and he invited me to speak about my own studies of bereavement at Billing's Hospital. Here I met a remarkable young trainee working, in his department, on the problems of cancer patients. Her name was Elizabeth Kubler Ross and she subsequently adapted Robertson, Bowlby and Parkes's (Bowlby & Parkes, 1970; Robertson & Bowlby, 1952) Phases of Grief to describe the Phases of Dying (Ross, 1970). I mention this because Kubler Ross has some-

times been credited with discovering the Phases of Grief as well as the Phases of Dying. Both of these concepts have subsequently given rise to a fair amount of controversy and several alternative models have been described.

While working at the Tavistock I had met Gerald Caplan who played a large part in the development of Community Psychiatry in the USA. His name is associated with Crisis Theory and he was a friend and colleague of Eric Lindemann. Gerald invited me to join his unit at Harvard for a year in order to direct the Harvard Bereavement Project. This was a systematic short longitudinal study of unselected widows and widowers over the first four years of their bereavement. Its aim was to discover why some people did well after bereavement and came through without the need for help from outside their families while others did not. It enabled us to identify risk indicators, which could be used to recognise people before or at the time of a bereavement who were at risk of problems later. We also described the characteristic reactions that followed sudden, unexpected and untimely deaths, the deaths of partners on whom the bereaved person had been very dependent and the conflicted grief of people whose relationships were highly ambivalent (Parkes & Weiss, 1983).

Since that time many other researchers have contributed to our understanding of bereavement risk. The current thinking is summarised in the table below. Of particular note is Doka's category of Disenfranchised Grief (1989). This arises in situations in which, for various reasons, grief is discouraged and social supports are absent.

Table 1
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 (i.e. losses that cannot be acknowledged or 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.
-

While in the USA I received a visit from a physician whom I had previously met in London. She was Cicely Saunders and she brought with her the plans of a new kind of therapeutic community for people with late-stage cancers. I was most impressed by her work and delighted when, in 1966, she invited me to join her in setting up support services for the families of her patients.

St Christopher's Hospice provided a test bed in which 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. The idea of sending volunteers into the homes of newly bereaved people proved controversial, even at St Christopher's. It was only after the suicide of a young widow of one of our patients that I was able to persuade the staff to let me carry out a random-allocation study in order to find out if we were doing good or harm. Fortunately for me the results of this study confirmed the value of our intervention (Parkes, 1981). The effect of the counselling was to improve outcome as measured by a shortened version of the Health Questionnaire used in the Harvard Bereavement Study to about the same level as that of a low risk group who received no counselling. Looked at more closely, it was the males who benefited most significantly from a type of intervention that, at that time, was influenced by Lindemann's model.

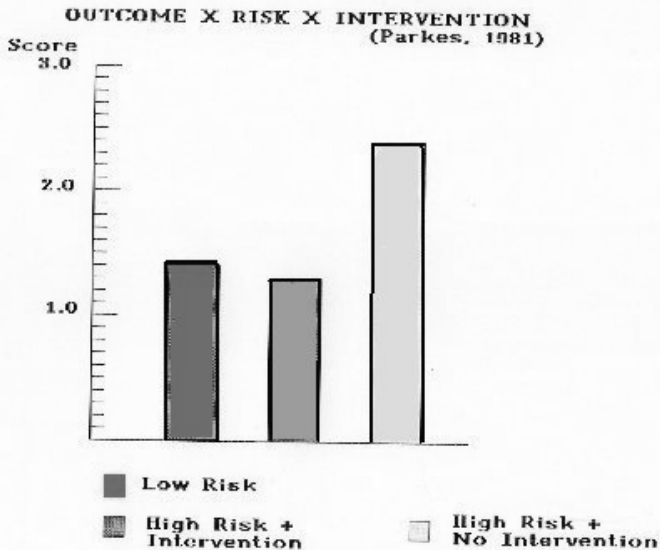


Figure 1

Outcome study by risk by intervention results of the Harvard Bereavement Study

Note. The score was measured by a shortened version of the Health Questionnaire used in the Harvard Bereavement Study.

None of this work was taking place in a vacuum. A colleague who was also working in Caplan's unit was David Maddison. He returned from Boston to Australia where he carried out a study of risk factors in bereavement and came up with similar results (Maddison, Viola, & Walker, 1969; Maddison & Walker, 1967). One of his trainees, Beverley Raphael, set up her own Bereavement Service and carried out an evaluation of the effects of intervention in high-risk bereaved people using a very similar method to my own and also with very similar results (Raphael, 1977). The main differences between her study and mine were that we were in different continents and that, in her case, all of the interventions were provided by a highly trained psychiatrist specialising in bereavement problems, herself, whereas mine were provided by volunteers.

Under Raphael's influence the Australian *National Association for Loss and Grief* has developed training courses for professionals who provide a high standard of care for bereaved people. In recent years many of these have been employed by firms of funeral directors who are able to offer counselling as part of the package of services provided when somebody dies.

In the UK it is voluntary services for the bereaved that have flourished, some of them linked with Hospices and others based in the community. The best organised of these is *Cruse Bereavement Care* which has branches in most parts of the UK and which publishes the journal *Bereavement Care*. This has now become an international journal for all who work with bereaved people. It is published by Routledge on line and in print.

In the USA things seem to have taken a rather different turn. 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 Counseling* (ADEC) and a variety of excellent professional services are now available including some run by funeral directors. The use of trained volunteers is largely confined to hospices and palliative care units but it is mutual help groups that have come to dominate the scene. These owe much to another of Caplan's protégées, Phyllis Silverman, who has devoted her working life to developing Widow-to-Widow and other projects aimed at bringing bereaved people together (Silverman, 1969). Unfortunately there have been few attempts to demonstrate, by scientific means, the value of this work, and those that have been carried out, such as Mary Vachon's comparative study, have not shown clear-cut benefits (Vachon, Lyall, Rogers, Freedman, & Freeman, 1980).

Important contributions to teaching have also been made by William Worden whose 'Tasks of Grieving' constitute a check-list which has been found very useful by counsellors (Worden, 1982, 4th edition 2009).

Related topics – psychological trauma

While these approaches were being developed other research was taking place which, although not primarily focused on bereavement, has come to overlap with this field and to have triggered important developments. This is the field of stress studies which developed largely independently of the field of loss and grief. There is no space here to go into this in detail but the work of Horowitz and his colleagues in San Francisco, who developed the Impact of Event Scale, has done much to bridge the gap between these overlapping areas of study (Horowitz, 1986; Horowitz, Wilner, & Alvarez, 1979).

A landmark event whose influence is still not fully appreciated was the inclusion of Post-Traumatic Stress Disorder (PTSD) in the 3rd and subsequent editions of the Diagnostic Statistical Manual of Psychiatric Disorders (American Psychiatric Association, 1994). 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 Martinek (1997) and Horowitz, Bonnano, and Holen (1993) have tried to formulate criteria for the diagnosis of pathological grief but the most impressive work in this field stems from Holly Prigerson, Vanderwerker, and Maciejewski (2008) whose systematic studies have established clear diagnostic criteria for Anderson's Prolonged Grief Disorder (previously known as 'Chronic Grief', 'Traumatic Grief Disorder' and 'Complicated Grief Disorder'). The distinctive feature of PGD, which distinguishes it from other disorders, is pining for a person who is lost. This places it in the category of attachment disorders, a concept which owes much to attachment theory.

Note that these criteria allow for the inclusion of grief that has been delayed provided that it then becomes prolonged.

Related topics – attachments

Attachment theory stems from the seminal work of John Bowlby whose *magnum opus Attachment and Loss* was published in three volumes in 1969, 1973 and 1980. He greatly extended our understanding of the bonds which tie people to each other and of the consequences when separations and losses occur. He highlighted the dangers of separating small children from their mothers and the influence of such separations on later relationships. My own studies have confirmed that high scores of separation in childhood correlate significantly with high anxiety and a tendency to cling after bereavements in adult life (Parkes, 2006). Bowlby formulated the concept of the 'secure base'. In childhood this is provided, or should be provided, by a secure relationship

Table 2

*Proposed criteria for the diagnosis of Prolonged Grief Disorder in the DSM
(Prigerson, Vanderwerker, & Maciejewski, 2008)*

A. Event Criterion: Bereavement (loss of a loved person)

B. Separation Distress: The bereaved person experiences at least one of the three following symptoms which must be experienced daily or to a distressing or disruptive degree:

1. Intrusive thoughts related to the lost relationship
2. Intense feelings of emotional pain, sorrow, or pangs of grief related to the lost relationship
3. Yearning for the lost person

C. Cognitive, Emotional, and Behavioural Symptoms:

The bereaved person must have five (or more) of the following symptoms:

1. Confusion about one's role in life or diminished sense of self (i.e., feeling that a part of oneself has died)
2. Difficulty accepting the loss
3. Avoidance of reminders of the reality of the loss
4. Inability to trust others since the loss
5. Bitterness or anger related to the loss
6. Difficulty moving on with life (e.g., making new friends, pursuing interests)
7. Numbness (absence of emotion) since the loss
8. Feeling that life is unfulfilling, empty, and meaningless since the loss
9. Feeling stunned, dazed or shocked by the loss

D. Duration: Duration at least six months from the onset of separation distress

E. Impairment: The above symptomatic disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities).

F. Medical Exclusion: The disturbance is not due to the physiological effects of a substance or a general medical condition.

G. Relation to Other Mental Disorders: Not better accounted for by Major Depressive Disorder, Generalized Anxiety Disorder, or Posttraumatic Stress Disorder.

with one or both parents and by the familiar home in which the child grows up. Given a secure base children learn to explore their world and cope with the challenges which they meet. 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 (Bowlby, 1988).

The further development of this field owes much to the American psychologist, Mary Ainsworth. She developed a systematic way of studying the

attachments between parent and child in her Strange Situation Test (Ainsworth, Blehar, Waters, & Wall, 1978). As a result she distinguished between secure and insecure attachments and, with the help of her colleague Mary Main (Main & Hesse, 1990; Main & Solomon, 1990), identified three main types of insecure attachment, the Anxious/ambivalent pattern, Avoidant pattern and Disorganised/disoriented pattern.

Anxious/ambivalent children have anxious, overprotective parents who are insensitive to their needs for autonomy. The children tend to become anxious and clinging. Avoidant children have parents who are intolerant of closeness. They learn to inhibit attachment but their apparent independence masks underlying anxiety. Each of these types of children have learned to cope with their parents, the former by staying close, the latter by keeping their distance. Children in the Disorganised/disoriented category have no such strategies for survival. They grow up in families in which high levels of stress and depression make their parents unpredictable and inconsistent in their parenting. The children grow up unhappy and helpless. These patterns have turned out to be remarkably stable and, indeed, to predict attachment problems later in life.

This work has initiated a lot of new studies in all parts of the world; as a result the field is developing very rapidly. Among other things is the identification of similar categories of attachment in adult life (Bartholomew & Perlman, 1994). 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 (Parkes, 2006). Among those with insecure attachments predictions based on attachment theory have mostly been confirmed. To summarise a large number of statistical correlations:

Adults who describe themselves as having been anxious/ambivalent children tended, in later life, to have conflicted relationships with their partners. Following bereavement they suffer protracted grief and a continued tendency to cling. They are most vulnerable to PGD. Adults who, as children, learned to avoid attachments remain aggressive and assertive in adult life. They have difficulty in expressing both affection and grief. Adults who grew up with family rejection, violence, danger and depression describe themselves as deeply unhappy children. 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.

Attachment theory emphasises the importance of the family as our main source of security and support at times of trouble. Indeed it is the possession of a supportive family that explains why most bereaved people do not need counselling. By the same token, the absence of such support makes bereavement hard to bear. Kissane, McKenzie, Bloch, Moskowitz, and McKenzie (2006) have developed ways of assessing support and a method of intervention that has passed the test of a random allocation study. Their Family-Focused Grief Therapy enables families to resolve conflicts, solve problems and share grief in ways that benefit them all.

Controversies and recent developments

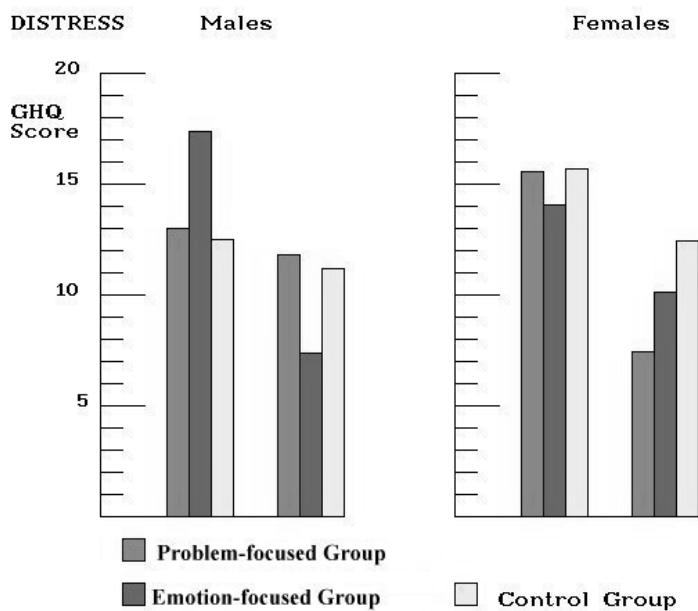
In recent years psychologists and sociologists have challenged several of the assumptions made by the pioneers. Freud's concept of 'grief work' has been questioned by Wortman and Silver (1989) and by the Stroebe (1991). Wortman and Silver based their argument on the observation that people who show the most distress before bereavement are more, not less, distressed afterwards. They equate high initial distress with 'grief work'. This argument only holds water if we assume that distress is the same thing as 'grief work' and that lack of 'grief work' is the only or main cause of problems in bereavement. My studies suggest that this type of severe reaction is to be expected in people whose attachments are anxious/ambivalent or disorganised.

More constructive than Wortman and Silver's approach is the Dual Process Model of Bereavement put forward by the Margaret Stroebe and Henk Schut at the University of Utrecht (1999). 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 lost 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 PGD, the latter with avoided or delayed grief (the delayed form of PGD).

This model does seem 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 the provision of a secure base in which people 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 (Schut, Stroebe, van den Bout, & de Keijser, 1997). 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 they found that both of the counselled groups did rather better than the control group. Looking more closely they found that, as in my own study at St Christopher's Hospice, 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.



From Schut et al. 1997 British Journal of Clinical Psychology, 36, 63-72.

Figure 2

GHQ-level of the intervention by gender effect in the Schut et al. (1997) study on conjugal bereavement

Another sacred cow that has come under attack is the concept of stages of grief (Wortman & Silver, 1989). A recent study showed that, although the features described by Bowlby and Parkes tend to peak in the predicted

order, they do not replace each other (Maciejewski, Zhang, Block, & Prigerson, 2007). Many bereaved people accept the reality of loss from the start while others are able to accept the loss as time passes. Yearning is often present from the start and remains prominent while declining over the first year. Numbness is not always present but when present is most pronounced at the outset and declines fairly rapidly thereafter. Anger is less common, it often coexists with yearning. 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 (Parkes, 1975) and Fitzgerald's studies of blindness (Fitzgerald, Ebert, & Chambers, 1987) gave rise to the concept of Psycho-Social Transitions (Parkes, 1996). 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.

It is the match between our assumptive world and the world that we meet that gives direction, purpose and meaning to life. After bereavement there arises a disjunction between the world that is and the world that should be. This is experienced as a loss of meaning and recent work has paid attention to the importance of helping bereaved people to discover new meanings as they rebuild their assumptive world. Neimeyer (2000; 2001) speaks of this as a change in the narrative of our lives.

But letting go of obsolete assumptions 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 Dennis Klass, Silverman, and Nickman (1996) in the book of that name.

Another contribution to our understanding of Psycho-social Transitions comes from Janoff-Bulman (1992), who points out that the assumptive world includes basic assumptions regarding our security, worth and the protection of others. In her book *Shattered Assumptions* she described how traumatic life events can easily shatter these assumptions and leave us feeling insecure, unworthy and unprotected. This concept has been found helpful in the understanding of many traumatic stresses (Kauffman, 2002).

One other area of controversy is Engel's notion of grief as a disease (Engel,

1961). Engel pointed out that grief is a cause of great mental pain, it produces a variety of bodily and psychological symptoms and it interferes with our ability to function effectively. Bereaved people find that their concentration, memory and judgement are impaired and a period of time off work is often needed. These are the criteria normally thought of as evidence of illness. Yet, the consequences of severe grief are not covered by health insurance and bereaved people receive no medical help or legal compensation for the suffering which they undergo.

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 onto others and even take a drug (such as alcohol) which will relieve some of our feelings of distress.

Given current prejudice, it seems wise to reserve attributions of psychiatric disorder for the minority who meet DSM criteria for psychiatric disorders and, in addition, to include Prigerson's criteria for PGD.

Contrary to popular belief, most psychiatric disorders respond well to treatment and this includes PGD. A recent random allocation study has shown significant benefits from what Shear, Frank, Houck, and Reynolds (2005) call 'Complicated Grief Therapy'. They treat people with PGD by focussing attention on the loss and restoration components of grieving, use 'Revisiting Exercises' to treat trauma symptoms (including role played conversations with the deceased person), use a 'memory questionnaire' to identify positive and negative memories, and 'Motivational Enhancement Therapy' to identify goals and monitor progress. Techniques of this kind constitute an amalgam of the emotive and cognitive approaches that are now recognised as most likely to benefit bereaved people.

Visions for the future

So what of the future? It is possible that the inclusion of 'Prolonged Grief Disorder' within the orbit of psychiatric diagnosis and its inclusion in the Diagnostic Statistical Manual of the American Psychiatric Association (DSM) will pave the way to a greater recognition of the fact that losses of one sort or

another impair the lives of many of us. By widening the range of mental disorder to include the temporary impairment of function that follows many of the traumatic life situations that we face, we may eventually reduce the stigma. People may come to see grief as an injury for which help may be needed in much the same way that we now view the consequences of a bodily injury.

Regardless of this, 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 who will do just that and who understand about grief.

Recent years have seen a steady increase in the numbers of such counsellors 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. However some encouraging results are already being obtained from on-line help for people suffering depression, anxiety disorders (Proudfoot, Ryden, Everitt, Shapiro, Goldberg, Mann et al., 2004) and PGD (Wagner, Knaevelsrud, & Maercker, 2006), all of which are common after bereavement. With the rapid deployment of low-cost computers across the world, it seems likely that these will become the most popular sources of help.

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? As attitudes to counselling continue to change we may find that people in positions of power will come to recognise their own needs for support.

Anger, we know, is a part of grieving. It can also bring about cycles 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.

I am not pessimistic. In my life time I have seen a new science and art of hospice and palliative care arise for families faced with death. I have seen training in bereavement become a part of the curriculum of many doctors and

nurses and, although there has never been enough money to do things in an ideal way, I have seen important progress made whenever people who care have come together to work with each other to achieve change. Above all I have come to respect the potential of the many people who volunteer to help the dying and the bereaved.

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 (Gupta, 2000). 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; where the global village, with all its soap operas and other trivia, brings everyone who needs it within reach of proper and effective help; where parents as well as children, leaders as well as followers, receive the cherishing and support that they need; where the griefs that are a necessary part of life are recognised as such and those who suffer them receive understanding and wise counsel.

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