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CARING FOR BEREAVED PEOPLE 1: MODELS OF BEREAVEMENT

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This is part 1 of a two-part unit on caring for bereaved relatives. It discusses manifestations of grief and explores three theoretical perspectives.

LEARNING OBJECTIVES

1. Describe the emotional, physical, behavioural and psychological responses to bereavement.

2. Understand three perspectives of bereavement theory.

Although over 572,000 people die in the UK each year (General Register Office for Scotland, 2007; National Statistics Office, 2007; Northern Ireland Statistics and Research Agency, 2007), the impact of death on survivors is easily underestimated (Ellershaw and Ward, 2003). As such, those who are bereaved do not always receive the care and understanding they need.

The vast majority of deaths occur within institutional settings – mostly as a result of chronic illness, mental health problems and accidents (Cobb, 2004; Husband and Henry, 2002) – so it is highly likely that bereaved relatives will, at some point, come into contact with nurses and vice versa (Russell, 2007). Consequently, nurses need to know how to care for these vulnerable people.

Although the focus of this unit is on bereavement in relation to death, it is vital to remember grief follows all types of loss: loss of a job, a home after moving into care accommodation, or a relationship. Illness itself brings many losses, including the loss of body parts or function (Russell, 2007).

UNDERSTANDING LOSS

Understanding the terms surrounding loss is an important starting point. In simple terms, loss can be expressed as 'losing what we prefer to keep, being deprived or being without' (Read, 2002). As it follows loss, bereavement can be understood as the objective state of having lost someone or something that is significant (Stroebe et al, 2002). While the terms 'bereavement' and 'grief' are often used interchangeably, the latter can be seen as the emotional reaction to the former. Grief is an emotion that draws us towards something or someone who is missing (Parkes, 2000) and is, essentially, a condition of the human spirit (Prior, 2000).

The set of behaviours that allow a person to express these emotions is known as mourning (Payne et al, 1999). Mourning rituals – such as bereavement attire and the organisation, place of and attendance at funerals – change over time and vary between communities and cultures.

Grief manifests itself through a variety of emotional, physical, behavioural and psychological responses (for full details see Table 1 in Portfolio Pages). Every person is unique and the response to bereavement depends on numerous factors, including age, gender, coping skills, personality, culture, previous experiences, circumstances surrounding the death, relationship to the dead person and the perceived implication of the loss (Anstey and Lewis, 2001).

BEREAVEMENT MODELS

A model is a descriptive way of categorising responses that are observed and/or experienced. Understanding bereavement models can help nurses offer an initial and sensitive response to the loss, assess both its impact and the person's reaction, thus identifying when additional support is appropriate (Field and Payne, 2003).

Medical perspectives

The medical model expounded by Engel (1961) and cited by Parkes (1998) identified that all sources of major grief share the defining characteristics of major illness. The severity of these manifestations depends on the extent of the illness and grief, but both:

- Cause pain;
- Disturb physical and mental functions;
- Affect concentration;
- Impair memory;
- May cause 'sufferers' to take a break from their normal responsibilities.

From this premise, it is logical to conclude that grief is an illness and its manifestations are symptoms of that illness. If bereavement is an illness, it represents an undesirable 'state' and 'cure' is desirable. Terms such as 'resolution' and 'recovery' are used to describe the outcome of bereavement, suggesting the individual is getting over an illness (Payne, 2004). Bereavement models influenced by this theory tend to possess a developmental framework, suggesting bereaved people progress through each phase or stage in a logical and linear manner.

Phases and stages

A number of writers have proposed phase models for bereavement. Perhaps the best known is Kubler Ross, who tried to categorise the behaviour she observed from her work with dying patients. Having interviewed over 200 people dying from cancer, she identified five bereavement stages:

- Denial;
- Anger;
- Bargaining;
- Depression;
- Acceptance.

Through these interviews she concluded that those facing death generally passed through each of these five stages (Kubler Ross, 1969). It was not her intention to suggest a sequential pattern but this was a consequence of how others interpreted her use of the term 'stage', compounded by the order in which they appeared in her book.

Bowlby (1980; 1969) suggested a four-phase model of bereavement, based on observations of the behaviours of young children separated from their mothers:

- Phase 1 – numbness, lasting from a few

hours to a week, possibly interrupted with periods of intense distress or anger;
- Phase 2 – yearning and searching, which may last for months or years;
- Phase 3 – disorganisation and despair;
- Phase 4 – greater or lesser degree of reorganisation.

Bowlby divided these behaviours into three distinct linear phases:
- 'Protest' – marked by anger, loud crying and constant searching for the mother;
- 'Despair' – characterised by less vigorous crying and withdrawal;
- 'Detachment' – marked by an outward display of cheerful behaviour while the child remains emotionally distant.

Worden (2001) used the phase model of bereavement to develop a therapeutic model called 'the tasks of mourning':
- Task 1 – to accept the reality of the loss;
- Task 2 – to work through the pain of grief;
- Task 3 – to adjust to an environment in which the deceased is missing;
- Task 4 – to relocate the deceased emotionally and move on with life.

In this model, bereaved people should work through the tasks of mourning. Bereavement is a job, which takes time and considerable effort if the loss is to be made real. Working through these tasks enables individuals to accept the loss, resolve their grief and live in a world in which the deceased is absent. Modified since it was first published in 1982, the final task of the model now suggests a less final break with the dead person (Worden, 2001).

If a person fails to move through the phases, stages or tasks of bereavement successfully, they are considered to have become 'stuck' in their grief. Thus, this approach has given rise to the idea of 'normal' and 'abnormal' grief (Payne, 2004).

Although widely used in healthcare, the phase models have been criticised as being rigid and prescriptive, suggesting all people go through each phase and in the same order. Perhaps the greatest criticism came from bereaved people, who did not think the models reflected their experiences.

Social perspective

In the 1990s sociologists offered another perspective to address the criticisms. They proposed grief is not a set of psychological and physical responses, but a transaction between what one thinks is happening and what is going on in the environment (Klass et al, 1997; Walter, 1996). This perspective:
- Emphasises the changes that occur in social roles and relationships following bereavement, for example, wife to widow, child to orphan;
- Recognises that expressions of grief are influenced by social and cultural factors, for example differences in funeral traditions.

For sociologists, the purpose of grief is to construct a biography of the deceased, enabling the living to integrate the memory into ongoing lives (Walter, 1996). It is important to recognise shared memories, keep possessions and discuss the dead person, but it is also normal for the living to maintain a connection with them and recognise that this connection is not static.

Bereaved people construct an inner representation of the deceased that lets the relationship diminish but not disappear. There is continual activity while they seek to make sense of the loss and give meaning to the place the dead person holds in their ongoing life. Following a loss, there is an emphasis on negotiating and renegotiating the measure of that loss over time. Accommodation, rather than recovery or resolution, occurs.

The term 'narrative' or biography is often used in relation to this model as the narrative of the relationship with the deceased needs to be rewritten in the context of their absence. The sociological perspective brought with it an understanding that grief is not exclusively a reaction to death but a normal response when a person loses something important.

Transactional approach

Stroebe and Schut (1999) further expanded our understanding by suggesting the dual process model of bereavement (Figure 1 in Portfolio Pages). This model offers a psychological approach while recognising that bereavement takes place within a social context. Bereaved people have to cope with the loss and subsequent changes. Stroebe and Schut (1999) categorise the behaviours into two sets of activities: the first focuses on those aimed at facilitating and expressing grief; the second focuses on those aimed at continuing to live. This model avoids single-focused interpretation of normal grief and lets many patterns of 'normal' grief coexist.

CONCLUSION

Loss can create intense grief that hurts both physically and psychologically (Field and Payne, 2003; LaPorte Matzo et al, 2003). ■

- *Part 2 of this unit, which explores how nurses can help those who are bereaved, will be published in our next issue.*

KEY REFERENCES

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The full reference list for this part of the unit is available in Portfolio Pages at nursingtimes.net