

## The Stage Theory of Grief

**To the Editor:** The cohort study investigating the stage theory of grief by Dr Maciejewski and colleagues<sup>1</sup> presents a review of the literature that we feel is selective. We believe that the variability in the nature and course of grief<sup>2,3</sup> makes it untenable to maintain that “the stage theory of grief remains a widely accepted model of bereavement adjustment. . . .”<sup>1</sup> Not everyone goes through an orderly sequence of reactions with defined stages.

A 2001 report by the Center for the Advancement of Health<sup>4</sup> concluded that “grief theory has moved away from the original multistage theory most closely associated with Dr Elisabeth Kubler-Ross; as currently understood, grief is not divisible into distinct stages.” A subsequent report<sup>5</sup> concluded that “. . . responses to loss are widely variable and there is no one clearly defined course or process of bereavement or grieving.”

In the article by Maciejewski et al,<sup>1</sup> almost one fifth of the participants did not fit the stage model in advance, and the authors excluded these 58 participants (18%) with complicated grief disorder before they conducted their statistical analyses. An additional 168 individuals (>65% of those who refused to participate) declined to be interviewed because they were either “doing fine” (n=23) or were not interested or had no reason (n=145). These may have been persons who experienced no distress in response to their loss. Thus, almost 40% of the eligible bereaved participants (226/575) were excluded (by choice or design) from the reported analyses. A selective exclusion of these tails of the distribution could have maximized the possibility that “stages” would be found in the remainder of the sample.

Additionally, although the data were collected longitudinally, they were not analyzed longitudinally to examine within-participant patterns of response. Instead, 1 data point was randomly selected per respondent for analysis. This strategy would mask within-participant fluctuation in response over time that has been found in bereavement research<sup>6</sup> and thereby inflate apparent across-time differences.

A mistaken belief in the stage model of response to loss can have devastating consequences. Not only can it lead bereaved persons to feel that they are not coping appropriately, but it also can result in ineffective support provision by members of their social network as well as unhelpful and potentially harmful responses by health care professionals.

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**To the Editor:** Dr Maciejewski and colleagues<sup>1</sup> present the first empirical investigation of the stage model of grief. While the study adds important information, I disagree that their data represent “normal patterns of grief processing over time.”

First, the authors excluded participants who met criteria for complicated grief, but they did not account for other neuropsychiatric entities such as major depression, dementia, or personality disorders. Each of these could affect normal bereavement. In this case, “average” is a better descriptor than “normal.”

Second, “normal” exists within the context of culture. Normal grief processing for a Catholic New Englander might be different from that for a Tibetan Buddhist or a devout Southern Baptist. These are empirical questions, but this study did not account for the participant’s country of origin, religious affiliation, religiosity, or spirituality.

Third, as the authors point out, patterns of acceptance, anger, and disbelief may be dependent on the circumstance of death, which in Western countries may be different from that in other parts of the world. For example, most

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**Letters Section Editor:** Robert M. Golub, MD, Senior Editor.

US residents die in an acute care hospital or nursing home,<sup>2</sup> frequently after agreeing to or refusing potentially life-extending medical treatments. While US medical culture asks the patient and family to assume such weighty decision-making responsibilities near the end of life, physicians may not be trained to facilitate these discussions.<sup>3</sup> This can lead to iatrogenic psychological harm, potentially altering the path of grief.<sup>3</sup> In one study conducted in France, 82% of relatives who participated in end-of-life decision making for the terminally ill patient in the intensive care unit had clinically significant symptoms of posttraumatic stress at least 3 months after the patient's death.<sup>4</sup>

Fourth, the authors also point out that patterns of grief can be affected by preparation for death. Loved ones may be poorly prepared for a patient's death, and this may be associated with greater depression, anxiety, and complicated grief during bereavement.<sup>5</sup> Given that preparation is affected in part by the quality of medical communication, it is not clear if these kinds of grief reactions should be considered abnormal or culture bound.

In the absence of more data, I would caution against applying the word "normal" to these observed stages of grief.

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**To the Editor:** Investigators of bereavement have long noted the paucity of empirical support for the widely held assumption that grief reactions progress through a series of specific stages.<sup>1,2</sup> Dr Maciejewski and colleagues<sup>3</sup> claim to have identified "normal stages of grief." However, we believe that even with their study there is no solid empirical evidence for the stage theory.

The data actually contradict the stage theory. Acceptance of the death is purported to be the final stage of grieving. However, in their study, acceptance was the most frequently endorsed item at every measurement point. Even in the earliest months of bereavement, the mean frequency of acceptance experienced by participants was between daily and several times a day, significantly more than any other grief item. These data are consistent with other evidence associating acceptance of death with widespread resilience to loss.<sup>4</sup>

Moreover, there are significant methodological limitations in this study. Genuine evidence for a stage model should show

that most people progress in the same sequence through the same stages; it also would be imperative to measure the stages reliably. But in the study by Maciejewski et al, the data were not longitudinal; the trajectories were implied from variability in different participants at different points in bereavement. The hypothesized stages were not measured reliably; only a single questionnaire item was used to assess each stage.

Despite these serious limitations, the authors conclude that their findings could serve to educate professionals and family members about bereavement. They argue, for example, that focusing on stages enhances our understanding of how the average person processes a loss. But one important reason why the stage model has failed to generate empirical support is that it lacks explanatory value. The aspects of grief encompassed by the stage model may be informative but they are certainly not the only critical factors in processing a loss. Grief stages tell us little about how people might cope with the loss; why they might experience varying degrees and kinds of distress at different times; and how, over time, they adjust to a life without their loved one. Considering the evidence from other studies that contradicts the idea of an "average" normal response to loss,<sup>1,5</sup> this is a misleading message.

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**In Reply:** The stage theory of grief has captured the imaginations of clinicians and the public. Despite its recognized limitations (eg, that it will not predict exactly how every bereaved person will grieve), it remains taught in medical schools, posted on authoritative Web sites (eg, National Cancer Institute),<sup>1</sup> and continues to guide thinking about bereavement for many clinicians, educators, and researchers. Although several reviews have concluded that this theory has no support, our study represents the first empirical test of the stage theory. We are aware of no previous study that used the necessary grief measures or the analytic strategy to explicitly test the stage theory of grief.

Drs Silver and Wortman suggest that our sample and data analytic strategies were selected to support the stage theory. By design, the sample focused on the most typical circumstance of bereavement—widowhood following death from natural causes. Study participants were largely representa-

tive of widowed individuals in the sampled region. There is no basis for assuming that study participants would provide more support for the stage theory than study nonparticipants. Because we sought to focus on the normative rather than extreme responses to loss, we removed cases of prolonged grief disorder, and excluded cognitively impaired individuals. By “normal” we refer to the statistical norm (or average) bereavement response, not to a subjective judgment of what is or is not normal. As Dr Weiner notes, replication in other contexts (traumatic modes of death, different cultures) is needed.

Silver and Wortman claim that our data were not analyzed longitudinally and that our analytic strategy would mask within-participant fluctuation in response over time. However, the data were analyzed longitudinally (Table 2 in our article). In addition, the regression models included time from loss as an independent variable. Consequently, time was factored into the analyses; the analyses were not cross-sectional. Silver and Wortman also are concerned that the analyses would inflate apparent cross-time differences. However, random selection of observations in the regression analyses served to remove bias and dependence between observations, thereby generating unbiased results.

Drs Bonanno and Boerner state that single-item indicators represent a methodological flaw because these items were unreliable. However, these items have been evaluated and found to be among the most informative and unbiased in the evaluation of prolonged grief disorder.<sup>2</sup> The assertion by Bonanno and Boerner that the stage model “lacks explanatory value” belies the fact that it predicts the sequence of peaks that emerged from the data. Nevertheless, we agree that the finding that acceptance is the most commonly reported response (even soon after the death) lends support to research indicating that most bereaved individuals show great resilience in the face of loss. Understanding of normative responses to loss requires careful empirical study. Although the results reveal some discrepancies with the theory, they suggest that stages of grief remain an important construct for understanding bereavement.

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## Posttraumatic Stress Disorder and Cognitive Behavioral Therapy

**To the Editor:** In their study of the treatment of women with posttraumatic stress disorder (PTSD), Dr Schnurr and colleagues<sup>1</sup> reported the superiority of prolonged exposure over present-centered therapy. We believe that their use of present-centered therapy as a comparison group is problematic.

Present-centered therapy was described as “clinically relevant” and as a “control for the nonspecific benefits of therapy.” Present-centered therapy was used so that the effects of prolonged exposure could be attributed to prolonged exposure rather than the purported “benefits of good therapy.” Present-centered therapy, however, did not appear to represent a bona fide therapy. The treatment was described as primarily involving discussion and review of “general daily difficulties,” specifically prohibiting any exposure or cognitive restructuring. Their methods article discusses present-centered therapy in more detail, stating that if the patient mentions “trauma-related issues, the therapist gently redirects her to discuss other material.”<sup>2</sup>

It is difficult to understand how a therapy for PTSD that forbids all discussion of trauma-related material can be considered fully therapeutic, as trauma is a core component of the disorder. Indeed, present-centered therapy seems to more accurately resemble a weak placebo intervention than a bona fide psychotherapy. Its description does not reference any established approach to psychotherapy. It appears to not be based on any psychological process, to prohibit discussion of relevant issues, and to contain no active ingredient (eg, exposure, addressing recurring relationship patterns). Interventions that lack such ingredients generally perform worse than therapies that are fully intended to be therapeutic.<sup>3,4</sup>

The authors state that present-centered therapy is typically used for women in the Department of Veterans Affairs (VA) system with PTSD.<sup>5</sup> However, while in the current trial present-centered therapy was delivered according to a manual, less than 10% of VA therapists use treatments according to a manual.<sup>5</sup> Many VA practitioners at least occasionally use exposure techniques and restructuring of trauma-related thoughts, both of which were forbidden in the present-centered therapy manual.<sup>5</sup> An estimated 70% to 80% of VA clinicians use coping skills training during their treatment of PTSD patients,<sup>5</sup> while the present-centered therapy used by Schnurr et al contains no reference to any skill-building component.

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