

Discourse

Loss and Bereavement: Perspectives, Theories, Challenges

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Loss is a common experience in human existence. Major loss stimulates both personal and social responses, often of high intensity, as was observed throughout the world after the tragic accidental death of Princess Diana in 1997. Knowledge of loss and grief has been reflected in poetry, paintings, novels, myths, and plays across the centuries of recorded history. Understanding the complex influence of loss on human adaptations and collective responses has come about in the 20th century through scientific approaches to the creation of knowledge.

Historical Overview

Origins of Studies on Loss

The first systematic study on loss is credited to the psychoanalyst Freud (1957), who proposed that grief is a process in which loss is resolved through hypercathexis followed by gradual decathexis related to internalized bonds of attachment. Eliot identified the need for studies on family grief (1930) as well as for a social psychology of bereavement (1933). Lindemann's (1944) psychiatric study of acute-grief responses of survivors of a deadly nightclub fire served as a stimulus for the development of research and theory by investigators in many fields.

Research on loss and bereavement was closely associated with the emergence of the "death" movement in the 1950s and 1960s. Perspectives on mourning as a process of adaptation were found in the writings of Irion (1954) and Jackson (1957) in the field of pastoral psychology. Marris (1958) described the bereavement responses of women

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to the death of their spouse, and Parkes (1964) outlined the effects of bereavement on widows' mental and physical health. On the subject of catastrophic loss, Lifton (1963) wrote of the numbing effects of mass atomic death on the survivors of Hiroshima. Interest in the study of death led to systematic research in many disciplines, the emergence of interdisciplinary journals and organizations, and the development of death education for both lay persons and professionals (Pine, 1977).

Viewpoints and Theories

Observation of the loss experiences of children led to clinical studies and, in turn, theories to explain the contribution of loss to human development. Proponents of psychoanalytic theory focused on reactions to loss and separation as tied to psychic conflicts in childhood (Peretz, 1970). Proponents of attachment theory (Bowlby, 1973, 1980) perceived grief as an adaptive response that takes account of present as well as past meanings of loss, and environmental as well as intrapsychic influences. Both perspectives provided the bases for subsequent studies on loss and bereavement in children and adolescents.

Knowledge of bereavement in adult life was stimulated by Parkes's (1972) studies, which included identification of predictor variables for estimating bereavement outcomes after the loss of a spouse (Parkes & Weiss, 1983). In a comprehensive review of research on loss, grief, and bereavement, Raphael (1983) found that the phenomena had been studied from many theoretical perspectives. She reported that studies focused on growing old, surviving disaster, and caregiving, in addition to death losses experienced by children, adolescents, and adults.

The proliferation of studies on loss and death in many fields brought new terminology to describe and explain the observations. Adding to the language of loss were concepts of anticipatory grief (Schoenberg, Carr, Kutscher, Peretz, & Goldberg, 1974), grief work (Worden, 1982), cultural variations in bereavement (Rosenblatt, Walsh, & Jackson, 1976), complicated mourning (Rando, 1992–93), disenfranchised grief (Doka, 1989), and transcendence of loss (Weenolsen, 1988). Research served to broaden our understanding of bereavement to include special meanings of parental grief (Klass, 1988), sibling bereavement in adolescents (Balk, 1990, 1996; Davies, 1991), and the effects of parental death on child adjustment (Worden & Silverman, 1996). By the 1990s, differences in viewpoint on the processes and outcomes of bereavement were stimulating debate in the literature on myths and misconceptions associated with loss and grief (Stroebe, van den Bout, & Schut, 1994; Wortman & Silver, 1989).

Programs and Interventions

A basic component of the hospice, begun in the 1960s to provide humane care to the dying, was bereavement services for survivors (Corr & Corr, 1983; Stoddard, 1978). The clinical needs of people struggling with various losses contributed to the development of grief counselling and grief therapy (Worden, 1982).

Crisis-intervention programs and teams had origins in Caplan's (1964) thinking on preventive psychiatry. Suicide-prevention programs were established in many communities, and crisis teams were assembled to manage disaster situations. Mutual-help groups sprang up in response to growing needs for assistance with bereavement. Among these were the Widow-to-Widow program initiated by Silverman (1980, 1986) and Compassionate Friends, an organization for bereaved parents (Klass, 1988). In the 1990s, guidelines were developed to help schools to set up bereavement services for students and staff (Stephenson, 1994).

Literature on how to assist bereaved persons and groups has grown extensively over the past two decades. This literature includes guidelines for clinical caregivers (Rando, 1984), proposals for helping children (Wass & Corr, 1984), strategies for assisting adolescents (Corr & Balk, 1996), and proposals to guide work with specific populations such as persons with AIDS and their survivors (Nord, 1996) and the bereaved elderly (Caserta & Lund, 1992).

Loss from a Nursing Perspective

Perspectives and Programs

Nursing literature is rich in anecdotal accounts of loss and bereavement, which are often accompanied by proposals for clinical interventions. Research on terminal illness contributed to perspectives on personal loss, group loss, multiple loss (Benoliel, 1971, 1985a), professional loss associated with clinical practice (Benoliel, 1974), and guidelines for nursing practice (Benoliel, 1985b).

Bereavement research added perspectives on parental health and adaptation to the loss of a child (Miles, 1985; Williams & Nikolaisen, 1982), sources of guilt in parental bereavement (Johnson-Soderberg, 1981; Miles & Demi, 1983–84), family influences on sibling bereavement (Davies, 1988, 1991), and the salience of ongoing attachment in adolescent sibling bereavement (Hogan & Balk, 1990; Hogan & DeSantis, 1992). From research on widowhood came insights on grief resolution (Saunders, 1981), adjustment processes (Demi, 1984a), and health and

coping among elderly widows (Gass, 1987; Heath, 1990). Studies in the 1990s have added perspectives on the search for meaning in loss (Steeves, 1996), grief among older women whose husbands died in hospice care (Jacob, 1996), loss associated with family caregiving in AIDS (Brown & Powell-Cope, 1995), and bereavement tasks of families (Steeves & Kahn, 1994).

Guided by clinical interests, nurses have helped to initiate assistance programs for various populations of bereaved persons. These programs include hospice services for children (Davies & Eng, 1995), a community-based bereavement network (Kirschling & Osmont, 1992–93), bereavement interventions in hospital emergency departments (Coolican & Pearce, 1995; Mian, 1990), and family bereavement services in pediatric oncology (Johnson, Rincon, Gober, & Rexin, 1993; Ruden, 1996). Nurses have also participated in the evaluation of support programs for parents (Heiney, Ruffin, & Goon-Johnson, 1995) and hospice bereavement services (Longman, 1993).

Models and Theories

The search for outcome predictors was pioneered by Vachon and colleagues in their studies of conjugal bereavement (Vachon, Rogers, et al., 1982). More recently, Kristjanson and colleagues sought predictors of family functioning subsequent to the palliative-care experience (Kristjanson, Sloan, Dudgeon, & Adaskin, 1996). Tests of theory-based interventions were conducted by Vachon, Lyall, Rogers, Freedman-Letofsky, and Freeman (1980), who studied the effects of social support on adaptation among widows, and by Murphy and colleagues, who developed and tested a preventive intervention for bereaved parents after vehicle-related deaths of adolescent/adult children (Murphy, 1996; Murphy, Aroian, & Baugher 1989; Murphy, Baugher, et al., 1996).

Bereavement models in the 1980s were multidimensional and process-oriented (Demi, 1984b; Dimond, 1981; Murphy, 1983). Research evidence provided the base for models of parental bereavement guilt (Miles & Demi, 1983–84), caring in early pregnancy loss (Swanson-Kauffman, 1986), recovery from disaster loss (Murphy, 1989), a theory on adolescent sibling bereavement (Hogan & DeSantis, 1996), and an experiential theory of bereavement that encompassed the concept of personal growth (Hogan, Morse, & Tason, 1996). Developed to guide practice as well as research, this body of intellectual work by nurses reflects a range of clinical situations of which loss and bereavement are salient components.

Current and Future Challenges

As acceptance of loss and bereavement as serious human problems increased, so too did the numbers of people facing serious losses — many without the support of traditional family and kinship systems. The rapid pace of social and technological change has fostered environments in which human beings are vulnerable to the lethal effects of nuclear technology, virulent microorganisms, illegal drug use, and public and private violence (Benoliel, 1997). Around the world people are living with loss brought about by such human pursuits as warfare, terrorism, racism, genocide, and environmental contamination — which Leviton (1991) refers to as “horrendous death.”

The changed world of the late 20th century has brought with it a proliferation of groups living with multiple losses. These groups include refugees, the frail elderly, people with AIDS and their survivors, and persons disabled by injury and chronic mental and physical illness. This latter group is expected to grow in the next century. By World Health Organization projections, the leading causes of disease burden for the year 2020 are ischemic heart disease, unipolar major depression, and road accidents (Murray & Lopez, 1996).

In developed countries, bereavement services were slow to develop because they did not fit well with the organizing framework of disease and treatment. Funding for hospice and palliative care did not come easily, and the implementation of many of these services relied heavily on volunteers. Bereavement care has had low priority in the ranking of health-care needs and has relied on the good will of sensitive providers and the availability of resources from privately funded organizations. Private groups like the Red Cross have fulfilled basic needs and provided crisis services in situations of catastrophic loss affecting masses of people. Such crises, however, require help beyond that which can be provided by established agencies.

Nurses have been major players in confronting the challenges of loss and bereavement over the past 50 years. Meeting the new challenges of the 21st century will require them to move beyond the traditional ways of thinking about loss and grief — that is, as individual and family matters. Development of national and international programs geared to the human needs of large numbers of people will require new perspectives on caregiving and new forms of leadership in interdisciplinary efforts to help bereaved persons in all parts of the world.

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