

Cautioning Health-Care Professionals: Bereaved Persons Are Misguided Through the Stages of Grief

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Abstract

Science and practice seem deeply stuck in the so-called stage theory of grief. Health-care professionals continue to “prescribe” stages. Basically, this perspective endorses the idea that bereaved people go through a set pattern of specific reactions over time following the death of a loved one. It has frequently been interpreted prescriptively, as a progression that bereaved persons must follow in order to adapt to loss. It is of paramount importance to assess stage theory, not least in view of the current status of the maladaptive “persistent complex bereavement-related disorder” as a category for further research in DSM-5. We therefore review the status and value of this approach. It has remained hugely influential among researchers as well as practitioners across recent decades, but there has also been forceful opposition. Major concerns include the absence of sound empirical evidence, conceptual clarity, or explanatory potential. It lacks practical utility for the design or allocation of treatment services, and it does not help identification of those at risk or with complications in the grieving process. Most disturbingly, the expectation that bereaved

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persons will, even should, go through stages of grieving can be harmful to those who do not. Following such lines of reasoning, we argue that stage theory should be discarded by all concerned (including bereaved persons themselves); at best, it should be relegated to the realms of history. There are alternative models that better represent grieving processes. We develop guidelines to enhance such a move beyond the stage approach in both theory and practice.

Keywords

Stage theory, Kübler-Ross, Bereavement, Grief, Review

Theoretical models of bereavement should serve the function of increasing understanding of grief and grieving, particularly given the physical and mental health ramifications of this severe life event (Parkes, 1972/1996), which may require professional intervention (Shear, 2015). Among these approaches, so-called stage theories, postulating that grief progresses through specific emotional stages, have remained highly influential. Indeed, such adoption of a stage approach follows a long tradition in psychology (e.g., in developmental, health, social, and clinical domains) as well as in psychiatry and medicine. A stage theory can offer new ways of understanding complex systems of human behavior, ways that may be helpful for diagnostic purposes and to guide intervention (McGorry, 2007). However, those stage theories that have proven valuable show the evidence of scientifically based principles (e.g., postulating discrete changes in the nature of underlying stage-related processes or cognitive levels, providing empirical evidence for a sequential progression/for efficacy in treatment). Does the stage theory of grief meet such criteria? Is it a valid and useful model of grief and grieving? Answering such questions requires evaluation of both its scientific and practical value. Therefore, the aim of this article is to review and assess the contribution of the stage theory of grief.

To this end, in the next section, we trace how stage theory emerged historically, documenting its remarkable, persisting popularity in the face of ongoing opposition. Then we focus on emergent lines of argument against stage theory, covering conceptual concerns, lack of empirical validity, its failure to assist in identifying those at risk or with complications, and the potentially negative consequences for bereaved persons themselves. As we show, the stage theory of grief falls short in all these respects. There is no scientific foundation, and decades of research have shown that most people do not grieve in stages. Using stages as a guide in work with bereaved is unhelpful and may even cause harm. Our critical assessment leads to the conclusion that stage theory should be relegated to the past and eliminated from contemporary clinical practice. We discuss what actions can be taken to move on, suggesting an alternative approach and providing initial guidelines for health-care professionals and bereaved persons.

Stage Theory in Historical Perspective: Claim and Refutation

The emergence of stage theory is usually ascribed to Elisabeth Kübler-Ross's (1969) monograph "On Death and Dying," which documented her observations of adjustment among dying patients. In essence, Kübler-Ross's stage perspective held that dying people go through five stages of grieving: denial, anger, bargaining, depression, and, finally, acceptance (sometimes called the DABDA model). Each stage was described in a separate chapter, with "stage" in the heading of these, strongly suggesting that they were distinct and sequential, even linear (although minimal acknowledgment of fluctuations between stages, individually varying time sequences, and coexisting stages can be detected on close reading). Later, in reintroducing the stages and focusing more on the bereaved (Kübler-Ross & Kessler, 2005), this was contested (though separate, sequential descriptions remained).

It is important to note that Kübler-Ross herself extended the application of the stages of dying to the situation of (anticipatorily) bereaved persons already in her 1969 book. Excerpts from her chapter "The Patient's Family" make this clear:

Family members undergo different stages of adjustment similar to the ones described for our patients. At first many of them cannot believe it is true. They may deny the fact that there is such an illness in the family. . . . Just as the patient goes through a stage of anger, the immediate family will experience the same emotional reaction. . . . When anger, resentment, and guilt can be worked through, the family will then go through a phase of preparatory grief, just as the dying person does. (Kübler-Ross, 1969, pp. 168–169)

In the decades following the publication of *On Death and Dying*, prominent writers (including many with cautionary words) reported Kübler-Ross's stages of grief relating to bereavement. For example, already in 1975, Lopata referred to the existence of a "stages of grief ideology" (p. 50), describing: "the currently popular conception of stages of widowhood." She went on to regret that: "However the stages of widowhood originated, it has become disseminated to at least the Chicago area women with great effectiveness. . . . Significant others . . . have an ideal typical sequence of stages in mind" (Lopata, 1975, p. 50).

Other formulations of stages or phases appeared over the following decades (Bowlby, 1980; Horowitz, 1976; Jacobs, 1993; Sanders, 1989; Shuchter & Zisook, 1993), varying in labels (e.g., various combinations of disbelief, numbness, yearning, shock, and guilt), numbers of stages (e.g., 3, 4, and 7), and general guidelines (e.g., emphases on fluidity vs. rigidity). It is beyond our scope to review all, but our arguments can be considered in the context of these approaches.

It was Kübler-Ross's volume which became an international bestseller, even, according to Friedman and James (2008), reaching the status of "one of the most influential books in the history of psychology" (p. 37). Indeed, Kübler-Ross succinctly both formulated and popularized stage theory, promoting it throughout her life. She was also a charismatic person, much admired and loved by her followers, even described as "legendary"; in 1999, *Time Magazine* named Kübler-Ross as one of the "100 Most Important Thinkers" of the past century (from her obituary); in 2007, she was posthumously inducted into the United States Women's Hall of Fame. Already by 1982, Kübler-Ross estimated that her stages had been taught in 125,000 courses in colleges, seminaries, medical schools, hospitals, and social work institutions (Rosenbaum, 1982; Wortman & Silver, 1987). By 2016, *On Death and Dying* reached a remarkable figure of well over 11,000 citations in Google Scholar.

Contributions of both Parkes and Bowlby, around the time that Kübler-Ross's monograph was published, avoided some of the pitfalls of stage theory, going on to become major contributions to understanding of the course of grief and grieving.¹ These researchers incorporated the notion of phases in a theory-based manner (following attachment theory principles; Bowlby, 1980; Parkes, 2006). More cautiously than Kübler-Ross's (1969) presentation of stages, Bowlby (1980) stated: "these phases are not clear cut, and any one individual may oscillate for a time back and forth between any two of them" (p. 85).

Looking across the decades, a highly influential source of opposition to stage theory came from Wortman and Silver (Silver & Wortman, 1980; Wortman & Silver, 1987, 1989, 1992), who drew attention to the alarmingly widespread adoption of stages among health-care professionals, with disastrous consequences for the bereaved, despite lack of solid evidence. Their classic article of 1989, "The Myths of Coping With Loss," criticized Kübler-Ross's expectation of recovery through to the final, acceptance stage of grieving, pointing to longer, varying courses of grieving among many bereaved people (without indications of pathology). Their conclusions were echoed in the Institute of Medicine's authoritative review, which cautioned:

The notion of stages might lead people to expect the bereaved to proceed from one clearly identifiable reaction to another in a more orderly fashion than usually occurs. It might also result in inappropriate behavior toward the bereaved, including hasty assessments of where individuals are or ought to be in the grieving process. (Osterweis & Green, 1984, p. 48)

A strongly worded statement by Neimeyer (2000) extended the concerns to stage theory's use as a conceptual model for underpinning counseling, denouncing use of

suspiciously simplistic models, such as stage theories of grieving that have been largely repudiated by contemporary theorists and researchers...grief

counseling . . . rarely draws on the best available theories regarding the nature of bereavement and its facilitation. (p. 547)

Many other researchers and clinicians have taken issue with stage theory. For example, Shuchter and Zisook (1993), describing the course of normal grief (in three flexible phases), too cautioned against the literal use of stages: “Grief is not a linear process with concrete boundaries but, rather, a composite of overlapping, fluid phases that vary from person to person” (p. 23). Similarly, Jacobs (1993) drew attention to oversimplification:

Although it is sometimes instructive to conceptualize the manifestations of grief in this manner, it is important to emphasize that the idea that grief unfolds inexorably in regular phases is an oversimplification of the highly complex, personal waxing and waning of the emotional process. (p. 18)

Since the early 1990s, Corr (1993, 2011) has become a major opponent of the stage theory approach for dying patients and for the bereaved (Corr, 2015), reviewing earlier criticisms (e.g., lack of scientific corroboration, conceptual inadequacies, and inappropriateness of the language of stages leading to prescriptive use by practitioners).

Neither these nor other criticisms impacted on Kübler-Ross’s adherence to stages. The title of her 2005 monograph with Kessler, *On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of Loss*, leaves little doubt about that. This volume, like its 1969 forerunner, continued to strongly divide opinion among readers (it was positively reviewed by Bolden (2007)). The authors responded to the criticisms from previous years in the opening lines of Chapter 1:

The stages have evolved since their introduction, and they have been very misunderstood over the past three decades. They were never meant to tuck messy emotions into neat packages. They are responses to loss that many people have, but there is not a typical response to loss, as there is no typical loss. Our grief is as individual as our lives. (Kübler-Ross & Kessler, 2005, p. 7)

Such a disclaimer seems inadequate in the face of lack of evidence for the stages. The authors still assumed that people experience the stages. In fact, Kübler-Ross and Kessler (2005) seemingly go on to weaken their own case, noting that “they are not stops on some linear timeline in grief. Not everyone goes through all of them or in a prescribed order” (p. 7). Friedman and James (2008) counter argued “If there are no typical responses to losses, and not everyone goes through them or in order, how can there possibly be stages that universally represent people’s reactions to loss?” (p. 41). Despite opposition from other experts too, continued promotion of the stages approach came, somewhat

surprisingly, from a team of empirical researchers (Maciejewski, Zhang, Block, & Prigerson, 2007), but this (as we shall see) was met with strong criticism.

To this day, stage theory is still widely known, taught, and used in clinical practice. Konigsberg's book (2011), entitled *The Truth About Grief: The Myth of its Five Stages and the New Science of Loss*, though accessibly reviewed by Balk (2011) and Neimeyer (2012), has remained apparently unheeded and relatively uncited. As a final illustration of perseverance, the stages approach has recently been claimed state of the science of bereavement theorizing in an article by Jurecic (2015). According to Jurecic, what is "emblematic of modern loss and grief" in medicine is a progression through Kübler-Ross's five stages (1969), which "encourage an orderly process of bereavement," that contemporary (medical) approaches propose that "mourning progresses in predictable stages" and that there is a "right way to mourn." This misrepresentation of current scientific understanding in the bereavement field (elaborated below) does our field—to say nothing of bereaved people themselves—no good. Worryingly, her claims may even promote the use of stages. Again the enormous resistance to moving beyond the stages approach is demonstrated. There are compelling arguments to be made as to why this situation must change.

Criticisms and Assessment of Stage Theory

From the claims and refutations traced earlier, five main categories of criticism emerge:

1. *Lack of theoretical depth/explanation.* In contrast to Bowlby's phases, Kübler-Ross's stages (1969) were not derived from theoretical principles. As Archer (1999) pointed out, the approach "does not address the issue of what might be the principles underlying this organization" (p. 100). This therefore fails to address the question: What is the function of grief? In Bowlby's (1980) case, the phases were related to attachment phenomena, serving the purpose of regaining proximity to the person from whom the separation had occurred. No such underlying principles were postulated for the stages. Bonanno and Boerner (2007) expressed their doubts as follows:

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, this is a misleading message. (p. 2693)

The aforementioned shortcomings have a further, major implication: Stage theory does not help us identify those at high risk or with complications in the grieving process of great importance for diagnostic systems such as

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and International Statistical Classification of Diseases and Related Health Problems (ICD-11).

2. *Conceptual confusion and misrepresentation of grief and grieving.* Among this class of critical comments, the following stands out: It is unclear what the sequential stages (i.e., denial, anger, bargaining, depression, and acceptance) really are and what they represent. Some denote affective states, others cognitive processes. So there is a mixture of different types of constructs which do not fit coherently or sequentially together. There is no theoretical rationale for this particular arbitrary use of dividing lines between states. Further examples of conceptual concerns are given in Table 1. Taken together, rather than providing us with “the knowledge of grief’s terrain” (Kübler-Ross & Kessler, 2005, p. 7), it becomes clear from the points listed that stage theory misrepresents phenomena associated with bereavement.
3. *Lack of empirical evidence.* Kübler-Ross’s (1969) knowledge was not derived from systematic, empirical investigation (of bereaved persons) but through the contact of “over two hundred dying patients” (p. 38). Despite this number, in Parkes’ (2013) view, there was lack of scientific rigor: *On Death and Dying* was simply “a collection of case studies in the form of conversations with dying patients” (p. 94). Surprisingly little empirical testing of stage theory has been subsequently undertaken—as Archer (1999) pointed out, this is difficult to do. Table 2 reviews relevant studies, indicating little support and quite some refutation of the stages. In conclusion: While there is empirical evidence that people experience (some of) the emotional and cognitive reactions some of the time, there is little to support the sequential development of these in stages.
4. *The availability of alternative models.* The stages approach has been supplanted by finer grained, sometimes theoretically based, more-representative-of-the-grieving-process models of grief and grieving (see Table 3; for reviews, see Boerner, Stroebe, Schut, & Wortman, 2015; Doka & Tucci, 2011; Stroebe & Schut, 2001). These alternative perspectives, developed over the years, are well known but received no acknowledgment or discussion by Kübler-Ross and Kessler (2005).
5. *The devastating consequences of using stage theory.* Last, but certainly not least, it is important to recognize that using the stages approach as a guideline in supporting bereaved persons may raise undue expectations, even presumptions about the course that grief should take. Naturally, some bereaved people may feel affirmation from reading about incorporation of emotions such as anger or despair in stage theory: If they fit one’s personal experience, they provide verification. Kübler-Ross received a large fan mail confirming this. However, such positive appraisal does not

Table 1. Misrepresentation of Grief and Grieving in Stage Theories: Major Concerns.

Oversimplicity	Approach does not account for enormous diversity in grief reactions either between individuals or across time. Theoretical models should at least attempt to explain variability.
Passive model	Describes what a bereaved person is <i>put through</i> ; the effortful struggle of coming to terms with loss is not represented.
Complex nature of coping with loss	Takes no account of recuperative purpose of avoiding reality of death at times of doing other things to regain strength to cope.
Inclusion of poorly defined concepts	Stage formulations incorporate broad, imprecise terms (some stages are emotions, some cognitive processes; e.g., “depression” could range from clinical depression to sadness).
Implication of smooth progression	Notion of replacement of one stage by another poorly represents all we know about the course of grief over time, particularly regarding the fluctuations between emotions and cognitions that typify grief and grieving.
Prescriptive statements/interpretations	“Anger is a necessary stage of the healing process. Be willing to feel your anger, even though it may seem endless. The more you truly feel it, the more it will begin to dissipate and the more you will heal” (Kübler-Ross & Kessler, 2005, p. 12). While anger is a common grief symptom (Archer, 1999), evidence shows it is not a universally experienced emotion (Bonanno & Keltner, 1997; Shuchter & Zisook, 1993).
Failure to account for secondary stressors	Lack of attention to other stressors not related to grief that needs to be taken into account in assessing adaptation (e.g., ongoing life changes, new roles, and identities).
Neglect of the social/cultural context of grieving	Neglects broader social context of grief and grieving. No account of interpersonal factors (e.g., processes relating to family members coping together; Stroebe & Schut, 2015), culturally shared meanings (Rosenblatt, 1983, 2013), social relations and power dimensions (Thompson, 2002), and historical and cross-cultural influences (Jalland, 2013).

provide evidence for the sequence of stages in general, nor does it follow that the stages should be taught or used in therapy. Silver and Wortman (2007) stated:

A mistaken belief in the stage model . . . can have devastating consequences. Not only can it lead bereaved persons to feel that they are not coping appropriately, but

Table 2. Empirical Investigation of Stage Theory: Claim and Refutation.

Authors	Study Overview	Comments
Barrett and Schneweis (1981)	Investigated shorter versus longer term adjustment among older adults through in-depth interviews. Finding few differences according to length of bereavement and multiple continued difficulties among those bereaved for many years, the authors concluded that adjustment does not transpire through successive stages but continues to be stressful long after bereavement.	An early exception to the general lack of empirical investigation
Bonanno (2009); Bonanno et al., (2002)	Identification of trajectories of grief based on prospective, longitudinal data spanning from the time before the loss to the time after. Research showed the kind of grief trajectory that would resemble the notion of grief stages is far from being the most dominant pattern. Grief trajectories were first identified based on the changing lives of older couples study (CLOC; Bonanno et al., 2002; Bonanno, Wortman, & Nesse, 2004). Nearly half of the CLOC participants (46%) were labeled as “resilient” because they reported stable low distress levels over the course of the study. Only 11% showed the trajectory of grief traditionally assumed to be common (low distress prior to the death; then after the death, moving from high distress to low distress over time). Another trajectory identified in this study, labeled as “depressed improved,” reflected elevated distress before and improvement after the loss (10%). A similar drop in distress levels postdeath was found in prospective studies with pre- and postdeath data from dementia caregivers (Aneshensel, Botticello, & Yamamoto-Mitani,	Strong evidence against the occurrence of stages without directly testing them

Table 2. Continued

Authors	Study Overview	Comments
Maciejewski, Zhang, Block, and Prigerson (2007)	<p>2004; Schulz et al., 2003; Zhang, Mitchell, Bambauer, Jones, & Prigerson, 2008) as well as more general caregiver samples (Li, 2005). Only about 17% showed a distress trajectory reflecting the so-called "common" grief after the death (Aneshensel et al., 2004; Zhang et al., 2008).</p> <p>Claimed to have accomplished the first true empirical examination of the stage theory and found evidence supporting the stages. Examined the patterns of change in five stages symptoms (representing disbelief, yearning, anger, depression, and acceptance) over time. They drew the following conclusion: "Identification of the normal stages of grief following a death from natural causes enhances understanding of how the average person cognitively and emotionally processes the loss of a family member" (p. 16).</p>	<p>Letters to the editor of <i>The Journal of the American Medical Association</i> (which published this work) raised questions about the design and methodological features of the study (Bonanno & Boerner, 2007), shedding serious doubt on the soundness of the empirical foundation for this claim (see also Friedman & James, 2008, p. 38; Weiner, 2007, for further critical evaluations).</p> <p>Prigerson and Maciejewski subsequently suggested relabeling and reconceptualizing stages as "multidimensional grief states that evolve and diminish in intensity over time" (2008, p. 436), leaving unclear whether they still endorse their earlier claim re: stages usefulness</p>
Holland and Neimeyer (2010)	<p>A "conceptual replication and extension of these findings" of Maciejewski et al. (2007, p. 103). They concluded that their additional results were neither corroborative nor entirely inconsistent with stage theory.</p>	

Table 3. Moving Beyond the Stages of Grief and Grieving: Suggestions and Guidelines.

1. Nonexistence of stages	<ul style="list-style-type: none">• Grieving is not a stage-like, sequential, orderly, predictable process across time• Bereaved people do not (and should not expect to) go through a set pattern of specific reactions.• Grief can involve complex, fluctuating, emotional reactions (sometimes experienced as a “roller coaster”).• There are different patterns of “normal” (as well as complicated) ways of grieving.• Patterns vary greatly in terms of specific reactions, time-related changes, and duration of acute grieving period.• There are large individual/cultural differences in reactions to loss.• There is no sound scientific basis for Kübler-Ross’s stages.• The aim of theoretical models is to understand (and try to explain) the grieving process, not to be prescriptive about what people have to go through.• There are alternative scientific perspectives that better represent the course of grief and grieving (e.g., trajectories approach (Bonanno, 2004), cognitive stress theory (Folkman, 2001), meaning making approach (Neimeyer, 2001), psychosocial transition model (Parke, 1971), two-track model (Rubin, 1981), dual process model (Schut & Stroebe, 1999), new model of grief (Walter, 1996), and task model (Worden, 1982). For a review, see Stroebe and Schut (2001).
2. Theoretical considerations	<ul style="list-style-type: none">• Most bereaved people adjust to their loss in their own manner (not through stages) over the course of time.
3. Clinical implications	<ul style="list-style-type: none">• It is wrong to expect bereaved people to go through stages of grief in order to adapt.• Not experiencing stages does not mean that grieving is running a complicated course (only a minority of bereaved people need professional help; most do fine with their informal support networks/own resources).• Counselors, clinicians, and other health-care professionals should not use stages as guidelines for bereaved clients.• Placing expectations on bereaved people about needing to experience stages of grief can be harmful.
4. Practical moves/actions to be taken	<ul style="list-style-type: none">• Develop strategies to ensure that stage theory loses its appeal and is no longer taught or practiced.• Develop guidelines to promote a shift away from the use of stage theory.• Produce flyers for circulation to researchers/clinicians/bereaved persons and those in their networks.

(continued)

Table 3. Continued

	<ul style="list-style-type: none"> • Inform people of nonexistence of set stages and existence of theoretical developments/alternative perspectives. • <i>The Internet</i>: Start a drive to better inform Internet sites (e.g., bereavement support services) against promoting the stages approach and to detail alternative approaches/premises. <i>Teaching</i>: Inform teachers of death, dying, and bereavement courses; scrutinize content of textbooks and syllabuses; and revise the teaching of stage theory to present it only as a historical entity. <i>Health-care professionals</i>: Spread the word, this article.
5. Derive postulates	<ul style="list-style-type: none"> • Stage theory should not be used by practitioners (e.g., physicians, counselors, therapists, social workers) or by bereaved people themselves as a framework to guide understanding of (others' or own) grieving. • It should only be taught as part of curricula in courses of death, dying, and bereavement in its historical context and as an unacceptable assumption (cf. Weinstein [Holland & Neimeyer, 2010] in Thompson, 2002, p. 196). • Bereaved people need to know <i>not</i> to expect to go through stages.

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 professional. (p. 2692)

Such fears were endorsed by Friedman and James (2008) who expressed concern about the “horror stories . . . heard from thousands of grieving people who’ve told us how they’d been harmed by them.”

Many writers have also drawn attention to the dangers for bereaved people of prescriptive interpretation. The stages, it was often said, were meant to be descriptive. However, they have been taken to be prescriptive (browsing the Internet provides ample evidence). Caregivers mention clients worrying because they are not experiencing the stages in “the right order” (and that a not-uncommon reason for seeking professional help is a failure to experience one or more of the stages of grief). Whatever the intention, the theory promotes the idea of an orderly progression through distinct periods of grief and grieving, ones which can be identified and described by particular features.

Conclusions

Where do these criticisms leave us? Certainly, Kübler-Ross’s enormous impact must be acknowledged. Her writing (indeed, her whole extraordinary career) drastically altered the care and treatment of dying patients (see, e.g., Friedman & James, 2008). Her work brought death and dying out of the closet. Furthermore, bereaved people stand to benefit from her compassionate, easily accessible writing and teaching. However, such merits are on a completely different level from evaluation of the actual stages; it does not follow that the stages are adequate representations of what grieving people go through.

Why has stage theory been so impossible to dislodge from its favored position among many teachers, clinicians, and clients? The abiding appeal is perhaps its simplicity. In the midst of such emotional complexity as characterizes the bereavement experience, the stages offer something to hold on to, both descriptively and prescriptively. Bereaved people want to know what to expect and how long the upset will last (Friedman & James, 2008). As Hall (2014) expressed, “Stage theories have a certain seductive appeal—they bring a sense of conceptual order to a complex process and offer the emotional promised land of ‘recovery’ and ‘closure’” (p. 8).

What we need, then, is not a plethora of alternative perspectives but an accessible, easily comprehensible, informative, single substitute for stages (but one that at least attempts explanation at a theoretical level). In our view, we should aim for further theoretical integration. Having a range of alternatives presents a weak, nonunited front to stage theory. That is perhaps a major next step for researchers to take: to work toward developing a theory that explains the process of dealing with loss and ongoing life, reflecting the experience of

bereaved persons, their thoughts, and feelings. Indeed, some of the perspectives [e.g., trajectories, Dual Process Model of Coping with Bereavement (DPM), meaning making] are compatible in important ways (e.g., in their focus on both loss and change; Marris, 1974; Parkes, 1971; Stroebe & Schut, 2015). Furthermore, concrete steps must be taken to encourage the move beyond stages in practical as well as in such theoretical terms (see Table 3).

In summary, the critical points outlined earlier provide a strong case for abandoning the stage theory of grief and grieving. We have argued that, while it is the nature of the endeavor that scientists try to identify regularities, the regularities of stage theory are too simplistic and limited; they fail to represent the complex emotions and processes of grief and grieving. They also lack empirical foundation. Using stages in practice is potentially harmful, and yet an (perhaps *the*) ultimate goal of theory construction in our field is to enable health-care professionals to provide tangible help to those who need it.

Therefore, our urgent appeal is for the stages to be relegated to the shelves of history. They are, after all, only “manmade”: As Rosenblatt (1983) puts it, “The stages are, of course, mental constructions of researchers, clinicians, and theoreticians. They are not real, quite abruptly delineable sets of events that are obvious to any observer” (pp. 38–39). It is our sincere hope that this article will help eradicate adherence to stage theory and promote discussion of alternatives, in the best interests of bereaved people and those who endeavor to support them.

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Note

1. The question whose ideas they were in the first place has been raised (Archer, 1999; Bonanno, 2009; Parkes, 2013). Kübler-Ross was inspired by the earlier work of Bowlby and his collaborators but failed to acknowledge such origins. In Parkes’ (2013) words:

her claim in *On death and dying* to have discovered the ‘stages of grief’ fails to mention that these stages were originated by James Robertson and John Bowlby in their studies of children separated from their mother (Robertson & Bowlby, 1952) and applied by Bowlby and myself (Bowlby & Parkes, 1970) to the reactions of adults suffering bereavements. She knew about our work, for I met her and lectured on the subject at Billings Hospital, where she was doing her research She makes no reference to this work in her text. (p. 95)

References

- Aneshensel, C. S., Botticello, A. L., & Yamamoto-Mitani, N. (2004). When caregiving ends: The course of depressive symptoms after bereavement. *Journal of Health and Social Behavior, 45*(4), 422–440.
- Archer, J. (1999). *The nature of grief: The evolution and psychology of reactions to loss*. Florence, KY: Routledge.
- Balk, D. (2011). Ruth Konigsberg's demythologizing project. *Death Studies, 35*(7), 673–678.
- Barrett, C. J., & Schneeweis, K. M. (1981). An empirical search for stages of widowhood. *Omega (Westport), 11*(2), 97–104.
- Boerner, K., Stroebe, M., Schut, H., & Wortman, C. B. (2015). Theories of grief and bereavement. In N. Pachana (Ed.), *Encyclopedia of geropsychology* (pp. 1–10). Singapore: Springer.
- Bolden, L. A. (2007). A review of on grief and grieving: Finding the meaning of grief through the five stages of loss. *Counseling and Values, 51*(3), 235–238.
- Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59*(1), 20.
- Bonanno, G. A. (2009). *The other side of sadness: What the new science of bereavement tells us about life after loss*. New York, NY: Basic Books.
- Bonanno, G. A., & Boerner, K. (2007). The stage theory of grief. *The Journal of the American Medical Association, 297*(24), 2692–2694.
- Bonanno, G. A., & Keltner, D. (1997). Facial expressions of emotion and the course of conjugal bereavement. *Journal of Abnormal Psychology, 106*(1), 126.
- Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., . . . Nesse, R. M. (2002). Resilience to loss and chronic grief: A prospective study from preloss to 18-months postloss. *Journal of Personality and Social Psychology, 83*(5), 1150.
- Bonanno, G. A., Wortman, C. B., & Nesse, R. M. (2004). Prospective patterns of resilience and maladjustment during widowhood. *Psychology Aging, 19*(2), 260.
- Bowlby, J. (1980). *Attachment and loss*. London, England: Hogarth Press & Institute of Psychoanalysis.
- Bowlby, J., & Parkes, C. M. (1970). Separation and loss within the family. In E. Anthony (Ed.), *The child and his family* (pp. 167–216). New York, NY: Wiley.
- Corr, C. (1993). Coping with dying: Lessons that we should and should not learn from the work of Elisabeth Kübler-Ross. *Omega (Westport), 17*(1), 69–83.
- Corr, C. (2011). Strengths and limitations of the stage theory proposed by Elisabeth Kübler-Ross. In K. Doka & A. Tucci (Eds.), *New perspectives on dying, death, and grief* (pp. 3–16). Washington, DC: Hospice Foundation of America.
- Corr, C. (2015). Let's stop "staging" persons who are coping with loss. *Illness, Crisis & Loss, 23*(3), 226–241.
- Doka, K., & Tucci, A. (2011). *New perspectives on dying, death, and grief*. Washington, DC: Hospice Foundation of America.
- Folkman, S. (2001). Revised coping theory and the process of bereavement. In M. Stroebe, R. Hansson, W. Stroebe & H. Schut (Eds.), *Handbook of bereavement*

- research: *Consequences, coping, and care* (pp. 563–584). Washington, DC: American Psychological Association Press.
- Friedman, R., & James, J. W. (2008). The myth of the stages of dying, death and grief. *Skeptical, 14*, 37–42.
- Hall, C. (2014). Bereavement theory: Recent developments in our understanding of grief and bereavement. *Bereavement Care, 33*(1), 7–12.
- Holland, J. M., & Neimeyer, R. (2010). An examination of stage theory of grief among individuals bereaved by natural and violent causes: A meaning-oriented contribution. *Omega (Westport), 61*(2), 103–120.
- Horowitz, M. (1976). *Stress response syndromes*. New York, NY: Jason Aronson.
- Jacobs, S. (1993). *Pathologic grief: Maladaptation to loss*. Washington, DC: American Psychiatric Association.
- Jalland, P. (2013). Bereavement in the English family 1850–1980: Exploring change over time. *Family Science, 4*(1), 4–11.
- Jurecic, A. (2015). No protocol for grief. *The Lancet, 386*(9996), 848–849.
- Konigsberg, R. (2011). *The truth about grief: The myth of its five stages and the new science of loss*. New York, NY: Simon and Schuster.
- Kübler-Ross, E. (1969). *On death and dying*. New York, NY: Macmillan.
- Kübler-Ross, E., & Kessler, D. (2005). *On grief and grieving: Finding the meaning of grief through the five stages of loss*. New York, NY: Scribner.
- Li, L. W. (2005). From caregiving to bereavement: Trajectories of depressive symptoms among wife and daughter caregivers. *The Journals of Gerontology B: Psychological Sciences and Social Sciences, 60*(4), P190–P198.
- Lopata, H. Z. (1975). On widowhood: Grief work and identity reconstruction. *Journal of Geriatric Psychiatry, 8*, 41–55.
- Maciejewski, P. K., Zhang, B., Block, S. D., & Prigerson, H. G. (2007). An empirical examination of the stage theory of grief. *The Journal of the American Medical Association, 297*(7), 716–723.
- Marris, P. (1974). *Loss and change*. London, England: Routledge & Kegan Paul.
- McGorry, P. D. (2007). Issues for DSM-V: Clinical staging: A heuristic pathway to valid nosology and safer, more effective treatment in psychiatry. *The American Journal of Psychiatry, 164*(6), 859–860.
- Neimeyer, R. (2000). Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death Studies, 24*(6), 541–558.
- Neimeyer, R. (2001). *Meaning reconstruction and the experience of loss*. Washington, DC: American Psychological Association.
- Neimeyer, R. (2012). The (half) truth about grief. *Illness, Crisis & Loss, 20*(4), 389–395.
- Osterweis, M., Solomon, F., & Green, M. (1984). *Bereavement: Reactions, consequences, and care*. Washington, DC: National Academy Press.
- Parkes, C. M. (1971). Psycho-social transitions: A field for study. *Social Science & Medicine, 5*(2), 101–115.
- Parkes, C. M. (1996). *Bereavement: Studies on grief in adult life* (1st/3rd ed.). New York, NY: International Universities Press. (Original work published 1972)
- Parkes, C. M. (2006). *Love and loss: The roots of grief and its complications*. London, England: Routledge.

- Parkes, C. M. (2013). Elisabeth Kübler-Ross, on death and dying: A reappraisal. *Mortality*, 18(1), 94–97.
- Prigerson, H. G., & Maciejewski, P. K. (2008). Grief and acceptance as opposite sides of the same coin: Setting a research agenda to study peaceful acceptance of loss. *The British Journal of Psychiatry*, 193(6), 435–437.
- Robertson, J., & Bowlby, J. (1952). Responses of young children to separation from their mothers. II Observations of the sequence of response of children aged 18 to 24 months during the course of separation. *Courier*, 3, 131–142.
- Rosenbaum, R. (1982). Turn on, tune in, drop dead. *Harpers (N Y N Y)*, 265(1586), 32–37.
- Rosenblatt, P. (1983). *Bitter, bitter tears: Nineteenth-century diarists and twentieth-century grief theories*. Minneapolis, MN: University of Minnesota Press.
- Rosenblatt, P. (2013). Family grief in cross-cultural perspective. *Family Science*, 4(1), 12–19.
- Rubin, S. (1981). A two-track model of bereavement: Theory and application in research. *American Journal of Orthopsychiatry*, 51(1), 101.
- Sanders, C. M. (1989). *Grief: The mourning after: Dealing with adult bereavement*. Chichester, England: Wiley.
- Schulz, R., Mendelsohn, A. B., Haley, W. E., Mahoney, D., Allen, R. S., Zhang, S., . . . Belle, S. H. (2003). End-of-life care and the effects of bereavement on family caregivers of persons with dementia. *The New England Journal of Medicine*, 349(20), 1936–1942.
- Schut, M., & Stroebe, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies*, 23(3), 197–224.
- Shear, M. K. (2015). Complicated grief. *The New England Journal of Medicine*, 2015(372), 153–160.
- Shuchter, S. R., & Zisook, S. (1993). The course of normal grief. In M. Stroebe, W. Stroebe & R. Hansson (Eds.), *Handbook of bereavement: Theory, research and intervention* (pp. 23–43). New York, NY: Cambridge University Press.
- Silver, R. C., & Wortman, C. B. (1980). Coping with undesirable life events. In J. Garber & M. Seligman (Eds.), *Human helplessness: Theory and applications* (pp. 279–375). New York, NY: Academic Press.
- Silver, R. C., & Wortman, C. B. (2007). The stage theory of grief. *The Journal of the American Medical Association*, 297, 2692–2694.
- Stroebe, M., & Schut, H. (2001). Models of coping with bereavement: A review. In M. Stroebe, R. Hansson, W. Stroebe & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 375–403). Washington, DC: American Psychological Association Press.
- Stroebe, M., & Schut, H. (2015). Family matters in bereavement: Toward an integrative intra- interpersonal coping model. *Perspectives on Psychological Science*, 10(6), 873–879.
- Thompson, N. (2002). *Loss and grief: A guide for human services practitioners*. Basingstoke, England: Palgrave Macmillan.
- Walter, T. (1996). A new model of grief: Bereavement and biography. *Mortality*, 1, 7–15.
- Weiner, J. S. (2007). The stage theory of grief. *The Journal of the American Medical Association*, 297(24), 2692–2694.

- Worden, J. (1982). *Grief counseling and grief therapy: A handbook for mental health practitioner* (1st ed.). New York, NY: Springer.
- Wortman, C. B., & Silver, R. C. (1987). Coping with irrevocable loss. In G. VandenBos & K. Bryant (Eds.), *Cataclysms, crises, and catastrophes: Psychology in action* (pp. 189–235). Washington, DC: American Psychological Press.
- Wortman, C. B., & Silver, R. C. (1989). The myths of coping with loss. *Journal of Consulting and Clinical Psychology, 57*(3), 349–357.
- Wortman, C. B., & Silver, R. C. (1992). Reconsidering assumptions about coping with loss: An overview of current research. In S. Filipp, L. Montada & M. Lerner (Eds.), *Life crises and experience of loss in adulthood* (pp. 341–365). Hillsdale, NJ: Erlbaum.
- Zhang, B., Mitchell, S. L., Bambauer, K. Z., Jones, R., & Prigerson, H. G. (2008). Depressive symptom trajectories and associated risks among bereaved Alzheimer disease caregivers. *The American Journal of Geriatric Psychiatry, 16*(2), 145–155.

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Margaret Stroebe is Professor Emeritus at both the Department of Clinical and Health Psychology, Utrecht University, and the Department of Clinical Psychology and Experimental Psychopathology, University of Groningen, The Netherlands. She has specialized in the field of bereavement research for many years. With Henk Schut she developed the Dual Process Model of Coping with Bereavement. Her book publications include “Bereavement in Later Life: Coping, Attachment, and Developmental Influences” (2007) with Robert Hansson. She edited “Complicated Grief: Scientific Foundations for Health Care Professionals” (with Henk Schut and Jan van den Bout) in 2013. Her current interests still cover theoretical, empirical, and reviews of the bereavement area (e.g., critical evaluation of coping models, intervention efficacy; implementation of network analyses; health consequences) as well as investigation of the “mini-grief” of homesickness. Her honors include an Honorary Doctorate from the University of Louvain-la-Neuve, Belgium, the Scientific Research Award of the American Association of Death Education and Counseling, in the U.S.A., and the title in 2011 of Officer of the Order of Orange Nassau, in the Netherlands.

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