

# 16 A scientist's role in bereavement research

## The case of Wolfgang Stroebe

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### How did it all start?

Writings on the health consequences of bereavement can be traced back across many centuries, with fascinating contributions as long ago as the seventeenth century. One widely read and highly influential book, first published in 1621, was Robert Burton's *The anatomy of melancholy* (republished in 1977). Burton drew the conclusion that grief can have negative effects on those smitten with it. He cited cases such as the suicide of Aegeus, who drowned himself, "impatient of sorrow for his son's death" (p. 360). Another landmark was the publication of probably the first systematic examination of differential mortality rates across marital statuses by William Farr (1858), who reported excesses in deaths among widowed persons and went on to comment: if "unmarried people suffer from disease in undue proportion the have been married [by whom he meant the widowed] suffer still more" (p. 440).

Clinical investigations of bereavement began in earnest, though, only during the early part of the twentieth century (Freud, 1917). Attention initially focused on the implications of bereavement for mental health and pathological reactions. In the 1930s and 40s, however, investigators began to broaden that focus to examine more normal grieving reactions and how they might differ from pathological grief. Clinical work by Lindemann (1944), for example, led to a formulation of the nature of grief as a syndrome, its component symptom clusters, and its course. The most striking features of

the grief response were established through his work not only with patients suffering from ulcerative colitis, but also bereaved victims of the so-called Coconut Grove fire disaster. Despite the unusual composition of his sample, Lindemann was able to identify most of the features of the grief response typically observed with recently bereaved individuals, including somatic distress, preoccupation with the image of the deceased, guilt feelings, hostile reactions to others, and loss of usual patterns of activity.

This focus on normal grief raised a host of related questions among researchers from many disciplines; Lindemann's conceptualisation of grief-related symptomatology was generally replicated, expanded, and refined using diverse samples of persons experiencing normal bereavements (e.g., Parkes, 1972/1996; Parkes & Weiss, 1983). Particular attention focused on short- and long-term consequences for physical and psychological health, potential social and economic consequences of widowhood (e.g., Lopata, 1993, 1996), and the identification of individuals (or classes of individuals) who might be at greater risk for poor outcome (e.g., Sanders, 1989). Ethnographic studies offered insights into cultural factors that shape the experience and symptomatology of grief (Rosenblatt, Walsh, & Jackson, 1976). Studies of informal and formal interventions began, targeting bereaved persons experiencing both complicated and uncomplicated bereavements (e.g., Marmar, Horowitz, Weiss, Wilner, & Kaltreider, 1988; Raphael, 1977). Theory development progressed within many disciplines to account for the increasing complexity apparent in bereavement (M. Stroebe, Stroebe, & Hansson, 1993). Research relating bereavement phenomena to more fundamental topics in emotion, human development, and social-psychological process, and assessing the applicability to bereavement of broader models of stress and coping, began to appear. Demographers, epidemiologists, and health planners examined implications for the future of medical practice and for public institutions.

Originally, the burgeoning body of bereavement research was greatly fragmented, with investigators throughout the world often pursuing research questions specific to their clinical or academic discipline, publishing in their own disciplinary journals, and seldom locating their work in the context of other perspectives. Integration was much needed. From the 1980s onwards, this goal was furthered through a series of interdisciplinary volumes co-edited by Wolfgang Stroebe. Other major reviews across the decades include Archer, 1999; Genevro, Marshall, and Miller, 2004; Osterweis, Solomon, and Green, 1984; Parkes, 1972; Raphael, 1983; Walter, 1999. It was, in fact, about this time that Stroebe entered the field of bereavement research—but more of that shortly.

In the first of these co-edited volumes, *Bereavement and widowhood* (Hansson, Stroebe, & Stroebe, 1988), topics ranged from the psychobiology of loss to the social/cultural context of grief, risk factors, support systems, and counselling and therapy. This volume's special contribution to the field was its emphasis on the interpersonal implications of loss and adaptation, in addition to the more usual intra-personal focus on individual experience and

coping. The volume focused solely on widow(er)hood—other types of intense loss experiences (including loss of a child, parent, or sibling, etc.) were beyond consideration.

The bereavement field expanded rapidly in the years following this first publication. This was reflected in the range of topics in the second integrative review, *Handbook of bereavement: Theory, research, and intervention* (M. Stroebe et al., 1993). One section of this work focused on contrasting conceptualisations of normal and pathological grief. Another expanded theoretical coverage of the nature of grief, contrasting social, cognitive, anthropological, and clinical perspectives. Topics addressed also included animal loss, neuroendocrine changes, mortality, late-life bereavement, and the different types of loss (death of a child, parent, partner to AIDS, and the experience of Holocaust survivors), all of which were absent in the previous volume. The field was expanding fast, not only with respect to the scope of subject matter available but also in provision of its review.

A completely new range of topics again was featured in the third volume *Handbook of bereavement research: Consequences, coping, and care* (M. Stroebe, Hansson, Stroebe, & Schut, 2001). Similarly reflecting developments in the field, emphasis was placed on novel theoretical approaches, as well as on stringent methodology and ethical rigour in empirical investigation. More sophisticated research had been conducted, particularly in the areas of coping, lifespan development, risk factors, psychotherapeutic and pharmacological interventions, and efficacy in treatment for bereavement. The fact that there were 29 robust chapters on such a range of topics, from authors across many countries of the world, shows that bereavement research had come a long way and could by then be considered an established scientific discipline.

An abiding topic of concern across the decades sketched above dealt with the most extreme consequence of the loss of a loved one, namely the mortality of bereavement: Is it really the case that people can die of a broken heart following the death of a loved one? This merits closer inspection.

### **Death causing death?**

It was within this line of inquiry that Wolfgang Stroebe entered the field of bereavement research. It started like this, as Kenneth and Mary Gergen remember:

In the spring of 1977 Wolfgang and Margaret Stroebe invited Kenneth and Mary Gergen, to visit Schwabia, Germany. Late one afternoon, they arrived in the village of Murrhardt, where they decided to take a walk. They discovered an ancient cemetery and started perusing the grave-stones. They noticed among the husbands and wives buried next to each other how remarkably similar their death dates were. This observation became the focus of animated dinner conversation. Is it possible that the

death of one's mate could hasten the death of the remaining spouse? How could such a pattern be explained? A plan was made to re-visit the graveyard the following morning and take down birth and death dates of all the couples in the cemetery in order to do some later analysis. So out they went, roving among the gravestones (despite a raging rainstorm that soaked their pages), to collect their data. Little did they know what lay ahead.

As the data analysis subsequently demonstrated, their suspicions were confirmed. By comparing the death date of the remaining spouse with the death date of the deceased as opposed to a randomly selected individual with the same birth date, they found that, on average, losing one's mate could have a significant impact on one's lifespan. This generated much speculation regarding possible causes. Were these the results of loss of desire to live, with attendant loss in self-care? Perhaps the single individual during these early times could not manage adequately alone. Or, perhaps couples suffered similar diseases. Whatever the reason, both the findings and the causes deserved further attention. While gathering data they coined the phrase *loss effect*, to refer to the reduction in lifespan resulting from the loss of a loved one.

They first published the results of their review of the mortality research area in German (W. Stroebe, Stroebe, Gergen, & Gergen, 1980). Scanning further sources they were also able to reach the tentative conclusion that men were more vulnerable than women to the death of their spouse, and that the death of a child could significantly decrease the lifespan of a parent (M. Stroebe, Stroebe, Gergen, & Gergen, 1981). They then went on to formulate tentative conclusions as to the dynamics underlying the loss effect (W. Stroebe, Stroebe, Gergen, & Gergen, 1982). Subsequently, these early explorations led to what became known as the Tübingen longitudinal study of bereavement, a large-scale research project mounted by the Stroebees and their colleagues at the University of Tübingen to generate a more thorough understanding of the effects of bereavement on health.

### **Where did it all go?**

The main objectives of the Tübingen study were the examination of (a) consequences of bereavement on the health of the widowed across time, and (b) factors associated with health risks in bereavement outcome (cf. W. Stroebe, Stroebe & Domittner, 1987). This project was theoretically based on the Stroebees' deficit model of partner loss (W. Stroebe & Stroebe, 1986, 1987; W. Stroebe et al., 1980; W. Stroebe et al., 1982), which was derived from cognitive stress theory (see Lazarus & Folkman, 1984, and Folkman & Moskowitz, Chapter 12, this volume). The Tübingen study was further designed to examine a series of more specific questions that were either derived from the deficit model of partner loss or were controversial issues

raised in the literature, which needed careful investigation. The use of sophisticated design and methodology in addressing these issues was characteristic of the study, a central feature being the use of a carefully matched non-bereaved control group. Furthermore, it involved two data-collection techniques: questionnaires and interviews. Among other things, this allowed collection of questionnaire data from some of the bereaved who did not want to participate in the study (but who agreed to fill out a questionnaire); this made the examination of a probable selection bias possible (M. Stroebe & Stroebe, 1989). We return to this in the next section.

A sample of 30 widows and 30 widowers mostly in their early fifties was included in the study. These persons were individually matched by sex, age, socioeconomic status, and number of children to 60 married persons. Data were collected by extended structured interviews and questionnaires at three time points: 4–7 months after bereavement, and approximately 14 months and 2 years after loss (see W. Stroebe et al., 1987, or W. Stroebe & Stroebe, 1993).

Many variables were investigated in the Tübingen study, but here we focus on major issues to do with differential patterns of selection in bereavement research, bereavement-specific health trajectories (i.e., identifying individual difference factors in adjustment that are not just reflections of risk factors in the general population), and the role of coping in adaptation to loss. These selections serve to illustrate how an individual research programme such as the Tübingen study fits within the more general developments in bereavement research across the decades of the twentieth century, as outlined above.

### **Who participates in bereavement research?**

At first, this question may seem mundane, but in fact it is critical in bereavement research. Bereaved people are frequently distressed and vulnerable. No pressure should be put on them to participate in research on bereavement, and in fact, large proportions choose to turn down such a request (M. Stroebe & Stroebe, 1989). When investigating the health consequences of loss, then, every researcher needs to ask the question how representative are the bereaved persons in their samples of the bereaved in general. The decision not to participate may have much to do with grief status and health status (frequently these are the very variables under investigation), but this may be related to different underlying health-related factors: Do they refuse because they have come to terms with their grief, are feeling good, and want to move on? Or is the opposite the case: are they so overwhelmed by their loss and suffering from health problems that they cannot face taking part in a bereavement study? Both alternatives seem plausible.

Surprisingly, these potential biases had (and still have) received very little empirical investigation. Such selection bias was a major worry in setting up the Tübingen study, but it is potentially, of course, a very difficult matter to investigate (most particularly for ethical reasons: those who refuse should be

left in peace). However, what could be done (taking care not to put pressure on them) was to ask persons who refused participation, first, if they would share their reasons for refusal, and second, and uniquely in this study, if they did not want to be interviewed, whether they felt able to fill in a postal questionnaire. A sufficient number of “refusers” agreed to fill in questionnaires, enabling comparisons with those who had participated in interviews on health measures.

At first glance, the results seemed reassuring: for example, there was no significant difference between interview participants and refusers in depression levels. It seemed that, so far as could be evaluated on the basis of these data, results from the participants could be taken as representative of the bereaved in general. Closer examination, however, identified an interaction: when gender differences were examined, it emerged that while widows who were (significantly) more depressed more frequently agreed to participate in interviews, quite the opposite was the case for widowers: the more depressed men were refusing interviews and agreeing simply to answer the postal questionnaires.

These patterns were understood in terms of traditional gender roles, which would mostly pertain among these participants in southern Germany at the time of the study. Men would have felt more uncomfortable showing distress in front of strangers, whereas for women crying and expressing emotions would be less of a problem.

The implications for interpretation of gender differences in health following bereavement in the Tübingen study were far reaching: conclusions about well-being among widows based on the interview respondents would likely overestimate distress, while for widowers, they would underestimate it (M. Stroebe & Stroebe, 1989). There is every reason to believe that such biases are present in other data sets, and similar caution is always needed in interpreting results.

### **Does help help?**

Another important interaction effect that could be examined in the framework of the study was the well-known social support perspective’s “buffering hypothesis”. In fact, the results of the study could be evaluated from the perspectives of two very different—but both highly impactful—theories, namely the social support and attachment perspectives, as we shall see.

The buffering hypothesis (Cohen & Wills, 1985) proposed that social support (support from family and friends) is a protective factor against stress. Applied to bereavement (W. Stroebe & Stroebe, 1987), one would assume that the widowed who have the supportive company of family and friends might be better able to deal with the loss experience and show fewer psychological symptoms than the widowed who lack social support. The idea here is that loss of a partner also means loss of social support; this deficit might be compensated to the extent that close others fulfil the supportive function of

the lost partner. In other words, the crucial prediction here is that of an interaction between marital status and social support: Whereas the bereaved with high social support would be somehow protected against detrimental consequences of partner loss, the widowed with low social support should show an excess in psychological symptoms as compared to their married counterparts.

This turned out not to be the case (W. Stroebe & Stroebe, 1987; W. Stroebe, Stroebe, Abakoumkin, & Schut, 1996). Social support exhibited only a main effect on symptoms (depression and somatic complaints), which contradicts the buffering hypothesis. However, this result is compatible with attachment theory (Bowlby, 1969; Weiss, 1975). A marital partner is an attachment figure providing feelings of security. Losing such a person cannot be simply compensated by support from family and friends; an attachment figure is probably only to be replaced by another attachment figure. Nevertheless, it is important to keep in mind that a supportive social network plays a role in its own right.

Weiss (1975, Chapter 15, this volume) proposed that deficits either with respect to attachment figures or social network might result in two distinct types of loneliness: If an attachment figure is lacking, emotional loneliness occurs, while a deficit in social network is associated with social loneliness. Loneliness is seen as the mediating mechanism between a deficit and psychological symptoms. Yet, depending on the type of deficit, a different type of loneliness mediates the relation between deficit and symptomatology. According to this reasoning, both marital status and social support should have an impact on symptomatology, however via two distinct pathways, namely emotional and social loneliness respectively. That is in fact what emerged from the Tübingen study (W. Stroebe et al., 1996).

All in all, the pattern of results provided more support for the attachment than the social support perspective. Losing a partner means losing a major attachment figure, for which social support from family and friends (though generally useful to bereaved and non-bereaved alike) cannot compensate. This finding is consistent with sentiments expressed by bereaved persons in the Tübingen study, who explained to the investigators that, while they found their friends and other family members around them to be a great help, these persons could in no way replace the lost loved one.

### **Does grief work work?**

Following Freud's early formulation, the notion that people have to do their grief work in order to come to terms with their loss became widely accepted. However, in the latter part of the twentieth century, a number of researchers called this notion into question (Rosenblatt, 1983; Wortman & Silver, 1989). The Tübingen study provided a testing ground for this hypothesis (M. Stroebe & Stroebe, 1991). The coping strategies of confrontation versus avoidance of grief could be examined in this data set, and their

impact on depression across the 2-year period of bereavement evaluated. In this way, an indication of the impact of doing grief work during the early months of bereavement could be obtained. Contrary to expectations, depression among the widows was not related to grief work. On the other hand, widowers seemed to profit somewhat more from confronting their grief.

This finding was interpreted as being in line with traditional social roles, which do not encourage disclosure of emotions among men. As regards the grief work hypothesis, the Stroebees suggested that “working through grief may not be as essential for adjustment to loss as has been frequently assumed” (W. Stroebe & Stroebe, 1993, p. 225).

These and other early findings (e.g., Rosenblatt, 1983; Wortman & Silver, 1989) were to fuel subsequent research, to which other researchers have also contributed in more recent years (e.g., Bonanno, 2001), but the early findings on grief work and gender differences were more intriguing than conclusive. Next we examine how they led beyond the Tübingen study data to further reviewing of bodies of research and conceptual analyses. We give two examples.

### **Who suffers more?**

Classic studies such as those of Parkes (1972/1996) had shown that both men and women suffered from poor health, distress, and depression following widowhood. But do widows or widowers suffer more, or are there similar responses between the genders? Impressions of caregiving professionals that, for example, widows show more depression and enter care programmes in greater numbers than widowers seemed to be confirmed by early research (M. Stroebe, Stroebe, & Schut, 2001), but we know that women in general get more depressed (Nolen-Hoeksema, 1987), that there are more widows than widowers, and that such factors as these—rather than a “true” excess in suffering—could account for the excessive number of widows, compared with widowers, in these statistics.

There was need for careful review of empirical studies on gender differences in the health consequences (including mental and physical health and mortality) of bereavement. Most of all, rates for non-bereaved counterparts need to be taken into account. This is because there are general (non-bereavement-specific) gender differences not only with respect to depression but also on other health consequences (e.g., mortality: males have higher rates). Thus, in such a review, *relative* rates of symptomatology need to be calculated in the following way: the rates of widower to married men’s rates need to be compared with widow to married women’s rates. When this was done, results were different from the impressions described above. If one compares carefully, controlling for the differences in total numbers in the different bereaved and control groups, it can be seen that what researchers have found is that widowers are *relatively* worse off than widows (M. Stroebe & Stroebe, 1983; M. Stroebe et al., 2001; M. Stroebe, Schut, & Stroebe, 2006).



In short, widowers suffer relatively higher rates of depression, and greater health consequences, most notably in their death rates, than widows.

Researchers need to conduct further empirical research to provide adequate explanation for this phenomenon. In all likelihood, leads will be found through further investigation of differences in sex roles and relationships, in coping styles of widows and widowers, and with respect to factors to do with the whole context within which bereavement takes place for males and females.

### **To continue or break bonds?**

A second line of research that emerged from the earlier investigation of the grief work hypothesis had to do with the *functions* of grief work: should grief work be aimed at relinquishing dependency and re-establishing a full and productive life, or should it be directed towards continuing a healthy relationship with the deceased? In historical perspective, the former orientation was identified as modernist. Cultural modernism places a strong emphasis on rational decision making, autonomy, and continuous participation in the work force. From this perspective, continuous rumination on loss is maladaptive, and ultimately inimical to one's well-being. Yet, viewed in terms of cultural history, one could also locate the latter orientation. In this case life's meaning is located in one's intimate relationships. The loss of a loved one thus metaphorically threatens one with the breaking of the heart. The modernist pressure to "get one with life" is an intensification of the break, and counterproductive. Successful grieving means sustaining a relationship with the deceased. It seemed clear from this analysis that the relationship between health and grieving was culturally specific. Much depends on how loss is understood, and no one therapeutic formula for successful grief work was sufficient. These thoughts and their implications for multiple forms of successful grieving were then published in *American Psychologist* (M. Stroebe, Gergen, Gergen, & Stroebe, 1992).

The Stroebe and their colleagues then set out to explore these issues more extensively. At the present writing the question of healthy grieving still remains open. As M. Stroebe and Schut (2005) conclude in their comprehensive review of both clinical and empirical studies, "There is simply no choosing between the two apparent alternatives. Put simply, it has become evident . . . that certain types of continuing bonds may sometimes be helpful/harmful, whereas certain types of relinquishing bonds may sometimes be helpful/harmful" (p. 13). One may suppose that the door remains open to more fine-grained analyses of the various modes of healthy grieving, and in fact empirically examining the links between types of bonds and health outcomes is a major interest in contemporary research (e.g., Field, Gal-Oz, & Bonanno, 2003). Yet, if the effects of loss are vitally dependent on the interpretive processes of the survivors, and this process is embedded within continuing conversations—with loved ones, within the sub-culture, and

within the culture more generally—there may be no means of ultimately pinning down healthy forms of grieving. The challenge for the professional may be to contribute frames of meaning that can help these conversations to yield healthy benefits for all.

### **Where does it go from here?**

Not only the continuing bonds issue just discussed, but also the other questions raised above, are still major concerns in bereavement research in general and for Wolfgang Stroebe in particular. An emerging topic that encompasses nearly all of these strands is emotional disclosure (see Zech, Rimé, & Pennebaker, Chapter 17, this volume). For example, in the most recent review, many of these lines of argument were brought together, as indicated in the title, *Grief work, disclosure and counselling: Do they help the bereaved?*. The answers that the authors (W. Stroebe, Schut, & Stroebe, 2005) provided to this question have already attracted considerable attention, not only in the bereavement research field, but also in the popular media and among counsellors.

The article reviewed four research domains: social support, emotional disclosure, experimentally induced disclosure, and grief intervention. Within each area, the empirical evidence was put to stringent methodological test: were the claims made by the authors in terms of the benefits of, say, social support or professional intervention, really justified on the basis of the data collected? In none of these areas did the authors find sound empirical evidence that emotional disclosure facilitates adjustment to loss in *normal* bereavement—it simply takes time to heal from the loss of a loved one and precious little can be done to speed up the process.

### **In conclusion**

We have documented the development of scientific research on bereavement across several decades. We have illustrated the participation in this process of one scientist, Wolfgang Stroebe, posing here the sorts of questions that are typical of those that he himself asks. We have described the patterns of results that urged him on to further questions, mirroring the process of sequential exploration and discovery that is fundamental to scientific investigation. Fortunately for us, he did not do any of this work in isolation, but—quite typically—in interaction with others, including all of us. Thus, we have been able to reflect here with pleasure, from the inside of this particular scientific process.

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