THE FUNDAMENTAL PARADOX IN THE GRIEF LITERATURE: A CRITICAL REFLECTION

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ABSTRACT

A key theme in the bereavement literature is the recognition that every grief experience is unique and dependent on many variables, such as the circumstances of the death, characteristics of the bereaved individual, their relationship with the deceased, the provision and availability of support, and a myriad of sociocultural factors. Concurrently, there are corresponding efforts to define "normal" grief and delineate it from "complicated" grief experiences. The discord between these two potentially opposing statements remains a paradox evident within the three major tensions within the thanatological literature—the dominance of grief theories, the medicalization of grief, and the efficacy of grief interventions. Three recommendations for moving beyond the paradox are discussed—the provision of improved grief education for service providers, the bereaved, and the wider community; the conduct of research that emphasizes the context of grief and is relevant to service provision; and the examination of current grief interventions.

A clear and consistent theme within the thanatological literature is the assertion that the grief experience is very much affected and influenced by a myriad of variables and the interactions between these variables. Various key reviews (e.g., Center for the Advancement of Health, 2004; Sanders, 1993; W. Stroebe & Schut, 2001) indicate that these determinants that mitigate and obfuscate the

experience of grief are related to numerous factors: the circumstances of the death, such as whether or not the death was anticipated, violent, able to be prevented, or followed a lengthy illness; the relationship to the deceased, with closer relationships between the deceased and the bereaved usually yielding a potentially more distressing grief experience; the characteristics of the bereaved individual, including one's age, cognitive style, coping strategies, gender, spirituality/religiosity, previous life history, and concurrent crises; the availability, type, and extent of interpersonal support received by the bereaved, and whether or not the support is perceived as helpful by the bereaved; and an assortment of sociocultural factors that include the presence and perceived relevance of mourning rituals, customs, and traditions; the impact of the rise of the professional roles related to death and grief (e.g., morticians, counselors); attitudes toward death and dying; and whether or not the loss is "demoralized" (Fowlkes, 1990) or "disenfranchised" (Doka, 1989, 2002). Indeed, many authors agree that, based on the presence and interplay of these factors, every grief experience is unique (e.g., Center for the Advancement of Health, 2004; Kellehear, 2001; Rando, 1993; Winslade, 2001).

However, this assertion stands in stark contrast to similarly clear and consistent, yet parallel, discourse that attempts to describe "normal" grief and delineate it from what is not "normal." Indeed, the apparent conflict between the demarcation of "pathological" forms of grief and the concurrent identification of the circumstances of the bereavement that render it unique was described two decades ago as a "paradox" (Parkes & Weiss, 1983, p. 170). Parkes and Weiss further remarked, "it may well be that the pathological variations are no more than extreme forms that appear in response to particularly unfavorable circumstances" (pp. 15-16). This fundamental paradox underpins the three key tensions within the grief literature—the extent to which the classic grief theories, and the understandings of grief that emerge from them, can be applied to all grief experiences; the mounting trend toward the medicalization of grief, including the debate concerning "Complicated Grief Disorder" as a diagnostic category; and the efficacy of grief services and interventions. In the following section we summarize each tension and articulate the ways in which the fundamental paradox permeates each.

THE DOMINANCE OF CLASSIC GRIEF THEORIES

An examination of often cited articles and books published on grief over the past century reveals that our understandings of grief are based on a number of assumptions. These are: a) grief follows a relatively distinct pattern; b) grief is short-term and finite; c) grief is a quasi-linear process characterized by stages/ phases/tasks/processes of shock, yearning, and recovery; d) the grief process needs to be "worked through"; e) for people bereaved through illness, the work of grief begins in anticipation of the death; f) meaning in and/or positives gained from the death must be found; g) grief culminates in the detachment from the

deceased loved one; and h) the continuation of grief is abnormal, even pathological (see Breen, 2007; Center for the Advancement of Health, 2004; Davis, Wortman, Lehman, & Silver, 2000; Foote & Frank, 1999; Fulton, Madden, & Minichiello, 1996; Klass, Silverman, & Nickman, 1996; Lindstrøm, 2002; Rando, 1993; Valentine, 2006; Wortman & Silver, 1989, 2001).

The recent empirical evidence related to these assumptions is hardly supportive (e.g., Bonanno, 1998; Bonanno & Field, 2001; Bonanno & Kaltman, 2000; Center for the Advancement of Health, 2004; Davis et al., 2000; Lindstrøm, 2002; M. Stroebe & Schut, 2005; M. Stroebe, Stroebe, Schut, Zech, & van den Bout, 2002; Wortman & Silver, 1989, 2001), yet, these assumptions remain dominant in many settings. For example, research has demonstrated that the above assumptions continue to be drawn upon by grief researchers, those providing services to the bereaved (such as clergy and other religious figures, counselors, therapists, nurses, doctors, and funeral directors), those in the media, as well as laypersons (Center for the Advancement of Health, 2004; Foote & Frank, 1999; Lindstrøm, 2002; Murray, 2002; Payne, Jarrett, Wiles, & Field, 2002; Rando, 1993; Riches & Dawson, 2000; Walter, 2000, 2005-2006; Walter, Littlewood, & Pickering, 1995; Valentine, 2006; Winslade, 2001).

Despite rigorous empirical and conceptual challenges in recent years, Jordan (2000) asserted that "many of the clinical constructs that have guided bereavement interventions over the years may be not much more than collectively shared assumptions . . . that "everyone knows" to be true" (pp. 461-462). Consequently, these fiercely-held beliefs are rarely questioned by those who hold them, despite their fervent critique in the literature. Indeed, Wortman and Silver (1989) argued that these "myths" are remarkably impervious to challenges because of the tendency to search for and interpret data that supports held beliefs. More recently, Lindstrøm (2002) suggested that the notion of "working through" grief persists because of three strong cultural norms—emotional expression following bereavement is regarded as "natural," the absence of negative emotion following bereavement is deemed offensive, and the deceased is perceived to be "owed" and thus needs to be "properly" mourned. Thus these myths are pervasive and resistant to challenge.

Importantly, these "myths" have the potential to have deleterious effects on the bereaved. For example, the bereaved are often treated by service providers and their social networks according to the myths, leading to insufficient support and/or maltreatment based on erroneous assumptions. Rando (1993) contended that service providers pay lip-service to the notion of grief as an individual process while focusing the timelines of grief. She stated that the following behaviors are often assumed to be indicators of complicated mourning, when she believes they are not—having a continued relationship with the deceased, maintain aspects of environments in order to promote memories of the deceased, experiencing feelings other than sadness, engaging in attempts to promote the memory of the deceased in others, experiencing some aspects of grief over many years/forever, or

grief that does not decrease in a linear fashion over time. Further, she argued that "helping" the bereaved to forget the deceased and move on has the capacity to interfere with the development of a healthy connection to the deceased, and may in fact cause the grief to become "pathological" (Rando, 1993). The uncritical adherence to the assumptions of the dominant grief discourse is likely to lead to three potentially deleterious outcomes for the bereaved—service providers are likely to be unhelpful, family and friends of the bereaved are unlikely to be able to provide adequate support, and the bereaved themselves might become distressed when their experience of grief differs from their beliefs about "normal" grief (Wortman & Silver, 2001). As examples, Kauffman (1989, 2002) coined the term self-disenfranchisement to describe the individual who disenfranchises his or her grief, while Walter (1999) described the self-regulation or "policing" of one's grief.

It is pertinent to stress that we do not believe that the dominant grief discourse drawn from the classic theories is "wrong." Rather, it may be that it is more likely to capture grief experiences of those on whom the theories were based (i.e., primarily North American, white, middle-class, and mature women bereaved through the deaths of their husbands through illness) (see Center for the Advancement of Health, 2004; Schlernitzauer et al., 1998; M. Stroebe, 1998; M. Stroebe, Stroebe, & Schut, 2003; Valentine, 2006, for reviews) and might be less able to account for the grief experiences of others, such as parents grieving the loss of a child, bereavement resulting from sudden, violent, preventable, and stigmatizing deaths, and grief experiences in cultures beyond the dominant North American culture.

Given the potential lack of transferability of this dominant grief discourse to the above populations, its uncritical application to all grief experiences might give rise to situations where the bereaved might be judged, and might judge themselves, according to the dominant cultural prescription, with potentially harmful consequences. Despite the bulk of the literature having "moved on" from the uncritical acceptance of the assumptions in the dominant discourse, the prevailing construction of grief, endorsed by laypersons, mass media, and many service providers, remains a stage-based reaction, where recovery occurs within a relatively short time frame, where there are normal and abnormal reactions to grief, and continued attachment to the deceased is pathologized.

MEDICALIZATION OF GRIEF

Attempts to distinguish "normal" grief from "pathological" forms have been occurring for almost a century. A multitude of terms have been used to describe so-called aberrant grief forms (see M. Stroebe, van Son, Stroebe, Kleber, Schut, & van den Bout, 2000). Essentially, these constructions considered grief to be "pathological" when the "work" of grief is not progressed to completion. Indeed, these medicalized terms have increasingly been used to describe grief that

deviates from a standardized or "typical" norm (Kristjanson, Lobb, Aoun, & Monterosso, 2006; Rando, 1993; M. Stroebe et al., 2000).

Given the increasing focus toward medicalization, it is perhaps no surprise then that calls for a separate diagnostic category for complicated grief have been occurring for two decades (e.g., Hartz, 1986; Horowitz, Bonanno, & Holen, 1993; Jacobs, 1993, 1999; Kim & Jacobs, 1991; Marwit, 1991; Raphael & Middleton, 1990), and the trend is rapidly gaining impetus. In the last decade or so, two distinct groups of researchers have proposed complicated grief as a distinct mental disorder—Horowitz and his colleagues (see Horowitz et al., 1997) and Prigerson and her colleagues (e.g., Prigerson et al., 1995, 1996 1997, 1999; Prigerson & Jacobs, 2001; Prigerson & Maciejewski, 2005-2006). Primarily based on data from widows and widowers, both teams propose criteria for Complicated Grief Disorder, and both argue that the disorder is a separate clinical entity because it is clinically distinct from depression, anxiety, post-traumatic stress disorder, and "normal" grief. Essentially, they argue that, while grief itself does not predict negative physical and psychological outcomes such as serious illness, suicidal ideation, and impairments in quality of life, the presence of complicated grief symptoms does predict such outcomes (Jacobs & Prigerson, 2000; Prigerson et al., 1997, 1999; Silverman et al., 2000).

Despite the development of criteria for Complicated Grief Disorder, there is a vigorous debate concerning whether or not "complicated" grief reactions should be classified as a mental disorder. With the growing evidence for the recognition of complicated grief and the ongoing preparation of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), a special issue of *Omega: The Journal of Death and Dying* was devoted to debating the inclusion of complicated grief as a mental disorder. While the majority of contributors concluded that further empirical and conceptual validation is required, those that concluded that Complicated Grief Disorder should be included in the DSM nosology could not agree where. Horowitz (2005-2006) suggested that complicated grief should be included, alongside post-traumatic stress disorder, in a new category of Stress Response Syndromes; Prigerson and Vanderwerker (2005-2006) recommended that complicated grief be included in a new category of Attachment Disorders; and Parkes (2005-2006) tentatively suggested complicated grief could be included with Personality Disorders. Including complicated grief in the DSM-V, but only within Appendix B as a disorder proposed for further study, was also suggested (Goodkin et al., 2005-2006)!

Despite reservations concerning the definition of complicated grief, distinguishing it from other diagnostic categories such as depression, and the potential for all grief to become pathologized (e.g., Hogan, Worden, & Schmidt, 2003-2004; M. Stroebe, Hansson, et al., 2001a, 2001b; M. Stroebe & Schut, 2005-2006; M. Stroebe, Schut, & Finkenauer, 2001; M. Stroebe et al., 2000; Walter, 2005-2006), it appears increasingly likely that Complicated Grief Disorder will be

included in a future DSM edition. In face of these concerns, Prigerson and Maciejewski (2005-2006) countered;

> . . . as has been repeatedly demonstrated, . . . bereaved subjects who meet our criteria for CG are at heightened risk of serious adverse outcomes such as suicidality, high blood pressure, increased smoking and alcohol consumption as well as physical and social impairment and distress, then it appears that concerns about pathologizing, stigmatizing, medicalizing, and labeling the grief reaction are unfounded (p. 16).

They and others (e.g., Bambauer & Prigerson, 2006; Horowitz, 2005-2006; Kristjanson et al., 2006; Parkes, 2002), have fervently argued that the presence of the diagnostic category might in fact lead to better identification of those "at-risk," improved treatments, increased funding for treatments, and greater social recognition of the needs of those with the disorder. However, research has demonstrated that bereaved persons who are concerned with being labeled with a psychiatric diagnosis are significantly less likely to seek professional help (Bambauer & Prigerson, 2006).

Importantly, the current discussion regarding the differentiation between "normal" and complicated grief reactions is largely acontextual. That is, within the criteria proposed by both Horowitz et al. and Prigerson and colleagues, there is little to no recognition of the complex factors that impact on the experience of grief. Indeed, empirical research clearly demonstrates that the dominant discourse does not adequately capture the grief experiences of many groups, such as bereaved parents and those bereaved through violent means (e.g., Breen, 2007; Currier, Holland, & Neimeyer, 2006; Doka, 1996; Harwood, Hawton, Hope, & Jacoby, 2002; Lord, 2000; Murphy, Johnson, Wu, Fan, & Lohan, 2003; Riches & Dawson, 2000; Rosenblatt, 2000). Yet, no distinction is made between their description of grief in their samples, which were primarily widows and widowers bereaved following the life-threatening illnesses of their spouses (e.g., Chen et al., 1999; Prigerson et al., 1995, 1996, 1997, 2001; Prigerson & Jacobs, 2001; Schlernitzauer et al., 1998; see also Hogan et al., 2003-2004; Prigerson & Maciewjewski, 2005-2006), and the subsequent prescription of these "normal" and "complicated" reactions to different samples.

EFFICACY OF GRIEF INTERVENTIONS

Clearly, the recent conceptualization of grief within clinical frameworks has increased the importance of understanding grief to service delivery. One of the potentially great barriers to effective grief intervention is the general lack of understanding of grief in the service professions, which is at least partly explained by the discord between grief researchers and service providers (Center for the Advancement of Health, 2004). A gap exists between information in the literature and the use of that information by service providers (Bridging Work Group, 2005;

Center for the Advancement of Health, 2004; Jordan, 2000; Neimeyer, 2000a). For example, a recent study demonstrated that service providers rated scientific journal articles on grief as least helpful in their practice (Bridging Work Group, 2005), despite journals being the most popular avenue for researchers to disseminate their findings and containing the most recent information. Instead, the service providers preferred to gather information from books, colleagues, and workshops. The result is that, although the assumptions within the dominant grief discourse have been subject to robust empirical and theoretical challenges in recent years, they remain uncritically accepted by many service providers. Indeed, these assumptions are evident in university training in a number of disciplines and continue to be endorsed within both grief education and grief interventions, as demonstrated below.

Grief Education

In a review of the current state of death education for service providers, Wass (2004) estimated that less than a fifth of students in health-related professions are exposed to sufficient death education. She further characterised death education in medical and health-related fields as "inadequate" (p. 293). Surveys of American and British medical, nursing, pharmacy, and social work schools demonstrated that most presented at least some information on grief but the information was limited (e.g., Dickinson & Field, 2002; Dickinson, Sumner, & Frederick, 1992). Further, of the nursing and medical schools in the United States and the United Kingdom that provided grief education, the majority reported that their curriculum endorsed "stages of grief" models, particularly those of Kübler-Ross (1969), Parkes (1972, 1986), and Worden (1982, 1991, 2002).

A survey of general practitioners in Wales indicated that, while only a quarter reported receiving any grief training as a medical student, 70% reported receiving grief training as a GP registrar (Barclay et al., 2003). However, 17% reported receiving no grief education in any aspect of their academic and professional careers. Surveys of nurses employed in accident and emergency departments in London and Glasgow revealed that less than half report having received any death education, half report feeling ill-equipped in providing bereavement support to families, and the majority report that they are not familiar with current bereavement literature (Hallgrimsdottir, 2000; Tye, 1993). Similarly, in a recent survey of nursing homes in the United States, 63% of homes reported being dissatisfied with the training of staff on death and dying (Moss, Braunschwieg, & Rubinstein, 2002). In a recent Australian study of general practitioners' attitudes to palliative care, the general practitioners articulated a strong desire for professional development related to bereavement support (O'Connor & Lee-Steere, 2006).

These studies and reviews highlight that the grief education of health providers is overlooked on the whole, and when it does exist, it is narrow in focus. Further,

the education that does exist usually emphasizes "end-of-life" issues relevant to hospice settings and palliative care (see Barclay et al., 2003; Dickinson & Field, 2002; Wass, 2004) and the quality of the information presented on grief (in terms of theorists, models, etc.) is generally not known. Thus, research shows that death education is limited, and where it does exist, it usually pertains to end-of-life issues, rather than reflecting the full diversity of bereavement experiences.

Grief Interventions

Despite little research on the efficacy of grief interventions (see Center for the Advancement of Health (2004) for a brief review) the literature reveals a trend toward current interventions being based on the dominant grief discourse. For example, a study of 29 grief counselors in the United Kingdom revealed that, although they recognized the grief experience is unique to each client, they reported drawing primarily on stages/phases/tasks/processes models in their work. Further, despite their acknowledgment that the stages are not progressive or necessary, the counselors believed that client could become "stuck" within particular stages, articulated that grief is time bound, and many prioritized facilitating closure of the relationship between the client and the deceased (Payne et al., 2002). Similarly, Wiles, Jarrett, Payne, and Field (2002) interviewed 50 general practitioners in the United Kingdom. The general practitioners also drew solely upon constructions of grief as linear, stage/phase-based, and time-bound. While these findings are concerning, they are perhaps unsurprising, given that material directed at helpers and popular press often reflects the assumptions inherent in the dominant discourse (Wortman & Silver, 2001).

The acceptance of the assumptions in the dominant discourse, often uncritically and without significant supporting empirical evidence, appears rife in grief interventions. Some service providers attempt to rigidly fit the person to the prevailing theory and many hold unrealistic expectations about grief, especially concerning the timeline of "healthy" grief and the detachment from the deceased (Rando, 1993). Grief theories that assert a stage-based and finite conceptualization of grief led to the situation where many service providers were and are engaged in a process of the assessment and diagnosis of and intervention with bereaved individuals, according to their "progress" through the grief process. As examples, Worden (1982, 1991, 2002) encourages service providers to identify the task or tasks of mourning that are not completed and help the bereaved to resolve each task, while Cook, White, and Ross-Russell (2002) recommended that staff in pediatric intensive care units detect "unusually absent or excessive reactions" (p. 38) as signs of "pathological" grief. Further, despite Complicated Grief Disorder not (at least yet) being officially recognized in DSM nosology, Kristjanson et al. (2006) recommended that service providers screen the bereaved for the disorder if symptoms persist beyond six months and/or appear severe. In light of the uncritical acceptance of the assumptions underlying the dominant grief

discourse, the Center for the Advancement of Health (2004) highlighted the serious problem that has plagued grief interventions—the failure to distinguish between the description of grief in unrepresentative samples and the subsequent prescription of these "normal" reactions to other samples.

Grief interventions are further complicated by the belief held by most service providers that their interventions are efficacious (Jordan & Neimeyer, 2003). However, research has demonstrated that grief interventions for those with "normal" grief show little to no effect, and in a high proportion of cases, the bereaved participants would have been better off without the intervention (e.g., Hansson & Stroebe, 2003; Jordan & Neimeyer, 2003; Schut, Stroebe, van den Bout, & Terheggen, 2001). Nevertheless, interventions appear more effective for those with "risk" variables and/or "complicated" grief reactions (Jacobs & Prigerson, 2000; Jordan & Neimeyer 2003; Murray, Terry, Vance, Battistutta, & Connolly, 2000; Neimeyer, 2000b; Schut et al., 2001).

Finally, the provision of support following bereavement is complicated by people's discomfort with and anxiety concerning death. Studies have shown that counselors experience significantly higher levels of discomfort and display low empathy in dealing with death and dying when compared to other potentially sensitive issues (Kirchberg & Neimeyer, 1991; Kirchberg, Neimeyer, & James, 1998). Another study demonstrated that 30% of nurses looking after critically-ill patients reported feeling uncomfortable dealing with the bereaved family members (Kojlak, Keenan, Plotkin, Giles-Fysh, & Sibbald, 1998).

To summarize, grief education and grief interventions remain primarily based on the dominant discourse, and are additionally obfuscated by factors such as death anxiety and discomfort. Despite the interest in and the proliferation of grief interventions, empirical research has shown that the interventions are likely to be of benefit, but only for grief that is deemed "at-risk" or "complicated." In fact, interventions are potentially deleterious for "normal" grief. However, despite some exceptions (e.g., Murray et al., 2000) interventions remain largely focused on grief following end-of-life care and deaths in hospital settings (e.g., Foliart, Clausen, & Siljestrom, 2001; Kaunonen, Tarkka, Laippala, & Paunonen-Ilmonen, 2000; Nesbit, Hill, & Peterson, 1997; Reilly-Smorawski, Armstrong, & Catlin, 2002), rather than following bereavements that are perhaps just as likely or even more likely to result in "complicated" outcomes, including sudden, violent, preventable, and stigmatizing deaths; and deaths outside hospital and palliative care settings, because the bereaved are not easily "known" and identified by service providers.

MOVING BEYOND THE PARADOX: RECOMMENDATIONS FOR GRIEF EDUCATION, INTERVENTION, AND RESEARCH

The parallel discourses concerning the recognition of grief as unique and dependent on a number of variables, and the differentiation between "normal" and

"complicated" grief reactions and their treatments, remains a fundamental paradox in the thanatological literature. The paradox clearly pervades efforts to develop grief theory, identify and diagnose aberrant or "complicated" grief responses, and provide quality grief interventions. A greater recognition of the uniqueness of grief experiences beyond the rhetoric is required in order to resolve this incongruence. We need to emphasize that what is a *description* of a bereaved individual or sample is not necessarily a *prescription* for others. This will not "just happen." In order to move beyond the fundamental paradox, we provide three recommendations.

The first recommendation concerns the provision of and access to improved grief education. It is clear from this review that there is a need for greater sensitivity to and recognition of the diversity of experiences and needs of the bereaved in order to provide appropriate and effective supports and services. In order that the diversity of grief experiences are recognized without necessarily being problematized, we require the provision of systematic grief education to three groups of stakeholders—all those involved in service provision to the bereaved, including funeral directors, religious and spiritual leaders, general practitioners, psychologists, psychiatrists, counselors, and nurses, the wider community, and the bereaved themselves.

Although most bereaved people do not access assistance from many of these service providers, the Center for the Advancement of Health (2004) recommended that, "at a minimum, however, physicians and other health care providers should be capable of responding compassionately to bereaved persons" (p. 557). In addition to service providers, the dominant discourse has also permeated lay understandings of grief, and as such, there is the potential that family, friends, and work colleagues might impose it rather than understand the needs of the bereaved following the deaths of their loved ones. Further, one study demonstrated that the bereaved who may be in the most need of structured support were significantly less likely to access support services (Prigerson et al., 2001). Given the potential for a lack of support, the presence of community-wide grief education would potentially increase awareness of, and support for, the bereaved. Murray (2002) recommended educating the community to provide the care required, while Hansson and Stroebe (2003) concluded that "helping professionals are likely to be most effective by providing support to natural helpers" (p. 519) such as the family, friends, and neighbors of the bereaved and the religious, social, and business groups they belong to. Importantly, community-wide grief education and education/information aimed specifically for people bereaved would also lessen the likelihood of bereaved people internalizing the dominant discourse, which may lead to less self-disenfranchisement (Kauffman, 1989, 2002) and less policing of ones' grief (Walter, 1999).

The provision of grief education to the above groups would likely shield the bereaved from the potential for subsequent distress that might occur when they are unwittingly excluded, traumatized, and victimized (e.g., Opotow, 1990; Reiff,

1979; Tehrani, 2004) by the existing services and interventions, their social support networks, and themselves. The provision of relevant and sensitive grief education about the diversity of experiences to all three stakeholder groups would enable them to understand and empathize more easily with the perspectives of the bereaved, which in turn would mean that these experiences would not remain unrecognized and unsupported. However, we also need to recognize that the provision and access to improved grief education is complicated by the general lack of quality grief education and training provided to service providers, and the discomfort, insensitivity, and/or indifference in dealing with issues concerning grief, especially following the death of a child and/or sudden, violent, preventable, and stigmatizing deaths.

Second, we recommend changes to the ways in which grief research is conducted and disseminated. While there is a plethora of research on grief, the focus remains on the intrapsychic or individual experience of grief, including the description of "symptoms," "risk" factors, and outcomes, without significant attendance to the context of the bereavement itself on the resulting grief experiences (Center for the Advancement of Health, 2004; Neimeyer & Hogan, 2001; Valentine, 2006). In a critical review of the literature, Neimeyer and Hogan (2001) highlighted the inverse relationship between the volume of research on grief and the amount of information contained within it and concluded, "although the human experience of bereavement has often been studied, it has not often been studied well" (p. 110).

While bereavement is a universal phenomenon, the experience of grief is not. Grief is a unique experience that occurs within a historical, social, cultural, and political context, and our research endeavors need to recognize it as such. These contextual factors all affect an individual's grief experience and, as such, must not be omitted or viewed as extraneous variables. Instead, they need to be held in as much regard as the grief experience itself. Despite the wide acceptance that grief experiences are embedded within a context (see Center for the Advancement of Health, 2004; Sanders, 1993; W. Stroebe & Schut, 2001), there remains a tendency in thanatological research to examine individual factors in isolation with no, or minimal, attempt to look at the complex interplay between the variables that influence an individual's grief experience, such as the impact of family and friends, professional helpers, social norms, legal and medical systems, and so on. In addition, these factors are important in terms of mediating and moderating the grief experience. For example, understandings of grief may affect the amount and type of support one receives from family and friends, the status of a particular bereavement might impact one's access to professional help, and cognitive appraisal may affect how one perceives the support he or she receives.

The ability to incorporate all these factors into a research project presents both an academic challenge and one that would require substantial resources (Center for the Advancement of Health, 2004; Lindstrøm, 2002). However, the ability to conduct applied research is further complicated by three factors that also explain

the discord between grief researchers and service providers—flawed dissemination of research findings to service providers, deficiencies in communication between researchers and service providers, and the inadequate application by service providers of research findings (Center for the Advancement of Health, 2004). Further, researchers and service providers experience diametrically-opposed pressures—the culture of academia requires publications with theoretical rather than practical significance, whereas service providers give a low priority to research that is not specifically applicable to the demands of their workplace (Bridging Work Group, 2005; Jordan, 2000; P. R. Silverman, 2000).

Two developments are required for greater interdependence between research outcomes and service provision—researchers must attend to the applications of their findings so that they can inform service provision, and present this information in a format that is most likely to be incorporated by service providers (Center for the Advancement of Health, 2004; Jordan, 2000; Wolfe & Jordan, 2000). While most grief research focuses on quantitative methodologies and measures, service providers are most likely to utilize findings from research that is "natural," contextual, relevant to service provision, involves multiple stakeholders, incorporates the research literature, and uses cases as examples with verbatim data from informants (Bridging Work Group, 2005; Center for the Advancement of Health, 2004; Jordan, 2000). Thus, researchers need to present research in ways that render their findings most useful to and valued by service providers.

Quantitative studies remain dominant in the thanatological literature (Neimeyer & Hogan, 2001; Thorson, 1996; Valentine, 2006). Perhaps related to the reliance on quantitative methods is the dearth of research on the experience of grief from the perspectives of the bereaved themselves. For example, Neimeyer (2000a) argued for the greater integration and exchange of ideas between grief researchers and practitioners. However, another group can be included in the dialogue—the bereaved. As Fulton (1999-2000) argued, health care professionals and researchers must be sensitive and not impose their views about the grief experience on to those living the experience. Instead, he suggested that health care professionals must first identify "how the individual constructs their experiences and the meaning attached to it" (p. 50), before suggesting the type of support (if any) that may be appropriate.

In addition to the above conceptual and methodological imperatives, we have identified gaps in the literature in a number of areas. Despite the volume of grief research, it is narrow in scope (Center for the Advancement of Health, 2004; Neimeyer & Hogan, 2001), with considerable focus on North American, white, middle-class, and mature women bereaved through the deaths of their husbands through illness. Findings drawn from research on these samples might be less able to account for the grief experiences of others, such as parents grieving the loss of a child, bereavement resulting from sudden, violent, preventable, and stigmatizing deaths, and grief experiences in cultures beyond the dominant North American

culture. Therefore, research that actively samples from a wide range of the bereaved population would lead to a body of literature that would be better able to describe and account for the diversity of grief experiences that are in existence.

With these conceptual, methodological, and sampling issues in mind, research that utilizes multiple perspectives from multiple informants (including service providers and the bereaved) in order to investigate the context of diverse grief experiences is essential. In light of the discord between current grief research and service provision, researchers need to purposely aim their research so that it is most likely to be used and incorporated by service providers; that is, conducting research that is "natural," contextual, involving multiple stakeholders, is relevant to service provision, with the presentation of cases as examples with verbatim data from the informants, and incorporates the research literature (Bridging Work Group, 2005; Center for the Advancement of Health, 2004; Jordan, 2000). In doing so, the research would provide a useful foundation for the delivery of services and supports that recognize the diversity of grief experiences.

The third recommendation pertains to the examination of current interventions and services to determine the ways in which the assumptions inherent within the dominant discourse are uncritically maintained and reproduced. Service providers who uncritically accept and apply the dominant grief discourse regardless of context demonstrate a superficial understanding of the diversity of grief experiences that result following bereavement. Further, related to the improvement of grief services and interventions is the examination and amelioration of the barriers to effective service provision, including the lack of grief education and training provided to service providers, and the likelihood that service providers might experience discomfort, insensitivity, and/or indifference when dealing with issues concerning grief, especially those experiences following the death of a child; bereavement resulting from sudden, violent, preventable, and stigmatizing deaths; and grief experiences in cultures beyond the dominant North American culture.

Achieving these three recommendations necessitates holistic and complex changes requiring: a) multiple strategies at multiple levels, including the policies and practices of intervention settings and the education and training of service providers; and b) working partnerships between researchers, practitioners, managers, funding bodies, legislators, and clients and their families. Relying solely on the dissemination of material to service providers is largely ineffective in producing change (Grol & Grimshaw, 2003; Grol & Wensing, 2004). Further, these changes, especially if done properly, are likely to be slow.

We propose a complementary research agenda to determine the ways in which the contemporary grief literature can be embedded into the visions, policies, and practices of grief service providers. A number of questions require further examination—What do service providers consider to be best-practice grief intervention? To what extent do service providers draw upon constructions such as "normal" and "complicated" grief in their practice? What facilitates and impedes the incorporation of contemporary literature into the delivery of grief services?

What are the attributes of service providers that do maintain current standards in their practice? How can the contemporary grief literature be best incorporated into curricula accessed by service providers? How can service providers be encouraged to become life-long learners in order to incorporate the latest literature into their practice? How can they access training that better allows them to work effectively with the diversity of grief experiences? How might the efficacy of such changes be measured? The answers to these questions have the potential to improve the delivery of services accessed by bereaved individuals and families. The alignment of grief literature, policy, and practice is integral to this aim.

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