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THE PHASED APPROACH TO GRIEF AS A HISTORICAL ARTIFACT

Traditional grief counseling has long been dominated by linear stage models, though modern research increasingly challenges these rigid assumptions. This article traces the theoretical evolution of bereavement from C. Darwin and S. Freud to contemporary frameworks like the Dual Process Model (DPM) by M. Stroebe & H. Schut. By identifying the «oscillation» between loss-oriented and restoration-oriented processes, the DPM validates individual coping, including necessary avoidance. Clinical examples illustrate how children and adolescents utilize these shifts for emotional regulation. The author concludes that while the DPM offers a flexible scaffolding, clinicians must prioritize the unique, simultaneous experiences of joy and pain over standardized instructions.

Keywords: grief work; Dual Process Model (DPM); loss-oriented stressors; restoration-oriented stressors; oscillation (pendulation); stage models (phase theories); bereavement support; coping strategies; avoidance and denial; individual differences in grief; family dynamics in loss; attachment theory.

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ФАЗОВИЙ ПІДХІД ДО ГОРЮВАННЯ ЯК ІСТОРИЧНИЙ АРТЕФАКТ

У статті подано критику лінійних фазових моделей у консультуванні з питань горя та представлено сучасні дослідження, які дедалі більше ставлять під сумнів припущення, що людина, яка переживає втрату, повинна пройти фіксовану послідовність фаз, щоб досягти переорієнтації. Враховуючи, що людські реакції на втрату за своєю суттю є ідіосинкратичними, ці жорсткі рамки зараз розглядаються як потенційно обмежувальні або навіть контрпродуктивні, коли застосовуються як універсальний клінічний стандарт.

У статті розглядається еволюція теорії втрати, від фундаментальних біологічних і психоаналітичних концепцій Ч. Дарвіна та З. Фрейда до фазових моделей Е. Ліндеманном та Д. Боулбі. Вона підкреслює зсув парадигми до сучасних рамок, зокрема Моделі подвійного процесу, яка підкреслює нелінійну та ідіосинкратичну природу горювання.

Модель подвійного процесу визначає два паралельні процеси: процес, орієнтований на втрату, що зосереджується на горюванні, та процес, орієнтований на відновлення, що зосереджується на життєвих змінах та відволікаючих факторах.

Основою моделі є «коливання» між цими двома станами. Наведені клінічні випадки, що ілюструють застосування моделі подвійного процесу в роботі з дітьми та підлітками.

Автор робить висновок, що стадійні моделі слід відкинути на користь новіших теорій, які визнають необхідність заперечення та уникнення як дійсних механізмів подолання труднощів. Зокрема в статті активно підтримується Модель подвійного процесу і доводиться її клінічну релевантність. Автор також наголошує, що спеціалісти з горювання, повинні пам'ятати про «одночасність» – здатність відчувати людини, що горює, радість і біль одночасно. Зрештою, кожна людина, яка переживає втрату, унікальна, і теоретичні моделі повинні слугувати гнучкими інструментами, а не жорсткими інструкціями.

Ключові слова: *робота з горем; Модель подвійного процесу (DPM); стресори; орієнтовані на втрату; стресори, орієнтовані на відновлення; коливання (маятник); стадійні моделі (фазові теорії); підтримка у втраті; стратегії подолання; уникнення та заперечення; індивідуальні відмінності у горі; сімейна динаміка у втраті; теорія прив'язаності.*

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Statement of the problem in general terms

The traditional understanding of grief has long been dominated by «stage models». These models suggest that bereaved individuals must pass through a linear sequence of phases: a shock phase, a denial phase, an acceptance phase, and a processing phase, before finally reaching a reorientation phase where they find a way to live on. However, modern research strongly challenges these assumptions. People are different and react differently to loss; research shows that grief processes are as individual and unique as the human beings themselves. There is a growing professional concern that rigid adherence to these stages by health personnel can be counterproductive, leading to a call for these models to be laid aside in favor of a platform that better supports the actual needs of the grieving.

Analysis of recent research or publications in which the solution of this problem was initiated and on which the author relies

The evolution of grief theory has transitioned from early biological observations to complex, non-linear psychological frameworks. Historical foundations were laid by C. Darwin (1872) [8], who identified innate physiological expressions of sorrow, and were later expanded by Sigmund Freud (1917). S. Freud's [10] seminal concept of «grief work» (Trauerarbeit) emphasized the necessity of detaching emotional energy from the deceased to

reclaim it for new relationships. This linear perspective was further codified through the phase-based models of E. Lindemann [13] (1944) and J. Bowlby [4; 5; 6], who integrated attachment theory into a four-stage progression, as well as W. Worden's (1983) [17] functional approach to grief tasks. However, these traditional models have been increasingly scrutinized for their rigid, prescriptive nature, which often pathologizes individual variations and imposes a harmful burden on the bereaved by suggesting there is a «correct» way to grieve.

A significant shift in scholarship was initiated by C. Wortman and R. Silver (1989) in their work «Myths of Coping with Loss» [18], which challenged the validity of universal stages. This critique paved the way for more dynamic frameworks, most notably the Dual Process Model (DPM) introduced by M. Stroebe and H. Schut (1991) [16]. The DPM provides a nuanced integration of existing theories by focusing on the adaptive oscillation between loss-oriented and restoration-oriented stressors. This modern trajectory is further supported by the empirical research of G. Bonanno (2004, 2019) [3], whose studies on grief trajectories demonstrate that resilience is the most common response to loss, suggesting that many individuals possess innate regulatory mechanisms that do not fit into traditional «grief work» phases.

Contemporary discourse has further evolved to include the Continuing Bonds theory pioneered by D. Klass, S. Silverman, and S. Nickman (1996) [12], which posits that healthy adaptation involves maintaining a transformed internal relationship with the deceased, rather than achieving total detachment. Furthermore, practitioners such as R. Neimeyer (2001, 2022) [15] emphasize meaning-reconstruction as a central process, arguing that grief is not a state to be «resolved» but a continuous renegotiation of one's identity and world-view. This perspective is reinforced by M. Stroebe and H. Schut's (2010) later updates to the DPM, which incorporate social support and gender-specific coping styles [11; 16]. By synthesizing these views, a consensus has emerged among Western scholars – including K. Boerner, H. Prigerson, and G. Bonanno [2; 3] – that phase models should be regarded as historical artifacts rather than clinical guidelines. Consequently, effective intervention must be non-prescriptive, prioritizing the individual's agency and the specific socio-cultural context of their loss.

Purpose of the Article

This article advocates for transitioning from traditional phase-based theories to the Dual Process Model in clinical practice, emphasizing its role as a flexible professional platform that validates individual differences and the adaptive necessity of avoidance and distraction during grief.

Presentation of the main material of the research with a full justification of the obtained scientific results

People are different and react differently, also to loss. Newer models of the grief process allow more room for diversity.

According to the so-called phase models, the grieving person goes through different phases, such as the shock phase, the reaction phase, the processing phase, before finally ending in a reorientation phase where one finds the way back to life.

With C. Wortman and R. Silver's article «Myths of coping with loss» (1989) [18], assumptions about grief, grief phases and grief work were strongly challenged. Among other things, they pointed out that people do not necessarily go through fixed phases in their grief, and that research shows that grief processes are as individual and unique as the person themselves.

A few years ago, psychologist A. Dyregrov wrote an article about the newer understanding of grief (2006) [9]. He concluded by expressing the hope that the phase model would be put aside and that people would no longer have to hear health professionals' comment that the grieving person was now in the «processing phase».

The utility of bereavement models lies not in pathologizing a natural life event, but in providing a necessary professional scaffolding. While loss does not universally warrant clinical intervention, the heterogeneity of grief and its varying impact across developmental stages necessitate a robust methodological framework. In cases where support is required, personal intuition and communicative competence alone are often insufficient; thus, an evidence-based theoretical platform is essential for ensuring the efficacy and quality of professional assistance.

The interest and awareness that grief can create physical and mental challenges goes back a long way. Many have tried to describe grief and its consequences, and the first written references are from the mid-19th century.

One of those who tried to describe grief and the grief process in the 19th century was the biologist C. Darwin (1872) [8]. The researcher had observed that many animal species screamed when they were separated from other animals with which they had a close relationship. C. Darwin claimed that grieving people also had such a cry that they often tried to suppress if they experienced a loss. He also speculated whether the facial expression that people in grief had was produced by special «grief muscles», and whether these muscles were less voluntarily controlled than other muscles in the face.

However, it is S. Freud who has been the starting point for much of the professional approach to grief. In 1917, he published the article on «Grief and Melancholy» [10]. At that time, World War I was almost over, and many people in the Western world were affected by loss. The war had been a violent mass

murder, and 10-15 million people had died. The need to help people in grief was enormous. S. Freud was concerned that the mourner had to break the emotional ties to the person who had died. In this way, the energy that had been invested in the deceased could be released back.

Love and commitment to other people was something that one had in limited quantities. By breaking ties and withdrawing energy, the grieving person gained strength and energy to focus on new relationships – to living people. This painful process was important and had to be carried out even if the person intuitively wanted to oppose it. This required active effort from the grieving person, and grief was described as work, «grief work». Freud argued that if one failed to draw energy and attention away from the dead person, one would end up in what he called melancholy (depression).

As World War II drew to a close, a new important contribution to the understanding of grief came. E. Lindemann studied survivors of an accident in Boston (1944) [13]. He developed and refined S. Freud's concepts of grief. E. Lindemann introduced three phases in his grief model: 1. Shock and denial, 2. Acute grief, 3. Detachment [13].

After this, J. Bowlby [4; 5; 6] became one of the most important contributors to the field. He believed grief was a natural response to separation from someone with whom one had strong emotional ties. Reactions such as anger, crying, searching, and protest were therefore natural behaviors, each of which was a way to restore attachments to the person who was gone. Bowlby operated with four different phases in his model: numbness (shock and denial), screaming and searching (often characterized by anger and protest), disorganization and despair (depression and powerlessness), and reorganization (acceptance).

W. Worden described grief a little differently (1982) [17]. He was concerned that grief was a process and not a state. Worden argued that the mourner had to work through the emotional pain and at the same time get used to his new situation when it came to changes in roles, status and identity.

Like S. Freud, E. Lindemann, J. Bowlby and J. Worden were all psychologists. Over the past 20 years, new professional groups have constantly made contributions that have continued to expand perspectives on grief and the grief process. These contributions have provided a greater understanding of grief processes, stress and relationship theory, as well as awareness of family interaction after a loss are some of the elements that have helped to nuance the understanding of grief.

The dual process model attempts to provide a more nuanced picture of the grief process. The two researchers M. Stroebe and H. Schut (1999) [16] claim that they have attempted to integrate the most important features of many of the already established models. Instead of creating a new one, the

dual process model distinguishes between two different types of stressors in grief: it describes a loss stressor where the focus is on the loss and separation, and a secondary stressor, where the challenges are the results of the loss, such as poorer finances and new practical tasks that come as a result of the death. The two different types of stressors give rise to two different coping processes, and there is a pendulum movement between these two parallel processes.

In the loss-oriented coping process, the bereaved person focuses on the loss and on what was. The grieving person can go into themselves, be with others they trust, or focus on a god or something else that is bigger than themselves. In this process, many struggle with questions such as: «Why did this happen?» or «Why me?». People remember what has happened, talk about the deceased, watch videos and pictures, smell smells and perfumes, play music that reminds them of the deceased, and are preoccupied with the deceased's belongings. Some choose to confront the loss by visiting the grave, the crime scene, or other places that remind them of the deceased. Many describe this part of the process as a time when they look back on what has happened, but also grieve for everything that never came to be. At the same time, they deny, or avoid dealing with, the consequences and changes that the loss has brought about, both now and in the longer term. This form of denial or avoidance means that those around the grieving person may experience that the grieving person is so paralyzed at times that everyday things such as opening the mail or eating/drinking become completely unimportant. The loss-oriented coping process means that the grieving person does not make the changes and adjustments in everyday life that the outside world expects. Traditional grief support work has in many ways described only this part of the model. Loss-oriented and the grief work that comes with it are in focus.

The second parallel process is a solution-oriented coping process. Here, one focuses on the consequences and changes that the loss has caused. One works to establish a stable everyday life, and tries to focus on activities or tasks that can divert thoughts from grief. The grieving person enters into new roles and focuses on how to take care of different types of tasks; both those that must be done in the short term, and the tasks that the deceased had, where new solutions must be found in the longer term. The solution-oriented person is concerned with reorientation, finding new roles and new goals. Many people find that they have gained a hard-earned experience that makes them look for opportunities for their own growth and positive change. On this side of the model, you also find statements or thoughts that are a denial of what has happened, such as «this is just a dream» or «dad will probably be back soon». The solution-oriented process removes us from the pain, at least

for short periods. The process also does not physically hurt the body, and some people pay a relatively high price to be as much as possible in this process instead of the loss-oriented one. A lot of hard work, computer games or other activities that require high concentration are examples of strategies that can be used. We meet and see young people and adults who use unfortunate solutions such as drugs and self-medication to keep the pain at bay.

The key thing in M. Stroebe and H. Schut's model is that you fluctuate between these two different coping processes. The movement back and forth is really important.

According to the model, experiencing the pain of loss is only part of the grief. Engaging in physical activities and experiences that allow you to create distance from the pain is just as important. Working on accepting the loss is key, but you also need to focus on the consequences and how your daily life has changed. At some times, the bereaved will focus on the different aspects of the loss and at other times they will avoid them. Both are natural and important. The bereaved should cycle back and forth on the same day, or in a conversation.

This section examines the clinical application of the Dual Process Model as a therapeutic tool for bereavement support. By analyzing anonymized case studies, the article demonstrates the model's utility in facilitating psychological recovery.

Within the context of bereavement support, the model is typically introduced to clients during the initial or secondary session. Clinical observations suggest that this framework is highly effective for children and adolescents when appropriately adapted to their developmental stage. For school-aged children, the conceptual components are simplified, and the model is co-constructed visually using the child's own narrative.

To illustrate the practical utility of this developmental adaptation, the following case studies provide a detailed examination of how the model functions across various clinical scenarios. These examples highlight the transition from abstract conceptualization to functional intervention, demonstrating how tailored visual representations of the model facilitate emotional regulation and cognitive processing in children and adolescents. By analyzing these specific instances, we can observe the model's capacity to validate diverse coping mechanisms and harmonize fragmented family dynamics.

Case 1. Addressing Maladaptive Coping in Adolescence [1]

Subject – an 11-year-old male, 10 months post-paternal loss following a brief illness.

Clinical Presentation. The subject exhibited significant academic concentration difficulties, social withdrawal, and a refusal to verbalize the loss. Coping strategies included the consumption of alcohol and reliance on sedatives to manage insomnia.

Intervention. The practitioner utilized the DPM to reframe the subject's behavior not as a failure to grieve, but as an active, albeit rigid, choice to maintain distance from emotional pain. His reliance on alcohol was identified as an over-fixation on the "restoration/avoidance" axis of the model.

Outcome. Externalizing these processes allowed the subject to transition toward conscious oscillation. This shift resulted in a proactive request for the practitioner to present the model to his school class, thereby fostering social validation and peer understanding.

Case 2. Family System Desynchronization and Conflict Resolution [1]

Subject – a family unit (parents and siblings) several years after the death of a child/sister.

Clinical Presentation. The family experienced chronic interpersonal tension characterized by silence and a lack of emotional resonance.

Intervention. By co-constructing the model, family members identified their disparate positions. The father predominantly occupied the restoration-oriented side (pragmatism and task-focus), while the mother was primarily loss-oriented (emotional processing and rumination).

Outcome. The intervention validated the premise that it is «impossible to grieve in sync». Recognizing these differing styles as equally legitimate helped the family reduce mutual resentment, fostering a more supportive and flexible communicative environment.

Case 3. Emotional Regulation and Affective Titration in Children [1]

Subject – two siblings (a 10-year-old girl and her brother) following the death of their father.

Clinical Presentation: during the narrative recall of their father's illness, the children experienced sudden, intense affective flooding (violent crying).

Intervention: the model served as a self-regulatory tool. Upon reaching a point of emotional overwhelm, the eldest sibling independently identified the need to «switch sides» on the model. The practitioner supported this shift through play therapy (modeling balloon animals).

Outcome: the children acquired foundational self-regulation skills. Distraction was successfully reframed as an adaptive mechanism that allows for necessary respite from distress, rather than a maladaptive escape.

Case 4. Identifying Latent Grief Intensity through Non-Directive Interaction [1]

Subject – a female teenager grieving the loss of her younger sister.

Clinical Presentation. The subject maintained a detached, factual tone throughout the session, avoiding explicit emotional expression despite the presence of her parents and family photographs.

Intervention. Adhering to the DPM's principle of autonomy, the practitioner allowed the subject to control the duration and intensity of her engagement with «loss-oriented» materials (the photographs). The conversation remained light and factual, respecting the subject's boundaries.

Outcome. Despite the lack of overt emotionality, the subject concluded that the meeting was profoundly useful, noting that she had rarely spent so much time on the «loss-oriented side». This highlights the importance of safe containment, where the model allows for contact with pain in a controlled, non-threatening format.

These case studies demonstrate that the Dual Process Model serves three critical functions in pediatric and family bereavement [1; 11; 16]:

1) psychoeducational: it mitigates guilt regarding «atypical» grieving styles by validating both emotional expression and distraction;

2) regulative: it empowers clients to consciously manage the intensity of their emotional experiences through oscillation;

3) relational: it provides a shared metaphorical language for families, acknowledging that diverse coping styles can coexist without invalidating the grief of others.

The Dual Process Model serves as a vital clinical framework that validates avoidance and distraction as adaptive, necessary components of the bereavement process. By shifting focus from rigid clinical criteria to the individual's need for respite, this model empowers children and adults alike to oscillate between loss and restoration. Ultimately, while theoretical structures are instructive, they must remain secondary to the foundational element of therapy: a secure, trust-based relationship. It is this relational safety that facilitates a client's authentic movement through grief, ensuring that the human experience is never overshadowed by the model itself.

Those who come to us and are affected by grief can often feel that they are left without a choice. Loss is not something we can choose, nor are the concrete consequences in everyday life. We experience that the model can eventually help give the individual an experience of feeling more normal, and that one can to a certain extent choose whether to use a loss-oriented or solution-oriented coping style. In some of our grief groups, we experience that participants experience that they can set aside time to grieve when they

get together with others in a grief group, or in everyday life where they or no grief.

In working with children and young people, we also encounter the network. The solution-oriented process removes us from the pain, at least for short periods.

Regularly, the grief support program includes an evening session for the participants' wider social network, including teachers, coaches, and relatives. These individuals often seek to provide support but frequently report feeling insecure or uncertain in their roles. Clinical experience suggests that the Dual Process Model offers a valuable framework for these caregivers, as it validates practical, restoration-oriented activities as legitimate «grief work». For instance, a relative recently noted that the model helped her realize that engaging in routine activities, such as playing football with her grandsons, was not a distraction from their mourning, but an essential and supportive part of their psychological recovery.

Despite its utility, the Dual Process Model (DPM) faces criticism for its perceived individualistic focus and Western cultural bias. Furthermore, practitioners observe that standard literature often fails to account for the "emotional simultaneity" frequently reported by the bereaved. Clinical experience suggests that the pain of loss does not necessarily vanish during restoration-oriented activities; rather, joy and distress often coexist. This is evidenced by adults navigating new relationships while simultaneously experiencing the pain of past loss, as well as by children who demonstrate a capacity for simultaneous emotional states. For instance, a child may engage joyfully in play while seeking sensory comfort from a memento of a deceased parent, illustrating that grief is not merely a state of «going in and out», but a complex, concurrent experience of multiple affects.

However, a significant gap remains between these contemporary understandings and current pedagogical practices. In many educational and professional development settings, traditional phase models continue to dominate curricula, often at the expense of more nuanced, modern frameworks. This lack of theoretical updates in academic institutions has resulted in a slow evolution of clinical practice, limiting the active application of newer, more flexible grief models in direct therapeutic encounters.

Those who have worked in this field for a while may notice that it is a bit right to be fussy. The model by M. Stroebe and H. Schut [11; 16] opens up too much on the mentioned phase model. At the same time, we would like to emphasize that the two-process model gives us professionals greater freedom, and is more in line with the individual's differences.

In summary, a transition from historical stage-based models toward contemporary frameworks, such as the Dual Process Model, is essential to

adequately address individual diversity in bereavement. While these theoretical constructs provide necessary clinical scaffolding, practice must remain centered on the idiosyncratic experience of the bereaved. Furthermore, the integration of such models enables the validation of divergent coping styles within families, acknowledging the clinical reality that synchrony in the grieving process is inherently unattainable.

Conclusions

1. Traditional stage-based models should be transitioned into a historical framework, acknowledging their role as foundational milestones in the evolution of our understanding of bereavement while recognizing their limitations in contemporary practice.
2. The Dual Process Model (DPM), developed by Stroebe and Schut (1991), provides a more robust clinical platform, offering practitioners the flexibility to address the inherent diversity of human responses to loss beyond linear trajectories.
3. Within the DPM framework, cognitive avoidance and denial are reconceptualized as adaptive coping mechanisms essential to the oscillation process, rather than pathological symptoms requiring clinical correction.
4. While theoretical frameworks like the DPM serve as essential heuristic tools, they must not supersede the idiosyncratic experience of the bereaved or the primacy of the therapeutic alliance in clinical intervention.

Future research should prioritize longitudinal analyses of Dual Process Model oscillation patterns and emotional simultaneity, particularly in children, while focusing on the development of cultural adaptations, age-appropriate therapeutic tools, and family-based protocols to address desynchronized grieving and systemic stability.

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