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ANTICIPATORY GRIEF: A REVIEW

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Abstract—In this review the term anticipatory grief is defined and described. Misconceptions about the reaction which may have been applied in previous literature are noted and their origin discussed. Empirical studies of the impact of an anticipatory grief reaction on subsequent adjustment are presented, with a discussion of the reasons for their disparate results and suggestions for future research. The relevance to the clinician of the anticipatory grief reaction in both family and professional caregivers is considered.

Key words—anticipatory grief, dying, death, bereavement

INTRODUCTION

This review will address the following questions:

(1) Does a phenomenon 'anticipatory grief' exist? If so, what are its characteristics? Does it differ from post-death grief?
(2) Does it follow a clearly definable sequence of stages?
(3) What is the impact of anticipatory grief on subsequent adjustment?
(4) What are the issues which future studies of anticipatory grief should attempt to address?
(5) What is the relevance of knowledge of anticipatory grief to clinicians?

Anticipatory grief is defined by Aldrich [1] as "any grief occurring prior to a loss, as distinguished from the grief which occurs at or after a loss" (p. 4). The term was first introduced by Lindemann [2] in what has since become the classic paper on acute grief. Writing during the Second World War, he was surprised at the reactions of relatives of members of the armed forces where the threat of death was ever present. Relatives not only passed through the phases of grief but occasionally the resolution of their grief was so complete that a returning soldier would be met with rejection. Similarly, Fulton and Fulton [3] point out the difficulty of re-integration faced by those released from jail, or long hospital stays, since in their absence their families have established new role relationships which no longer include them. David [4] has described this difficult situation as "The Resurrection of the Dead Syndrome". Since Lindemann coined the term, anticipatory grief has usually been discussed in the context of families and patients facing a lengthy terminal illness such as cancer. The term has now come to be generally accepted as a fact and indeed has been the subject of two books known to the authors [5, 40]. It is assumed that the family members of dying patients are so concerned with their adjustment in the face of the potential loss that they slowly experience all the phases of normal grief as they cope with the illness or endure separations prior to death, and as a result of this emotional preparation they experience less grief after the death.

DOES ANTICIPATORY GRIEF EXIST?

Although writers like Gerber [7] note that clinicians generally agree that future survivors will show signs of emotional grief work similar to those seen after a sudden or unexpected death, most would agree that the existence of anticipatory grief must be confirmed through empirical study.

Empirical studies describing a phenomenon which might be labelled as anticipatory grief follow an interesting pattern. The majority of these studies were conducted during the 1950s and 1960s and document the reactions of the parents of children with malignant diseases. More recently, investigations have attempted to investigate relatives of dying adult patients. These studies will now be described.

Studies of the reactions of the relatives of dying patients

Richmond and Waisman [8] present observations made during their management of 48 children with leukaemia and many other children with malignant diseases. They document parental withdrawal, feelings of unworthiness, preoccupation with thoughts of earlier times in the life of their child, and anxiety about both their responsibility for the development of the illness, usually resulting in guilt, and also around the prospect of separation from the child, resulting in a feeling of emptiness. They note their belief that, because malignant diseases do not usually result in sudden death, the mourning process occurs prior to the death of the child. Although the parents were involved solely with their own child during its initial period on the ward, a shift occurred with time so they developed the desire to care for the other sick children on the ward as well. Richmond and Waisman regarded this capacity to give to other children as marking a turning point in parental adjustment reflecting acceptance of their child's illness and ultimate death.

In a study of parental adaptation to the threatened loss of their children from acute leukaemia, Bozeman *et al.* [9] collected data from focussed interviews with 20 mothers. The initial reaction to the diagnosis was one of shock—refusing to believe it, or receiving it as like a physical blow. This was followed by an

effort to deny the fatal diagnosis, screening out the reality of the situation or attempting to alter it by, for example, consulting other doctors or searching for information to conflict with the fatal nature of the diagnosis. The authors describe parental guilt concerning responsibility for the illness, and anger and hostility focussed at the physician. The stage of hospital admission resulted in separation anxiety with clinging to the child and concern with its condition and treatment. Acceptance of the diagnosis was associated with an intellectual but not emotional rejection of hope.

Natterson and Knudson [10] describe a triphasic response in mothers whose children survived more than 14 months from the fatal prognosis. The first phase was associated with denial, either of the reality of the diagnosis or of its fatal nature. Twenty-five of these 33 mothers were tense, anxious, withdrawn and weepy. The second phase was associated with efforts to prolong the child's life—despite the abandonment of conscious denial, the mothers clung to a hope of saving their child. Natterson and Knudson describe the final phase (for 19 mothers) as one of "calm acceptance" of the fatal outcome. These mothers could express a wish for their child's death in order to end the suffering. Their interest in the disease and in the provision of physical aid was no longer directed solely towards their own child, but towards all children on the ward, and when their children eventually died their reactions were a mixture of calm sorrow and relief.

Chodoff *et al.* [11] describe the reactions of 46 parents of 27 children under treatment for malignant disease as forming an orderly and predictable "natural history" of adaptation to the situation. Prior to the actual diagnosis some parents experienced uneasiness because of their suspicions. The diagnosis was received physically as "a stun". Although their child's hospital admission usually resulted in an intellectual acceptance of the grim reality of the diagnosis and prognosis, emotional denial continued. The most common parental coping defences at this stage were isolation of affect (giving an impression of coldness, as though they were dealing with the tragedy of another family) and/or excessive physical activity. Chodoff *et al.* note a reciprocal relationship between these strong denial processes and the anticipatory mourning which they describe as occurring most clearly if the child's illness lasts for over 3–4 months, and which they relate to an emotional acceptance of the fatal nature of the disease and a reduction of hope. They describe this grief as associated with somatic symptomatology, preoccupation with thoughts of the ill child, and also a gradual detachment of investment from their child. They describe the post-death reactions of the 4 parents who had clung to denial rather than experience anticipatory mourning as being the most distressing.

Binger *et al.* [12] conducted a retrospective interview study of 20 families who had lost a child from acute leukaemia. The diagnosis was received as a hard blow with reactions typical of shock or denial. Binger *et al.* note that from the time of the diagnosis through the child's illness and its subsequent death, parents manifested 'anticipatory' as well as subsequent grief reactions. They describe the anticipatory grief reaction as being one of physical distress, depression, inability to function, anger, hostility and self-blame.

> The actual death was not always the most important event in the parents' recollection of the child's illness. Often, the time of initial diagnosis was equated with death, and it was then that grieving began. The parents of 10 children expressed a sense of relief as well as grief at the time of the child's death. Some were relieved that the child's suffering was at an end; others felt released from longstanding worry over when and how the child would die (p. 417).

It is interesting that this point in the chronology corresponds roughly with a number of publications which clearly consider grief as a process or series of stages. Bowlby [13] published 'Processes of Mourning' with a description of the way in which "loss of loved object leads to a behavioural sequence which, varied though it be, is in some degree predictable". He presents the following three phases of mourning: (1) Urge to recover lost object—characterised by yearning, searching behaviour, and frequent anger. (2) Disorganisation and despair—characterised by aimless or restless behaviour, depression and apathy. (3) Reorganisation and resumption of life directed towards a new object. Bowlby [14] amended this description with the addition of "an important first phase which is usually fairly brief", that of numbing. In addition, he describes the anticipatory grief process for the parents of fatally ill children in terms of these phases of mourning, i.e. initial numbing followed by disbelief and attempts to reverse outcome (the equivalent to urge to recover lost object), despair and disorganisation, and finally a subsequent reorganisation. Similarly, Parkes [15], described by Shackleton [16] as "heavily influenced" by Bowlby, with whom he worked, presents data which he notes confirms "in general... Bowlby's belief that grief is a phasic process although the transitions from one phase to another are seldom distinct and features from one phase of grief often persist into the next". He describes these phases as numbness, followed by protest and yearning, then disorganisation, then reorganisation as the bereaved person begins to pull life back together.

A watermark publication in the anticipatory grief literature was that of Kubler-Ross's book, 'On Death and Dying' [17]. Written after $2\frac{1}{2}$ years of listening to, and learning from, the stories of dying patients, Kubler-Ross presents the way in which some American people coped with the prospect of their own death as a series of stages. These form the titles of chapters in the book:

First stage:	Denial and Isolation.
Second stage:	Anger.
Third stage:	Bargaining.
Fourth stage:	Depression.
Fifth stage:	Acceptance.

In her comparatively brief discussion of the reactions of the relatives of dying patients, Kubler-Ross describes the different stages of their adjustment as similar to the ones undergone by the patients themselves. She cites initial denial, reassurance-seeking and secrecy about the diagnosis among family members. This is followed by anger, often projected

at the medical staff, and guilt at opportunities missed. The third stage is the expression of the emotions of grief and the sharing of the sad situation with the patient. Kubler-Ross believes that families who can share these emotions will be able to gradually face the reality of the impending death and separation and come to a state of acceptance—which is the final stage of preparatory adjustment on the part of the relatives of a dying person. While it should be recognised that a number of criticisms have been brought against this stage model [18–20], these will not be discussed here.

Following this presentation of familial adjustment as a sequence of stages, Futterman *et al.* [21] describe parental anticipatory mourning as "a series of interdependent part processes" which "emerge and reach prominence at different points in time" (p. 252). Their observations suggest the sequence of these processes as:

(1) Acknowledgement of the inevitability of the child's death.
(2) Grieving—experiencing and expressing the emotional impact of the anticipated loss.
(3) Reconciliation to the child's expected death, but preserving a sense of the worth of the life it has left.
(4) Detachment—a withdrawal of emotional investment from the child as a person with a future, and finally
(5) Memorialisation—the development of a fixed representation of the child (either abstract/generalised traits, or idealised) which will endure after the child's death.

In a study of 73 women (median age 53 years) whose husbands died of cancer, Vachon *et al.* [22] note that 40% of them reported that they had refused to accept the fatal prognosis (using denial to cope with the stress of terminal illness). They point out that it is possible to perceive of such an illness as either 'terminal' (and so leading to death), or as 'lingering' (in which case death is not anticipated).

In one of the few available studies to attempt to explore the experience of anticipatory grief in family members of dying patients using a recognised questionnaire, Welch [23] administered a 12-item revision of the Texas Inventory of Grief [24] to 41 relatives of cancer patients. She found significantly higher mean grief scores (which she regarded as indicative of more problems coping with unresolved grief responses) to be associated with:

(1) The patient being treated in a specialised oncology unit (possibly due to the salience of the diagnosis in these units).
(2) Feeling panicky about the possibility that something might happen to the patient while they are at home.
(3) Crying about the diagnosis.

Lower mean grief scores were associated with having previously lost a relative to cancer and with having an elderly patient. Welch concludes that "anticipatory grief is very much a normal and expected process in coping with the anticipated death of a loved one" [23, p. 156].

Jacobs *et al.* [25] compared 150 acutely bereaved widows and widowers with a group of 68 non-bereaved married persons whose spouse was hospitalised with life-threatening illness. They used a structured interview comprising items constructed from statements of acutely bereaved adults, tailored to assess numbness–disbelief and separation anxiety, plus a depression scale to assess manifestations of sadness and despair. Those threatened with imminent loss had lower depression and numbness–disbelief scores than the bereaved; however, those items which characterised the pangs of grief were not specific for actual bereavement and, it was concluded, "appear to be equally an assessment of distress evoked by an imminent threatened loss" [25, p. 34].

Discussion

The literature with regard to the reactions of parents of dying children seems remarkably consistent, so much so that it is almost as if one is reading the same study over and over again. The change that occurs in studies conducted and published at a later date is not in the nature of the reactions observed, but in the way they are documented. Instead of describing the adjustment of these parents in rather general terms, the move is towards systematising reactions into a series of well-defined stages. Certainly this makes for simplicity, but the question then arises whether, as with Kubler-Ross's [17] presentation of stages in the emotional adjustment of dying patients themselves, people have responded to the stages in the adjustment of the family members somewhat too literally, and now expect them to pass through them in a neat serial fashion.

Possibly the name 'anticipatory grief' has contributed to this problem of definition. Such a label would tend to lead to the assumption that anticipatory grief is exactly the same as post-death grief (generally defined as a series of phases [15, 26]). Only a few authors actually note that this cannot be the case. Aldrich [1] points out that anticipatory grief differs from conventional grief in that (1) it is usually experienced by both the patient and his family, (2) it cannot be infinitely prolonged since there is always the endpoint of the death, (3) theoretically it should accelerate rather than diminish with time, (4) should ambivalence be present, the potentially dangerous impact this will have on the vulnerable patient may lead anticipatory grief to be more easily denied than conventional grief, and (5) finally, of course, only anticipatory grief can include a phase of hopefulness. In their discussion of anticipatory grief as "a psychosocial concept", Fulton and Gottesman [27] point out a further difference between conventional and anticipatory grief in that truly bereaved persons can wholly take on their rôle as such, in comparison with survivors to be who are in the difficult and ill-defined position of being unable to really take on the rôle of 'bereaved person'. Among the misconceptions about anticipatory grief noted by Rando [40] is the belief that, just as overcoming conventional grief in a healthy way requires a final detachment, so the final stage of anticipatory grief must be a withdrawal from the dying individual. She asserts that detachment and the provision of care and love are not mutually exclusive.

Certainly, no one would argue with the fact that knowledge of a terminal illness in a significant other will result in a set of emotional changes. However, the existing investigations of the nature of anticipatory grief which are largely based on observation do not allow us to confidently support the notion that these changes are so similar to conventional grieving that they should be termed 'anticipatory grief'. Siegel and Weinstein [28] question whether such a clearcut phenomenon exists at all, and assert that possibly it has become a self-fulfilling prophecy with clinicians seeing what they expect to see.

THE IMPACT OF ANTICIPATORY GRIEF ON POST-BEREAVEMENT ADJUSTMENT

Anticipatory grief has generally been regarded as protective in that it should allow the future survivor time to rehearse some of the emotions normally associated with bereavement in advance. As noted by Pine

> Our notions about anticipatory grief suggest that people who work through the grief of loss while it is still potential are better able to cope with death because, in effect, they have resolved their grief in advance [29, p. 38].

Studies of the effects of an anticipatory emotional reaction on subsequent adjustment differ from those on the nature of the putative anticipatory grief process on several counts: firstly, their subjects are nearly all adults bereaved of a spouse (rather than a child); secondly, they have generally attempted to base their conclusions on empirical data rather than subjective observations; and thirdly, they have been conducted since 1970—rather as if this was the date at which anticipatory grief came into existence as a real concept whose effects could then be studied. These investigations will also be reviewed chronologically.

Studies of the impact of an anticipatory emotional reaction on subsequent adjustment

Clayton [30] describes a study to investigate "not whether anticipatory grief exists, but whether it is psychologically useful in mitigating the post-mortem grief of the survivor" (p. 47). This study provides data (obtained by interview after a death) on 81 widows and widowers (average age 61 years) at three time periods: during the illness of the spouse (retrospectively), 1 month, and 1 year since the death. If subjects confirmed a constellation of depressive symptoms during the terminal illness, it was considered "an anticipatory grief reaction"; and it was termed "a normal depressive reaction" if it was present following the death of a spouse. Results showed (1) that length of terminal illness (over or under 6 months) was unrelated to the prevalence of symptoms after the death, and (2) that the 'anticipatory grief' depressive cluster was positively associated with depression 1 month after the death, but there was no such relationship a year later.

Gerber *et al.* [31] compared 65 widows and widowers (mean age 67 years) whose spouse had died after a 'chronic' illness (defined as being of 2 or more months' duration) with 16 whose spouse had died after an 'acute' illness (defined as occurring without any warning, or as being of under 2 months' duration). Since their measures of medical adjustment 6 months after bereavement showed no significant differences between those whose spouse died after an 'acute' rather than a 'chronic' fatal illness, Gerber *et al.* tentatively conclude that exposure to anticipatory grief has no effect on subsequent medical adjustment in this group of subjects. However, those elderly bereaved subjects whose spouse had died after more than 6 months' fatal illness did report more physician office visits and more occasions when feeling ill without seeing a physician than those whose spouses died after a shorter term fatal illness. Gerber *et al.* therefore suggest that it is lengthy experience with anticipatory grief (described as an "extended death watch"), which accounts for poor subsequent medical adjustment rather than the phenomenon itself—possibly because of the emotional pressure, plus neglect of the survivor's own health while their spouse was dying.

In a postal questionnaire study of 80 widows, Ball [32] found that both age of the widow and mode of death of the husband were significantly related to the intensity of the grief reaction. Sudden death (operationally defined as less than 5 days from onset of symptoms and assumed to be a situation where no anticipatory grief occurred) was associated with a more intense grief response than prolonged death (6 or more days of illness, anticipatory grief assumed to have occurred). In addition, the younger widows (aged 18–46) had the most intense reaction. Ball concludes that anticipatory grief results in improved subsequent adjustment in young bereaved persons and that, in fact, age is more predictive of outcome than mode of death for whether there is a severe grief response.

Sanders [33] conducted the first available study to attempt to assess post-mortem grief directly using a questionnaire rather than assuming adaptation from other variables (such as depression). She administered the Grief Experience Inventory, a self-report instrument [34] to 102 newly bereaved individuals (mean age 52 years) approx. 2 months after the death. She found no significant group differences in the reaction to 'sudden' (defined as within 7 days of illness/accident) compared with 'chronic' illness death. Nor did length of illness at home make any difference in reducing bereavement intensities.

Similarly in Bowling and Cartwright's [35] book 'Life After Death—A Study of the Elderly Widowed', the authors note no association between subsequent adjustment and length of the spouse's terminal illness, the place of death, or whether the widow had been aware of the fatal prognosis or expecting the death.

In their account of the Harvard Bereavement study (in which interviews were conducted with 43 widows and 16 widowers at 3 weeks, 2 months, 13 months and 2–4 years after the death of a spouse aged less than 45 years from natural causes or accident), Parkes and Weiss [36] address the effects of unanticipated vs anticipated loss. Those bereaved in the 'unanticipated'/'brief forewarning' group had less than 2 weeks' warning that their spouses' deaths were imminent. When compared with the 'anticipated bereavement' group they were more likely to have

expressed disbelief at news of the death, and to exhibit anxiety, depression, guilt, anger and self-punitive wishes throughout the recovery period. Even 2–4 years after bereavement they were more likely to be unable to accept the death, to be emotionally disturbed, and to have made a poor social recovery (to be isolated, less likely to be remarried). Parkes and Weiss do not view these results as confirmation of a reaction which can be termed 'anticipatory grief' and which therefore reduces the post-death grief. Rather they regard unanticipated bereavement as qualitatively different (more traumatic) from anticipated bereavement. They explain this in terms of the sudden way in which it invalidates the survivor's assumptions about the world and the fact that it confirms the world as unpredictable and anxiety provoking—best coped with by withdrawal and social isolation. Survivors of anticipated bereavement, on the other hand, have had a chance to become socialised into their new rôle with time to create a new set of expectations and assumptions that increase the chances of a smooth transition into the new life situations.

Rando [44], in the only available study of post-bereavement adjustment in subjects whose children (rather than spouses) had died, collected data via a structured interview with 54 parents whose child had died from cancer 2 months to 3 years previously. Rando attempted to operationalise anticipatory grief as the numerical sum of 8 behaviours engaged in during the child's terminal illness (e.g. discussing with someone the possibility that their child would die). She also assessed post-death grief via the Grief Experience Inventory [34]. She believes her results confirm the importance of anticipatory grief prior to the death in that it was positively associated with preparedness at the death and with fewer atypical responses after the death. She suggests that there may be an optimum length of terminal illness in terms of subsequent parental grief experience: parents whose child died after an illness shorter than 6 months or longer than 18 months were least prepared for the death and had poorer subsequent adjustment. Rando therefore concludes that, in terms of adjustment after the death, there is an optimum amount of anticipatory grief, and she comments that there can be "too much of a good thing". She relates this to the possibility that during a short illness the parents may not have enough time to prepare themselves sufficiently, but during a long illness they cannot prepare adequately either because of the lengthy period of stress and the denial which may arise after a series of remissions and relapses.

In an investigation which measured past bereavement adjustment in terms of registered days of sickness per year, Lundin [37] compared 32 relatives, aged 40–50 years, who had suffered sudden and unexpected bereavement (operationalised as the deceased being under 65 years, without prior chronic illness, fatal illness lasting under 2 hr, news of death given without any preparation), with 55 control relatives where death had been expected. He found that, when compared with prior to bereavement, there was a significant increase in sick days (particularly for psychiatric illnesses) taken by relatives after a sudden death. There was no increase in number of sick days taken by the control relatives after bereavement. Lundin therefore concludes that sudden and unexpected bereavement is associated with increased psychiatric morbidity, and that such persons should be regarded as a high risk group. In a follow-up study [38] 8 years after bereavement, the adjustment of these subjects was assessed using the Expanded Texas Inventory of Grief. It was found that, even at this stage, relatives of suddenly and unexpectedly deceased persons had a higher degree of mourning, significantly more guilt feelings, reported more numbness, missed the dead person more and had a greater need to cry. In other words, as Lundin notes, this group had more pronounced grief reactions than those of persons whose deaths were more expected.

Jacobs *et al.* [39] interviewed 114 acutely bereaved spouses in order to test clinically based impressions that widowers in comparison to widows, and the older bereaved in comparison to middle-aged subjects, would report distinctive aspects of grief and less intense distress. They used a structured interview comprising items constructed from statements of acutely bereaved adults, tailored to assess numbness–disbelief and separation anxiety, plus a depression scale to assess manifestations of sadness and despair. They were surprised to find no significant attenuation of grief among the elderly as compared with middle-aged subjects. By assuming firstly that the death of a marital partner is less unexpected and untimely for elderly persons, and secondly that this means anticipatory grief would have occurred amongst this group of subjects, Jacobs *et al.* conclude that these results do not support the idea that anticipatory grief attenuates the intensity of the actual distress after a loss occurs.

DISCUSSION

In contrast to the consistent literature with regard to the emotional reactions of the relatives of dying patients, studies of the impact of anticipatory grief on the adjustment of bereaved persons give conflicting results. Advanced warning of death is positively associated with good subsequent outcome in some studies [32, 36–38]. In other studies there is no association between advanced warning and outcome following bereavement [30, 31, 33, 35, 39]. Lastly, Clayton *et al.* [30] found that anticipatory grief, when defined as depression, was positively associated with depression soon after bereavement, but not 1 year later, and the studies by Gerber *et al.* [31] and Rando [44] demonstrated that an extended terminal illness was related to poor post-death adjustment.

A number of explanations have been offered for these contradictory findings [27, 28, 40]. The first arises as a product of the fact that anticipatory grief is a subjective experience which has never been consistently operationally defined. One result of this is a huge variation in the length of time marking the division between sudden or unanticipated death and anticipated death: anything from 2 hr [37, 38] to 6 months [30]. Additionally, anticipatory grief is often assumed to have occurred just because of the fact that the death is anticipated. But, as Vachon *et al.* [22] point out, there is often a high degree of denial

of a fatal prognosis with surviving relatives perceiving the illness as either terminal or lingering. Although Clayton *et al.* [30] attempt to overcome this by defining anticipatory grief as a cluster of depressive symptoms prior to bereavement, this may not be the most appropriate assessment. One could argue that a grief reaction constitutes far more than merely depression.

Similar problems occur in the definition of post-bereavement adjustment which the different studies use—for example, self reports of medical symptoms [31], depressive symptomatology [30], social isolation [36]. Once again, it could be argued that adjustment is far more global than can be recorded by these specific measures.

Not only do the studies differ in the definition of the variables which they investigate, but they also differ in methodology. One example of this is in the ages of the subjects studied: from 'aged widows and widowers', mean age 67 years [31] to widowed subjects from 18 years old [32]—this author points out an inverse association between age and severity of the grief response. Other examples of methodological differences include the range of subjects studied (parents, widows, or both widows and widowers), the variation in the nature of the data collected (anything from several lengthy interviews to a postal questionnaire), the number of interviews that were conducted, and lastly, the ways in which the data were analysed. In their discussion of these issues, Fulton and Gottesman [27] conclude:

> the methodological difficulties and differences reviewed here raise compelling questions as to the reliability, comparability and validity of the studies, and casts serious doubts upon the conclusions reached (p. 49).

Another issue to confound the research findings is the numerous elements associated with a lengthy terminal illness besides the possible presence of anticipatory grief. Siegel and Weinstein [28] cite factors such as the emotional isolation and physical exhaustion, and they suggest that such sequelae of a lengthy terminal illness may serve to negate any gains which result from a period of anticipation. An additional dimension which distinguishes anticipated from unanticipated bereavement is the fact that sudden (unanticipated) deaths are often also very traumatic, being the result of violence or accident, or are untimely since the decreased is often younger [36, 40]. The distinction is therefore also between a 'high grief potential' death (the sudden death of a person on whom others depend) and a 'low grief potential' death [3].

A final factor which has not been addressed in the available studies on the relationship between anticipatory grief and subsequent adjustment is that it must be subject to individual differences. Bourke [41] points out that those with a history of uncomplicated grief in the pre-death period might be expected to cope in a satisfactory way after a death, whereas those with a difficult pre-death period will probably experience difficulty following bereavement. If this is the case, subjects might require to be studied individually in a longitudinal fashion throughout the pre- and post-death period, because analysis on a group basis will eliminate any individual differences.

CONCLUSIONS FROM PREVIOUS RESEARCH AND ISSUES FOR FUTURE STUDIES

The early observational studies with respect to 'anticipatory grief' reactions in parents of sick children are consistent in recognising a phase-like process, with initial shock and efforts to deny the fatal diagnosis, followed by clinging and mourning behaviours. The last phase, usually after 3–4 months, is that of emotional detachment from the child, and this is generally taken to be associated with calm acceptance of the death. Similar reactions to the terminal illness of adult relatives have also been detailed. However, studies of the possible value of anticipatory grief in mitigating post-bereavement grief have yielded conflicting results. This should not be a surprise. Presumably, the literature describing 'anticipatory grief' reactions is consistent precisely because the studies are all investigating the same process, whereas studies of the impact of anticipatory grief have employed widely different designs and subject groups and have investigated different aspects of the pre- and post-bereavement reaction.

In order to confidently answer questions on the nature and impact of an anticipatory grief reaction, future studies require to develop an operational concept before trying to define its characteristics, and then to investigate the impact it has on subsequent adjustment. This would yield studies with comparable results. In addition, investigations of the pre- and post-death periods as one unit on a subject-by-subject basis might provide information on individual differences which is obscured by whole group analysis. It might also highlight those individual characteristics which are associated with the risk of poor adjustment both before and after the death of a significant other.

THE RELEVANCE OF ANTICIPATORY GRIEF TO THE CLINICIAN

When considering the relevance of anticipatory grief to the clinician, it may again be convenient to separate the nature of the anticipatory grief process from its impact on subsequent adjustment.

The reactions to the terminal illness of a loved one which have been described repeatedly are such as to cause not only distress but potentially also to spoil the last few months or weeks of the relationship [3, 27, 28, 40]. Firstly, grief is not only painful. There is evidence that bereavement increases the risk of physical and psychological illness. Secondly, a gradual emotional detachment from the ill person may also be associated with a physical withdrawal. Potential negative consequences of this include the private guilt and public censure of the 'callous' future survivors who do not exhibit the grief that is expected of them during the terminal phase of a long illness. It could also impinge on the dying patients themselves who, as well as having to cope with the fact of their own imminent deaths, may believe that their relatives are not particularly concerned or aggrieved at their dying—and who may find themselves physically as well as psychologically isolated, surrounded only by the paraphernalia of modern medical care.

The majority of terminally ill patients and future survivors are left largely without professional support during this period. Lebow [42] has detailed a set of practical casework goals for the clinician in order to provide an opportunity for both family and patient to grapple with crucial issues of the adaptional process in a mutually beneficial fashion. These 'adaptational tasks' are as follows:

(1) Remaining involved with the patient—responding to their experience and sharing those of the rest of the family.
(2) Remaining separate from the patient—believing in oneself as an individual who can and will exist in a future without the patient.
(3) Adapting suitably to rôle changes—assuming immediate new duties and anticipating future new responsibilities.
(4) Bearing the affects of grief—acknowledging and expressing the feelings aroused by the terminal illness.
(5) Coming to terms with the reality of impending loss—being able to tolerate thoughts of the future and making the practical plans required to deal with it.
(6) Saying goodbye—acknowledging the end is near and communicating a verbal or non-verbal farewell.

As well as the importance of intrafamilial mutual support for coping with a death, the validity of more formal support groups for the future survivors has been documented [43]. They allow for a sharing of factual information, and for the normalisation and expression of the emotions of the anticipatory grief process at a time when their relatives or friends may actually be avoiding them in order to reduce their own awkwardness or pain at the situation. Again, the aim is to encourage successful closure of the relationship, reduce guilt, and so reduce the chances of a 'bad' post-bereavement grief.

It is not only the family members who require information on the nature of the anticipatory grief reaction, and support as they live through it. Caregiving staff are involved as well. If not fully prepared for their rôle of providing care for dying patients rather than curing them, they may be unable to fully support the patient and family—and, in addition, find themselves excessively stressed, or feeling as if they have somehow failed when they experience the reactions of grief. If not dealt with, potential effects of this situation are staff burnout, withdrawal from patients and the guilt of the caregiver who believes that good carers cannot have bad feelings [6].

The contrary conclusions of the literature concerning the subsequent impact of anticipatory grief preclude firm guidelines for clinicians to aid in the identification of potentially 'at risk' survivors. While there is some evidence that a greatly extended terminal illness or an 'untimely' death is related to poor post-death adjustment, the best guideline might be that every person's reactions will be individual, based on factors such as their previous loss experience and coping history, the nature of their relationship with the decreased and the meaning they attach to illness and death.

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