

**REVISITING ELISABETH KUBLER-ROSS:  
PASTORAL AND CLINICAL IMPLICATIONS OF THE  
DEATH AND DYING STAGE MODEL IN THE CARING PROCESS**

By  
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During the last centuries, different events and circumstances have intensified researchers' interest in studying the human experience of death and dying. A significant event in 1941, a fire in which 300 persons died at the Coconut Grove night club in Boston, persuaded Erich Lindeman<sup>1</sup> to study the experience of grief among surviving family members. Later during the 1960's, as cancer became the leading cause of death among Americans, authors like Elizabeth Kübler-Ross (1926-2004)<sup>2</sup> became a leading figure in unveiling death from the prevailing taboos of the time. Most recently, AIDS as the new global illness has generated a fresh new interest in understanding the experience of dying.

Two distinct areas of study have led research in this field.<sup>3</sup> One is the biomedical perspective, which includes sciences such as thanatology and pathology. The other is the psychosocial perspective, represented primarily by the fields of psychology, sociology, theology and psychiatry. Together, these fields conduct research seeking to understand how humans cope and respond emotionally, socially and spiritually to the experience of dying.

This article will explore some of the studies produced from the psychosocial perspective, only. My interest in the topic of death and dying will be limited to examining Kübler-Ross' stages of death model. I have chosen her work for one basic reason. Having arrived to Puerto Rico after years doing clinical work abroad, it was surprising to me that her theory continues to be a dominant theoretical framework used by the pastoral caregivers engaged in understanding the patient's dying experience. To a certain extent, Kübler-Ross' model or theory seems to be the rubric by which most arrive at their theological and pastoral care decisions. In my work experience, this issue did not come as a surprise. Already I was aware that, amidst scholarly critique to Kübler-Ross' work, the model had greatly influenced most disciplines and had prevailed. To find some answers to this dilemma, the next following discussion will focus on understanding the basic axioms of Kübler-Ross' theory and the pastoral and clinical implications in the caring process.

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<sup>1</sup>Erich Lindeman, "Symptomatology and Management of Acute Grief," *American Journal of Psychiatry* 101 (1944): 141-149.

<sup>2</sup>Elizabeth Kübler-Ross, *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy, and Their Own Families* (New York: McMillan Co., 1969).

<sup>3</sup>For a complete survey of the development and direction of Thanatology literature see: Samuel Southard, *Death and Dying: A Bibliographical Survey* (New York: Greenwood Press, 1991).

## Genesis of Kübler-Ross Stage Model Theory

At popular levels, people relate, and usually limit their understanding of Kübler-Ross work to the first part of the title of her book, "*On Death and Dying*." However, it is in the less notorious subtitle of her work, "*What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families*," where one can find a better summary of the intentions and motivations of her book. The subtitle suggests that Kübler-Ross' attempt was to increase caregivers' and health care providers' levels of sensitivity and awareness concerning the dying person's needs. In her words, "We have asked him [the patient] to be our teacher so that we may learn more about the final stages of life with all its anxieties, fears, and hopes."<sup>4</sup> With that purpose in mind, and after her research on the subject, she proposed a five stage model in order to facilitate our understanding of the patient's experiences during the dying process.

The stages are: denial and isolation, anger, bargaining, depression, and acceptance. Although she clearly states that the stages are not rigid and they will last for different periods and will replace each other or exist at times side by side,<sup>5</sup> the way she articulates her theory is not consistent with the graph she produced to present the model. For that reason, although one can read in her description of the stages the non-progressive aspect of her theory, one can also see in the visual design of her model the interconnected and ascendant aspects of her theory. Clearly this aspect suggested the perceived concept of a sequential progression, whether this was her intention or not. The following table represents the model as proposed in her book.<sup>6</sup>

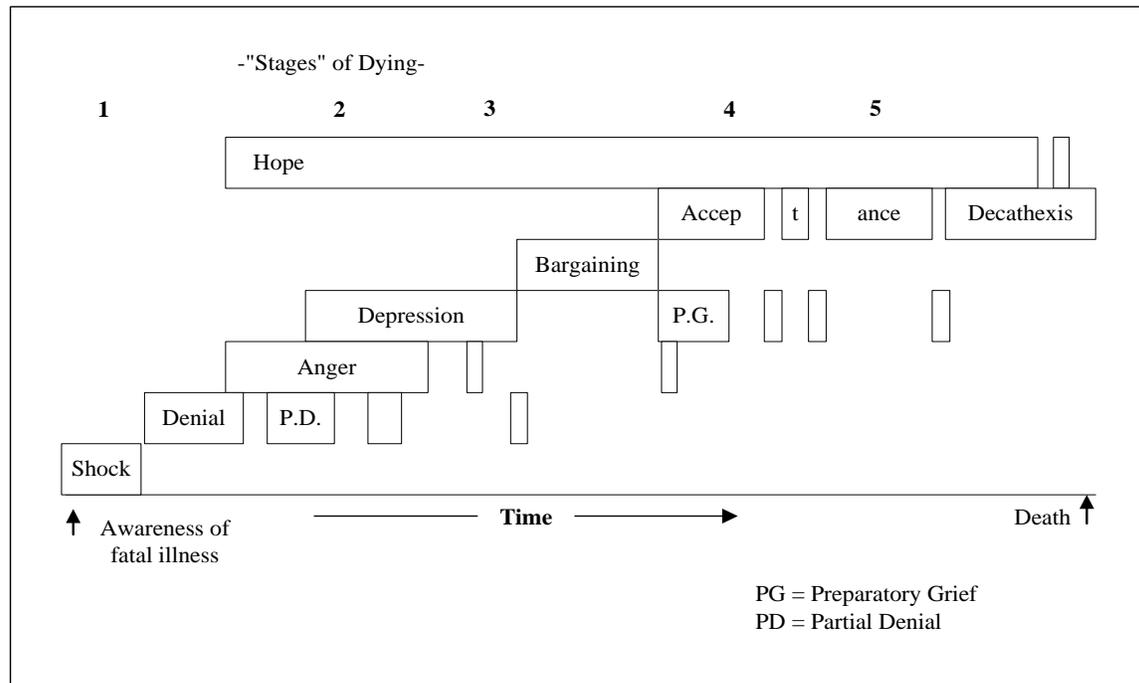
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<sup>4</sup>Kübler-Ross, *On Death and Dying*, xi.

<sup>5</sup>Kübler-Ross, *On Death and Dying*, 139.

<sup>6</sup>*Ibid.*, 264.

## Kübler-Ross: Dying Stages Model



Kübler-Ross explains that she developed her model as a result of her "experiment," with over two hundred terminally ill patients. Concerning the genesis of her study, she states:

In the fall of 1965 four theology students of the Chicago Theological Seminary approached me for assistance in a research project... Their class was to write a paper on "crisis in human life," and the four students considered death as the biggest crisis people had to face.<sup>7</sup>

This request motivated her to engage with the students in the study of the dying at the University of Chicago Hospital. Indications of both the extension of her research and her research protocol are not clear in her book.

### The Death and Dying Stages: A Review

1. **Denial and Isolation.** Kübler-Ross states that, "Among the over two hundred patients interviewed, most reacted to the awareness of a terminal illness at first with the statement, "No, not me, it cannot be true!" The patients, she argues, made use of denial not only in the initial stages of their illness, but in later periods also. Hence, denial "... functions as a buffer after unexpected shocking news, allows the patient to collect himself and, with time,

<sup>7</sup>Kübler-Ross, *On Death and Dying*, 21.

mobilize other, less radical defenses."<sup>8</sup> Eventually, she states, "Denial is usually a temporary defense and will soon be replaced by partial acceptance."<sup>9</sup>

2. **Anger.** This is the substituting stage to denial. From her perspective, "When the first stage of denial cannot be maintained any longer, it is replaced by feelings of anger, rage, envy, and resentments."<sup>10</sup> This stage is distinguished from denial in the fact that patient's displace their feelings of anger toward medical staff, family, the physician, onto the environment, etc.<sup>11</sup> Kübler-Ross suggest that since the patient's reasoning to be angry may be irrational, the patient's anger, when cast on to others, should not be taken personally.

3. **Bargaining.** From her point of view, although this stage is not well known, it is equally helpful to patients, at least for brief periods of time. During this stage, states Kübler-Ross:

If we have been unable to face the sad facts in the first period and have been angry at people and God in the second phase, maybe we can succeed in entering into some sort of an agreement which postpone the inevitable happening: If God has decided to take us from this earth and he did not respond to my angry pleas, he may be more favorable if I ask nicely.<sup>12</sup>

From her perspective, this stage could be related to children first demanding, then asking for a favor. In that sense, patients who are in the stage of bargaining may use the same maneuvers. In her words:

He [the patient] knows, from past experiences, that there is a slim chance that he may be rewarded for good behavior and be granted a wish for special services. His wish is most always an extension of life, followed by the wish for a few days without pain or physical discomfort.<sup>13</sup>

In Kübler-Ross' conception, the bargaining stage is a period of negotiation with a higher being. She describes this aspect of bargaining by suggesting that:

...[bargaining] is really an attempt to postpone; it has to include a prize offered "for good behavior," it also sets a self-imposed "deadline (i.e., one more chance to perform on stage, the chance to attend the son's wedding), and it includes an implicit promise that the patient will not ask for more if this one postponement is granted.<sup>14</sup>

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<sup>8</sup>Ibid., 39.

<sup>9</sup>Ibid., 39.

<sup>10</sup>Ibid., 50.

<sup>11</sup>Ibid., 52.

<sup>12</sup>Ibid., 82.

<sup>13</sup>Ibid., 82-83.

<sup>14</sup>Ibid., 83-84.

4. **Depression.** Two distinct aspects of depression are made in this stage, the reactive, and the preparatory depression. The reactive depression is associated to the feelings displaced by a patient before what they perceive has been lost, or what they are about to forcefully surrender as a consequence of their illness (i.e., the amputation of a leg or the loss of movement of the extremities).<sup>15</sup> The preparatory depression is one "...which does not occur as a result of a past loss but is taking into account impending losses."<sup>16</sup> Kübler-Ross sees in this type of depression a pre-stage to acceptance, "... a tool to prepare for the impending loss of all the love objects, in order to facilitate the state of acceptance."<sup>17</sup> To further elaborate this concept of bargaining, she adds:

The patient is in the process of losing everything and everything he loves. If he is allowed to express his sorrow he will find final acceptance much easier... This is the time when the patient may just ask for a prayer, when he begins to occupy himself with things ahead rather than behind."<sup>18</sup>

Kübler-Ross concludes her remarks on this stage by suggesting that this type of depression is "... necessary and beneficial if the patient is to die in a stage of acceptance and peace. Only patients who have been able to work through their anguish and anxieties are able to achieve this stage."<sup>19</sup>

5. **Acceptance.** In her conception, patients who have been assisted in working with the prior stages, will reach a stage during which he is neither depressed nor angry about his fate.<sup>20</sup> Characteristically of this stage is that patients' feels tired, quiet and weak, with a need to doze off to sleep and in brief intervals very similar to that of a newborn.<sup>21</sup> With regards to these moods, Kübler-Ross argues that these characteristics should not be taken as resigned and hopeless giving-up, rather they are indicators of the beginning of the end of the struggle, but they are not acceptance.<sup>22</sup>

As she describes it, "Acceptance should not be mistaken for a happy stage. It is almost void of feelings. It is as if the pain had gone, the struggle is over, and there comes a time for "the final rest before the long journey."<sup>23</sup> She distinguishes between the patient who fights death as means to deny it, and the patient who comes to terms with death and begins to detach from their loved-ones and this world, as the patients who are in acceptance. Concerning the first type of patient she states, "The harder they struggle to avoid the inevitable death, the more they try to deny it, the more difficult it will be for them to reach this final stage of acceptance with peace and dignity."<sup>24</sup> Though not specifically stated, it seems that

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<sup>15</sup>Ibid., 86.

<sup>16</sup>Ibid., 86.

<sup>17</sup>Ibid., 87.

<sup>18</sup>Ibid., 87.

<sup>19</sup>Ibid., 88.

<sup>20</sup>Ibid., 112.

<sup>21</sup>Ibid., 112.

<sup>22</sup>Ibid., 112-113.

<sup>23</sup>Ibid., 113.

<sup>24</sup>Ibid., 114.

she considers the second type of patient, (those who gradually detach from family, husbands, with this world, etc.,) the type of patients who fully reach the stage of acceptance.

### **Analysis and Critique to Kübler-Ross Model**

There is no question that it was Elizabeth Kübler-Ross who popularized the studies on the human experience of dying with her book *On Death and Dying*. It should be noted that she undertook this task at a time when at a societal level, the subject was considered taboo. In this book she elaborated what popularly came to be known as *the crisis stages of the terminally ill patient*. Although most contemporary scholars at the time the book was published initially questioned and resisted her theory and model, her work has survived her critics and her popular stages on death and dying has permeated most disciplines to this day.

As I will demonstrate, in this brief critical analysis of her work, Kübler-Ross' model was not supported by most of her contemporary researchers in the field. As we will also demonstrate, experts in the field consider the use of Kübler-Ross' model (as originally stated) a serious hazard, both to the patient and the care provider.

In general terms, it could be said that critique of her work will focus on three specific areas: 1) lack of traditional scholarly preparation; 2) the use of stages for the model, and 3) the clinical use and misuse of the stages. I will proceed to examine each of these areas of critique.

#### **1. Lack of Traditional Scholarly Preparation**

Many readers of Kübler-Ross assume that the studies on the subject of death and dying began with her work. In other words, many think of her as the pioneer in the field. I assume that such attributions are the result of her own claims, when she stated that she lacked direction when she was asked to write the book, or to her claims that her research was limited by the lack of data on the subject. Concerning her lack of direction, she states:

When I was asked if I would be willing to write a book on death and dying, I enthusiastically accepted the challenge. When I actually sat down and began to wonder what I had got myself into, it became a different matter. Where do I begin? What to include?<sup>25</sup>

Concerning the lack of existing data in the subject and how to establish a protocol for her work with patients she states:

Then the natural question arose: How do you research on dying, when the data is so impossible to get? When you cannot verify your data and cannot set up experiments? We met for a while and decided that the best possible way we could study death and

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<sup>25</sup>Kübler-Ross, *On Death and Dying*, xi.

dying was by asking terminally ill patients to be our teachers... I was to do the interviews while they stood around the bed watching and observing. We would then retire to my office and discuss our own reactions and the patient's response. We believed that by doing many interviews like this we would get a feeling for the terminally ill and their needs which in turn we were ready to gratify if possible.<sup>26</sup>

From her own words, we can assume that Kübler-Ross did not make use of traditional scholarly preparation on the topic of death and dying, although some serious research on this field had been in existence since 1955. Some literature predating Kübler-Ross' work was: K.R. Eissler, *The Psychiatrist and the Dying Patient*; Herman Feifel, *The Meaning of Death*; Robert Fulton, *Death and Identity*; Barney G. Glasser and Anselm L. Strauss, *Awareness of Dying*; Edwin S. Shneidman, *Essays In Self-Destruction*, and David Sudnow, *Passing On*.<sup>27</sup> These authors seem to be the real pioneers in the field, however, Kübler-Ross made no use of their research. It seems that she ignored what they had to say.

## 2. The Concept of "Stages" in the Model

Kübler-Ross' five-Stage model (denial and isolation, anger, bargaining, depression, and acceptance) have been vastly scrutinized by leading researchers. Early as 1973, critique concerning the usefulness of the Stage model began to emerge.<sup>28</sup> In the process of researching these sources, George Fitchett (one of her strongest critics, and one of my CPE supervisors) shared with me an unpublished essay in which he and Glen A. Davidson undertook the task of examining in depth the work of Kübler-Ross.<sup>29</sup> A unique contribution in their work, which we have not been able to find anywhere else, relates to their extensive and unsurpassed work analyzing Kübler-Ross' theory against five major topics in thanatology, and clinical thanatology (the scientific, humanistic, moral, management, and training programs in Kübler-Ross' theory and Stage model). Being that this particular area of their research is beyond the intentions of this segment, I will limit myself to acknowledge Fitchett and Davidson's work in this respect.

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<sup>26</sup>Kübler-Ross, *On Death and Dying*, 22-23.

<sup>27</sup>Some literature predating Kübler-Ross work was: K.R. Eissler, *The Psychiatrist and the Dying Patient* (New York: International Universities Press Inc., 1955); Herman Feifel, *The Meaning of Death* (New York: McGraw-Hill Book Co., 1959); Robert Fulton, *Death and Identity* (New York: John Wiley and Sons, Inc., 1965); Barney G. Glasser and Anselm L. Strauss, *Awareness of Dying* (New York: Aldine Publishing Co., 1965); Edwin S. Shneidman, *Essays In Self-Destruction* (New York: Jason Aronson Inc., 1967), and David Sudnow, *Passing On* (New Jersey: Prentice Hall Inc., 1967).

<sup>28</sup>Some important literature addressing the use and misuse of Kübler-Ross model are: Charles A. Garfield, ed., *Psychological Care of the Dying Patient* (New York: McGraw-Hill, 1978); Richard Schultz and David Aderman, "Clinical Research and the Stages of Dying." *Omega* 5, no. 2 (1974): 137-143; George Fitchett, "Wisdom and Folly in Death and Dying." *Journal of Religion and Health* 19, no. 3 (Fall 1980): 203-214.

<sup>29</sup>George Fitchett and Glen W. Davidson, *Toward Understanding "On Death and Dying"* Unpublished. I have asked permission to Fitchett to state in this note that if any reader wishes to contact them to request copies of this magnificent essay they shall contact Fitchett at Rush-St Luke's Medical Center, Chicago Illinois.

Analyzing the emerging critique to Kübler-Ross, Fitchett and Davidson refer to Schultz and Aderman's evaluation of Kübler Ross' Stage model. Schultz and Aderman's came to the following conclusion:

Unfortunately, the usefulness of Kübler-Ross' work is limited by its ambiguity, in large part the product of the highly subjective manner in which observations were obtained and interpreted. Kübler-Ross failed to explicitly specify assessment procedures for determining through which stages of dying a patient has passed. Judging from the interview protocols Kübler-Ross has presented as evidence in support of her stage model, it appears that she depended more on intuition to define a particular stage than any systemic pattern of responses from the patient.<sup>30</sup>

Concerning the reliability and replication problems of Kübler-Ross' model, Schultz and Aderman compared her model and findings, with researchers who plotted the emotional trajectory of the dying patient with more objective methods. Their study concluded that:

On the basis of her interviews with terminally ill patients, Kübler-Ross proposed a five stage model of the dying process. Other investigators, relying less on clinical insight and more objective measurement, have reported data which call into question the validity of Kübler-Ross' observations. Whereas these researchers have generally found, in agreement with Kübler-Ross, that most terminal patients experience depression shortly before death, they have failed to obtain any consistent evidence that other affect dimensions also characterize the dying patient.<sup>31</sup>

Furthermore, Edwin Shneidman, in his diverging with Kübler-Ross concerning the universal attributions of her model states:

My own limited work has not led me to conclusions identical with those of Kübler-Ross. Indeed while I have seen in dying person's isolation, envy, bargaining, depression and acceptance, I do not believe that these are necessarily "stages" of the dying process, and I am not convinced that they are lived through in that order, or, for that matter, in any universal order. What I do see is a complicated clustering of intellectual and affective stages, some not unexpectedly, against the backdrop of that person's total personality, his "philosophy of life."<sup>32</sup>

Garfield also expressed concerns about Kübler-Ross' theory and stage model, or any other model claiming universal applications. He states:

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<sup>30</sup>Ibid., 15. Fitchett and Davidson quote: Schultz and Aderman, "Clinical Research and the Stages of Dying," 138.

<sup>31</sup>Ibid., 15. Fitchett and Davidson quote: Schultz and Alderman, "Clinical Research and the Stages of Dying," 142.

<sup>32</sup>Ibid., 16. Fitchett and Davidson quote: Edwin S. Shneidman, *Deaths of Man* (Baltimore: Penguin Books, 1973), 6.

To date, no researcher or systemic clinical observation has verified any preprogrammed set of stages in the dying process; that is, researchers and practitioners have not yet empirically identified any set of linear, unidirectional, and invariant stages. Certainly many patients who are dying exhibit denial, anger, depression, and occasionally acceptance, but it is inaccurate to suppose that all individuals, regardless of belief systems, age, race, culture, and historical period die in a uniform sequence. It is more likely that existing theoretical frameworks become self-fulfilling prophecies imposed by health care professionals who may coerce the dying person into conforming to a powerfully suggested typology.<sup>33</sup>

These sources are only a brief sample of the vast scholarly critique to the Stage model of Kübler-Ross. Amidst the stated critique to her model, researchers' feedback to the model was ignored by the health care professionals at the time her theory was gaining grounds.

### 3. The Clinical Use and Misuse of the Stage Theory

After the publication of Kübler-Ross' book *On Death and Dying*, the impact on health professionals was monumental. In a passionate essay addressing how Kübler-Ross' Stage model was affecting adversely the health care professionals, especially in the hospital environments, Larry Churchill states:

Kübler-Ross' portrayal of the dying person as passing through stages has become, if not an official doctrine, the dominant exemplary paradigm for understanding dying—one without a significant rival either in the health sciences or the general culture.<sup>34</sup>

Churchill perceived Kübler-Ross' model as a service as well as a disservice to the health sciences.<sup>35</sup> He also cautions about the hazards of taking her work as more than an intention to examine critically our [health care profession] attitudes about, and practices with, the dying.<sup>36</sup> He focused his critique in two basic areas: a) the effects that the expectations of a progressive stage model could have in the care providers, b) the implications of a stage model with an aesthetic appeal in the treatment of terminally ill patients. I will briefly examine these areas of critique.

a) **The effects that the expectations of a progressive stage model could have in the care providers.** Although Churchill accepts that there is a certain utility in the stage model, in the sense that it provides one with, " ...handles or points of entry to comprehend what

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<sup>33</sup>Fitchett and Davidson quote: Garfield, *Elements of Psychosocial Oncology* 103.

<sup>34</sup>Larry R. Churchill, "The Human Experience of Dying: The Moral Primacy of Stories Over Stages," *Soundings* 62, no. 1 (Spring 1979): 24.

<sup>35</sup>*Ibid.*, 24.

<sup>36</sup>*Ibid.*, 25.

before was enigmatic even chaotic,"<sup>37</sup> he also questions the progressive bias of the stages. Churchill sees in Kübler-Ross' Stage model an embedded dangerous appeal to implement a stage model that could represent a hazard, both, to the patient and the care provider. In the words of Churchill:

The temptation to engineer the process of dying for our patients... [in which] our expectations become shaped by the progressivist philosophy in such way that the genuine experiences of dying are pre-empted by our sense of how people ought to die. The progressivist philosophy carries an implicit norm, such that we even feel an obligation to move the dying along —to get them through denial, anger, bargaining and depression to acceptance. We feel frustrated, cheated, or that we have failed if this does not happen. We become obsessed with the stages as normative protocol we are treating dying as a technical problem.<sup>38</sup>

b) **The implications of a stage model with an aesthetic appeal in the treatment of a terminally ill patient.** Churchill's concern could be stated in the following question: How does a progressive stage model that begins with four initial negative stages and concludes in a positive final stage affect the health care professionals, when the final stage implies that the "*good dying patients*" are the ones who accept death with serenity or calmness? Churchill sees in this aesthetic expectation of Kübler-Ross' model a bias that:

...makes [the] acceptance [stage] morally desirable, and places an obligation on health care professionals to realize it in their patients. In other words, the sequence of progressive stages culminating in acceptance has an aesthetical pleasing quality. The tranquil, accepting dying person causes no disturbances and is simple to manage.<sup>39</sup>

Finally, Churchill views the aesthetic implications of the Kübler-Ross model as an attempt to label and control the experience of the dying person. In Churchill's words:

Far more important than any reservations we might have about the progressivist philosophy of dying or the achievement of an aesthetically pleasing death is the fact that the stages provide labels to place upon the dying person. The effect of the labels is to categorize and control —to manage not only the dying person (who is "out of Control" by Western technocratic standards), but to control the meaning of the experiences as well.<sup>40</sup>

Fitchett also arrives to similar conclusions regarding the implications of a stage model with an aesthetic appeal. His critique suggests that for the medical staff to classify beforehand

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<sup>37</sup>Ibid., 25.

<sup>38</sup>Ibid., 25-26.

<sup>39</sup>Ibid., 26.

<sup>40</sup>Ibid., 27.

the patient in any of the stages could be hazardous to the patient. He also argues that the stage model promotes an impersonal approach to care.<sup>41</sup>

#### D. Responses to Kübler-Ross Model

There is no need to debate the fact that Kübler-Ross' work played a crucial role in the field of death and dying theories. When one compares the effect of prior research on death topics, to the arrival of Kübler-Ross' theory, one can safely say that the preexisting work remained secluded at a scholarly level, while Kübler-Ross' work impacted and shook the foundations of our society. In that sense, it can be said that to a great extent, the current social openness to discuss topics of death and dying can be attributed to her.

Amidst the above attribution to Kübler-Ross' work, the researched sources allow me to conclude that although Kübler-Ross' stage model reached immense popularity, the model never gained the same level of acceptance from her professional peers. The model was perceived as lacking in coherency and cohesiveness. My sense is that these attributions relate to several factors. On the one hand, it seems that Kübler-Ross failed to examine, and to incorporate significant preexisting research on the topic when she developed her theory. From my perspective, this factor led her to develop a model isolated from existing investigation. Thus, leaving behind a model based mostly on anecdotal discussion of personal experiences, and vague treatment of the dying stages.

On the other hand is the universal claims of Kübler-Ross' model. Since she did not consider important variables such as the role of culture, gender, ethnicity, belief systems, ages, behaviors and other important variables in the analysis of death and dying, I will suggest caution in the application of the model as originally stated. I base my concern in the fact that common knowledge suggests that these variables play an important role in the dying process of a person, and cannot be underestimated.

Concerning researchers' critiques in what they perceive as a fixed rigidity in the order the stages should develop, my sense is that this may be a partially fair critique. Though I understand that much of the criticism is based in assumptions drawn from her own definitions, and use of vocabulary to describe the transitions between the stages, I am also aware that Kübler-Ross herself suggested in various parts of her book that the stages could coexist or take place simultaneously. My sense is that besides the vocabulary issues, a stronger contributing factor may be based in the way the model was graphically presented. From that perspective, no matter what position one takes, if rigid stages or not, the graph leads to contradictions between Kübler-Ross' claims of how the stages can coexist side by side, and the sequential process suggested by the graph.

With regards to Churchill's perceived hazards of the stages to the patients and care providers who are exposed to Kübler-Ross' theory, I firmly agree that the potential of hazard exists, as described by Churchill. Particularly when the model is accepted uncritically. My experience in the hospital setting is that the staff who expects the patient to "progress" from

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<sup>41</sup>George Fitchett, "Is Time To Bury the Stage Theory of Death and Dying," *Oncology Nurse Exchange* 2, no. 3 (Fall 1980): 97-104. This author represents one of the leading challenging pastoral voices toward Kübler Ross model.

one stage to the other, treat patients impersonally or, as Churchill suggests, as a technical problem. They also tend to reprimand patients for not cooperating with a perceived natural process of dying as defined by Kübler-Ross.

In other cases I have personally provided counseling to staff who developed a sense of inadequacy because they feel they have failed in facilitating a smooth progression of the patient from one stage to another. I have also experienced patients who feel frustrated because they perceive themselves stagnating between stages. Furthermore, I have also invested many hours with patients who feel confused because they have not been able to reach "the ideal stage of acceptance" or as Kübler-Ross states, the good dying stage. At some levels I have found myself "deprogramming" staff and patients concerning the death and dying model as originally stated by Kübler-Ross. On the other hand, staff and patients who have approached Kübler-Ross theory critically, make use of her theory, as Churchill suggest, as "handles or ports of entry" to understand and initiate conversations on death and dying issues.

Though I can agree or disagree with particular aspects of Kübler-Ross' theory and her critics, the following questions need to be addressed: Why did the model have such an impact? Why has the model prevailed to this day amidst strong scholarly critique? What remains of the model today? I will attempt to provide some answers to these questions.

### **1. Why Did the Model Have Such Impact?**

On the one hand, Kübler-Ross' theory was produced in the midst of the generation of the sixties. This is an important clue for me. One must remember that this period was notorious for the counter culture movements. People were defying authority. Social values were changing. All fronts of society were being challenged. In that sense, in a world that was experiencing social revolution, taboo themes, such as death, were being redefined, questioned and freely examined by everyone. No longer did the church or the academic institutions held the absolute truths. No longer were the powers that be remaining unchallenged. In light of the context, it is my opinion that Kübler-Ross, willingly or unwillingly, became part of the social revolution of the time by addressing a theme reserved to specific social and academic authorities.

Along those lines, is Kübler-Ross' use of common language combined with anecdotal narratives to describe complicated psychological, and existential processes. By using the minimum scholarly oriented language to describe her theory, she managed to address her concepts to the average and less sophisticated person. In that sense, when one reads her book, it seems that one is reading a novel. As a sort of novel, the use of terms such as anger, denial, depression, bargaining, and acceptance, along with the anecdotes that explained the stages, had the effect of placing the readers face to face with "real life episodes and characters" to whom they could relate. In other words, the labels she used to describe the stages worked as metaphors of life accessible to anyone. With the same token, while able to engage the masses with the use of "down to earth language," she lost the support of her peers.

## **2. Why Has the Model Prevailed to this Day, Amidst Strong Scholarly Critique?**

My best guess is that since the model has permeated most disciplines, and all levels of society, and thus, the death and dying stages have been coined into our language and thinking, people have assumed that the model is authoritative in its claims and therefore, accepted by everyone with little critique. On the other hand no one denies that terminally ill patients, as well as people in crisis in general experience anger, denial, depression, bargaining, and acceptance, at some levels in one form or the other.

## **3. What Remains of the Model Today?**

Although the model is still well and alive, the current use of Kübler-Ross theory is limited to the recognition of anger, denial, depression, bargaining, and acceptance, but not as rigid or sequential stages. People mostly recognize these as episodes or ways in which crisis may manifest in some patients, without having to subscribe to the stage model as described by Kübler-Ross. By comparison with other theories that have influenced the world, I can safely suggest that in the same way that hardly no one uses Freud's theory as originally stated by him, few use Kübler-Ross as originally stated by her. Both are still vital theoretical frameworks for various disciplines, though both have undergone revisions, actualization, and changes.