The theory I have chosen to evaluate is that of Dr. Elisabeth Kubler-Ross and her theory concerning the five stages of dying leading to the Grief Curve (1969). I have decided to do this as I have used an adaptation of this in some of the work I do with groups, looking at how they, as leaders, manage change for themselves and others when facing changes at work – the "change curve".

The stages of the change curve very closely resemble those of Kubler-Ross' grief curve. I became aware that not only was the original research completed by Kubler-Ross being questioned, (Gorle 2002) (Fitchett 1980) (Chaban 1999), but work undertaken by others (Dunphy and Stace 1988), (Bridges 1995) and (Senge 1999) were all putting forward their own ideas, assumptions and understandings of organisational change which conflicted with hers.

Why has the theory from Kubler-Ross that was later adapted to apply as a tool to help individuals manage change become so popular recently? In my opinion, the strength of the theory may be in its apparent simplicity. Dr Kubler-Ross presented 5 stages that a terminally ill person may go through when trying to cope with this news. She categorised these 5 stages as denial, anger, bargaining, depression and acceptance. Whilst she may not have explicitly stated that a person needed to go through all 5 stages in sequence, this is how it has been interpreted by many. This has been further changed over the years by many, including doctors, nurses and other health care professionals, into the 5 stages of grief.

The change curve based on Kubler-Ross' work and used by some consultants including the author, states that individuals facing change may go through some or all of the following stages: shock, retreat, self doubt, apathy, resolve, taking stock and new goals. The stages of the curve represent the stages people may go through or become stuck at when change occurs, regardless of whether that change is positive or negative. The curve is applicable to change that is acceptable and welcomed or unacceptable and imposed, although the latter will probably be more difficult to manage.

John Fisher (1999) also further supports this work with his personal transition curve, outlining how individuals deal with personal change. The phases of this curve are anxiety, happiness, fear, threat, guilt, depression, disillusionment (this stage was added in 2003), hostility and

denial. He argues that any change, no matter how small, has the potential to impact an individual and may generate conflict between his or her existing and anticipated changed values and beliefs.

Fisher and Dr David Savage (1999) wrote about personal construct psychology theory, building on the work of George Kelly (1955) which proposed that "*we must understand how the other person sees their world and what meaning they attribute to things in order to effectively communicate and connect with them*". This theory claims that people have the power to change and grow. They are only limited by the vision they have of themselves and by their own internal "blinkers" that might prevent future development.

All of the above have stages or phases that people can begin to put a name to and use to justify their feelings. In my opinion, people like to put themselves into a box and create meaning. For example, Honey and Mumford's learning styles inventory (1982), Belbin's team roles (1981) and Blanchard's situational leadership model (1969). It is not the author's view that this is correct or to be encouraged. However, people like to know more about themselves and try to find out why they are thinking, feeling, behaving as they are. Total experience for 20 years first as an employed trainer within the public sector, and then a consultant working in both large and small organisations throughout the UK, shows that this may be so. In managing others, it can help to start to formulate a plan to help them through one stage and on to the next. I am not suggesting it will always be easy, but it is easy to understand.

However, is its weakness in its simplicity? The work that Kubler-Ross completed in the 1960s and 1970s has been questioned as none of her research has been published, there is no explicit empirical base, and the number of patients used was relatively low upon which to base predictions. Some patients did not know that they were dying and/or being used for research. It is also alleged by Chaban (1991) whilst doing some research for her PhD thesis that Kubler-Ross had access to the work of many others, including two books by Glaser and Strauss (1965 and 1968) which bore similarities to her subsequent book, *On Death and Dying* (1969).

Heather Robertson, in the *Elm Street Magazine* in September 1999, writes of her disappointment when she discovered that Kubler-Ross' research "*seemed to be derived from*

rambling conversations with anonymous patients at the University of Chicago's Billings Hospital". She goes on to describe how the book contained only parts of these interviews and that the work is difficult to verify because of Kubler-Ross' practise of using either first names or pseudonyms with no dates. Whilst this might seem to be protecting confidentiality, this is also in conflict with Kubler-Ross' practice of interviewing patients, sometimes on television, without them and/or their families knowing they were dying. Therefore, in my opinion, there are some questionable ethical issues to be considered. In fact, Chaban goes on to suggest that Carl Nighswonger, a Billings Hospital chaplain who jointly interviewed patients with Kubler-Ross and was a professor at the University of Chicago Divinity School, was in fact responsible for the theory. Kubler-Ross appears to reduce all personal experiences to predictable universal stages.