

BARGAINING STAGE

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1. Core Definition and Context

The **Bargaining Stage** constitutes the third component within the seminal model describing the psychological processes associated with confronting terminal illness, loss, or impending death, often referred to as the Five Stages of Grief. This model was initially developed by Swiss-American psychiatrist **Elisabeth Kübler-Ross** and articulated in her influential 1969 work, *On Death and Dying*. Positioned sequentially after Denial and Anger, the bargaining stage represents a temporary shift in the patient's psychological stance from outright rejection or hostile resentment toward the reality of their situation, moving instead toward a desperate, albeit often irrational, attempt to regain control or negotiate an extension of life. It is fundamentally characterized by the individual seeking to strike a deal, typically with a higher power, destiny, or medical professionals, in exchange for specific behavior modification or devotion.

This phase is profoundly rooted in the human need for agency, particularly when facing an overwhelming and inescapable reality like imminent mortality. Having exhausted the efficacy of denial and finding that anger does not alter the circumstances, the individual retreats into a cognitive state where they believe that good behavior, spiritual piety, or a profound life change could somehow reverse or delay the inevitable outcome. Psychologically, bargaining serves as a critical defense mechanism against profound helplessness and terror, providing the individual with a temporary, structured hope that allows them to cope with the present moment. This process rarely involves explicit, verbalized negotiations with others; rather, it often manifests as intense internal promises or silent, fervent prayers that establish an implied contract with the universe: "If I am granted more time, I will dedicate myself to charity, reconcile with my estranged family, or cease all bad habits."

The nature of the bargains struck during this stage reveals much about the individual's core values and unfulfilled desires. A common theme is the request for more time to achieve a specific milestone, such as witnessing a child's graduation, attending a wedding, or completing an important personal project. **Kübler-Ross** noted that the bargaining stage is intrinsically linked to guilt--the idea that the illness or fate is a punishment, and that the bargain itself is a form of atonement or reparations that might appease the entity delivering the judgment. Although these bargains are often unrealistic and based on magical thinking, their significance lies in their ability to transition the patient away from paralyzing fear and towards an active, albeit misguided, engagement with their condition, setting the stage for the subsequent emotional processing that characterizes depression.

2. The Mechanics of Negotiation

The negotiation tactics employed during the **Bargaining Stage** are diverse but share the central theme of conditional surrender: the individual offers something of perceived value--often a promise of exemplary conduct or spiritual devotion--in exchange for a reversal or delay of their death sentence. This psychological maneuver is an attempt to introduce conditional terms into a situation that is inherently absolute and unconditional. In religious or spiritually-inclined individuals, the negotiation is directed toward God, the universe, or fate, often manifesting as intense prayer, a sudden increase in religious observance, or vows of future piety. The individual seeks a temporary reprieve, a pause button on mortality, believing that their renewed commitment warrants divine intervention or a benevolent alteration of destiny.

Clinically, the manifestation of bargaining can sometimes be subtle, extending beyond purely spiritual promises. Patients may attempt to bargain with their medical team, promising perfect adherence to painful or difficult treatments if the doctor guarantees a specific outcome or longevity. They might meticulously follow restrictive diets, engage in rigorous exercise regimens far exceeding their current physical capabilities, or undertake alternative therapies, all driven by the underlying belief that their extraordinary effort will somehow change the statistical probability of their prognosis. This behavior stems from the deep-seated psychological need to assert some level of influence over uncontrollable circumstances, turning the passive experience of dying into an active negotiation where personal effort is the currency.

Crucially, the bargaining phase is a temporary holding action, psychologically speaking. It is fueled by residual hope that conflicts sharply with the increasing awareness of reality. This phase is typically short-lived because the nature of terminal illness rarely allows for the successful completion of the bargain. When the desired outcome (i.e., a miraculous recovery or significant extension of life) fails to materialize despite the patient's promises, the emotional mechanism of bargaining collapses, leading almost inevitably to the next stage of the model: profound **Depression**. The failure of the bargain reinforces the reality of the impending loss, transitioning the individual from an active, future-oriented hope to a passive, present-oriented grief focused on the losses already experienced and those yet to come.

3. Historical Development within the Kübler-Ross Model

The introduction of the **Bargaining Stage**, along with the other four stages (Denial, Anger, Depression, Acceptance), revolutionized the field of thanatology--the study of death and dying--by providing a framework for understanding and discussing the emotional state of the terminally ill. Prior to **Elisabeth Kübler-Ross's** 1969 publication, *On Death and Dying*, discussions surrounding mortality in Western medicine were often clinical, cold, and focused primarily on physical management, neglecting the patient's immense psychological and existential distress. Kübler-

Ross's work arose from extensive, groundbreaking interviews with hundreds of dying patients, establishing the stages not as prescriptive steps but as common coping mechanisms observed in those facing imminent loss.

The theoretical foundation for the bargaining stage draws heavily on psychoanalytic concepts related to guilt and magical thinking. Kübler-Ross observed that patients often felt a need to "make amends" or achieve a state of moral perfection before death, viewing their illness, consciously or subconsciously, as a form of divine punishment for perceived failures or transgressions. The bargaining phase provides an avenue for the ego to manage this guilt by externalizing the control mechanism onto a supernatural or external force, offering a deal that potentially mitigates the severity of the perceived punishment. This framework allowed caregivers to recognize and validate the intense spiritual and psychological turmoil experienced by patients, moving end-of-life care beyond purely biological concerns.

The original intent behind delineating the **Five Stages** was to train medical personnel and family members on effective communication and emotional support for the dying. The concept of bargaining provided a critical lens through which to understand sudden, dramatic shifts in a patient's behavior--such as religious fervor or uncharacteristic generosity--not as signs of improvement or irrationality, but as understandable, if temporary, psychological attempts to cope with overwhelming dread. By framing bargaining as a natural, identifiable step, caregivers could respond with empathy and validation, rather than dismissing the patient's hopes or promises, thereby fostering an environment of trust and acceptance that was vital for the patient's eventual move toward the final stage of **Acceptance**.

4. Relationship to Other Stages

Understanding the **Bargaining Stage** requires placing it correctly within the dynamic continuum of the Kübler-Ross model. It acts as a transitional phase, bridging the intense, externalized emotions of **Anger** with the introverted, internalized suffering of **Depression**. When the patient is in the Anger stage, they are often directed outward, raging against the unfairness of their fate, blaming doctors, family, or God. Bargaining represents a subtle but significant tactical shift: instead of fighting the external forces, the individual attempts to co-opt them. The energy previously used for hostility is channeled into a strategic effort to negotiate a path out of the predicament, suggesting a temporary, conditional ceasefire in the patient's psychological war against mortality.

Following the unsuccessful culmination of the bargaining attempts, the individual is forced to confront the immutable reality that no promise, prayer, or deal will reverse the process. This realization precipitates the descent into **Depression**, often viewed in the model as the darkest stage. The depression phase is characterized by anticipatory grief, mourning the losses already incurred (health, mobility) and the impending losses (future experiences, relationships). The failure

of the bargain transforms the hopeful, albeit desperate, energy of the previous stage into profound sadness, regret, and detachment. Thus, bargaining serves a vital, if painful, function: it exhausts the final vestiges of magical hope, clearing the psychological path necessary for the patient to eventually reach a state of peaceful, realistic acceptance.

It is imperative, however, to acknowledge the primary critique of the model: the stages are rarely experienced in a neat, linear fashion. Patients often cycle repeatedly between stages, exhibiting denial one day, anger the next, followed by a period of fervent bargaining, only to revert to denial again. For instance, a patient might move from bargaining with a deity to becoming angry at the deity when the bargain fails, and then fall into depression over the perceived abandonment. The **Bargaining Stage** is therefore better conceptualized not as a fixed time period, but as a recurring coping strategy that surfaces whenever the individual feels a surge of hope, or when faced with a new medical setback that triggers a desperate search for control.

5. Clinical and Spiritual Significance

In palliative care settings and hospice environments, recognizing the manifestation of the **Bargaining Stage** is crucial for effective patient support. When a patient engages in bargaining behavior, healthcare providers must acknowledge the underlying emotional distress without necessarily encouraging the magical thinking. The appropriate clinical response is not to confirm or deny the potential success of the bargain, but to validate the patient's needs--which often center on unfinished business, reconciliation, or expressions of love--that fuel the negotiation. By addressing these needs directly, such as facilitating family visits or helping the patient complete a minor task, caregivers can ease the patient's burden of feeling that they must "earn" their time, thereby allowing them to let go of the impossible bargain more gently.

The spiritual dimensions of bargaining are often profound, particularly in cultural contexts where fate, karma, or divine will are central to understanding suffering. The negotiation process can involve intense spiritual introspection and confession, leading to significant emotional catharsis. Religious leaders and chaplains play a vital role here, helping patients navigate the theological implications of their illness and their attempts to strike a deal. They often guide the individual toward unconditional acceptance and forgiveness, minimizing the burden of guilt that drives the necessity of the bargain. This support facilitates a transition from conditional hope ("If I do X, I will live") to unconditional peace ("I am at peace, regardless of the outcome").

Furthermore, bargaining can significantly influence family dynamics and decision-making during end-of-life care. Family members, observing the patient's desperate attempts at negotiation, may either enable the behavior by seeking out unproven treatments (hoping to fulfill the patient's implied promise) or, conversely, become frustrated by the patient's seeming refusal to accept reality. Educating families about the **Bargaining Stage** helps normalize this behavior as a natural

part of the psychological process, encouraging them to respond with compassion rather than conflict. When this stage is handled sensitively, it can provide the patient with a final opportunity to express deep-seated anxieties and desires, which, once articulated, often dissipate enough for the patient to move forward emotionally.

6. Debates and Criticisms

While the **Bargaining Stage** and the overall Five Stages model have achieved iconic status in popular culture and hospice training, they are subject to significant academic criticism, primarily concerning their empirical validity and universal application. The model, including the specific sequence of bargaining, was derived primarily from clinical observations rather than rigorous quantitative research, leading critics to argue that the stages lack statistical predictability and may impose a rigid framework onto a fluid, individualized process. Psychologists frequently note that forcing grief into a linear model can inadvertently pathologize or invalidate a person's experience if their emotional trajectory does not match the expected sequence--for instance, if they never bargain or jump directly from anger to acceptance.

A significant debate centers on the cultural specificity of the stages. The underlying psychological mechanism of bargaining--the belief that personal virtue can influence fate or a higher power--is heavily influenced by Western spiritual and moral frameworks, particularly those rooted in Judeo-Christian concepts of sin, punishment, and redemption. In cultures with fundamentally different metaphysical understandings of death, suffering, and the afterlife (e.g., Eastern traditions emphasizing cyclical existence or collectivist spiritual beliefs), the need or ability to engage in personalized, contractual bargaining may be less pronounced or manifest in entirely different ways that are not captured by Kübler-Ross's original description.

Modern thanatology has largely moved toward more holistic and less prescriptive models, such as the Dual Process Model of Grief, which emphasizes oscillation between loss-orientation and restoration-orientation, or meaning reconstruction approaches. These newer models acknowledge the behavioral elements described in the **Bargaining Stage** but treat them as facets of coping strategies rather than necessary, sequential steps. Critics contend that while Kübler-Ross succeeded in opening the dialogue about death, the continued over-reliance on the sequential interpretation of the stages, including the bargaining phase, risks oversimplifying the complex, multifaceted nature of human response to loss and impending mortality.

Further Reading

[Elisabeth Kübler-Ross \(Wikipedia\)](#)

[Kübler-Ross model \(Five Stages of Grief\) \(Wikipedia\)](#)

[Psychology of Dying and Grief \(NCBI Bookshelf\)](#)