

OPPRESSION OF THE BEREAVED: A CRITICAL ANALYSIS OF GRIEF IN WESTERN SOCIETY

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ABSTRACT

Bereaved individuals often experience profound social pressure to conform to societal norms that constrict the experience of grief rather than support it. This article explores grief in Western society¹ through an analysis of the underlying structures and values that are a part of this social system, utilizing the lens of critical theory. Critical theory examines social norms and conditions in order to identify and expose oppression in various contexts. This article examines the social rules that govern the expression of grief, the role of attachment, social pain, and shame as potent forces that promote compliance with social rules, and the ways that the underlying assumptions and values in Western society shape how bereaved individuals are expected to react. Implications for clinicians who work with terminally ill or bereaved individuals are then reviewed.

¹The term, "Western society" describes a society where there is a prevalence of industry that is built upon capitalism and a market-based economy. Because the emergence of industry and capitalism are typically attributed to Western Europe and North American countries, it is often assumed that the term, "Western" generally refers to these countries. However, other countries in various regions of the world also now incorporate the values of capitalism into their social structures; thus, the discussion in this article refers to a philosophical stance that is deemed as "Western-oriented," but not limited to a geographic location or particular culture or ethnic identification.

INTRODUCTION

This article began as a point of intersection between a scholarly exploration of social influences on bereavement and the real-life issues that arose in my clinical practice setting with clients who were bereaved. Over time, I have found that one of the more common questions that clients raise in the context of grief counseling is how one *should* grieve after a significant loss (i.e., what is *normal*?). Clients frequently report distress over not just the loss(es) they have experienced, but also to their responses to these losses. Sadly, the distress is often magnified by how these responses are perceived by others with whom they interact on a daily basis, including family, friends, coworkers, and healthcare practitioners. Upon reflection, I realized that much of my work as a counselor has been spent attempting to normalize grief responses that have been deemed as abnormal by social indices, un-doing the unhealthy suppression of grief, and attempting to re-frame the pathology-based approach to grief that seems prevalent in Western society in order to counteract the paralyzing effects that these influences have upon many of my bereaved clients. As a result, I wanted to uncover and explore the social context in which these clients have to function in order to help them to better understand themselves, and to hopefully feel a greater sense of freedom and empowerment in the midst of their grief. What follows is my attempt to delve into the social construct of grief in Western society. The purpose of this article is to explore grief in current Western society through an analysis of the underlying structures and values that are a part of this society, utilizing the lens of critical theory.

DEATH AND LOSS: A CRITICAL ANALYSIS

Although initially focused on small groups that were mostly white and middle-class, bereavement research has broadened in the last 20 years to include many diverse groups of griever and types of losses, and attempts have been made to engage with the larger social context and underlying assumptions that are part of the response to death and loss in Western society (Parkes, 2001). There is now awareness that children grieve differently than adults and that their grief is often misunderstood because it is different (Oltjenbruns, 2001; Silverman, 2000). The role of gender socialization in grief responses after a significant loss is also better understood (Doka & Martin, 2002; Golden, 1996; Hockey, 1997; Lund, 2001; Staudacher, 1991). It is now known that grief may continue for a long time and, in fact, that it is very common for a relationship to continue with a deceased loved one (Klass, Silverman, & Nickman, 1996). It is also understood that there is a wide variance in how people respond to loss based upon many factors that are both external and internal (Sanders, 1999; Stroebe, Hansson, & Stroebe, 2001; Worden, 2009). However, despite much research and anecdotal accounts that confirm the normalcy of many diverse responses to loss, social expectations of

uniformity (and conformity) are still placed upon bereaved individuals in current Western society.

Because I see the empowerment of bereaved clients in their subjective experiences as a crucial part of my work, I looked for a framework that incorporates power dynamics into social analysis. I began with critical theory, as it examines social norms and conditions in order to identify and expose power, control, and oppression in various contexts. Oppression is defined as the act of using power to empower and/or grant privilege to a group at the expense of disempowering, marginalizing, silencing, and subordinating another group (Brown, 1994). The root of the word oppression is the key element, *press*. The experience of oppressed people is that the living of one's life is confined by barriers which are not accidental and thus avoidable. These barriers are also systematically related to each other in such a way as to catch one between and among them and restrict or penalize motion in any direction (Frye, 1998).

One of the cornerstones of critical theory is that knowledge is power. It is assumed that when oppressive forces are identified and understood, the potential exists to enact change which will allow freedom from these forces (Littlejohn, 1992). A critical analysis in a social context will almost always include questions about the ways in which inclusion and exclusion criteria (understood as social norms) serve the interests of the dominant group (which supports an ideology or basic belief held by the elite within a particular social structure). In turn, a critical analysis will also examine how the dominant group utilizes these inclusion/exclusion criteria to oppress those who do not fit into these categories as a means of maintaining dominance (Brookfield, 2005).

The underlying premise of this exploration is that if we are aware of the factors that influence our perceptions of an experience, we have the opportunity to consciously act and respond with intentionality and purpose, rather than to simply react or follow rote patterns without reflection. Critical theorists emphasize reflexivity, or the human capacity to reflect upon our history and our actions, as essential for liberating social change (Swenson, 1998). In the context of bereavement, dissecting out social and cultural expectations of how bereaved individuals are expected to respond to loss (i.e., how they *should* respond) from the actual reality of their loss experience (how they *actually do* respond) provides an ability to normalize the human response to loss without the oppressive factor of shame and the inhibition caused by external social constraints which may have the potential to suppress adaptive, but socially uncomfortable or stigmatized responses.

For the purpose of this article, a working definition of grief will be utilized rather than a theoretical one. Thus, grief will be simply defined as the highly unique, personal response to loss (Lang & Caplan, 1993). This definition allows for the inclusion of all aspects of the grief response (i.e., emotional, social, cognitive, physical, behavioral, etc.) by focusing on the loss experience as identified subjectively by an individual rather than a specific type of response to be explored, or the internal/external mechanisms which may mediate the grief response (i.e.,

attachment style, coping style, method of death). This response to loss occurs within the social construction of what is viewed acceptably as “normal” grief in Western society. The use of the term *society* rather than *culture* is intentional. A society is an economic, social, and industrial infrastructure in which a varied multitude of people or peoples are a part, and members of a given society may consist of many different cultural and ethnic groups (Jenkins, 2002). This exploration focuses on the dominant group’s views of death and grief rather than upon those of the specific cultural traditions or ethnic groups that make up Western society.

GRIEF IN WESTERN SOCIETY

In general, Western society is basically described as a death-denying and product-driven society whose foundation rests upon capitalism and patriarchal hierarchies in all significant social institutions (Wood & Williamson, 2003). Individuals who are terminally ill are often viewed with pity for their dependency, and avoided by many due to their representation of mortality, serving as a reminder that all of us will eventually die. Death is typically viewed as the failure of medical technology and a source of shame (Reynolds, 2002). This foundation sets the stage for how bereaved individuals are perceived and the standards of acceptability for mourning after a loss.

There are several social rules for grieving in most Western societies that are not stated explicitly, but which are widely known and recognized. These social rules identify who, in a given society, is granted the privilege of any exemption from roles and responsibilities as a result of a socially-recognized condition that is legitimized through a political structure or authority figure, such as a physician. For example, Parsons (1951) described the concept of the *sick role* as a status that is granted by a physician to a patient who is deemed unwell. In response for being diagnosed as “legitimately” sick and therefore relieved of social responsibilities, the patient is also expected to comply with the rules of the sick role, which include following the doctors’ treatment recommendations and attempting to get better as quickly as possible. The use of “doctors’ notes,” which serve to excuse individuals from work, from certain responsibilities, or which give specific benefits to the recipients (such as tax deductions for items that are deemed medically necessary) underscores the power and legitimization of physicians in this society.

Exclusions from work and social responsibilities are legitimized through social rules, as well as the granting of special social support by identification with the prescribed role of mourning in losses that meet the criteria of acceptability. These rules are not posted on the doors of funeral homes and religious centers; they are implicit and imbued with a great amount of power in their ability to ascribe legitimacy to the grief response in a mourner. Doka (1989) defined the social rules of grieving as “A set of norms that attempt to determine who, when, where, how, how long, and for whom people should grieve” (p. 4). These rules are the

“shoulds” and “should nots” that govern individual responses to loss. In Western society, these rules identify the following:

- *Who has permission to be identified as bereaved and whether or not the relationship to the deceased is valid according to social expectations.* For example, grief is recognized through workplace leave policies as valid if the loss is that of a child or spouse, but not if the deceased is the ex-spouse or a close friend instead of a close family member. One of the functions of any society is to validate the legitimacy of a loss, and individual subjective experiences of loss are judged by the social norms of that society. Another example of lack of validation of loss occurs in perinatal loss, which is seen as a different loss than the loss of a child that lived outside of the womb. Because the parents may not actually “hold” their baby or have shared memories of the baby (often referred to as the “products of conception” rather than as a baby), the baby is premature, or has deformities, it is not seen as a “true” loss, although research supports the development of significant prenatal attachment, often at an early gestational age (Klaus & Kennell, 1976).
- *How long grief can last.* Funeral leave for most workplaces is 3 days for a close family member. In my presentations to public audiences, I often ask the question, “How long do you think grief should last”? The typical responses to this question are that someone is expected to grieve from 3 months to 1 year after a significant loss. Many of the clients in my clinical practice reflect this sentiment when they voice concern that they are still experiencing symptoms of raw grief a year after their loss. However, current research in the area of bereavement indicates that the length of time one grieves is dependent upon many varying factors, which may include personal grieving/coping style, cultural affiliation, concurrent stresses, and loss history (Klass et al., 1996; Stroebe et al., 2001; Worden, 2009). It often takes many years for bereaved individuals to feel they are able to function normally again. For many individuals, grief continues to manifest at important milestones throughout one’s life (Oltjenbruns, 2001). Grief may never really have a defined point of resolution, or the relationship with the deceased individual continues indefinitely after death, which also has implications for the grieving process (Klass et al., 1996; Parkes, 1997).
- *How grief can and should be manifest.* For example, women are generally allowed to cry “within reason” and men are generally expected to be “strong,” meaning to show no emotion (Martin & Doka, 2000). Gender socialization and stereotyping are strong social forces that shape the expectations of how individuals should grieve. Strong emotions of any type are usually stigmatized, and bereaved individuals often express embarrassment for “losing control” of their emotions in front of others.
- *If the manner of death is considered “acceptable” or if it is a loss with some stigma attached to it.* For example, family members of individuals who

complete suicide are frequently assumed to be dysfunctional. Deaths through AIDS and through acts of intention (i.e., murder) or volition (i.e., drunk driving or drug use) also have significant social stigma attached to them as well (Doka, 2002). Associated with losses that involve the legal system is the view that the public has a right to know about the details of deaths, even at the expense of the surviving family members, as the right of the press to expose such details supersedes the privacy and needs of the surviving bereaved individuals (Breithaupt, 2003). Although the detailed coverage of these types of deaths is rationalized by invoking reference to the freedom of the press, the reality is that sensationalized media content sells well, which is another example of how capitalistic values intrude upon the privacy and needs of grieving individuals and the survivors of these events.

Social Conformity in Bereavement

Doka (1989) used the term *disenfranchised grief* to describe grief that does not fit into socially acceptable norms within a given society. Violation of any of the social rules of grief can have a deep impact upon the bereaved individual, as these rules govern the social support and public policies that are extended after the death of a loved one. Social support is a very important factor in bereavement adjustment, and bereaved individuals will readily adhere to these social rules about their grief in order to prevent further losses that may occur through the withdrawal of their social support system if they do not conform to these unwritten rules (Nichols, 2001).

Many researchers describe the grief experience as a threat to the attachment system of the bereaved individual. Threats to the attachment system often result in a heightened activation of that same system, resulting in an increased sense of vulnerability in bereaved individuals and the need to seek the safety of social support (Parkes, 1981, 1997; Weiss, 2001). Another reason that bereaved individuals attempt to conform to social grieving rules can be found in the concept of “social pain,” which is described as the “specific emotional reaction to the perception that one is being excluded from desired relationships or being devalued by desired relationship partners or groups” (MacDonald & Leary, 2005, p. 202). These authors state that social pain is felt on many levels and that aversion to this pain is a powerful motivating force for compliance with social norms and rules. In addition, individuals who stray from accepted norms of behavior are often shamed by their social group, which functions as a powerful form of social control to ensure compliance with social norms (Wurmser, 1981). This sense of shame may also be internalized by the bereaved individual, who describes frustration at his or her inability to “keep it together” or to “move on and stop wallowing in self-pity.” Thus, there are many strong pressures that may influence bereaved individuals to try to conform to the social grieving rules, even when adherence to these rules could prolong their personal suffering after a loss.

CAPITALISM AND GRIEF: THE CLASH

The undercurrent of these socially-mediated grieving rules can be explored by understanding the values of the society in which they have been created. Reynolds (2002) concludes that it is not enough to state that Western society is basically death denying, and that bereaved individuals are marginalized because they represent the fact that we are mortal beings. Going deeper, he states that the relationship between Western society and death and grief is shaped by the driving forces of the capitalistic economic structure. A capitalistic society is governed by the high value placed upon productivity, competition, and consumerism. In a capitalistic society, the active seeking of economic growth, expansion, consumption, and the view of unlimited possibilities is highly prized. Brookfield (2005) describes capitalistic societies as those which tend to define human worth “in economic terms by the elevation of materialistic values over the human values of compassion, skill, or creativity” (p. 162).

Bereaved individuals are often impaired in their functionality by their grief experience. These same individuals are often not very good consumers of market goods (unless these market goods are targeted for bereaved individuals, such as self help books and pharmaceuticals). The potential for the lack of productivity and an inability to perform the socially-expected role of consumer presents a threat to the basic structure of a capitalistic society. If their grief response adheres to the previously described social rules concerning grief, bereaved individuals will be allowed a brief, temporary exemption from functionality and the expectation of being consumers and producers for a limited period of time.

In order to become more socially acceptable, and to counteract the potential for social isolation or exclusion from lack of conformity to expectations, grieving individuals may try to “mask” their grief in stoicism or find covert ways to grieve that keep their experience out of the public eye. By so doing, bereaved individuals internalize the oppressive forces that are enforced through the social rules of acceptability after a loss occurs. Death and grief signify vulnerability, which is a sign of weakness. In a social system that is based upon competition and acquisition, weakness is not tolerable, and so grief goes underground.

Western society also tends to be a patriarchal society, and patriarchy is perpetuated in capitalistic societies through the hierarchical structure of most large companies and social institutions, and the desire to compete and to “dominate” the market (Hartman, 1995; Rasmussen, 2005). Certainly, a patriarchal society favors the male-dominant patterns of stoicism and denial of emotionality, which are often hard to maintain in acute grief. Most bereaved individuals would share that the most frequent comments they receive from well-meaning others are those that would minimize their loss or offer distraction from their grief in an attempt to help them to regain control over their vulnerability and emotionality. This mandate to minimize one’s experience and to deny a potentially adaptive grief response in favor of the maintenance of a veneer of control and functionality represents a

unique form of oppression. The cost of noncompliance can be very high, manifest through job loss secondary to loss of productivity, loss of support, loss of status, and shame if one appears weak in a competitive market or is not pulling one's weight as expected.

Death and grief represent the ultimate loss of control over one's destiny, one's life, and one's choices. A capitalistic, patriarchal, consumer-driven culture values control and rationality in order to foster productivity (Bottomore, 1985). The large pharmaceutical industry feeds off these values, and quickly offers consumers the ability to control their grief through the use of antidepressants, anxiolytics, and sleeping medications. In Western society, the high value that is placed on youth and vitality, the warehousing of elderly or disabled individuals into institutional care out of the public eye, and the fact that most people die in institutional care settings removed from everyday life prevents a more reflexive and normative response to mortality. In addition, we do not have time to deal with death because we are busy producing and consuming, and unless we are personally affected by a loss, we can function efficiently and without hindrance because death is hidden from sight. And when all else fails, we can take medication to overcome our weakness.

The fact that these social norms are so deeply entrenched into every institutional structure and internalized into individuals' identification with the need to "be strong" and "in control" at all times prevents the exposure of these underlying themes and values as unrealistic and often unhealthy. Death is everywhere, but it is also nowhere. Grief is a universal experience, but it is expected to be hidden from sight as if it were a source of shame rather than the result of loving and attaching to others. As stated in the introduction, much of the focus in grief therapy and support is often upon the "un-doing" of these oppressive social norms, which ironically cause prolonged suffering in grieving individuals by preventing the potentially adaptive aspects of the grief process to unfold naturally without hindrance (Doka & Martin, 2002).

DIAGNOSIS AND GRIEF

Another aspect of how death is viewed in Western culture is the recent proposal to include diagnoses of "Complicated Grief Disorder" or "Traumatic Grief Disorder" in the soon to be published *Diagnostic and Statistical Manual, Volume Five* (DSM-V; Bolen, van den Bout, & Keijser, 2003; Hogan, Worden, & Schmidt, 2003-2004; Horowitz, Siegel, Holen, Bonanno, Milbrath, Stinson, et al., 2003; Prigerson & Maciejewski, 2005). It has been argued that the inclusion of these entities as specific disorders would separate the symptomatology of complicated grief from depressive disorders and traumatic grief from anxiety and trauma-related disorders, and these distinctions would assist bereaved individuals who fit these criteria to obtain appropriate treatment. In looking at this issue from a critical theory perspective, the inclusion of these new diagnoses would give social

legitimacy to specific manifestations of grief through inclusion in a definitive authoritative resource that lists diagnostic labels for psychiatric disorders. By assigning types of grief responses to diagnostic criteria in the DSM-V, these same responses would be recognized as a medical issue, legitimizing the associated role of the bereaved individual through medicalization (see Parsons, 1951) and potentially assisting with coverage from third party insurance when support is sought through professional avenues that require payment.

However, in legitimizing the grief experience by assigning it a DSM category, there is also an undertone of pathologizing it by including it as a mental “disorder” in this same resource. In other words, if a bereaved individual meets the criteria for this particular manifestation of grief, she or he may receive the social benefits of legitimization and access to resources. That same individual must then live with knowing that a certain degree of “abnormality” is being identified with his or her experience. In contrast, bereavement researchers and clinicians generally believe that grief is an adaptive response to loss, and that grief is not a disease or illness (Engel, 1994; Stroebe et al., 2001). Some researchers in the area of bereavement advise caution about labeling grief reactions in the DSM because an essentially normal reaction to the death of a significant person would then become placed in the realm of psychopathologies, and some of these labels may follow a client for the rest of his or her life (Hogan et al., 2003-2004; Stroebe, Schut, & Finkenauer, 2001).

CLINICAL IMPLICATIONS

Explore What’s Right About What’s Wrong

Bereaved individuals often mention that they feel that they are going crazy or “losing it” because their grief sometimes feels overwhelming or they are not able to function well because of distraction, exhaustion, or intense feelings. Many feel that something is wrong with them, and they hope that in coming for professional support, they will regain their functionality more quickly and be able to enter back into their world as they once did. Clinicians need to contextualize an individuals’ grief experience within the social rules of grief in Western society, which are based upon market economics rather than true human experience. It is important to help clients to recognize that it is normal to have difficulty focusing, that grief over a relationship that is not socially recognized as valid is still *their* grief, and deserves to be honored. Often, bereaved individuals may feel that something is wrong with themselves when the reality of their experience is juxtaposed with what is deemed right socially. The bereaved individual’s subjective experience needs to be re-framed as what is “right” against the social rules of grief that are just plain “wrong.”

Advocate and Inform Where Possible

Professionals who work in thanatology-related areas (i.e., hospice or palliative care, death education, bereavement counseling or support) are often called upon to provide information to the public as it relates to their area of expertise, and to offer comment upon current events that are relevant to death and grief. In these open discussions, it is possible to raise awareness about specific issues in death and loss that may marginalize bereaved individuals, including disclosure of recent research that speaks to the normal complexity of the grief experience. It is important to remind individuals that the societal pressure to make a quick return to functionality and efficiency can be highly unrealistic, given the amount of reconstruction that a significant loss requires on many different levels. Working with terminally ill and bereaved individuals provides an opportunity to see where the focus on productivity, youth, and consumerism has not served us well. Engaging the academic community in reflective analysis of social structures and their impact upon bereaved individuals is also an important aspect of this process. Finally, in death education, teaching about and discussing issues that relate to social justice and diversity in grief may also help increase awareness of the need to question social rules that oppress instead of support bereaved individuals.

Be Careful With Labels

As stated previously, it is important to be careful with labeling bereaved individuals with disorders through the use of pathology-based diagnostic systems or through subtle alignment with pressure to suppress the experience either through medicalization or adherence to social rules that subvert the normal grief response. Given the hegemonic propensity for the DSM to be utilized as a dividing line between those who are “healthy” and those who are mentally ill, great care must be taken when associating a client’s distress and pain with a reified set of criteria in a diagnosis code. This is not to say that in some instances, concurrent disorders may exist alongside the grief. It is also not the intent of this article to oppose the use of medication when a client may benefit from or require medication in order to help with daily functioning. However, the focus must remain on the client’s experience, feelings, and choices so that the unique grief experience of that client will be allowed to unfold without hindrance and with healthy support from a strengths-based perspective. It is also important to keep in mind that the ability to apply a diagnostic label reinforces the power differential between a client and a clinician, which may have implications for the therapeutic relationship (Brown, 1994).

CONCLUSION

In this article, I have tried to underscore the influence of the capitalistic values in Western Society upon attitudes toward death, dying, and bereavement. It is important to recognize that the social rules and expectations for those who are

terminally ill and bereaved in this society are grounded in values that are economically-based, and not humanistically-oriented. The clash of these values with the reality of the experiences of individuals who face terminal illness or who are bereaved often results in the marginalization of these individuals, rather than recognition of the situations where a market-based social system does not reflect acceptance or understanding of a normal and universal human experience. The role of individuals who work in thanatology-related areas in Western Society is clear: we must not allow the normal and healthy expression of grief to be considered a source of shame. Our imperative is to strive to find ways to normalize death as a natural part of life, and grief as a normal and adaptive response to the losses we encounter as a result of healthy human connection, which is necessary for our survival.

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