BOTTLED TEARS:

THE PATHOLOGIZATION, PSYCHOLOGIZATION, AND PRIVATIZATION OF GRIEF

LEEAT GRANEK

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Abstract

I examine how grief has become constructed by the psy-disciplines as a pathology, and the impact this approach to viewing grief has had on contemporary grievers. I argue that the psy-disciplines have constructed grief as a disorder so as to claim a role in professionally treating grief. Further, I argue that the construction of grief by mainstream psychology has influenced North American norms in the modern world. I show how these grief norms are reiterated in medical/psychological discourses, in mainstream media, and in public policy. By tracing the development of grief theory, originally conceived by Freud within a psychoanalytic framework, to the current conceptualization of grief within the disease model, I show how grief theory has evolved within the discipline of psychology to become a) an object worthy of scientific study within the discipline and subsequently, b) a pathology to be privatized specialized, and treated by mental health professionals.

Subsequent chapters examine the impact of psychological classifications on people's experiences of grieving. I argue that the power of the psy-disciplines to construct categories of human experience actively constructs new ways of being, thinking, and feeling when it comes to the expression and experience of grief. Using examples of mainstream media such as film, television, newspapers, magazines, self-help books, and memoirs, I show how the psy-construction of grief becomes thoroughly looped into people's consciousness so that the notion of pathological grief becomes the norm for people.

I also examine three intertwined cultural discourses that support and enforce the psy-construction of pathological grief including fear of the body and emotions, the denial of death, and subsequently the denial of grief, and the contemporary progress narrative that does not allow for expressions of prolonged sadness. I show that a significant outcome of all three of these discourses that support the construction of pathological grief is a sense of shame and embarrassment for the mourner.

The last chapter examines how modern grieving trends can be interpreted as new forms of rituals that have arisen in response to a culture that does not tolerate grieving, and offers no protocol on how to mourn one's losses.

For Irit Granek (1953-2005),
a dedicated, loving mother, and a loyal and passionate friend.

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A wise child once told me that when someone you love dies, your heart hurts so much it stretches and then there is room for more love after the pain goes away. One of the things that happened after my mother died is that I gained a new appreciation and overwhelming sense of gratitude for those around me. A result, I believe, of my stretched heart. There aren't enough pages for me to include all the people to whom I am thankful for. With that caveat in mind, here are a few out of the many that I wish to acknowledge.

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Preface

My mother died two years and ten months ago. In the same year I also lost an aunt, a close family friend, a woman who was my mother's 'chemo partner', and a deeply cherished professor. As with many writers, academics, and researchers, I chose to study grief because I have been personally touched by it.

I became curious about this topic because my own experience of grief surprised me. One of the things that I found most shocking about grieving was how shameful it felt to feel and express my sadness in public. I often felt like I was doing something wrong or taboo when I appeared (feeling rather) unhinged in public. Aries (1981) has argued that dying and mourning have been constructed as scandalous in Western culture. We have, according to Aries, "eliminated [death's] character of public ceremony, and made it a private act, and on the other hand, associated with this privatization of death was the second great milestone in the contemporary history of death: the rejection and elimination of mourning" (Aries, 1981, p. 575). This was true to my own experience. I often felt ashamed, embarrassed, and regretful for my sadness and I was sorry for burdening others with my pain.

Although I didn't know it then, I soon came to realize that the concept of grief as being shameful is a historically recent phenomenon. Up until the late 20th century, grieving in the West used to be a public affair, a clearly visible and marked process that involved community and a network of public rituals and ceremonies elaborately constructed to

support the mourners (Ashenburg, 2002). That I was embarrassed to appear in public in my sad state was as much a cultural restriction as it was a personal characteristic.

The experience of grieving is paradoxical in many ways; it is full of contradictions and ironies. One example of this paradox is that grief is experienced as a deeply personal, individually felt, and uniquely experienced phenomenon (Didion, 2005). Those who are grieving, and I include myself in this group, often cry out in frustration, "but you can't understand, you don't understand how hard this is!" This is profoundly accurate. The intensity and expression of grief depends on many factors, including who has died, how they have died, what kind of relationship you have had with them, where you live, whom you live with, what kind of personality you have, what has happened in the past, how old you are, what gender, what culture, and the list goes on (Stroebe, Stroebe & Hansson, 1993).

However, it is also the case that the expression of grief is culturally bound and historically contingent. In her treatise on death, Gilbert (2006) poignantly noted that:

> history makes death, even while there's also a corresponding sense in which death makes history... Different eras have had radically different views of death and dying, just as different cultures around the world imagine both the fate of the dead and the grief of the living in strikingly diverse ways. (p. 105)

In other words, how we grieve depends very much on where and when we live. In this project, I begin to explore how and why we grieve the way we do in the North America[1] at the beginning of the 21st century.

Horizon of Understanding

Earlier in the preface, I noted that I have grieved. My heart broke when my mother died of breast cancer after living (relatively peacefully) with the disease for eighteen years. We were exceptionally close. Unlike many mother-daughter bonds, our relationship was relatively uncomplicated. We enjoyed each other's company, we counted on each other for support, advice, and the unfailing ability to make each other laugh. We would see each other a few times a week, and speak on the phone daily. The loss of her pivotal presence in my life unhinged me. I was truly unprepared for the roller coaster of emotions that followed for the first few years after her death. In addition to feeling constantly immersed in pain and despair, I had the continuous sensation that I was orbiting around her death. As if my old life, my 'pre-loss' life that was filled with love, and laughter, and joy, and light was pushed to the periphery and replaced with a big black spiraling mandala of darkness and grief that seemed always to be at the core.

In addition to losing my cherished mother, I have also had other exposure to loss and grief over the past several years. As I noted earlier, four women I cared about died in the same year as my mom. I also began working in a psycho-oncology unit of a hospital where I dealt with cancer patients who were negotiating their own mortality and who

[1] Throughout this project, I use the term North America to refer to Canada and the United States.

would often talk to me about their fears and their anxieties around dying.

My personal grief has informed this project in a multitude of ways. Indeed, as with my Masters thesis on depression (Granek, 2006), I chose a topic in which I had a personal investment and took interest in the process specifically because I noticed how many inconsistencies there were between what I (and the people around me) were experiencing, and what I had learned to be true about grief as a psychologist.

One example of this contradiction is the matter of duration of grief. While I was in the acute phase of grieving which lasted close to a year, I often thought my pain and suffering would never end. I longed for the pain to abate and would have done anything at the time to make it stop. While this was happening, I was simultaneously getting the message from those around me that it was "time to move on" or "to seek professional help". I knew that Major Depressive Disorder (MDD) was diagnosed only two months after a major loss, but I did not know yet that bereavement was listed in the appendix of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or that there was a category called Complicated Grief (CG) that was widely in use by psy-professionals (people working in psychology, psychiatry, social work and other mental health professions). In response to an email where I described feeling particularly exhausted and down three months after my mother died, a colleague in my psychology department urged me to seek help from a psychologist or a psychiatrist so as to "avoid complicated grief or major depression", which she noted, "is diagnosed after only a few months". Other people

expressed similar sentiments telling me that my grief was "abnormal", was "going on too long" and that I should "see a shrink".

The pressure to seek professional help was not limited to my psychology colleagues who may have been more inclined towards expressing concern about my mental health as a result of their vocations. The message to "move on" came from close family and friends and sometimes even from acquaintances that I barely knew. As a griever, I became increasingly self-conscious about sharing my feelings of sadness with others and often wondered about whether I was abnormal. I would frequently choose to stay secluded rather than risk going out and embarrassing the people I was with because of my grief. When I did go out in public, I would find myself anxiously apologizing for being depressed and bringing everyone around me down. While this self-critical voice in my head was loud, there was also another quieter, more calm voice present as well.

This second voice was both intuitive and intellectual. The intuitive voice urged me to have perspective and normalized my experience by reminding me that my mother was an integral part of my life and that, since we were exceptionally close, and had an intensely bonded relationship, it was fine for me to be grieving her loss even months after she died. I later learned that North America is the only place in the world where grieving is pathologized after only a few months and that most people grieve intensely for at least two to three years, if not forever.

The intellectual voice also served me well. It reminded me that the construction of any experience as 'normal' or 'abnormal' is always contingent on a multitude of factors

whose motivations are sometimes questionable. I have a background in interdisciplinary studies and I am a critical psychologist. As a person who has taken courses in a wide array of disciplines including women's studies, anthropology, and sociology, and has studied the history of psychology from a critical perspective, I know that what is perceived as 'natural' and 'normal' is contingent on socio-historical factors and changes depending on the zeitgeist of the time. My master's research on depression brought home many of these lessons for me (Granek, 2006). I knew from previous academic pursuits that the construction of diagnostic categories is often socially - and politically motivated, and that these categories have a profound impact on people's understanding of themselves and their lives. Although not entirely conscious at the time, this knowledge helped me make decisions about how to respond to the messages I was getting about my grief, and, ultimately, helped shape the writing of this dissertation.

One example was the rejection of my colleague's suggestion that I was suffering from CG or MDD. Another example was my instinct to throw away the prescription I got from a physician who gave me an antidepressant only a month after my mother's death. I didn't think much of this at the time, or consciously know why I was making these decisions, but when I began this project two years later, I was in a better position to reflect on these experiences and question what had happened to me.

When I started this project, I had a vague sense that pathologizing grief might be a questionable endeavor. I didn't clearly know why, or even *if* this was the case, but I was curious to examine why I had *these* experiences of grief and not others. I took my own

experience as a griever as a starting point and systematically began to question whether they were rooted in my own individual idiosyncrasies or shaped by societal expectations and discourses. While it is impossible to fully separate these two realms of personhood, examining contemporary grief practices allowed me to take a step back from my own experience and examine how, and why, I came to experience grief in the way that I did. Furthermore, while my academic background in critical psychology (to be expanded on in the Introduction) gave me a general inclination that pathologizing grief might be problematic, I did not yet know if mainstream psychology and psychiatry even did this, and if they did, whether it was a good idea or not.

In addition to having experienced grief, I also hold an existential ontological orientation towards the world. The term "existential" is difficult to define, generally, however, the existentialists explore the "implication of human irrationality and human suffering... Truth is important, not as certainty but as authenticity. Authenticity is a basic honesty that comes from facing the predicament to life squarely, without blinders on" (Miller, 1992, p. 20). My ontological orientation began by thinking of grief as part of the predicament of living. I was not looking for *the Truth* about grief. I took a critical, social constructionist stance that rejects the notion of there being one Truth above all others. Indeed, the purpose of this project is to examine *how* a certain kind of Truth about contemporary North American grief has been constructed via the discourses of psychology and psychiatry.

My primary orientation then was not that there was a conclusive Truth about grief, but rather, instead, a belief that grief is part of the human experience, and thus, may be worthwhile in the process of "becoming". Existentialism deals with the deeply human process of "being" or "emerging". The term "existence" itself comes from the root word *exist-ere* in Latin and means literally to stand out or to emerge (May, 1967). To think of people existentially is to think about them as "becoming" human. Thus, to think of grief existentially is to think about it is as a process of growth in becoming fully human. Yalom (1980), an American psychotherapist writing on existentialism stated that it:

> ...emphasizes a different kind of basic conflict: neither a conflict with suppressed instinctual strivings, nor one with internalized significant adults, but *instead a conflict that flows from the individual's confrontation with the givens of existence*. And I mean by "givens" of existence certain ultimate concerns, certain intrinsic properties that are part, and an inescapable part, of the human beings existence in the world. (p. 8)

To think about grief existentially then is to begin with the assumption that it is part of the 'givens' of existence. My background as a person who has grieved, who is an existentialist, and who holds a critical, epistemological stance all contributed to my analysis of grief within the psy-disciplines as a pathology. While some people may argue that the pathologization of grief is a sign of progress, I began with a more skeptical view and was interested in examining what the motivations were for turning grief into a mental disorder.

Introduction

In this project I examine how grief has become constructed by the psy-disciplines as a pathology and the impact this approach to viewing grief has on contemporary grievers (Rose, 1989). I argue that the psy-disciplines (psychology, psychiatry, social work and other mental health professions) have constructed grief as pathological so as to claim a role in professionally treating grief. Furthermore, I show how this construction of grief functions to create a new narrative for people in North America around how to understand, and subsequently, experience their grief.

In many ways, the title of this project, *Bottled Tears: The Pathologization, Psychologization and Privatization of Grief* is an accurate description of what I aim to show in this dissertation. The image of bottled tears is dual. On the one hand, it refers to the subjective feeling of contemporary grievers who are taught to bottle up their sadness and repress their tears in public. On the other hand, bottled tears also alludes to my thesis: people's grief and their tears have become pathologized by the psychological professions and have literally become bottled, both in the sense that one is taught to express them only in private, and professional settings, and in the sense that grief and tears are now being treated with 'bottled' interventions such as medication and therapy.

Theoretical Foundation: Throughout this project, I focus specifically on the psy-disciplines construction of grief in North America within the past century. While the psy-disciplines are dominant in shaping and enforcing how grief is expressed and understood in

the West, it is necessary to note that North America is not a monolithic entity; within Western society, there exist many peoples from many different cultures that bring their own understanding of how grief should be experienced, and expressed. Indeed, not only do these competing discourses on grief exist, but they differ markedly from the mainstream norm of pathologizing, psychologizing, and privatizing grief.

While these distinctions exist and are taken into consideration, my analysis of grief in this project is not rooted in identity or gender classifications. In other words, while looking at the differences between *individual* expressions of grief is a worthwhile project, and one that I wish to undertake in the future, it is not the focus of this dissertation. Instead, I examine the way the construction of grief by mainstream psychology has influenced North American grief norms in the modern world. These grief norms are widespread and affect everyone regardless of gender or cultural background. They are reiterated in medical/psychological discourses (see chapter two), in mainstream media (see chapter three) and in public policy (e.g., number of days off work for bereavement needs. See chapter four.)

North America is a multicultural society and therefore, *in theory*, one should be able to practice one's grieving rituals anyway one likes. While the American metaphor for diversity is the "melting pot" (i.e., the goal is to assimilate to mainstream culture), Canadians tend to identify the "mosaic" as their symbol. The mosaic metaphor implies that people can potentially retain their own cultural practices and still participate in mainstream culture. What often happens, however, is that one's cultural practices clash with the

dominant norms of mainstream society and become impossible to assimilate (Kissane & Boch, 2001). While people may have their own traditions when it comes to grieving, they are living within a broader culture whose mainstream norms impact their own subjectivity and understanding of the grieving process. The looping of the psy-construction of grief into public consciousness transcends the boundaries of culture and ethnicity (see chapter three). For example, people of all religious, ethnic, and cultural backgrounds watch the *Oprah Winfrey Show* where mainstream psychological norms about grief are reiterated and enforced to millions of people (see chapter three) (Illouz, 2003). Furthermore, the rhetoric of science and psychology, and the rational approach to grieving which I outline in chapters one and two, can appeal to people irrespective of religious or ethnic identity. Indeed, as I will discuss in chapter one, modernization is the project of rationality and it purportedly is democratic and applies to *everyone* regardless of cultural background.

As a critical psychologist, I chose to study grief from within my own discipline. The form of critical psychology I adhere to in this paper is social constructionist.[1] Social constructionist, critical psychologists look at the development of particular forms of knowledge and ask questions about why certain knowledge claims are deemed 'truer' than others (Fox & Prilleltensky, 1997). A critical, social constructionist, hermeneutic approach has fundamentally different values than those of mainstream psychology. While knowledge and research in mainstream psychology is often viewed as objective, value free, and politically neutral, social constructionist psychologists see knowledge as being

[1] For a review of other types of critical psychology, see Teo (2005).

"infused with political uses and embedded within the subjectivity of its creators" (Prilleltensky & Fox, 1997, p. 11).

Teo (2008) suggested that critical hermeneutics "turns critical if it is accompanied by a stance that does not take the self-understanding of mainstream psychology for granted and tries to disclose epistemological and ethical shortcomings of the status quo" (p. 47). Indeed, critical, social constructionist psychology begins with the assumption that knowledge is deeply entangled with power, and uses that assertion to deconstruct 'truths' to reveal their political repercussions (Nightingale & Neilands,1997). Social constructionist psychologists acknowledge that there are no universal, neutral or a-historical laws of human behavior; they assert that all knowledge is political and power laden and is always situated within historical, social, and cultural contexts (Gergen, 1992).

Gergen (1985) described four key assumptions of social constructionist psychology that I use as my theoretical foundation in this project. The first is that one begins with a critical stance towards taken-for-granted knowledge, and the second is that all knowledge is produced within a historical and cultural context. The underlying principle in these assumptions is that any psychological knowledge considered to be 'natural' or 'pre-given' has a history that is situated within a particular social context. The third and fourth assumptions are that all psychological knowledge is sustained through social processes, and that knowledge and action always go together. The third assumption recognizes that some psychological knowledge is considered more valid and legitimate than other knowledge claims. (i.e., knowledge generated in powerful social institutions like the academy is

considered to be more legitimate than 'folk psychology' that is generated by lay people.) Finally, the kind of knowledge that is produced implicates outcome for people (Gergen, 1985). Danziger (1997) noted, for example, that psychological categories are inherently political because they are descriptive *as well* as normative. As I will argue in this project, psychological categories such as grief describe, create, normalize, and pathologize new ways of being for people.

Another related and fundamental value inherent in critical, social constructionist psychology is that individuals are not isolated and discrete beings who can be explained without any reference to context. Instead, individuals are viewed as so deeply intertwined with society and the culture in which they live, that they can never be adequately separated or understood in isolation from this context (Prilleltensky & Fox, 1997). Related to this notion is Richards' (1997) emphasis on taking the social context of psychologists into account when examining theories and ideas coming out of the discipline. In his book, *Race, Racism and Psychology*, Richards (1997) argued that psychology as a discipline is a product of the 'psychologies' of those within it, and thus, will always be reflexive in character.

To summarize, social constructionism takes the view that all human phenomena are social, cultural, and historical products. In order to understand the individual, you must understand the culture in which they are living (and vice versa). "Social constructionism holds that knowledge rests heavily on social consensus. Our social experiences and

interactions shape what we take to be reality and what we regard as truth" (Hare-Mustin & Mareck, 1997, p. 106).

Embedded within the social constructionist approach is the issue of historiography. While mainstream psychologists often dismiss the historical trajectory of the discipline (and its knowledge products) because they believe in the principle of scientific progress, or the idea that our current knowledge is an improvement over discoveries of the past, social constructionist psychologists begin with the assumption that the "essence of psychological categories (insofar as they have one) lies in their status as historically constructed objects" (Danziger, 1997, p. 12).

In chapter one I explain the distinction between grief as a 'natural kind' (the universal and cross-cultural reaction of despair, pain, and suffering in response to a significant loss), and grief as a 'psychological kind' (the modern, more restricted, peculiarly North American expression of grief that I argue is constructed by the psy-disciplines and appropriated and embodied by the public). While I will expand on this in subsequent chapters, it is necessary to note this distinction here to explain why I have chosen to focus solely on grief within the psy-disciplines in the last century, and why I chose to examine the history of the category within the disciplines. In his book, *Naming the Mind*, Danziger (1997) distinguished between psychological subject matter (i.e., sadness or anxiety), and constructed psychological categories (i.e., Major Depressive Disorder or Panic Disorder). He noted:

> The only part of history of psychology that has a relatively unproblematical subject matter is the part that is defined by the modern discipline of Psychology. Once texts and institutional structures of that discipline appear on the scene we have a clearly identifiable field with relatively sharp boundaries. This field is characterized by certain categories of discourse whose history can be investigated in a relatively straightforward way. (p. 15)

Following Danziger's (1997) model, this project enters the narrative around grief when the concept was first introduced into the lexicon of contemporary psychologists working in the established discipline of psychology. It is the most rational starting point for an endeavor such as this one because it illuminates a clear historical trajectory from the point when grief is first introduced as a psychological object, to the present, where it has become a pathology to be treated. By going back to the origin of the category, it will be possible to examine why, how, and who, first introduced grief as being of interest to psychologists and to study the metamorphosis of today's taken-for-granted knowledge about how we adjust to the loss of a loved one. Indeed, as Danziger (1997) noted, "The exploration of historicity...involves looking for the radical shaping of themes, questions, and even individuals, by particular historical circumstances" (p. 12). Like Smith (2005) who stated, "I want to add weight to the argument that our historical knowledge is essential to a capacity to make *meaningful* statements about the world" (p. 58), I believe the best way to examine the psychological construction of grief is by looking at its genesis as a psychological object of study.

In this project, I began with the assumption that while grief is a common emotional experience, the way it will be understood and experienced by people will depend on *where* and *when* they live. In order to understand what people take to be a reality and the truth about grief, it was necessary for me to begin by looking at the social experiences and the interactions people have around their grief.

I began this examination by looking at various discourses of grief that exist in the psychological professional sphere and in the lay public. After establishing that Freud (1917) published the earliest reference to grief within the psy-disciplines, I systematically looked at as many published articles and books that I could find in mainstream academic journals and books. My analysis of the way grief has been constructed within the psy-disciplines was influenced by reading and deconstructing this material for its implicit and explicit assumptions about the nature of grief and grieving. In addition, I also read various sociological and anthropological theories on grief (e.g., Bauman, 1992; Gilbert, 2006; Kellehear, 2007; Seale, 1998) that gave me an alternative perspective on the way other disciplines and academics understand, and deconstruct modern grief.

In later chapters, I review contemporary mainstream media outlets such as film, television, newspapers, popular self-help books, and memoirs that deal in some way with contemporary grief. While there are a large number of media resources to examine for the deconstruction of grief in mainstream culture, I chose to focus on the most popular sources that affect millions of people daily (e.g., *Oprah*, *The New York Times*, films such as

Ordinary People, and best-selling memoirs like Didion's *Year of Magical Thinking*, 2005).[2]

Finally, I research spontaneous shrines and online grieving communities from two perspectives. I examine literature written by psychologists and sociologists on the construction of these shrines, and sites, and I look at these sources first-hand by going online myself, and spending time exploring the websites that deal with grief.

Overview

I begin my examination by deconstructing grief as a product of psychology to explore the repercussions and consequences of viewing and understanding grief within this frame. Chapter one outlines the trajectory of how grief first became an object of psychological study. The study of grief as a topic worthy of scientific study is an early 20th century invention. Freud published his influential essay on mourning and melancholia in 1917. Prior to this publication, there were few researchers devoted to exploring the phenomenon of grief. Included in this chapter is a history of grief theory within the psy-disciplines, and the tracing of the development of the construct of grief from a psychoanalytic, to a psychiatric, to a psychological concept. I include an extensive review of various theories of grief within psychology, and discuss the establishment of death and dying journals in the 1970s.

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[2] One area I do not examine is grief in contemporary music. Due to the subjectivity involved in selection of music, there are few songs or albums that appeal to large amounts of people in the same way as other media sources (e.g., Oprah) do. For research on grief and music, see: Bright (2005), Smeijsters & Hurk (1999) & Sekeles (2007).

By tracing the development of grief, originally conceived by Freud within a psychoanalytic framework, to the current conceptualization of grief within the disease model, I show how grief theory has evolved within the discipline of psychology to become a) an object worthy of scientific study within the discipline and subsequently, b) a pathology to be privatized, specialized, and treated by mental health professionals.

While chapter one examines the basic trajectory in which grief developed as a psychological construct within the discipline, chapter two elaborates on how grief became pathologized. I begin by introducing the 'abnormality paradigm' where I contend that *both* normal and abnormal notions of grief have to be constructed and reified in order to fully co-opt grief into the psychological domain. This chapter illustrates both *how* grief became pathologized and the *reasons* that were motivating this trend. These motivations, which I call discursive sources, include the need for the psy-disciplines to forge a professional identity for themselves; the rise of managed care in North America and its impact on psychological services; the development of psychological grief counselling interventions that became widespread; and the influence of the pharmaceutical industries in encouraging researchers to pathologize every-day experiences.

While the first chapter focuses primarily on showing *how* grief became categorized in psychology, and the second chapter focuses on *why* psy-professionals are motivated to construct grief in these ways, chapter three examines the impact of these classifications on people's experiences of grieving. Here, I argue that the power of the psy-disciplines to construct categories of human experience not only gives people a new

perspective from which to understand themselves, but actively constructs new ways of being, thinking, and feeling.

Using examples of mainstream media such as film, television, newspapers, magazines, self-help books, and memoirs, I show how the psy-construction of grief is appropriated by its consumers and comes to define their personal and collective experiences, such that the notion of pathological grief has become the norm. Psy-disciplinary messages about grief are assimilated by its consumers, in part through exposure to mainstream media that has already appropriated these messages, thus beginning a looping process that results in widespread revision of what it means to grieve and be a griever. These messages include the obligation to be 'normal' in one's expression of grief; the evaluation of oneself on psychological terms of what normal versus pathological grief looks like; the attempt to follow the orderly five stages of the grieving process; the pressure to turn one's grief into a celebratory experience for personal growth; the pressure to do one's grief work; and the obligation to seek professional, psychological help if one cannot achieve these tasks on one's own.

The fourth chapter focuses on the collective repercussions of grief being constructed as a psychologized disease. I examine three intertwined cultural discourses that support and enforce the psy-construction of pathological grief including fear of the body and emotions; the denial of death and subsequently the denial of grief; and the contemporary progress narrative that does not allow for expressions of prolonged sadness. Moreover, in chapter four I argue that a significant outcome of all three of these discourses

that support the construction of pathological grief is a sense of shame and embarrassment for the mourner.

In chapter four, I also elaborate on the cultural context of how the death taboo in 21st century North America serves as the foreground to the psychologization of grief. In chapter five, I examine the ways in which people interpret these discourses to create their own rituals of grief, while at the same time do so in ways that reiterate and reflect psychological ways of being. This chapter examines how modern grieving trends (such as spontaneous shrines, makeshift memorials, and electronic mourning sites) can be interpreted as new forms of rituals that have arisen in tandem with a culture that does not tolerate grieving, and offers no protocol on how to mourn one's losses. I further contend in this chapter that the tension between the need for collective mourning through the medium of personal expression is a reflection of the culture's ambivalence towards how to express grief. On the one hand, these grieving trends are public, and collective, and thus, signify a social need or a desire to mourn within community. On the other hand, the way in which these shrines and sites come together via the individual is in line with the current psychological mores of self-expression, catharsis, and redemption.

Finally in the conclusion, I examine the implications of viewing grief as pathology and note the parallels between pathologizing grief and pathologizing other every-day emotional experiences such as depression and shyness. In the conclusion I also offer alternative interpretations to the 'problem of grief'.

Chapter One: Problematization

> Death has its history. This history is biological, social, and mental...Every historical era, every society and culture have had their own understanding, iconography, and rites of mortality. It may well be that all mythologies and religious or metaphysical systems and narratives are a mortuary, an endeavor, often ingenious and elaborate, to edify a house for the dead. (George Steiner, in Gilbert, 2006, p. 102)

Human vs. Natural Kinds: The Development of the Psychological Concept of Grief

While anthropologists, sociologists, and psychologists have contended that grieving is one of the few rites of passage that is cross-culturally and cross-historically consistent (Archer, 1999; Gilbert, 2006; Parkes, 2001; Rosenblatt, 1993; Rosenblatt, 2001), the emergence of grief as a topic worthy of psychological study is an early 20th century invention (Archer, 1999). Freud (1915/1966/1989) published his influential essay on mourning and melancholia in 1917. Prior to this publication, there were few researchers devoted to exploring the phenomenon of grief. While I noted this briefly in the Introduction, it is essential to begin by elaborating on this crucial distinction between 'grief' as a psychological concept, and grieving as a reaction to the loss of someone who has died. When I speak of grieving as a universal phenomenon as articulated by Steiner in the opening epigraph, I am referring to the experience of a person who is responding to the death of another human being whom he or she has loved. One definition offered is

that "bereavement refers to the loss of a loved one by death and grief refers to the distress resulting from bereavement" (Genevro, Marshall, Miller, & Center for the Advancement of Health, 2004, p. 498). Mourning is another closely related term and is frequently used as a synonym for grief. While some researchers make a distinction between defining grief as "a reaction to loss" (DeSpelder & Strickland, 2005, p. 268), and mourning as the "process by which a bereaved person integrates the loss into his or her ongoing life" (DeSpelder & Strickland, 2005, p. 269), I will be using the terms grief and mourning interchangeably in this project to refer to the emotional reaction to the loss of a loved one that can include sadness, longing, sorrow, despair, and anguish. The modern, psychological conception of 'grief' will be further distilled in subsequent chapters as I begin to show how the term has evolved since it was first introduced into the psychological domain.

Ian Hacking (1995) referred to this kind of distinction as categorical differences between *natural kinds* and *human kinds* of classifications in the social sciences. He defined *human kinds* as conceptual categories that meet the following criteria: they must be relevant to some groups of people, they must be studied in the social sciences, they must primarily sort people, their actions, and behaviours in various categories, and lastly they must primarily classify people as opposed to classify objects. He further articulated that *cutting edge human kinds* are those studied by at least one professional society of experts; regular conferences, one of which is major, and a number of others which are more specialized; at least one recently established professional journal to which the

authorities of the discipline contribute to; and in general the intention of intervening, helping, and/or improving the *human kind* that is the object of their study (Hacking, 1995). As will be shortly outlined, the concept of grief within the discipline of psychology is a clear example of a *cutting edge human kind* as described by Hacking (1995).

A *natural kind*, according to Hacking (1995), is one that is found in nature, but that often is transformed into a *human kind.* Hacking used the example of teenage pregnancy to make his point. There have always been young women who have been pregnant, however the classification of what constitutes 'young women', 'teenager', or the stigma associated with 'early parenting' is a *human kind* that was constructed by the social sciences (Hacking, 1995). These *human kind*s can only be developed within a social context that has invented the concept of adolescence and the social mores that stipulate pregnancy should happen when one is older. The same can be said of the distinction between grief as a *natural kind* and grief as a *human kind.* As indicated in the introduction, some have argued that grieving, or the reaction to the death of a loved one, is a *natural kind* that has always existed in some form (Archer, 1999; Gilbert, 2006; Parkes, 2001; Rosenblatt, 1993, 2001). While this is an intriguing contention to examine,[3] this project will focus on the conception of grief in the 21st century within the realm of

[3] For an examination of grief as a universal phenomenon, see Archer (1999) who provided an evolutionary explanation for the pervasiveness of grief historically and cross-culturally.

psychology as a constructed *human kind,* or what I have termed a *psychological kind* for the purpose of this project.[4]

The remainder of this chapter will be devoted to tracing the development of this *psychological kind* within the discipline. While volumes have been written about the ways in which people have grieved historically (both in the West and cross-culturally, see: Metcalf & Huntington, 1991; Parkes, Laungani, & Young, 1997; Rosenblatt, 1993), the focus for this project is solely within the discipline of psychology. In his book *Modernizing the Mind*, Ward (2002) has argued that modern psychology has done more than any other knowledge form to transform our conceptualizations of the self and mind as well as the routines of every-day life. He argued that psychology's modes of operating are so pervasive in the 21st century that to think, and to feel, means using terminology, classifications, and modes of understanding created by psychology (Ward, 2002). Illouz (2008) has similarly remarked that the 'psy-discourses', or what she termed the 'therapeutic discourse/outlook' has been particularly effective in making the "the practise of self-knowledge a simultaneously epistemological and moral act" (p. 3). She argued:

> Not only has half of the entire population consulted a mental health practitioner, but even more critically the therapeutic outlook has been institutionalized in

[4] In a more recent publication, Hacking (2007) distanced himself from the clear distinction he made between *natural kinds* and *human kinds*. His recent article primarily questioned the possibility of a natural kind to exist as a philosophical category. He wrote "my argument is that there are so many radically incompatible theories of natural kinds now in circulation that the concept itself has self-destructed" (p. 205). For the purposes of this paper, I use his earlier work to make a case for psychological kinds. I believe this is justified both because Hacking (2007) himself acknowledged that the concept of natural kinds can be useful in trying to frame a phenomenon, and because I focus more on the concept of human kinds in this project. Hacking does not renounce the concepts of human kinds, or cutting edge human kinds in his more recent work. See: Hacking (2007) for elaboration.

> various social spheres of contemporary societies (e.g., in economic organizations; mass media; patterns of child rearing; intimate and sexual relationships; schools; the army; the welfare state; prison rehabilitation programs; and international conflicts). ... The therapeutic discourse has crossed and blurred the compartmentalized spheres of modernity and has come to constitute one of the major codes with which to express, shape, and guide selfhood.... The therapeutic outlook has become one of the centers of that amorphous and vague entity known as Western civilization. (p. 6)

I agree with these writers in their emphasis on the power of the psy-disciplines to shape people's reality. As I will illustrate in this project, the discipline of psychology and its construction of grief as a *psychological kind* has had a profound influence on how people grieve in the West in the 21st century. This chapter, in which I will trace the development of grief as a psychological construct, is the genesis of this project. Before delving into this history, I briefly situate grief research within the modernist paradigm of contemporary psychology.

Ward (2002) has suggested that psychology is not only a product of modernism, but the discipline has been an active agent in constructing this modernist ontology. The main tenets of modernism are an emphasis on scientific rationality, reason, observation, and a belief in continuous progress (Gergen, 1991, 1992). Modern life emphasises goal directedness, functionality, rationality, and efficiency in all areas of living (Gergen, 1991, 1992). Stroebe et al., (1992) wrote that when applied to grief, the modernist paradigm:

> suggests that people need to recover from their state of intense emotionality and return to normal functioning and effectiveness as quickly and efficiently as possible. Modernist theories of grief and related therapeutic interventions encourage people who have experienced loss to respond in just this way. Grieving, a debilitating emotional response, is seen as a troublesome interference with daily routines, and should be 'worked through'. Such grief work typically consists of a number of tasks that that have to be confronted and systematically attended to before normality is reinstated. Reducing attention to the loss is critical, and good adjustment is often viewed as breaking of ties between the bereaved and the dead. (p. 1206)[5]

This description of grief research and theory is an accurate picture of how grieving is understood in the field of modern psychology. Grief has been constructed as a pathological condition necessitating psychological intervention in order for people to heal as quickly as possible (Engel, 1995; Green et al., 2001; Raphael, 1983; Zisook & Shuchter, 2001). The goal is to get people functioning, and back to work in a timely and cost efficient manner. While chapter two looks at how grief became psychologized, and chapter three is devoted to examining how these beliefs have affected how people mourn,

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[5] While Stroebe and her colleagues (1992) provided an excellent description of the modern, psychological approach to grief, it is worth noting the irony in their criticism. The purpose of this article, which was published in the prestigious journal *American Psychologist*, was to challenge psychology's modernist approach to understanding and treating grief. While the theory proposed is laudable, and in fact, one that I wholeheartedly agree with, it is ironic because the authors, M. Strobe and W. Stroebe are two of the most notable psychologists in the field of grief research. They have penned *hundreds* of journal articles, books, book chapters, and even grief scales that have reinforced the very binaries they are deconstructing in this article (M. Stroebe, Gergen, Gergen, & Stroebe, 1992)

this chapter will focus on how grief was introduced into the psychological domain in the first place.

Psychoanalytic Conceptualizations of Grief

While Freud (1856-1939) was the first to introduce the concept of 'grief', into the psychological lexicon, there were a few researchers who came before him. When I say researchers, I am referring to people who have studied the phenomenon of grief within a relatively close paradigm to the social sciences. In other words, while other texts can be found on the topic of grief prior to the seventeenth century,[6] the ones I focus on here attempted in some way to systematically or empirically document the process of grieving.

Burton (1577-1640) wrote about bereavement and other forms of loss briefly in his book, *The Anatomy of Melancholy*, published posthumously in 1651. Burton argued that grief is a kind of transitory melancholy that affects everyone at some point in their lives. While Burton referred to grief as a "cruel torture of the soul" (p. 259), he also emphasized the distinction between melancholy as a disease, and melancholy as a normal reaction to every-day events such as death of a loved one. He proposed that melancholy can either be found in disposition or in habit, the former referring to context specific melancholy and the latter referring to a person who is habitually melancholic in character. "In disposition, is that transitory melancholy which goes and comes upon every small occasion of sorrow, need, sickness, trouble, fear, grief, passion or perturbation of mind... and from these melancholy dispositions, no man living is free" (p. 143).

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[6] See: Cicero (1583), Dorrington (1695), Owen (1680), Reynell (1663), R.W (1695) & Temple (1693).

Perhaps ironically, Burton is used by contemporary psychologists to argue that the concept of depression has a historical continuity with the contemporary psychological definition of depressive disorder. A careful reading of Burton, however, can leave no doubt that his concept of melancholy was always context specific, while contemporary definitions of MDD are usually symptom-based, and do not provide an explanatory framework as to why the depression developed (Horwitz & Wakefield, 2007). Similarly, some psychologists (e.g., Archer, 1999) have suggested that Burton was the first theorist to define the concept of grief in psychological terms. While Burton did acknowledge grief, he did so in the context of describing a specific kind of melancholia, which as will shortly be illustrated, has little in common with the contemporary psychological definition of grief. While Burton (1651) did contribute to the *foundation* on which grief as a *psychological kind* developed, in the sense that he included it as part of the domain of medicine, he did not define it in the same way it is conceptualized today.

In the 17th century grief was often viewed as potentially fatal and it was widely believed that grief could make you mad and even lead to premature death (Cressy, 1997; Laurence, 1989). Benjamin Rush (1745-1813), an American physician, included grief in his book *The Diseases of the Mind* (1812/1947), although he did not think that grieving people were necessarily sick. Rush described a list of emotional and physical symptoms characteristic of grieving people such as aphasia, fever, sighing, loss of memory, and the development of grey hair. Rush offered a variety of remedies to 'heal grief' that included using opium, crying, and in intense cases, blood letting and purges (Rush, 1812/1947).

Darwin (1809-1882) also briefly touched upon grief in his book on emotional expression published in 1872. He described in detail the expressions of depression and grief including the mechanical aspects of crying and the accompanying facial expressions. Darwin also made a distinction between an active, frantic form of grief, and a passive, more depressive form, which he claimed had different etiologies. In addition to describing the physical characteristic of grief in people, Darwin also noted that animals such as monkeys and apes also display and experience grief (Darwin & Ekman, 1872/1972/1998).

The first thorough study of the psychology of grief was written by A. F. Shand (1858-1936) in a book (1914/1920) he wrote on instincts and emotions in which he referred to grief as 'the laws of sorrow'. He described four types of grief reactions; the first was active and directed aggressively to the outside world; the second was depressive and lacking in energy; the third suppressed through self-control; and the fourth involved frenzied and frantic activity. Shand (1920) also spoke about other aspects of grief including the need for social support, the continued relationship with the deceased, and the trauma associated with sudden death.

It was Freud's breakthrough theories, however, that have had the most impact on contemporary grief research within the discipline of psychology. While Freud (1917) is justifiably credited with producing the most significant text for the discipline on the topic of grief, one analyst preceded him. In 1911, a year before Freud published *Totem and Taboo (1912),* and six years before his prominent essay on mourning and melancholia

was published, Abraham (1877-1925) wrote about the distinction between grief and melancholy, or what he referred to as neurotic depression (1911). While Abraham's (1911) essay had a lesser impact on the discipline, Freud acknowledged this work in *Mourning and Melancholia (1917).*

In 1912, Freud published *Totem and Taboo* where he outlined his main ideas on grief that he expanded in *Mourning and Melancholia* (1917). Freud (1917) proposed that the mourner had the task of detaching their libido/emotional energy from the deceased and sublimating it into other areas of their lives. Freud's essay has often been interpreted to mean that those who failed to do their 'grief work', a term which has evolved into an ingrained western psychological concept, could end up with a psychiatric illness which resulted from their pathological grieving (i.e., Genevro et al., 2004). Emerging from this view are several Western assumptions that have remained central to psychological research on grief, including the idea that grief is an active process that involves an intense struggle to give up the emotional attachment to the person who has been lost, and that this struggle is a process which involves time and energy on the part of those mourning. It is somewhat ironic that Freud's work is used by later psychologists to justify the concept of 'grief work' and 'pathological mourning' (i.e., Archer, 1999; Stroebe et al., 1992) since Freud (1917) never intended to pathologize grief and in fact, he clearly stated in his famous essay that:

> although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition and to refer it to

> medical treatment. We rely on it being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (p. 252)

Freud's (1917) essay was a watershed in the history of the conceptualization of grief within the discipline. His essay was a pivotal landmark in the development of grief as a *psychological kind.* Notably, while it is true that this text was the seed from which grief as a *psychological kind* emerged, it was in some sense, grossly misunderstood. I would further argue that the text was manipulated to mean something that would be anathema to Freud. The idea that grief should ever be pathologized, or that one could ever do one's 'grief work' so thoroughly as to completely sublimate the emotional energy into something or someone else (as the process is understood in contemporary psychology today), was alien to Freud. In a letter to Ludwig Binswanger (1881-1966) who had lost a son, Freud wrote:

> Although we know that after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. And actually this is how it should be. It is the only way of perpetuating that love which we do not want to relinquish. (Freud, cited in Bowlby, 1980, p. 23)

While Freud advocated that the person grieving had to detach their libido or their emotional energy from the deceased and sublimate it into other areas of their lives, he also argued, as should be clear by the quote above, that this is a slow and laborious

process and that it is never completely resolved (Freud, 1917). Another aspect of Freud's essay that is often misrepresented is the conflation of grief as a result of becoming bereaved (that Freud called mourning) and grief that came from other losses (that Freud called melancholia), including loss of a relationship due to separation. Repeatedly, Freud emphasized that although mourning and melancholia may *look* the same symptomatically, they are *distinctive* because they are context specific. While Freud believed that mourning, or grieving the loss of a loved one who has died was a normal and time consuming process, it was not pathological. Melancholia, on the other hand - to which most of the paper was devoted - had the potential to become a disease because it was a reaction that occurred out of any understandable context (Freud, 1917). He argued:

> In mourning we found that the inhibition and loss of interest are fully accounted for by the work of mourning in which the ego is absorbed. In melancholia, the unknown loss will result in a similar internal work and will therefore, be responsible for the melancholic inhibition. The difference is that the inhibition of the melancholic seems puzzling to us because we cannot see what it is that is absorbing him so entirely. (p. 254)

Finally, it is worthy noting that while Freud (1917) did briefly mention the possibility of pathological mourning, defined as the inability to introject or sublimate the lost love object into something more constructive, he argued that this rarely happened in

the case of bereavement and that further, mourning takes time and is a long and drawn out process.

Many early 20th century studies of grief followed from Freud's theoretical analysis (Abraham, 1924; Deutsch, 1937; Klein, 1940). The psychoanalytic tradition analyzed grief as an emotional reaction in response to a significant loss and proposed various kinds of 'grief work' to process the loss. Abraham (1911), mentioned earlier, followed Freud (1917) and published another paper dealing with the subject in 1924. Like Freud (1917), Abraham (1924) argued that mourning and melancholia are related conditions but are indisputably distinct. "In the normal person", wrote Abraham (1924), grieving was:

> set in motion by real loss (death); and its main purpose is to preserve the persons' relations to the dead object, or - what comes to the same thing - to compensate for his loss. Furthermore, the conscious knowledge of his loss will never leave the normal person, as it does the melancholic. (p. 438)

Whereas Freud (1917) focused on sublimation of cathartic energy, Abraham (1924) focused more on the process of introjection of the lost object while mourning. In Abraham's (1924) conceptualization, the grieving person's 'grief work' involved taking in the dead person to oneself in order to heal from the loss. He stated, "the process of mourning thus brings with it the consolation; 'My loved object is not gone, for now, I carry it within myself and can never lose it'" (p. 437).

Perhaps the most interesting insight offered by Abraham (1924), and the one most often taken up by contemporary psychologists, is the point he made about 'normal mourning' in the first place. In this paper, he argued several times that psychoanalysis does not really know what 'normal mourning' looks like in a healthy person other than Freud's conjecture that the prime aspect of melancholia is ambivalence towards the lost object, whereas in 'real mourning', it is grieving over the loss of a dead person where there is no ambivalence. While I have argued, and will continue to illustrate throughout this project, that pathological mourning is a construction of contemporary psychology, it is interesting to note that from the beginning of its entry into the discipline, grieving was regarded as an explicitly problematic concept because there was no protocol to distinguish the 'normal' from the 'pathological'. I contend that both had to be constructed in order for it to be treated, and that these constructions could only be developed within the emerging discipline of psychology.

While Freud (1917) and Abraham (1924) set the tone for the pathologization of grief, the first person to truly conceptualize it in this way was Helene Deutsch (1884-1982). In her essay entitled *The Absence of Grief (1937)* she wrote, "it is well recognized that the work of mourning does not always follow a normal course. It may be excessively intense, even violent, or the process may be unduly prolonged to the point of chronicity" (p. 12). It is unclear on what basis Deutsch drew her conclusions. She does not cite anyone when claiming that it -"is well recognized that the work of mourning does not always follow a normal course"- and while she may have been drawing on her clinical

experience in making these claims, there are no known theorists that came before her to support these statements. In fact, as I just mentioned, the notion of a 'normal course of mourning' is unclear even to founding theorists of the concepts of 'grief work'. It is more likely that Deutsch was using these statements rhetorically to support her argument that the death of a loved person must produce a reaction in the bereaved, and that the absence of such grief is as much a pathology as is extensive mourning in time and intensity (Deutsch, 1937).

While Deutsch (1937) is rarely cited in the accounts of the psychological history of grief, her work is essential in tracing the chronology of the contemporary understanding of grief within the discipline. Even though Deutsch's work appeared to be based on little referenced evidence, her theoretical formulations were foundational on several accounts. Her idea that unmanifested grief is as pathological as chronic grief, is one of the underlying assumptions driving contemporary psychological research on the topic. While Freud (1917) never claimed that grief becomes pathological if it goes on 'too long' or 'too intensely', Deutsch legitimized the concept of pathological grief by claiming that another type of dysfunctional grief is the kind that is absent or unexpressed (Deutsch, 1937). She thereby introduced both concepts into the psychological discourse.

The second major theory she introduced that has become so widespread today it appears to be almost common sense is that unmanifested energy, in this case unmanifested or repressed grief, will resurface in other ways if not brought into consciousness and treated (Deutsch, 1937). She stated:

> the process of mourning as a reaction to the real loss of a loved person *must be carried to completion.* As long as the early libidinal or aggressive attachments persist, the painful affect continues to flourish, or vice versa, the attachments are unresolved as long as the affective process of mourning has not been accomplished. (p. 21)

Deutsch's (1937) ideas were pivotal in the process of grief becoming a *psychological kind.* In this short paper, she set the foundation for much of contemporary grief research. Her idea that pathological grieving can manifest in either intensity and chronicity *or* in the absence of any symptoms introduced the concept that all grieving people are potentially ill and need to be monitored for the process of their 'grief work'. Secondly, the notion that 'grief work' must be done or else it will resurface somewhere else, puts the onus of responsibility on the grieving person to self-monitor or risk becoming ill or psychologically unbalanced.

By 1940, psychoanalysts such as Melanie Klein (1882-1960) were openly referring to grief as a disease, albeit in different ways than one might think about it today. Klein (1940) argued that infants separating from their mothers in the form of weaning from the breast or actual physical separation from their maternal figures could be compared to adults mourning in later life. In her view, normal mourning involved the activation of early psychotic anxieties involving separation from the mother. She stated:

> the mourner is in fact ill, but because this state of mind is common and seems so natural to us, we do not call mourning an illness. (For similar reasons, until recent

> years, the infantile neurosis of the normal child was not recognized as such). To put my conclusions more precisely: I should say that in mourning the subject goes through a modified and transitory manic-depressive state and overcomes it, thus repeating, though in different circumstances and with different manifestations, the process which the child normally goes through in early development. (p. 322)

While contemporary psychologists cite Klein's work to justify modern understandings of 'grief as illness' or 'grief as a disease', Klein (1940) clearly meant something else in her conceptualization. The quoted paragraph is often cited as 'proof' that there is continuity between contemporary notions of pathological grief and early psychoanalytic work. While Klein does indeed refer to grief as an illness, several other caveats appear in her essay, including the comparison of the mourning process to normal 'infantile neurosis' and normal developmental processes of the child, and the notion that it is transitory, not a permanent state of disease. It is likely that Klein, writing in the context of psychoanalysis where psychopathology and mental health were on a continuum, believed that the 'ill mourner' was in a temporary state that was part of the normal process of grieving, and not literally ill or diseased as conceptualized by later psychologists (Engel, 1995; Green et al., 2001; Parkes & Weiss, 1983; Raphael, 1983; Zisook & Shuchter, 2001).

Klein's (1940) theory of mourning is complex, and layered, and in many ways is more about child development than about grief. In her view, adult mourning and grief was a replay of earlier losses in childhood where the infant went through a transitory

'depressive phase' in coping with losses associated with the mother. Most importantly, Klein (1940) believed that this phase of mourning for both the infant and the adult was transitory, normal, and part of healthy development. Klein's solution to the problem of adult grief included shedding of tears and the realization that grief and suffering can have positive effects. She stated:

> when grief is experienced to the full despair at its height... suffering can become productive. We know that painful experiences of all kinds sometimes stimulate sublimations, or even bring out quite new gifts in some people, who may take to painting, writing or other productive activities under the stress of frustrations and hardships. Others become more productive in a different way - more capable of appreciating people and things, more tolerant in their relation to others - they become wiser. (p. 328)

Klein's (1940) essay then is more theoretical than practical, and while Deutsch (1937) advocated (albeit subtly) for the intervention of psychoanalysis, it is not obvious from reading Klein (1940) that she intended any kind of intervention. In fact, she appeared more inclined towards realizing the growth potential in the grief process than in trying to 'treat' it. This theoretical approach to understanding grief changed radically with the shift from psychoanalytic conceptualizations to psychiatric ones.[7]

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[7] The conceptualization of grief as worthy of psychological study was also impacted by World War I and World War II. It is beyond the scope of this project to trace the social history of grief vis-a vis the wars. For two recent excellent books on the subject, see: Evans (2007), Gilbert (2006) especially chapter 7, Acton (2007), and Faust (2008).

Psychiatric Conceptualizations of Grief

While Freud put grief on the map, Lindemann (1944) charted the territory. Lindemann's publication *Symptomatology and the Management of Acute Grief* was a pivotal, transitional point in the development of grief as a *psychological kind.* During the early 20th century as psychology was solidifying as a discipline, the field of psychiatry was also seeking to expand its domain and influence (Capshew, 1999). While psychiatry was mostly relegated to the asylums in the 19th century (Burnham, 1996; Shorter, 1997), the discipline was beginning to expand into public settings and advocating psychotherapy as a cure for everyday ills (Ward, 2002). Building on their work treating veterans in the first World War, psychiatrists were gaining control over the emerging 'mental hygiene movement'.[8] As psychotherapy began to infiltrate the collective psyche and become more popular among the middle class, psychiatry began to shift its emphasis from psychosis, found exclusively in hospitalized settings, to the general well-being of the lay public (Capshew, 1999). As a result of this shift, psychiatrists began to expand their domain to the every-day behaviors and emotions of the general public. While more will be said

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[8] The Mental Hygiene movement began in 1908 in response to Clifford Beer's (1907/1953) autobiography entitled *A Mind That Found Itself,* which criticized the state of mental institutions at the time. Beers founded the *Connecticut Society for Mental Hygiene* and the *National Committee for Mental Hygiene,* which would later become the group to organize the *National Association for Mental Health* in 1950. These groups advocated better quality care for the mentally ill based on scientific research and methods and included prevention of mental illness and knowledge dissemination in their mandate. *The National Institute of Mental Health* (NIMH) took over this role in 1949 in the United States. The mental hygiene movement had a major role in reforming institutional care, expanding public education about mental health and the development of clinics throughout the States. In many ways the movement was about the promotion and dissemination of scientific, psychiatric, and psychological knowledge and it was thus a pivotal area for psychiatrists to gain control over in an attempt to professionalize their discipline (see: Brown, 1985; Grob, 1983).

about this later in this chapter, it is noteworthy that World War II would further impact professional boundaries as psychologists began to stake a claim into what was previously psychiatric territory (see: Buchanan, 2003). One of the newly co-opted concepts in the field of psychiatry was grief and it began with Lindemann's study.

Lindemann (1944) offered a rationale for psychologizing grief in the very first sentence of his article.

> At first glance, acute grief would not seem to be a medical or psychiatric disorder in the strict sense of the word, but rather a normal reaction to a distressing situation. However, the understandings of reactions to traumatic experiences whether or not they represent clear cut neuroses has become of ever increasing importance to the psychiatrist. (p. 141)

Lindemann's (1944) paper was the first to present an empirical study of bereaved patients. Its cachet and its novelty was in its 'scientific' and 'objective' approach in documenting the grieving process. By interviewing 101 subjects who had recently been bereaved, Lindemann claimed to produce a systematic, objective, and accurate representation of what the grieving process entailed and, further, argued that psychiatrists could, and should play a role in aiding the mourner in their grief work (Lindemann, 1944).

Lindemann's (1944) study revolutionized the concept of grief within the field by establishing several assumptions about the nature of the grieving process that have remained central to psychology today. First, he established that grief was a medical

disease (or in contemporary terms, a 'psychiatric/psychological disorder') that fell into the purview of psychiatry (and subsequently psychology). The first point he made in his treatise is that "grief is a definite syndrome with psychological and somatic symptomatology" (p. 141).

The second significant point is the development of a list of 'normal' and 'abnormal' grief symptoms in a systematic way. On this he wrote, "this [grief] syndrome may appear immediately after a crisis; it may be delayed; it may be exaggerated or apparently absent" and that further, "in place of the typical syndrome there may appear distorted pictures, each of which represent one special aspect of the grief syndrome" (p. 143).

By listing 'normal' and 'abnormal' symptoms and patterns of grief in his paper, Lindemann described the process of grief as a disease with an etiology that could be predicted, managed, and subsequently treated by professionals.

Lindemann's third major achievement in this paper was his argument that psychiatrists could, and should, be involved in the management of grief since they were experts in the field and knew the 'right' techniques to help the patient with their grief work. He stated:

> Proper management of grief reactions may prevent prolonged and serious alterations in the patient's social adjustment, as well as potential medical disease. The essential task facing the psychiatrist is that of sharing the patient's grief work, namely, his efforts at extricating himself from the bondage to the deceased and

> finding new patterns of rewarding interaction. It is of great importance to notice that not only over-reaction, but under reaction of the bereaved must be given attention, because delayed responses may occur at an unpredictable moment and the dangerous distortions of the grief reaction, not conspicuous at first, be quite disturbed later on. (p. 147)

Thus, Lindemann argued for the explicit intervention of psychiatrists in the grief process. He believed that psychiatrists should not only treat grief like a medical and psychological disease, but that patients should also be monitored for 'normal grief' reactions to see if they were doing their 'grief work' properly. Further, patients should *also* be monitored for not showing enough grief. Indeed, Lindemann went on to propose that psychiatrists should be involved in almost all cases of grief since patients will need psychiatric intervention to make sure they stay *on course* with their grief work, *and* if they are *too* grief stricken, *and* if they are not showing *enough* grief.

Lindemann goes as far as to claim that while it was once the case that ministers and religious institutions used to deal with the grief stricken, "comfort alone" from these people "does not provide adequate assistance in the patient's grief work" (p. 147). It is only a psychiatrist that can be of help to the bereaved and the use of social workers, ministers, and family members should be for the purposes of "urge[ing] the patient to ...see a psychiatrist" (p. 147). This approach of criticizing other resources for the grieving person including religious ministers, family, and friends will be a recurring theme that will emerge throughout the development of grief as a psychological construct.

Indeed, as will be discussed in the next chapter, destabilizing other institutions and resources for the mourner in order to step in and take over the role of expert and therapist parallels psychology's approach to professionalizing the discipline where every-day experiences became co-opted by psychologists as problems for them to solve (Daniels, 1967).

Finally, while Lindemann did not explicitly state this, he implied a distribution of responsibility to the mourner to do their grief work properly. Lindemann emphasized the idea that the duration of the grief reaction depends on the success with which a person does their grief work. This work involved the emancipation from the bondage of the deceased, a readjustment to the new environment in which the deceased was missing, and the formation of new relationships. Success for the mourner could only come from working on themselves and slugging through their grief work, which can be done properly only with the guidance of a psychiatrist. In this way, Lindemann set up a paradigm of success or failure for the mourner. This view will later become popularized in mainstream culture resulting in a new kind of self-consciousness for the griever. On this, Gilbert (2006) noted that in addition to the universal question of whether one is honoring the dead properly, "twentieth-century Western society has added another, distinctively clinical anxiety: Am I recovering from the illness of grief at a proper rate?" (p. 257). The genesis of this 'clinical anxiety' can be seen to be rooted in Lindemann's study.

In the years immediately following Lindemann's paper there were few large-scale empirical studies of bereavement. Brewster, writing in 1950, reiterated Lindemann's ideas about grief work and described a clinical case study of a bereaved woman going through the phases of the 'grief process'. Stern, Williams, and Prados (1951) followed shortly after by writing an article on the etiology of grief, describing the symptoms in the same manner as one would describe a disease in the medical field. These authors repeated Lindemann's (1944) warning that the grief work must be done in order to avoid pathology and described their small sample as disturbed, but none were "psychotic, nor was the depression of such a degree that electric shock treatment or hospitalization was necessary" (Stern et al., 1951, p. 261). While these articles were readily available in the public domain (i.e., Stern et al.'s paper was published in the *American Journal of Psychiatry*), they did not appear to have a profound impact on the field (as is evidenced by their rare citation in subsequent grief texts). The next major turning point for grief within the domain of psychology came with publications by Marris (1958), Hobson (1964), Gorer (1967) and Parkes (1964a, b, 1965, 1971) in the United Kingdom.

Grief Studies in the United Kingdom

As with the United States, psychology and psychiatry were experiencing a surge of popularity in the United Kingdom in the 20th century (Moncrieff & Crawford, 2001). Similar to the trajectory in America, the British psychological disciplines went through various explanatory paradigms for mental illness (Moncrieff & Crawford, 2001). While

psychoanalytic theory was popular in the early 20th century, it was increasingly replaced by a more empirical approach with a focus on a biological orientation for understanding and treating mental illness (Bennett, 1991; Healy, 1996; Shorter, 1997; Warner, 1994)[9].

In tandem to what was happening in the United States, British psychiatrists and psychologists began to heavily emphasize empiricism and psychopharmacological experiments during the 1950s and 60s in order to professionalize their disciplines. Moreover, the emphasis increasingly began to shift from severe cases of psychotic patients to the mental health of 'normal' people in the community in order to expand their reach and services (Moncrieff & Crawford, 2001). It was in this context that grief research began to emerge in the United Kingdom.

Although Marris's (1958) study was the first empirical examination of bereavement in the United Kingdom, as a psychologist, he had a substantially different view on the process than did Lindemann (1944). Marris (1958) interviewed 72 widowed women whose husbands had died within the previous two years. Like Lindemann (1944), he presented a systematic description of the typical patterns of grief. However, he also asked questions about the widows' social contexts, including their financial situations, if they had remarried, and their social support networks. Despite his emphasis

[9] The shift in explanatory paradigms for mental illness was also influenced by other historical movements within the psy-disciplines that included, but were not limited too, spiritism, behaviourism, and cognitive psychology. For a thorough review of each of these movements and their impact on psychological explanatory paradigms see: Capshew (1999), Freedheim (1992), and Daniels (1967).

on community, however, Marris's focus was mostly empirical and was a strictly quantitative study whose main purpose was to list the symptoms of grief.

Hobson (1964) interviewed widows from a small town in the Midlands of England, and like Marris (1958), found that physical symptoms in the grief process involved migraines, ulcers, asthma, chest pains, and skin complaints as particularly prevalent as well as a general feeling of fatigue, and a sense of being removed from reality.

Gorer (1905-1985) interviewed a sample of 80 bereaved people ranging in age from 18-80 living throughout the United Kingdom (Gorer, 1967). While Gorer described the process of grief and offered novel concepts to describe two particular types of intense and permanent grief reactions (mummification and despair), his contribution to the field is most notable in his critical analysis of the state of mourning in North America and Britain. Ironically, when Gorer is referenced in contemporary psychology texts, he is described as a qualitative researcher who should be taken with caution or summarily dismissed for his methodological limitations (i.e., Archer, 1999). What is rarely noted is the main point of his compelling book; that "the social denial and the individual repudiation of mourning" was becoming widespread in the U.K and America (p. x). Starting out as an anthropologist/sociologist, Gorer's intent was to identify the sociological and cultural implications of bereavement, which he argued was increasingly being treated "as exclusively or predominantly private and psychological" (p. viii).

He offered several fascinating conclusions that will be dealt with more extensively in the next chapter. In brief, however, he suggested that death and subsequently mourning, are treated with the same prudery as sexual impulses and expression were a century ago. Whereas it was once assumed that 'good' women had no sexual desire and that 'good' men could keep theirs under strict control, so today:

> it would seem to be believed, quite sincerely, that sensible, rational men and women can keep their mourning under complete control by strength of will or character so that it need not be given public expression, and indulged, if at all in private, as furtively as it were an analogue of masturbation. (p. 111)

Other insights included the idea that the disavowal of mourning may have to do with the pressure to have a 'fun-morality' or what he described as the ethical duty to enjoy oneself and appear to be well adjusted. He suggested that perhaps "the right to the pursuit of happiness has been turned into an obligation. Public and private mourning maybe felt as contravening this ethic" (p. x). While Gorer's project involved looking at the actual grief process, the main purpose of his study was to deconstruct the social context in which these grief reactions occurred. As with other examples within the discipline (i.e., Wundt and his Voelkerpsychologie[10]), only part of this thesis was 'translated' for public consumption within America. While some of his empirical

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[10] Danziger (1979) noted that only part of Wundt's prolific writings were translated from German to English, thereby, ignoring a large part of his philosophy and research. While the natural science component of Wundt's philosophy was consumed and disseminated among North American psychologists, his 'softer sciences' approach, which he called 'voelkerpsychologie' and that, included language, art, mythology and religion was excluded. As a result, North American psychology developed more along the lines of natural sciences than social sciences. Gorer wrote in English, so when I use the term 'translation', I mean that only the scientific or empirical parts of his work were adapted in North America. (Also see: Smith, 2005.)

concepts came into the psychological lexicon (e.g., mummification), his critical theory remained opaque to most psychologists and psychiatrists working in North America.

Collin Murray Parkes, however, has a different legacy. Parkes, a psychiatrist, working under the supervision of Bowlby, produced a series of articles about grief that were published within the same decade. While Bowlby's theories were largely psychoanalytic in their theoretical orientation, Parkes was heavily steeped in the empirical, scientistic rhetoric of the time, and it was ultimately his ideas that were assimilated into contemporary psychological culture. Parkes' clinical studies (1964a, b, 1965, 1971), which are credited as the "beginning of a sounder empirical basis for the description of grief" (Archer, 1999, p. 21), were largely concerned with atypical patterns of grief. In these studies, he interviewed bereaved patients in psychiatric hospitals (1964a, b, 1965, 1971) and bereaved widows in the general community (Parkes, 1970). These studies provided detailed descriptions of the grief process that were 'empirically sound' and grounded in science (Archer, 1999; Genevro et al., 2004). His contributions were significant for a number of reasons that parallel Lindemann's (1944) work.

First, he provided a further rationale for the pathologization of grief and set in motion what was about to become an explosion of research into the 'illness of grief'. In his 1964 publication, Parkes stated "the claim that grief is itself an illness, which has been defended by Engel is supported by the finding that 28/29 bereaved psychiatric patients interviewed by me were found to be suffering form variants of typical grief" (Parkes, 1964a, p. 180).

His second major contribution to the field was in justifying the use of psychiatry to treat this illness. In the same paper cited above, Parkes concluded that "it is time that the psychology of bereavement and the means by which help can be given to the bereaved were made part of the medical curriculum" (Parkes, 1964a, p. 279).

The third major achievement had less to do with content and more to do with methods. Parkes' studies were considered by the psychological, and psychiatric communities as sound description of grief based on hard evidence. As such, he provided not only information about the processes of grief but also an empirical *method* in which future psychologists could begin to study the phenomena. He published his articles largely in medical journals - the majority in the prestigious *British Medical Journal* - and included numerous scientific charts and statistics to make his points. He also focused heavily on the somatic aspects of grief in his studies and was the first to suggest that the bereaved have higher morality rates and physical problems, thereby turning grief into a physical *and* mental disorder to be treated by medical doctors (Parkes, Benjamin, & Fitzgerald, 1969).

Finally, in all his articles, Parkes referred to grief as a complex process requiring professional intervention. In this way, he firmly established grief as a *psychological kind* within the discipline by offering both the 'problem' (pathological grief) and the 'solution' (psychiatric intervention).

The Synergy of Psychology and Psychiatry

Parkes' work had a profound influence on the burgeoning field of clinical psychology that was gaining momentum mid-century. World War II was a significant turning point in the history of psychology. When the Veterans Administration (VA) in the United States, mandated that all members of the armed forces were eligible for psychiatric and/or psychological treatment, the number of available patients increased so dramatically that psychiatry could no longer handle the load of cases it had previously treated (Brown, 1985; Grob, 1983; Pickren & Schneider, 2005). The VA soon became the largest employer of psychologists. Subsequently, psychology began to take over psychiatry's turf in almost every domain. As a result of this shift, research being conducted in psychiatry was infiltrating into the exploding field of psychology, and along with co-opting the concepts came the co-opting of epistemologies and methods. While Parkes favored qualitative interviews, he often used empirical outcomes in his studies, citing charts and crude statistics to make his points. North American psychologists who were working at staking their claim as a scientific discipline comparable to psychiatry endeavored to follow the clinical tradition but opted for additional 'scientific measures' to test their concepts (Capshew,1999; Napoli, 1981).

In the introduction, I outlined Hacking's (1995) criteria for a *human kind* to become a *cutting edge human kind.* The transformation must include: at least one professional society of experts studying it; regular conferences, one of which is major and a number of others which are more specialized; one recently established professional

journal to which the authorities of the discipline contribute to; and in general the intention of interfering, intervening, helping and/or improving the *human kind* that is their object of their study (Hacking, 1995). The first and last of these criteria were fulfilled by the steady stream of psychoanalysts, psychiatrists, and a few psychologists who became increasingly interested in the concept of grief after Freud's (1917) original publication. These professionals were both a 'society of experts' studying the same phenomena and all had the intention of helping and/or improving their object of study. The rest of Hacking's (1995) criteria for becoming a *cutting edge human kind,* or what I have called a *psychological kind,* were fulfilled simultaneously and almost immediately following

Parkes' studies.

In 1970, *Omega: The Journal for Death and Dying* was established. *Death Studies* followed on its heels with its first edition coming out in 1971. In addition to these journals, a slew of standardized questionnaires appeared. These included scales that measured physical and psychological health (Clayton, Halikes, & Maurice, 1971, 1972; Maddison & Viola, 1968; Maddison & Walker, 1967) as well as scales for depression, anxiety, and psychological well-being (Vachon, 1982; Zisook, 1987).

A decade later, more questionnaires were produced which claimed to measure bereavement (Jacobs, Kasl, Ostfeld, & Berkman, 1986a, b; Jacobs, Kosten, Kasl, & Ostfeld, 1987-1988; Raphael & Martinek, 1997). *The Texas Inventory of Grief* (Faschingbauer, Devaul, & Zisook, 1977) was introduced in 1977 and was followed with

several revisions including a shortened version of the questionnaire (Zisook, Devaul, & Click, 1982). *The Grief Experience Inventory* was published in 1985 and is one of the most widely used scales today to measure grief (Sanders, 1980-1981). Other scales include the *Response to Loss Instrument* (Deutsch, 1982), *The Revised Grief Experience Inventory* (Lev, Munro, & McCorkle, 1993), *The Inventory of Complicated Grief* (Prigerson et al., 1995), *The Core Bereavement Items* (Middleton, Burnett, Raphael, & Martinek, 1996), and the *Perinatal Grief Scale* (Toedter, Lasker, & Alhadeff, 1988).

The explosion of these questionnaires is indicative of the scientific, and quantitative ethos of psychology at the time. While it used to be the case that psychological laboratories symbolized the serious nature of psychological science, the development of diagnostic instruments such as the questionnaires described above came to take over the physical space of the lab (Cohen, 1992). While I will discuss the construction of normal versus abnormal grief and the resulting psychologization of the concept in the next chapter, the statistical standardization provided by these measures situated grief as a scientific construct that could be evaluated for its degree of pathology. The study of grief as a psychological construct had transitioned from a psychoanalytic, to a psychiatric, to a mostly empirical endeavor in less than thirty years within North America and Britain.

In 1988, a special issue of the *Journal of Social Issues* on the study of grief was published. I note this publication in particular because it sits at the midpoint between Parkes' influential studies that came out in the late 60s and early 70s and today's

contemporary research on grief. What is striking about reading the introduction of this issue written by Stroebe, Stroebe, and Hansson (1981) (three pivotal figures in the field), is that while some of the theories of grief have changed since Parkes' work, little about the structure or approach of these studies had been modified. By this point, grief theory had become decontextualized from experience and had been 'psychologized' completely. The focus was entirely on symptoms, and the ability to measure, diagnose, and manage grief. The language of the authors is jargon-filled, scientific and inundated with references to the progress psychologists were making in treating grief. In their review of the grief literature, the authors point out two main themes, the first being the 'health consequences of mental and physical health and life expectancy of mourners'; and the second being 'pathological forms of grief' (Stroebe, Stroebe, & Hansson, 1988). By the early 1990s, the focus on grief was almost entirely on its dysfunctional nature. Phrases like "predictors of abnormal grieving and poor outcome" and the "effectiveness of intervention programs" are liberally sprinkled throughout this introduction. Contributions in this issue include articles on the biological correlates of loss in humans and nonhumans, high-risk groups for pathological grief, and the role of counselling and therapy in helping grievers heal from their losses (Stroebe, Stroebe, & Hansson, 1988). Having defined the pathological griever, and created questionnaires to identify him/her, the psychologist could now study the griever in new ways, and create even more categories of pathological grief to address, including those "at risk" for the condition.

While the next chapter will focus more specifically on the history of the discipline and the rhetorical tools used by psychologists in order to make it appear scientific, and therefore, more credible, it is worth noting that Stroebe, Stroebe and Hansson (1988) used typical strategies to validate their own concept of grief and discredit previous theories. They critique Freud (1917) for being 'non-empirical' and psychoanalytic, and cite Lindemann (1944) as the founder of the study of grief because of his empirical approach to studying the phenomenon. Indeed, they follow in his footsteps by emphasizing "that it is well established that bereavement can be detrimental to mental health and the effect of the loss can be so severe as to create or (exacerbate existing) emotional problems of clinical magnitude" (p. 6). While it would seem fitting to most people that bereavement would cause 'detrimental mental health' (at least for a short while), by this point what could be considered a normal process of grieving for a lost loved one had become a dysfunction within the discipline.

Following Hacking's (1995) criteria for *cutting edge human kind*s almost to the letter, the last point the authors emphasize, and which lies at the foundation of the psychological imperative to study grief, is the conclusion that a) grief may be a pathology; b) that it needs the help of the experts to solve the problem; c) that grief should be studied by the experts using expert methods that are based on an empirically sound foundation; and, d) that psychologists will be doing a great service to their clients by helping them with their grief work (Stroebe, et al., 1988). They stated that the work of these psychologists is:

> guided by a concern for the bereaved, and by the belief that to be effective in helping, we have to proceed from a sound base of theoretically oriented and empirically derived knowledge... It is not enough for us to stay close and to open our hearts to another person's suffering: valuable though this sympathy may sometimes be, we must have some way of stepping aside from the maze of emotion and sensation if we are to make sense of it. (p. 15)

By this point, grief had become so completely ingrained into the psychological purview it no longer required a justification.[11] The majority of psychologists researching grief today are entirely empirical in their orientation. Contemporary psychologists studying grief have focused on the phenomenology and measurement of grief with an emphasis on scale development (Jacobs, Kasl, Ostfeld et al., 1986a, 1986b; Middleton et al., 1996; Neimeyer & Hogan, 2001; Prigerson et al., 1995; Shuchter & Zisook, 1993; Steeves, 2002; Stroebe, Stroebe, & Schut, 2003; Toedter et al., 1988; Tomita & Kitamura, 2002).

Other psychologists have proposed the cognitive/ experimental theory of grieving that looks at the cognitive 'impairments' and processes during the phases of bereavement (Cohen, Mannarino, & Staron, 2006; Epstein, 1993; Folkman, 2001; Stubenbort & Cohen, 2006). Another related area of research looks at the physiological changes that

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[11] To illustrate this point, a search on *Psycinfo* (the database for psychological resources) with the terms "grief" and "mourning" as subject indicators yields only 40 hits from 1880 to 1970's. From 1970, when Parkes' work was becoming notable, to early 1990 a relatively modest sum of 570 hits comes up. From 1990 to the present, however, the number doubles to 1128 hits. When combining the search from the 1970 to the present, Psycinfo yields almost 2000 hits and judging by the literature that is coming out in recent years, this number is set to grow.

come with grief including endocrine disturbances, increased mortality risk, and physical ailments like heart troubles (Irwin & Pike, 1993; Kim & Jacobs, 1993; Laudenslager, Boccia, & Reite, 1993; Ott, 2003; Parkes, 1964a, 1964b; Prigerson, Bierhals, Kasl, & Reynolds, 1997; Stroebe & Stroebe, 1987).

The 'grief as trauma' perspective looks at the violent circumstances in which people die and how they impact the grieving process for the survivors (Cohen et al., 2006; Cohen, Mannarino, & Deblinger, 2006; Jacobs, 1999; Prigerson et al., 1997a, 1997b, 1999; Prigerson & Jacobs, 2001; Raphael & Martinek, 1997; Raphael, 1997; Rubin, Malkinson, & Witztum, 2003; van Doorn, Kasl, Beery, Jacobs, & Prigerson, 1998); while the 'stage model' of grieving, or the idea that grieving progresses in a set of orderly stages examines the sequence in which people move through the mourning process (Bowlby, 1980; Maciejewski, Zhang, Block, & Prigerson, 2007; Raphael, 1983; Seitz & Warrick, 1974; Volkan, 1981). The stage theory of grieving will be elaborated on in detail in chapter three.

The grief and adaptation perspective looks at personality and gender difference in how people cope and adapt to grief (Bonanno & Kaltman, 2001; Bonanno et al., 2002; Dutton & Zisook, 2005; Parkes, 1975, 1988; Volkan, 1977); While grief and attachment theories focus on the relationship between early development and grieving in later life (Bowlby, 1980, 1983; Field, Gao, & Paderna, 2005; Field, 2006; Jacobs et al., 1987-1988; Shaver & Tancredy, 2001; Stroebe, Schut, & Stroebe, 2005a; van Doorn et al., 1998; Weiss, 2001).

One of newest areas of research that will be expanded on and explained in the next chapter is grief within the disease model, or complicated grief (Averill & Nunley, 1988; Bonanno, 2006, 2007; Brewster, 1950; Engel, 1995; Hardison, Neimeyer, & Lichstein, 2005; Neimeyer, 2005-2006b; Ott, 2003; Parkes, 2005-2006; Prigerson et al., 1995, 2002; Raphael & Middleton, 1990; Vanderwerker, Jacobs, Parkes, & Prigerson, 2006; Volkan, 1984-1985; Zisook & DeVaul, 1983, 1985). In response to the growing trend of seeing grief as a disease, counselling psychologists have now begun to focus on developing grieving interventions and examining their efficacy (Cohen et al., 2006; Cohen, Mannarino & Deblinger, 2006; Cohen, Mannarino & Staron, 2006; Larson & Hoyt, 2007; Neimeyer, 2000, 2001a, 2001b; Stroebe, Schut, & Stroebe, 2005b; Stroebe, Zech, Stroebe, & Abakoumkin, 2005; Volkan, 1975).

Other psychologists interested in grief theory look at grief and meaning making or how people make sense of their losses and how it impacts the grieving process (Bosticco & Thompson, 2005; Neimeyer, 2001a, 2001b, 2005, 2005-2006a; Neimeyer, Prigerson, & Davies, 2002). Another notable theory includes the grief and 'continuing bonds' perspective that examines how people continue to maintain relationships with the deceased, and whether that hinders or helps the grieving process (Field et al., 2005; Field, 2006; Stroebe et al., 1992; Weiss, 2001). In addition to an explosion of articles on these subjects, several comprehensive reviews and books have been published including the *Handbook of Bereavement* (Stroebe, Stroebe, & Hansson, 1993) and the *Handbook of Bereavement Research* in 2001 (Stroebe, Hansson, Stroebe, & Schut, 2001).

In the introduction I explained that the modern view of grief proposes that grieving 'is a debilitating emotional response', that is seen as a troublesome interference with daily routines, and should be 'worked through' as quickly and efficiently as possible. As should be evident by the description of contemporary grief research in psychology, this view is widely held. The belief that grief is intrinsically traumatic and causally pathogenic is generally accepted among psychologists who study grief today. While this chapter was devoted to outlining the basic trajectory in which grief appeared as a psychological construct within the discipline, the next chapter will elaborate on how pathological grief became further problematized and psychologized within the discipline.

Chapter Two: Pathologization

The Abnormality Paradigm

> In the nineteenth century, grief was a condition of the human spirit or soul. It might sometimes be viewed as a cause of insanity, but it was not itself a mental illness. (Walter, 2005-2006, p. 73)

In the previous chapter I showed how the construct of grief became a scientific object over the course of the 20th century in the psy-disciplines. From the beginning of its entry into the psy-disciplines, grieving was a problematic concept because there was no protocol to distinguish the 'normal' from the 'pathological'. While contemporary psychologists claim to make a distinction between what they consider to be normal versus pathological grief, I contend that *both* 'normal' and 'abnormal' notions are constructed and reified when *any* research is undertaken on this topic. It's not *what* constitutes pathology that is important, but rather that a distinction is made between acceptable and unacceptable behavior. In other words, the specific criteria for diagnosing grief are not as relevant as the very idea that grief is something that can be evaluated on this kind of continuum. The paradigm of abnormality versus normality had to be firmly established before any diagnosis of pathology could be made. In order to make a case for treating grief, psychologists had to construct criteria that they deemed to be 'normal' as opposed to 'abnormal' before making the case for their services. These criteria do not exist in the world ready to be discovered, as some psychologists have argued (Engel, 1966/1995; Goodkin, Lee, Molina et al., 2005-2006; Prigerson et al., 1995; Prigerson,

Bierhals, Kasl, & Reynolds, 1997; Prigerson et al.,1997a, 1997b, 1999; Prigerson & Maciejewski, 2005-2006) but rather were developed alongside the emerging concepts of mental illness and the subsequent professionalization of the discipline.

Perhaps the most widely known theorist to deal with the archeological development of psychology was the French philosopher, Michel Foucault (1926-1984). In his book *Mental Illness and Psychology* (1976),[12] he outlined the historical constitution of mental disorder as beginning in the mid-seventeenth century. For Foucault, mental illness did not exist until this time when the madman replaced the leper as a threat to society. Whereas it was once the case that madness had been "overt and unrestricted... and present on the horizon" (p. 69), the development of internment houses for mad people revolutionized the course of the psy-disciplines. Throughout Europe, these internment houses were created with the intention of housing those who were mad, *as well as a* series of other types of people. In this list, Foucault included:

> the poor and disabled, the elderly poor beggars, the work-shy, those with venereal diseases, libertines of all kinds, people whose families or the royal power wished to spare public punishment, spendthrift fathers, defrocked princes... and all those who, in relation to the order of reason, morality, and society, showed signs of 'derangement'. (p. 67)

These internment houses were not meant to 'treat' the inmates, but rather to exclude them from the social fabric of society. Foucault described the impact of these

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[12]This work was originally published in French under the title *Maladie Mentale et Personalite* in 1954 by Press Universitaires de France. It was translated into English in 1976.

houses as depriving 'madness of its language' and for the first time in history, sentencing those who could not cope with daily life or couldn't fit into society into silence. These interment homes were intended to be a form of 'social assistance' in the eyes of the government.

The next shift in the history of madness was the humanistic revolution that came in the mid-eighteenth century and involved renegotiating the structure and purpose of these interment houses (Foucault, 1976). As part of this revolution, Foucault described the humanist reform of internment houses lead by Pinel in France, Tuke in England, and Wagnitz, and Reil in Germany. The idea was to abolish interment houses as a symbol of ancient oppression and transform them into places of 'reform' for the patients. "Internment", according to Foucault (1976), "took on a new signification at this point: it assumed a medical character" (p. 70). As an illustration, Foucault described Pinel's tactics in his asylum:

> After having 'freed the prisoners', he freed the mentally ill of the material bonds (though not all of them) that physically restricted them. But he reconstituted around them a whole network of moral chains that transformed the asylum into a sort of perpetual court of law: the madman was to be supervised in his every movement, to have all his pretensions shattered, his ravings contradicted, and his mistakes ridiculed; *sanctions were immediately applied to any departure from normal behavior.* All this took place under the direction of a doctor whose task

> was not so much that of therapeutic intervention as that of ethical supervision. Within the asylum, he was the agent of moral synthesis. (p. 71) (Italics added)

In this quote are several themes that I will elaborate on throughout this project; one of them is the notion of 'moral chains' or internal discipline replacing 'material bonds' in the treatment of mental illness that will be discussed in the next chapter. What is essential to note is the reification and enforcement of 'normal behavior' in the asylums. Foucault (1976) wrote:

> 'objective', or 'positive', or 'scientific' psychology found its historical origin and its basis in pathological experience... Man became a 'psychologizable species' only when his relation to madness was defined by the external dimension of exclusion and punishment and by the internal dimension of moral assignation and guilt. (p. 73)

Mental illness then was defined in relation to an average, a norm, or a pattern that was established by consensus of what was acceptable in a given culture. Deviancy and departure form the norm became the very *nature* of mental illness, and therefore, both 'normal' and 'abnormal' had to be clearly defined for each to exist. They became mutually inclusive categories that depended on each other for their coherence. Foucault (1976) wrote, "The pathological is no longer simply a deviancy in relation to the cultural type; it is one of the elements and one of the manifestations of this type" (p. 62).

Foucault's history of madness and his theories on how, and why, they developed,[13] are complex and beyond the scope of this project. What is important to take from Foucault, however, is that the construction of mental illness is dependent on the paradigm of being able to define the normal from the abnormal, and that both are necessary for each to exist. The criteria defining these categories have changed along with changes in social and historical context. While Foucault described this process in the mid-seventeenth century in the context of asylums and the revolution, I will examine how shifting criteria defining normality and abnormality in tandem with the development of psychiatry were pivotal in determining how grief was to be constructed in 20th and 21st century western psychology.

There were two simultaneous trajectories unfolding in the psy-disciplines in the 20th century that helped introduce and popularize the paradigm of abnormality in the West. Without the establishment of this paradigm, grief could not be pathologized in the way we understand it today. The first trajectory had to do with the introduction of Freudian theories in the United States, the expansion of psychiatry in the 20th century, and the development of the *Diagnostic and Statistical Manual of Mental Disorders*

[13] For example, as I will show in the next chapter, Foucault (1978) believed that power is dispersed among relations, rather than being located in institutions such as the Church, the government or the academy. In opposition to Marxist ideas that emphasized the oppressor and the oppressed, Foucault argued that power is a web of relations that circulated within society, and that everyone had the power to resist them. At the same time, however, he was also interested in the historical development, or what he called the archeology of madness, that at first seems to be in contradiction with his earlier ideas about power. In *Madness and Civilization* (1965), Foucault analyzed the ways in which madness was kept in circulation as a category, and what discourses were used to distinguish between those who were deemed normal versus those that were deemed abnormal. In this sense, he acknowledged that certain categories of people may appear to be less powerful as a result of the stigma placed on them, while at the same time challenge the notion of their powerlessness. I will discuss more about the diffusion of power in relation to grief in chapters 3-5.

(DSM) that would become an organizing artifact for the discipline (APA, 1994, 2000). The second trajectory that coincided and developed in relationship to psychiatry was the expansion of psychological expertise into the domain of the everyday. While the focus for this project is grief, it is necessary to understand the background context of these two disciplines in order to comprehend how grief came to be psychologized in this way.

Before elucidating on the impact of the classification on the abnormality paradigm and its relationship to grief, it is necessary to contextualize the field of psychiatry by briefly looking at Freud. While Freud was not an advocate of classification of mental disorders, he was pivotal to setting the stage for the abnormality paradigm and psychiatric classification to emerge. In 1909, Freud embarked on his first professional trip to America and gave five lectures at Clark University (1909/1990). His seminal book, *Introductory Lectures on Psychoanalysis* (1915/1966/1989) was later published in 1915. Since it is beyond the scope of this paper to elaborate extensively on Freudian thought, my emphasis is only to explore the general impact of Freud's ideas on American culture in relation to the entrenchment of the abnormality paradigm.[14]

In his Clark lectures,[15] Freud introduced two new ideas that were foundational for the establishment of the abnormality paradigm. The first was the focus on every-day life

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[14] For a thorough review of Freudian theories see: Brunner (1995) and Rieff (1979); for a historical account of the development of psychoanalysis and Freudian thought see Roazen (1973/1987) and Manning (2005); for a more elaborate discussion of the impact of Freudian ideas on epistemological narratives of the self, see Illouz, (2008).

[15] For a commentary on the significance of the Clark Lectures, see: Fancher, R. (no year available). *The Origin and Development of Psychoanalysis. Sigmund Freud (1910).* Available online: http://psychclassics.yorku.ca/Freud/Origin/commentary.htm. A hard copy text of this is also available. See: Freud, S. (1909/1990). *Five lectures on Psycho-Analysis.* New York: Norton.

as sources of interest for psychoanalysis; these included themes such as slips of the tongue, dreams, infantile sexuality, and the power of the unconscious in affecting people's every-day behaviors (Freud, 1909/1990). In Freud's Third Lecture, for example, he wrote:

> These are the bungling of acts (Feldhandlungen) among normal men as well as among neurotics, to which no significance is ordinarily attached; the forgetting of things which one is supposed to know and at other times really does know (for example the temporary forgetting of proper names); mistakes in speaking (Versprechen), which occur so frequently; analogous mistakes in writing (Verschreiben) and in reading (Verlesen), the automatic execution of purposive acts in wrong situations (Vergreifen) and the loss or breaking of objects, etc. These are trifles, for which no one has ever sought a psychological determination, which have passed unchallenged as chance experiences, as consequences of absent-mindedness, inattention and similar conditions. (Freud, 1910, Third Lecture, no page number available)[16]

Illouz (2008) noted that the inclusion of these seemingly insignificant human behaviors as central to analysis consisted of "making the un-meaningful, the trivial, the ordinary full of meaning for the formation of the self" (p. 38). The emphasis on every-day life as a realm worthy of investigation and analysis was a revolutionary new

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[16] See: http://psychclassics.yorku.ca/Freud/Origin/origin3.htm. A hard copy text of this is also available. See: Freud, S. (1909/1990). *Five lectures on Psycho-Analysis.* New York: Norton

epistemological stance that was inclusive and broad enough to encompass almost everyone and everything.

The second, and related idea introduced by Freud, was the link he made between the realm of the every-day, and the health of ordinary and dysfunctional people. According to Freud, health and pathology were on a continuum and there was no clear boundary between them. Psychoanalysis was intended to address both 'normal' and 'pathological' behaviors by analyzing occurrences in every-day life. On this, Freud (1910) wrote, "...by such therapeutic endeavors our knowledge of the mental life of the normal and the abnormal is widened and deepened" (no page number available).[17] Freud, therefore, effectively managed to blur the distinction between normality and abnormality, as well as what he conceived to be the symptoms that could distinguish among these categories. Illouz (2008) noted that this approach to psychology:

> Abolished the distance between normality and pathology and made "normal" and "pathological" behavior the two simultaneous objects of this new science... The straight line that Freud repeatedly drew between "normality" and "pathology" put the notion of (emotional) "health" and "normality" squarely at the centre of culture. (p. 43)

While the abnormality paradigm, or the evaluation of behavior on a normal versus abnormal continuum began with the internment houses described earlier by Foucault, this epistemological stance became popularized with the dissemination of Freudian ideas in

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[17] See: http://psychclassics.yorku.ca/Freud/Origin/origin3.htm. A hard copy text of this is also available. See: Freud, S. (1909/1990). *Five lectures on Psycho-Analysis.* New York: Norton

the United States. What is significant about this paradigmatic shift is not the specific criteria that constitute a pathology, but the very notion that one could evaluate a behavior or a condition on this continuum at all. While Freud was less interested in classification and distinguishing pathology, (i.e., he believed in a dynamic continuum between normality and abnormality that everyone moved along), he popularized the idea that every-day occurrences and situations could be included in the psychological realm. The move to concretely define mental disorders was introduced around the same time with Emil Kraepelin (1856-1926) who had different ideas about the etiology of pathology, but who shared the view that psychological pathology was an area worthy of scientific attention.

Psychiatry and Classification

In 1902, Emil Kraepelin, dubbed the 'father of psychiatry', wrote:

> the principal requisite in the knowledge of mental disease is an accurate definition of the separate disease processes... until this is known we cannot hope to understand the relationship between mental systems of disease and the morbid physical processes underlying them, or indeed the cases of the entire disease process. (Kraepelin, 1902/1921, p. 115)

In contrast to Freud, who was also writing at the time, Kraepelin wanted to prove that psychiatric disorders were hereditary and attempted to classify all mental disorders into common patterns. Interestingly, while Kraepelin conceded that it "is almost impossible to establish a fundamental distinction between the normal and morbid mental

states" (p.115), he devoted his entire career to establishing these distinctions. Indeed, Kraepelin's goal was to establish that all psychological symptoms were unambiguous and had 'physical foundations'. As with medical disorders, Kraepelin wanted to draw sharp lines between normal and abnormal mental states, even though he himself had difficulty making these distinctions.

Shorter (1997), a historian, described Kraepelin's contributions to psychiatry as a major revolution in the history of the discipline. The essence of the change was differentiating distinct diseases by looking at their outcomes in psychiatric patients and creating a system in which psychiatrists could reliably diagnose pathology. Shorter wrote that Kraepelin (1997):

> provided the single most significant insight that the late nineteenth and early twentieth centuries had to offer into major psychiatric illness: that there are several principal types, that they have very different courses, and that their nature may be appreciated through the systematic study of a large number of cases. (p. 100)

Indeed, despite the difficulty in establishing clear lines between normal and abnormal mental states, Kraepelin divided all psychiatric illness into 13 large groups, which were then split into two further groups; illnesses that had affective components and illnesses that did not (Shorter, 1997). Kraepelin did not offer any obvious organic cause as an explanation for these disorders, but rather focused on the types of symptoms patients presented with. While Kraepelin was more careful than contemporary

psychiatrists and psychologists in diagnosing patients within their social contexts (Horwitz & Wakefield, 2007), what he produced was a system where one could be diagnosed with a disorder based on meeting criteria for one of these broad categories.[18] This was a fundamentally radical new way of thinking about psychiatry. On this Shorter (1997) wrote:

> In addition to providing a new way of classifying illness, Kraepelin's system insisted that there was a number of discrete psychiatric illness, or diseases, each separate from the next...Finally, being 'Kraepelinian' meant that one operated within medical model, rather than a biopsychosocial model, as the battle lines later became drawn. A medically oriented psychiatrist believed in approaching psychiatric illness just as a cardiologist would approach heart disease. (p. 108)

Indeed, Kraepelin's 'new way of classifying illness' became the foundation for the development of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (Lane, 2007). The first diagnostic manual was called The *Statistical Manual for the Use of Hospitals for Mental Diseases* issued in 1918. It was based on Kraepelins' classifications and was primarily intended for use in mental hospitals as that is where most psychiatrists were working at the time. *The Statistical Manual* was used exclusively by psychiatrists to classify mental disorders from this first edition to its tenth edition published in 1942 (Horwitz & Wakefield, 2007).

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[18] Lane (2007) noted that although Kraepelin wanted to find biological causes for all mental disorders, he also took the patient's social situation into account when making a diagnosis. That is, he took into consideration that some mental disturbances would be a result of a specific event such as the death of a loved one, and thus, has an etiology that made sense in the context of the patient's life.

By the early 1950s, however, the field of psychiatry was radically changing (Scull, 1989). As outlined in the previous chapter, the role of psychiatry shifted from state hospitals, which focused primarily on psychiatric disorders, to outpatient therapy, with less severe patients that required more psychotherapy. Many of these changes had to do with the explosion of patients that resulted from World War II and the soldiers, which as a result of the VA bill, were now entitled to psychiatric 'treatment' (Horwitz, 2002; Pickren & Schneider, 2005).[19]

As an illustration of how popular the psy-disciplines became, one could look at the rising rates of employment for psychiatrists. The percentage of American psychiatrists working in private practice rose from 8 percent in 1917 to close to 30 percent in 1941. By 1970, almost 70 percent of psychiatrists were working in private practice to meet the demands of clients (Herman,1995). Due to the fact that the *Statistics Manual* was less relevant to the majority of patients that the psychiatrists were now treating (because it focused heavily on severe psychosis), in 1952 the American

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[19] The Veterans Administration (VA) Bill, or what is called the GI Bill of Rights, was passed by President Franklin Delano Roosevelt in 1944. It was a Bill guaranteeing soldiers returning from war access to education, training programs, loans on houses, and health services that included psychological diagnosis and treatment. (See: http://www.gibill.va.gov/) The passing of this Bill was a boon for the psy-disciplines as it provided them a deluge of new patients. The GI Bill Website set up by the U.S Department of Veteran Affairs noted that by the mid-1950s, over ten million people had used services that were funded by the VA. Interestingly, there is no reference on the website to the overwhelming use of mental health services by the soldiers, even though the Bill was used by countless people to treat their mental anguish. Barber (2008) noted that World War II "Produced an unprecedented stream of new patients for psychiatry: an endless supply of... 'battle fatigued' soldiers suffering from guilt, anxiety and terrifying flashbacks. There were a remarkable 1.1 million admissions for psychiatric disorders in military hospitals over the course of the war" (p 71). Also see Moore (1992). The central role of the psy-disciplines in the army continues to this day. A recent article in *Time Magazine* (June, 2008), entitled *America's Medicated Army* reported on the heavy use of antidepressants and therapists by the soldier's in the field, and by returning veterans. See: Thompson (2008).

Psychiatric Association codified and produced the first edition of the DSM that was intended to better reflect the nature of the psychiatry's changing role and changing population of patients (Horwitz & Wakefield, 2007).

The DSM has been subject to many revisions and has continually expanded adding mental disorders in each revision. Whereas the first DSM (DSM-I) had Kraepelin's original 22 categories, the second version (DSM-II) was published in 1968 and had 180 categories; DSM III-R (revised) listed 292 categories in 1987; and DSM-IV, published in 1994, has over 350 categories of mental disorders. In just under thirty years, the total number of mental disorders with which people could be diagnosed almost doubled and is continuing to expand (Horwitz & Wakefield, 2007).[20]

The development of the DSM is important for the understanding of the construction of grief for several reasons. First and foremost, it is essential to understand the impact the DSM has had on constructing and reinforcing the continuum on which pathology and normality rest. As stated throughout, without the paradigm of normality/abnormality, grief could not be constituted as a subject worthy of psychological study. The second reason why the DSM is important to understand is because, as will be discussed in the next section, there is a growing group of psychologists who want to include grief as a mental disorder in the next edition of the manual (Horowitz et al., 1997; Forstmeier & Maercker, 2007; Goodkin, Lee, Molina et

[20] Also, see: Kirk & Kutchens (1992), for the development of the DSM-III, and Caplan (1995) for a further critique.

al., 2005-2006; Prigerson et al., 1995, 1997a, 1997b; Prigerson & Maciejewski, 2005-2006; Prigerson & Jacobs, 2001; Prigerson et al., 2002).

The DSM is considered to be a valuable diagnostic guide intended to aid in understanding the symptomatology of mental disorders. It is pivotal in understanding how mental illnesses are defined and how decisions about pathology are made. The authors of the DSM-IV (1994), for example, stipulate that "Although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder'" (APA, 1994, p. xxi). Despite the careful wording, the very next paragraph reiterates the role of the DSM-IV in emphasizing that "[the term mental illness] has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM-IV" (APA, 1994, p. xxi). The authors further explain that the DSM-IV is a "categorical classification that divides mental disorder into types based on criteria sets with defining features. The naming of categories...has been the fundamental approach used in all systems of medical diagnosis" (APA, 1994, p. xxii). Mental disorders are understood, diagnosed, and most often treated as medical problems. The DSM-IV is both a powerful medically oriented diagnostic tool and a social gauge that determines the fine line between pathology and normality (Hillman, 1975; Horwitz, 2002; Kingwell, 1998).

The distinction between what is deemed 'normal' and 'abnormal' in turn has profound implications for cultural understanding of what is acceptable behavior (Kingwell, 1998). Hillman (1975), in his book *Revisioning Psychology,* stated that:

> When we are told what is healthy we are being told what is right to think and feel. When we are told what is mentally ill we are being told what ideas, behavior, and fantasies are wrong...The avenues of escape are blocked by the professional abuse of pathologizing. To refuse the mental health approach confirms one's 'sickness'. (p. 77)

Indeed, as Lane noted (2007), "the criteria psychiatry adopts when diagnosing mental and mood disorders have numerous implications for the general public" (p. 27).[21] While the DSM is meant to list pathology and its criteria, what it also implicitly lists is the criteria for normality as well. As the example of grief will show, it does not take much to deviate from what is considered normal and meet the criteria for pathology.

The Expansion of Psychology and the Construction of Pathology

From the beginning of the discipline's history, psychology sought to establish itself in a league with other fields that used the scientific method (Teo, 2005). Psychologists wanted to model themselves after the prestigious natural sciences and indeed, by the 1940s, it was established that psychology "was to join with the natural sciences and utilize their methods, epistemology, and experimental apparatuses" (Ward, 2002, p. 43).

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[21] The next chapter will deal more explicitly with how the psy-disciplines and artifacts like the DSM function to impact people's understanding and evaluation of themselves.

The use of these methods, epistemologies, and experimental apparatuses, were pivotal in co-opting the paradigm of abnormality discussed throughout. Because psychologists wanted to model themselves on the sciences, they wholeheartedly embraced everything about the scientific epistemology. This included the idea that mental disorders could be categorized into discrete, distinct entities, and that one could use the experimental methods of science to diagnose mental disorders (Scull, 1989). Ward (2002) noted that, "Incorporating such artifacts as statistics, measurements, and experimental methods served as proof that psychology was indeed an explanatory science on the same level as the natural sciences" (p. 56).

Indeed, the artifacts were pivotal in understanding the construction of the abnormality paradigm. Part of this approach involved what Espeland (2002) has called 'commensuration' or "using numbers to create relations between things" (p. 64). The successful importation of statistics and experiments was predicated upon the ability to replicate the mathematical precision and predictive nature of the natural sciences. A significant part of this process involved the use of empirically derived scales that were created by psychologists in order to measure psychological phenomena, which they had in themselves invented. In a thorough explanation of this process, Ward (2002) wrote:

> humans, now redefined as 'subjects', came to be seen as possessing measurable 'attributes', such as perception, intelligence and ...personality... timing of subject's identifying letters, answering math questions, responding to sounds or filling out inventories became both representations of these attributes

> and verification of their experiences. Detailed, timed studies allowed people to be rated along a continuum based on how long it took them to perform certain tasks or respond to particular stimuli. The data could then be aggregated to find statistical norms and standard deviations. This created a means for economizing on the other steps of investigation by determining how groups should be compared and what scores should be used. (p. 122)

The statistical normalization provided by these testing instruments was a revolution for the discipline and expanded the way standardized tests came to measure almost all domains of personhood (Herman, 1995). Normality and abnormality could now be established firmly simply by having subjects fill out one of these standardized instruments. The role of these questionnaires in establishing and defining the abnormality paradigm was an important one. It was not merely that these tests measured what was abnormal 'out there' in the 'real world', but rather, as I have been emphasizing throughout, they actively constructed the very notion that a given phenomenon should be evaluated at all. No one had an intelligence quotient score (IQ) before IQ tests were developed, nor did anyone have a learning disorder before achievement testing was developed and popularized. In other words, because these concepts did not exist independently of our ability to measure them, one could not be pathologized with one of these labels. In this sense, statistics and measures can be thought of more as what Rose (1996) has called "truth techniques" (p. 57) than observations of reality. "Experimental devices do not represent an unmediated reality but instead secure and stabilize its

meaning - or, as Hacking has put it, 'to experiment is to create, produce, refine and stabilize phenomena'" (Ward, 2002, p. 133).

While the quest to be scientific was present from the very inception of psychology, the influence of the discipline and its standardized tests began to spread rapidly at around the same time psychiatry began to take off. It was on the back of World War II that psychology's presence began to be felt in the academy, in the hospitals, and in the realm of everything therapeutic (Capshew, 1999).

The enforcement of the abnormality paradigm within the field of psychology was instituted by both the development of the standardized measurements described above *and* the continual relationship with the developing field of psychiatry and its scientific tools such as the DSM. While the goals of these two disciplines are often described as in conflict, their relationship developed in mutually inclusive frameworks where each required the other for their existence. The relationship runs deeper than merely the right to prescribe medications as some researchers have suggested (Antonuccio, Danton, & McClanahan, 2003).

While not all psychological research is directly applicable to practical situations, much research is done with the purpose of discovering efficacious treatment for various mental disorders. In this sense, psychologists are both direct producers and consumers of the psychiatric industry. Psychologists simultaneously contribute to the development of psychiatric taxonomy by doing research on psychological disorders, *and* consume these same concepts through the uses of manuals like the DSM. In addition, all of the

psychiatric literature functions on the framework of the psychological versus the psychiatric hierarchy. In the case of depression, for example, a psychological study must prove that Prozac works better than cognitive behavioral therapy in order for it to be a credible treatment option. More important, however, than *how* to treat a given disorder, is the confluence between the disciplines in establishing that a certain behavior, like depression or grief, is pathology in the first place. In this sense, it is clear that psychiatry and psychology co-exist and are dependent on each other, and thus, both contribute to the success of the abnormality paradigm.

The Pathologization and Psychologization of Grief

> As Foucault has cogently shown, the distinction between the normal and the pathological is the central intellectual device of psychiatric medicine, so once grief became medicalised and psychiatrized, it was inevitable either that all grief would be seen as mental illness, or that distinctions between normal and abnormal grief would be made and elaborated. Overwhelmingly, it is the latter that has occurred over the past forty years. (Walter, 2005-2006, p. 73)

Conrad (2007) described medicalization as the process in which "non-medical problems become defined and treated as medical problems, usually in terms of illness and disorders" (p. 4). The psychologization of grief can thus be described as turning what used to be considered an every-day, non-psychological problem into a psychological issue to be diagnosed and treated by psy-professionals. In order to understand the psychologization of grief it is necessary to ask a more general question: what makes a

valid mental disorder? In his book *Creating Mental Illness*, Horwitz (2002) stated, "The appropriate question to ask about a problematic condition is not whether it is 'really' a mental disorder, but what advantages stem from viewing it as such" (p. 11).

To begin to answer Horwitz's query as to the advantages of viewing mental illness, and more specifically, grief, in this way, I reiterate the point I have been making throughout this chapter; *all grief* became part of the abnormality paradigm when it was included within the psychological domain and, therefore, *all* grief has become potentially pathological in 21st century North America. By virtue of its inclusion as a psychological object of study, what was once considered to be a natural reaction to the death of a loved one has fallen under the purview of the psy-disciplines, and, has therefore, become monitored, understood, and experienced in a way that previous generations could not have conceptualized. Regardless of *how* grief has become pathologized within the discipline, the very inclusion of it as a subject has had a drastic effect on the way people understand their experience of bereavement. This was a necessary pre-condition for the psychologization of grief I am about to describe.

Pathological, traumatic, and complicated grief. While all grief is potentially pathological according to contemporary psychologists and psychiatrists, some grief is described as 'excessive', 'a disease', 'out of the norm', and a 'mental disorder' (Boelen & Van Den Bout, 2007; Forstmeier & Maercker, 2007; Goodkin, Lee, Frasca et al., 2005-2006; Hogan, Worden, & Schmidt, 2005-2006; Horowitz, 2005-2006; Melhem, Moritz,

Walker, Shear, & Brent, 2007; Prigerson et al., 1997b; Prigerson & Jacobs, 2001; Prigerson et al., 2002; Shear & Frank, 2006).

Bereavement is listed in the DSM-IV-TR as a V code, which indicates that it is a disorder that needs further research and further clinical attention (APA, 2000).[22] The extreme end of the pathologizing of grief is the diagnosis of Complicated Grief (CG), which is sometimes referred as traumatic grief or pathological grief (Stroebe & Schut, 2005-2006). CG is a proposed diagnostic category for the DSM-V that is set to come out in 2011 (Horowitz et al., 1997; Forstmeier & Maercker, 2007; Goodkin, Lee, Molina et al., 2005-2006; Prigerson et al., 1995, 1997a, 1997b; Prigerson & Maciejewski, 2005-2006; Prigerson & Jacobs, 2001; Prigerson et al., 2002). Although CG is not an official diagnosis yet, it is still widely used by researchers and clinicians and is often diagnosed in patients (Breen & O'Conner, 2007).[23] Moreover, there is a group of researchers

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[22] The DSM-IV-TR lists simply "bereavement" as a category worthy of further attention. By placing it in the manual, it effectively applies the abnormality paradigm, and in the process, makes it part of the psychological domain. The DSM noted: "This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to loss, some individuals present with symptoms characteristic of Major Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss)... The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are still present 2 months after the loss. However, the presence of certain symptoms that are not characteristic of "normal" grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode" (APA, 2000, pp. 311-312).

[23] Complicated Grief is so popular among the psy-professions it is a central focus of attention at conferences. The inclusion of a topic at an international conference is an indication of its widespread acceptance among a professional society (Hacking, 1995). *The Association for Death Education and Counseling* holds an annual, international conference on death and grief for people in the psy-professions. The most recent conference was held from April 30-May 3rd, 2008. The conference book listed the following presentations: Among the professional development courses, there was a symposium on "Complicated Bereavement and Grief therapy" (p. 9), and "Complicated Grief Treatment" (p. 10). Among the conference sessions, there were presentations on "Adaptive and Maladaptive Continuing Bonds" (p. 15); "Problematic Social Emotional and Parental Grief" (p. 17); "A Taxometric Investigation of Prolonged and Normal Reactions to Loss" (p. 17); and "Personality Predictors of Prolonged (Complicated) Grief" (p.

adamant about its inclusion that are working to research the pathological effects of CG and insist that it is a mental disorder like all other psychological disturbances.

According to some estimates, CG affects between 10 to 20 % of bereavement survivors (Bonanno, Wortman, & Nesse, 2004). This is a perplexing figure for several reasons. First, an estimate that spans from 10-20 %, is an indication that the definition of CG is unstable in the best case scenario, and invalid in the worst. Further, as will be shortly outlined, the determination of prevalence depends on the definition of CG and this has not been a clear-cut, 'scientific' enterprise to uncover the 'truth' about the condition. One study using one set of criteria for CG found the prevalence rate of the pathology to be 41% in one sample of bereaved people (Horowitz, Siegel, Holen, & Bonanno, 1997). Another study using a different set of CG criteria found that prevalence to be anywhere from 20-57 % depending on how much time has passed since the death of the loved one (Prigerson et al., 1997b). A more recent review has indicated that approximately 40% of the bereaved meet criteria for 'grief related' major depression a month after the loss and another 15% meet criteria after one year (Hensley, 2006a, 2006b). According to the DSM-IV, a diagnosis of major depressive disorder (MDD) can be given to a bereaved person two months after their loss (APA, 1994). The issue of conflating depression and grief is a serious one that I will address shortly. For now it is noteworthy that while it can be expected that depression will be part of the grieving experience, it is still diagnosed as pathology in people only two months after a loss (Hensley, 2006a).

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17). As should be evident from this list, the CG diagnosis, or the notion of pathological grief is popular among clinicians and researchers even though it is not an official diagnosis.

Pathological grief has been identified as being inhibited (such as absent or minimal grief) (Jacobs, 1999);[24] delayed (characterized by late onset and severe intensity) (Parkes, 1998); and prolonged or chronic (Parkes & Weiss, 1983). A recent definition found in *Psychiatric Annals* stated, "complicated grief is a debilitating disorder whose sufferers typically report a sense of disbelief about the death, anger, and bitterness, yearning and longing for the deceased and preoccupation with the deceased" (Shear, Frank, Houck, & Reynolds, 2005, p. 619). While CG is yet to be determined as an official disease category, several researchers have devoted themselves to accomplishing this task.

The leading proponents of including CG in the DSM-V are Prigerson and her colleagues, the majority of whom are affiliated with the Department of Psychiatry at the Yale Medical School (Prigerson et al., 1995, 1997a, 1997b; Prigerson & Maciejewski, 2005-2006; Prigerson & Jacobs, 2001; Prigerson et al., 2002). In their view, the main diagnostic components of CG include the following: A) 'chronic yearning, pining and longing for the deceased'; B) four out of eight symptoms such: as 'inability to trust others', 'uneasy about moving on', 'numbness/detachment', 'bleak future', and 'agitation'; C) the symptom disturbance must cause marked and persistent dysfunction in

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[24] Stroebe and Schut noted that "absent grief is a difficult phenomena to investigate, not least because it is hard to distinguish from no or low grief (i.e., when the deceased person is simply not missed or grieved for). In general, though, there is by now ample evidence that grief itself may take a complicated course" (Stroebe & Schut, 2005-2006, p. 59). It is interesting to note here that Stroebe and Schut take the typical medical approach to disorder by making this statement. Because absent grief is difficult to measure, they conclude that it must be the case that the person is either not grieving for or missing the deceased. This is akin to the tradition in medicine of the expert doctor concluding that if they can't see it on their scans or through their tests, it must not exist. Like the physicians who cannot contemplate the notion that their may be a disease even if their scans can't capture it [for the development of this trend in medicine see Foucault's *Birth of the Clinic,(1994)]*, the psychologists cannot imagine that the person may be grieving and missing the deceased intensely because they are not displaying the 'right' kinds of symptoms that *they* feel indicate grief.

the social and occupational domain; D) the symptom disturbance must last at least six months.[25] In order for CG to be diagnosed, all criteria must be met (See Appendix A). When challenged about how CG differs from 'normal grief' the authors responded by stating:

> as we and others have demonstrated in several publications, the symptoms of CG are associated with and predictive of substantial morbidity... adverse health behaviors... and quality of life impairments. Thus the symptoms are indicative of pathology. The issue is not whether the symptoms themselves fit into seemingly pathological versus seemingly normal symptom clusters. What our results demonstrate is that the set of CG symptoms that we have identified, at persistent (beyond six months post-loss) and severe (marked intensity or frequency, such as several times daily) levels, are predictive of many negative outcomes and that is the basis for distinguishing them from normal grief symptoms. (Prigerson & Maciejewski, 2005-2006, p. 15)

While Prigerson's criteria are the ones most often used in studies on CG, Horowitz et al. (1997) have also proposed diagnostic criteria for the DSM-V. He and his colleagues differentiate between three categories of symptoms including: 1- intrusion such as unbidden memories, emotional spells, and strong yearnings for the deceased; 2- avoidance such as avoiding places that are reminders of the deceased and emotional numbness towards others; and 3- failure to adapt symptoms such as feeling lonely or

[25] Prigerson et al. (1999) originally proposed that criteria had to be met for two months post loss in order to be diagnosed, however, because of criticism that this was too short a duration, they expanded the criterion to six months in order to take what they deem a 'conservative' diagnosis.

empty and having trouble sleeping (See Appendix B). The main difference between Horowitz et al., (1997) and Prigerson et al. (2005) is their criteria for duration and number of symptoms necessary for diagnosis. While Prigerson stipulated that a diagnosis can be made 6 months post loss, she also indicated that all four criteria categories must be met. Horowitz, on the other hand, proposed that diagnosis should be made 14 months after loss; he also has a fewer number of criteria to be met in order to be diagnosed.

In comparing these two sets of diagnostic criteria, Forstmeier and colleagues (2007) concluded that the "Horowitz et al. criteria set is more inclusive and less strict than the Prigerson et al. criteria set and thus leads to a higher prevalence" (p. 210). Interestingly, while these authors recognize that these diagnostic categories are constructions that depend on definition, they propose that their criteria be modified to fit into the DSM. "In our opinion, impairment should be assessed in a graded manner in order to allow a mildly impaired patient who otherwise has a full blown CG symptomatic to be diagnosed with CG" (Forstmeier & Maercker, 2007, p. 210).

The theme in all of these understandings of CG is the trend towards inclusiveness and pathologization, and reigning-in even the 'mildly impaired patient' as diseased. All proponents of CG as a disease category have this in common: they all concede that there is a fuzzy line between normal grief and pathological grief, but argue nonetheless that this is not important in making a diagnosis of CG. Indeed, researchers in the field claim that while normal grief and pathological grief look the same, it is a matter of duration and intensity that marks the distinction between the normal from the pathological, and further,

that psychologists and psychiatrists should err on the side of caution by over-diagnosing rather than missing a case. In agreement with Prigerson and her colleagues, Goodkin and his colleagues stated:

> though it *cannot* be concluded from the work thus far that complicated bereavement reaction differs from normal grief, it is not necessary to demonstrate a qualitative distinction between the two... at a certain point on the continuum of normal grief, perhaps where grief becomes significantly dysfunctional in social and occupational activities, we may define the processes of complicated bereavement reaction without calling the new diagnosis into question. (Goodkin, Lee, Molina et al., 2005-2006, p. 31)

These authors justify the potential overuse of diagnosis by citing the example of a high school student who had recently gone on a killing spree, murdering six people and then taking his own life. Goodkin et al, (2005-2006) use this as a cautionary tale of undiagnosed CG. The murderer's father had committed suicide four years prior to this event, and thus, the authors suggested that his violent rampage may have been a result of an 'undiagnosed complicated bereavement reaction'. Therefore, psychologists and psychiatrists should include CG as a diagnosis to prevent these kinds of events from happening and ensure that they are "providing access to care to those who are dysfunctional in social and occupational activities related to a loss" (Goodkin, 2005-2006, p. 32). The fact that this student's diagnosis was the author's conjecture and that there is no logical relationship between serial killers and people who are bereaved is

never mentioned. Indeed, just as people who go on killing sprees are not necessarily suffering from CG,[26] it does not seem reasonable for it to be a justification for pathologizing everyone who grieves.

Another theme that I have alluded to throughout in relation to CG and the indistinguishability between normal and pathological reactions to loss, is the notion of diagnosing CG as disordered when its duration is too long (or too short), and intensity is too expressive (or not expressive enough). What qualifies as disordered seems laden with value judgments, and while some theorists have argued that these distinctions are made depending on the cultural context (i.e., Horwitz, 2002), I argue that psychologists and psychiatrists have had an active role in constructing cultural expectations about what is deemed normal or abnormal. In the case of grief, it is the psy-disciplines that have determined what is 'too long', 'too short', 'too intense' or 'too absent' when it comes to pathological grief. As I have illustrated throughout, they have invented the very idea that grief can be evaluated in this way at all.

A quick glance into other cultures will validate this point. The Cherokee tribe, for example, often have visions and dreams of their dead spouses that they talk to, and take guidance from (DeSplender & Strickland, 2005). Such hallucinations are not mental illnesses as they would be in our culture because they are considered culturally appropriate ways of responding to grief. While Prigerson, Horowitz, and others included hallucinations as part of the diagnostic criteria for CG, some Native Americans consider

[26] It is also important to remember that the student was four years post loss!

it a privilege and a gift to receive a vision from a deceased loved one. Horwitz (2002) pointed out that:

> cultural values always enter into judgments over whether reactions to stressors are appropriate or disproportionate. The DSM, for example, considers a diagnosis of major depression after bereavement appropriate when symptoms persist for longer than two months. In Mediterranean societies, however, widows traditionally have been expected to grieve for periods of time that would be considered excessive by American standards. Grief of comparable intensity and duration might be a mental disorder in the United Stages but not in Greece. (p. 25)

The over-inclusiveness, pathologization, and overall conception of grief as a disease brings me back to Horwitz's (2002) question of the advantages of viewing a mental disorder within a medicalized and psychologized frame. To elucidate these benefits it is necessary to understand the intent of these authors in getting grief into the DSM-V in the first place.

In the first part of this chapter, I began to describe the process by which psychiatry, and subsequently psychology, became an increasingly medicalized and diagnostic field. In attempting to become more scientific, the fields emulated the natural sciences and medicine, part of which involved the use of classificatory systems.

As already illustrated, the main artifact that grounded this kind of psychiatry was the production of the DSM, or more specifically, the DSM-III that was heralding in the

new 'scientific' psychiatry (Kirk & Kutchins, 1992) . "The new diagnostic system not only had to invent categorical diseases to maintain a claim as a medical specialty and to satisfy researchers; it also had to invent many disease categories to maintain the allegiance of working clinicians" (Horwitz, 2002, p. 72). In other words, because the authors of the DSM wanted to make it relevant to all working groups in the psy-disciplines, they had to transform vague problems of living into discrete diagnostic categories. This was accomplished in several ways. The first was reclassifying the psychodynamic model of neuroses into overt diagnostic categories that had more to do with symptoms than with etiology (Kirk & Kutchins, 1992).

The second way the DSM became over-inclusive was by purporting to be etiologically atheoretical or neutral by focusing on observable symptoms, regardless of the cause of these symptoms (Horwitz, 2002). The need to achieve professional consensus where anyone using the manual (i.e., psychologists, psychiatrists, physicians, social workers, educators, etc.) could identify a given disorder meant that the focus had to shift from the causes and context of the 'disorder', to solely the observable symptoms.

The final way in which the DSM became over-inclusive, was by focusing on the technical issues of reliability instead of whether a given diagnosis was valid or not. Horwitz (2002) wrote, "An emphasis on reliability is a useful tool in developing a large categorical system because, in the absence of a valid definition of mental disorder, there is no limit to the number of discreet conditions researchers and clinicians can develop" (p. 75).

The concepts of grief and CG in particular have been constructed in order to fit into the DSM criteria. Indeed, as described in chapter one, and in the section on CG, the first thing researchers accomplished was constructing a set of symptoms to describe the 'normal' course of grief so that it, as well as pathological grief, could be treated. This was a pivotal first step in transforming grief from a 'vague problem of every-day living' (none of which could be more obvious than grief since unlike other disorders listed into the manual, everyone dies, and therefore, everyone will likely be bereaved at some point in their lives) into a dangerous, high-risk condition that could easily lead to pathology.

The second, and third conditions described above included making grief atheoretical, and therefore, symptom-based instead of context specific, and focusing on reliability of diagnostic categories instead of validity. Both of these conditions were essential in constructing grief as a disease. What the DSM has accomplished is the ability to strip the subjective, contextual, and validity of a human experience such as grieving in exchange for a symptom-based, decontextualized, and reliable diagnostic category. It is for this reason that almost any condition could be included in the manual; without context, anything and everything can be diagnosed as pathology if only you define it as such.[27]

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[27] Other examples of DSM disorders that are reflections of this over-pathologization include several diagnoses that can be found in the Appendix. These include categories such as "phase of life problem" that the DSM-IV-R (2000) defined as in need of clinical attention when there is "a problem associated with a particular developmental phase or some other life circumstances that is not due to a mental disorder... examples include problems associated with entering school, leaving parental control, starting a new career, and changes involved in marriage, divorce, and retirement" (p. 314). Other examples include "parent-child relational problem" (p. 306), "partner relational problem" (p. 306), "sibling relational problem" (p. 306), and the catch all, "relational problem not otherwise specified" (DSM-IV-R, 2000, p. 306). This last category should "be used when the focus of clinical attention is on relational problems that are not

Why Pathologize?

Pathologizing grief means both to medicalize it as a disease and to psychologize it as mental problem. Some clinicians may argue that based on clinical experience, some people are so grief-stricken, they cannot bear the thought of living anymore, and need psychological intervention to survive. In these cases, putting grief in the DSM could be beneficial to the individual suffering. Pathologizing grief in this instance would give legitimacy to a person's pain and provide what is perceived to be much needed intervention for the bereaved.

In addition to potentially helping the grievers, pathologizing grief also benefits the psy-disciplines. While the disciplines of psychiatry and psychology have different motivations in pathologizing grief, as I indicated earlier in this chapter, both essentially share the same goal of including grief within the abnormality paradigm. The pathologization of grief serves to make it part of the psy-disciplines' purview.

The push to get grief into the DSM, for example, benefits the psychiatric profession by legitimizing it as a disorder necessitating medical treatment such as the use of antidepressants. At the same time, including it in the manual also makes it a disorder that psychologists can treat with grief counselling. While the goals of these two disciplines are seemingly disparate, the underlying outcome is the same: the psy-disciplines benefit when a condition becomes pathologized because it opens the door for the possibility of research and intervention.

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classifiable by any of the specific problems listed above (e.g., difficulties with co-workers)" (p. 306). As should be evident by these broad classifications, anyone experiencing almost any normal life event can potentially be diagnosed with one of these 'disorders'.

Thus far I have outlined the ways in which grief became pathologized within the psy-disciplines. While I have traced how this has happened, I will put forth an interpretation as to why this occurred. The process of pathologizing grief coincided with the increasing professionalization of the disciplines and the push to psychologize every-day experiences into mental disorders. When understood in this context, what is surprising is that grief hasn't been psychologized until now. Perhaps grief has stayed out of the grips of the psy-professions up until this point because it seems obvious that grieving is situated within a coherent social context in which the etiology of grief is clearly linked to an identifiable external source, and has long been socially sanctioned as an appropriate response. That one would be depressed and sad after a person dies seems almost beyond debate.

The more ambivalent and fuzzy a category of emotion is, the easier it is to pathologize it. Lane's (2007) book, *Shyness: How Normal Behavior Became A Sickness*, cited a pharmaceutical insider elucidating this very point. He said, "No therapeutic category is more accepting of condition branding [medicalizing the experience and treating with drugs] than the field of anxiety and depression... mental illness is rarely based on measurable physical symptoms, and therefore, is open to conceptual definition" (p. 134). While grieving would at first appear to be closed to 'conceptual definition' since its presentation makes sense in the context of a bereaved person's life, this has not been the case in recent years.

As I have suggested, the main purpose in psychologizing and medicalizing mental disorders that included the construction of the DSM and, in general, the diagnostic, classificatory approach to psy-disciplines, was the need for the fields to justify themselves as scientific and medical enterprises. In order to survive they had to put together an identity for themselves that would fit into the increasingly medical and scientific framework that was, and continues to be, held in high regard. On this, Larson (1977) has suggested that professionalization can only be secured by: a) producing knowledge that is abstract and broad enough to attract a large audience; b) generate scientific interest and debate, *and;* c) must have a receptive market. As I have illustrated throughout, the psy-disciplines have managed to secure all three by simultaneously aligning themselves with the powerful profession of medicine in order to establish authority (and by expanding their power and control in the academic and professional institutions) while also retaining their influence in the popular sphere. On a very basic level then, psychologizing and medicalizing mental disorders was about finding a niche for psychiatrists and psychologists to work in; it was about professional identity and a carving out of a field in which to work that would be both theory-driven, and academically based, *and* practical and applicable to the every-day person.

Earlier, I used Conrad's (2007) definition of medicalization, which he described as "a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness and disorders" (p. 4). He also noted that medicalization transforms aspects of every-day life into pathologies with the effect of

narrowing what is considered to be acceptable behavior. Medicalization and psychologization also turned the focus on to the individual, with the solution being medical, individual intervention for isolated problems as opposed to understanding problems as rooted in a social context and looking for more collective or social solutions. In my view the construction and perpetuation of medicalization and psychologization of 'mental disorders' such as grief is the result of four discursive entities (professional identity, managed care, psychological counseling, and pharmaceutical industry) that worked in tandem to professionalize the psy-disciplines.

Professional identity. The pathologization of mental disorders, and the increasing psychologization of every-day problems, provided the psy-disciplines with an identity, a job, and something to do. This had to do with the market for clinicians and private practice as well as establishing a place in the academy, and a body of research and expertise to develop and disseminate. The construction of grief as a psychological or medical disorder is a case in point. I noted in the introduction that there is evidence to suggest that people have always grieved for those they have loved and lost. Whereas it was once the case that religious institutions and the community used to respond to death and tragedy by taking care of the mourners, this role has been co-opted by the psy-professions (Kellehear, 2007a). The vocabulary of grief has been thoroughly psychologized. Terms that I delineated in chapter one like 'coping', 'recovery', 'healing', 'denial' and 'grief work' or 'grief process' are all constructions of the psy-professions,

and today psychotherapy and medication are common ways in which grieving is dealt with. On this, Ward (2002) wrote that:

> In this moral transformation of death, psychology begins to replace religion as the conveyer of advice and solace in times of despair. Death, consequently becomes reconfigured from a moral experience to a 'psychological trauma' that requires therapeutic resolution. (p. 210)

The professional identity component that benefits the psy-professions is the *conceptual* victory of transforming grief from a moral, religious, or existential human experience into a 'psychological trauma'. What people in previous centuries, or even today in other cultures, view as resulting from moral or religious violations such as spiritual fragility or moral indiscretions, the psy-disciplines see as a result of pathology or other treatable psychological conditions (Illouz, 2008; Lears, 1983; Susman, 1973). Ward (2002) wrote:

> As the psychological perspective...replaced religion's moral authority over grief and death, psychology became a new type of civil religion. Within this new civil religion, therapy became as much a staple of every-day life as medicine, and therapeutic solutions became standard means for solving all types of problems. (p. 214)

Part of this professionalization process, or what Ward (2002) has called a new 'civil religion' and what Illouz (2008) named the 'therapeutic outlook', was the establishment of the abnormality paradigm in general; the other part is the thorough

psychologization of the phenomena in question, in this case, the construction of grief as part of the psychological domain in order to then resolve this 'problem'. The psy-professions have been extraordinarily successful in this goal.

The treatment of both large scale grief (i.e., events such as 9-11, school shootings or other acts of terrorism) as well as small scale grief (individual responses to deaths) has become the practice of psychology and psychiatry (i.e., for examples of psychology intervening and providing grief counselling see: Bisson & Cohen, 2006; Brown & Goodman, 2005; Dechant, Jellinek, Goodwin, & Prince, 2002; Metcalf, 2005; Rosenblatt, 2005; Shear, Jackson, Essock, Donahue, & Felton, 2006; Welt Betensky, 2007; Witztum, Malkinson, & Rubin, 2005). Groopman (2004) has called this phenomenon 'the grief industry' led by psy-professionals who claim that all bereavement requires intervention in order to avoid complicated grief reactions. The facilitation of this grief requires intervention of trained mental health workers who can aid the person in the four tasks of mourning including accepting the reality, experiencing the pain of the grief, adjusting to the new environment, and withdrawing emotional energy from the deceased (Worden, Worden, & Counselling and Grief Therapy, 2004). Whether it be for individuals, or for groups experiencing loss, the idea is that grief counselors are needed to help initiate the 'grief work' that enables people to express their feelings and begin the process of healing.

Despite the fact that there is little evidence that grief counselling actually works and, in fact, some (like Freud, 1917) have argued that it is even harmful (Groopman, 2004; Jordan & Neimeyer, 2003; Neimeyer, 2000; Schut, Stroebe, van den Bout, &

Terheggen, 2001) research on grief, grieving and bereavement counselling continues to proliferate. A quick search on Psycinfo with the key terms 'grief' and 'grief counselling' yields just under 10,000 hits. The push to get CG into the DSM is another indication of the growing field of grief research within the psy-disciplines. This carving out of a professional space gives psy-professionals a legitimate topic to research, which then leads to funding opportunities, scholarly posts, and the ability to produce academic texts such as articles to be presented at conferences. In addition, these texts go into journals and books that are published for students and lay people alike. It is a tautology that justifies the need for counselling *and* research on counselling that further expands the professional role in both constructing, maintaining and perpetuating the concept of grief. In short, the careers of some psy-professionals are built on the medicalization and psychologization of grief, giving them significant incentive to perpetuate the construct.

Managed care. The second discursive source leading to the medicalization and psychologization of mental disorders such as grief within the psy-professions has to do with managed care and the way the health care system works in the United States. In response to escalating health costs, health insurance companies stopped reimbursing patients *after* their treatments and began to stipulate what they would be covered for *before* they went to a physician (Barber, 2008; Luhrmann, 2001). With the proliferation of the psy-disciplines in the late 20th century, the awareness and demand for mental health services has gone up and, as a result of both economic prosperity and the popularization of psychology in the every-day domain, psychological services are now

included in many of these health insurance programs (Kirk & Kutchins,1997; Lane, 2007).

In order to qualify for treatment, however, one has to be diagnosed with a discreet mental disorder. In a self-perpetuating loop, the psy-disciplines create diagnoses that become popularized and consumed by the lay public. In response, people want to be treated for their newly diagnosed conditions, which means they have to be included in categorical systems such as the DSM to gain legitimacy. This in turn motivates psy-researchers in the field to advocate for their diagnosis to get into the DSM so that it can become an official medical disorder covered by the managed care services or governmental health coverage (Barber, 2008; Horwitz, 2002; Kirk & Kutchins,1997).

The motivation to pathologize is clear under these conditions. Psy-professionals can only gain from this process as the more medicalized and psychologized the 'disorder' the more work and space there is for them to take the role of the expert and healer. In a display of post-modern constructionism, psy-professionals create a problem in order to then solve it. This approach to medicalization and psychologization is supported by several social structures, one of which includes the managed care system, and it has been extraordinarily successful in both further medicalizing and psychologizing mental disorders, and upping the use of the psy-professional services. By the 1960s, about 14% of Americans received some type of mental health services, but by the mid-1990s that number had jumped to 46%. Other estimates have indicated that each year, ten million

Americans seek psychological and psychiatric services that are paid for by managed care insurance (Nolan, 1998).

Managed care has not only influenced the further medicalization and psychologization of mental disorders, but has also had an effect on the kinds of treatments that are prescribed. While some psychotherapy is included under health insurance in the United States, it is more cost and time efficient to give someone a medication than to treat them with psychotherapy (Luhrmann, 2001). In Canada, only psychiatrists are covered by universal health insurance. If one wants psychotherapy, one has to pay for it out-of-pocket, leading many people to choose free drugs that are covered in most drug plans, over expensive psychotherapy.

The trend of managed care influencing the understanding and treatment of mental disorders has heavily impacted the construct of grief within the psy-disciplines. The push to get CG into the DSM-V is premised on the assumption that if grief would be understood as a medical or psychological disorder, then it could be diagnosed as one, and therefore, could be legitimately treated by psy-professionals with medication or psychotherapy. Prigerson (2005-2006) writing about why pathological grief should be made into a medical diagnosis wrote:

> If a CG diagnosis enables bereaved survivors and their loved ones to gain greater insight into the nature and potential source of their suffering, if it promotes the more accurate definition of bereaved persons at *long term risk of maladjustment* to the loss and the development of *specific treatment that targets this particular*

> *distress...* if it *promotes and it improves reimbursement for specific services,* thereby, *increasing access* then it would appear that an empirically well validated criteria set of CG would prove useful. (p. 16) (Italics added)

The rhetoric of psychologization is evident in this text. The risk for long-term maladjustment has to do with the abnormality paradigm discussed throughout. There is no inherent difference between pathological grief and normal grief, however, one is at risk based on duration and intensity criteria, which fluctuates depending on the definition of CG. The second and third statements have to do with managed care. The terms 'specific treatment to target distress', 'promote and improve reimbursement', and 'increasing access to services' are all about justifying grief as a pathology in order to then make a case for treating it with specific services that require the aid of psy-professions. The diagnosis, as Prigerson pointed out, also aids in increasing access to services, because, as already stated, one is required to have a 'validated disorder' in order to get managed care to pay for the treatments. Similarly, Goodkin et al. (2005) whom I quoted earlier as referring to the serial killing as an undiagnosed case of CG, stated:

> While a legitimate consideration does exist for pathologizing grief with the addition of this diagnosis, an equal (if not greater) concern must be argued for providing *access to care to those who are dysfunctional in social and occupational activity related to a loss, but who would not be otherwise identified for treatment.* (Goodkin, 2005-2006, p. 32)

Again the emphasis here is on providing access to care by including the diagnosis so that people can be 'identified for treatment'. The authors go on to stipulate that including the diagnosis in the DSM-V is an essential step to identify them for treatment and to aid with 'access to care'. While the implicit assumption is that these justifications are about altruism and wanting to help the bereaved, the approach in these articles is rarely to talk about the bereaved person's suffering, but to focus instead on diagnostic and treatment issues necessary in order to be covered by managed care. As Walter (2005) noted on the confluence of psychologization of grief and managed care, "social or psychological need is less a property of individual clients than of organizations that must ration scare resources and that must refer clients" (Walter, 2005-2006, p. 74).

Psychological counselling.

> According to psychologists and psychiatrists, some twenty million Americans suffer from gambling addictions, eighty million have eating disorders, twenty five million are thought to be love or sex addicts, ten million have borderline personality disorders and fifty million are said to suffer from depression and anxiety. All this diagnosing has been made possible by the vast expansion of psychological language and services in every-day life. (Ward, 2002, p. 211)

Depending on how you define CG, up to 80% of people who are bereaved require counseling (Genevro, Marshall, Miller, & Center for the Advancement of Health, 2004). While there is little evidence that grief counselling actually helps people cope with 'normal grief' (Allumbaugh & Hoyt, 1999; Groopman, 2004; Jordan & Neimeyer, 2003;

Kato & Mann, 1999; Rosenblatt, 2000; Schut et al., 2001), this has not stopped the psy-industry from publishing numerous articles on the efficacy of interventions. Various bereaved populations have been targeted including *all* people who have experienced a loss through death; those bereaved in specific groups like widows or bereaved parents; and those with complicated grief (Genevro et al., 2004). In many of these interventions, the goal was to prevent 'normal' grieving from becoming pathological. It is here where the abnormality paradigm as a product of the psy-disciplines becomes most visible; the role for psychological intervention and counselling no longer even requires a diagnosis to become involved in patient's lives. They can argue that their intervention is necessary in order to *prevent* grief from becoming pathological. While the existence of pathological grief, or CG, is a necessary prerequisite for offering preventative counselling, one no longer needs to be diagnosed to need the help of psy-professionals.

As will be illustrated shortly, the evidence for counselling those at risk for CG is inconsistent and weak. Some research has shown that cognitive behavior therapy works moderately for certain symptoms of CG such as intrusion (intrusive thoughts), avoidance, and failure to adapt, however, the researchers also noted that:

> the percentage of patients who experienced reliable change was highest for intrusion and failure to adapt, but a considerable number of patients in the control group [who received no treatment] also showed reliable changes and low to moderate effect sizes. This replicates previous findings of natural declines in

bereavement-related symptoms. (Wagner, Knaevelsrud, & Maercker, 2006, p. 447)

In other words, those left to grieve on their own, and those who received extensive therapeutic intervention, had similar results in outcome, although the latter showed a *slight* improvement in certain symptoms of CG. Other studies have shown the potential, but minimal benefits of using cognitive behavior therapy to treat CG (Ehlers, 2006; Matthews & Marwit, 2004); while another study looking at interpersonal psychotherapy for treating depression-related bereavement showed that the intervention was no better than a placebo in treating traumatic grief (Hensley, 2006a). One researcher has proposed that interventions may provide some benefit, but only in the short-term (Schut et al., 2001).

Neimeyer (2000) did a meta-analysis of bereavement interventions and found that those treated for traumatic bereavement "showed a reliable positive effect" (p. 546), but only minimally. Moreover, what a reliably positive effect means in practice is ambiguous and difficult to decipher. However, Neimeyer (2000) noted that the positive effect emerged in contrast to studies where individuals with normal bereavement were *harmed* by the treatment (Neimeyer, 2000). Jacobs and Prigerson (2000) reviewed studies of controlled clinical trials of psychotherapeutic interventions and found that the studies of psychodynamically oriented treatments and cognitive behavior treatments had "some proven effectiveness and hold promise for Traumatic Grief" (Jacobs & Prigerson, 2000, p. 488).

Finally, Currier, Neimeyer and Berman (in press) conducted the most recent meta-review examining the efficacy of grief counseling. In this ambitious study, the authors examined 61 randomized outcome studies of bereavement interventions (i.e., psychological counseling, professionally organized support groups, crisis intervention, writing therapy, and formal visiting service) that were reported in 64 academic papers. The authors concluded that:

> bereavement interventions have a small but statistically significant effect immediately following intervention but that therapeutic outcomes failed to differ reliably from zero to later follow up assessments...On average recipients of bereavement interventions are not appreciably less distressed when compared to those who do not receive any formalized help. (p. 23)

According to the authors, the therapeutic outcome was small, and could only be found in the 'targeted groups' or those that "are genuinely in need of help" (p. 23). These groups, treated by "indicated interventions" (p. 7) were people who had a pre-established psychiatric disorder, or had "clinically significant difficulties" (p. 7) dealing with their loss. These groups were the only ones who showed a *slight* improvement in distress, but only immediately after the intervention.

Even when practitioners know that these interventions don't work, they often continue to use them. One of the fundamental paradoxes of grief counselling is the insistence that everyone grieves individually and uniquely, while at the same time promoting a body of research that primarily defines normal versus abnormal grieving

(Breen & O'Conner, 2007). When looking at the psy-literature on grief, Rando (1993) has found that while researchers and service providers pay lip-service to the notion that grief is an individual and unique process, they simultaneously insist on timelines in which grief should occur. Rando (1993) noted that while the caveat of uniqueness is often acknowledged, complicated, or pathological mourning is assumed and often diagnosed when grievers continue to have a relationship with the deceased, maintain environments that integrate and memorialize the deceased, talk to others about the deceased, continue to experience grief over many years, and experience the same intensity of grief even years after the death (Rando, 1993). Moreover, while grief practitioners often openly acknowledge and recognize that grief is a unique experience, they continue to draw on 'grief work' and 'stage theory' (see chapter three for elaboration) in their interventions (Payne et al., 2002; Wiles, Jarrett, Payne & Field, 2002). Breen and O'Conner (2007) wrote:

> Some service providers attempt to rigidly fit the person to the prevailing theory and many hold unrealistic expectations about grief, especially concerning the timeline for "healthy" grief and the detachment from the deceased. Grief theorists that assert a stage-based and finite conceptualization of grief led to the situation where many service providers were and are engaged in a process of the assessment and diagnosis of and intervention with bereaved individuals, according to their 'progress' through the grief process. (p. 206)[28]

[28] Breen and O'Conner (2007) provided examples such as encouragement of "service providers to identity the tasks or tasks of mourning that are not completed and help the bereaved to resolve each task" (p. 206).

While it would seem from this evidence that, overall, grief counselling is not very helpful, and even potentially harmful, psy-professionals working in the field have explained this phenomena by arguing that grief counselling may not work in the form that it is delivered in research studies, and that the positive effects of grief counselling is most likely masked by poor methodology and a need for different design and implementation of treatment (Jordan & Neimeyer, 2003). The focus on improved research design and methods in intervention studies is a theme that other psychologists have repeated in order to explain the poor outcomes of their studies (Schut et al., 2001). Jordan and Neimeyer (2003) have suggested that researchers should concentrate their efforts on studying and designing interventions for those people who are at risk for complicated grief.

The responses of these researchers further exemplify the rhetoric of pathologization and the carving out of a professional niche for the psy-disciplines. Rather than taking this research as evidence that grief counselling *does not work*, psychologists argue instead that it is flawed research methods and poor research design that leads to these poor outcomes. By focusing on methodological flaws instead of conceptual flaws in the construction of grief as a disease in need of intervention, the psy-disciplines guarantee that they will continue to have work in the form of new research on grief counselling and trying out of new counselling programs until one proves to be effective. Even more strikingly, Jordan and Neimeyer's (2003) suggestion that psychologists focus their energies on those who are *at risk* for complicated grief means that everyone who is

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Other recommendations included the notion that "staff in pediatric intensive care units detect unusually absent or excessive reactions as signs of pathological grief" (p. 206).

bereaved comes under the purview of psychological research and intervention, since everyone who is grieving is *potentially* at risk for CG. Hacking (1998) sarcastically, but accurately noted that:

> one of the incidental hazards of being involved in a mass disaster in America is that you will now be descended upon by traumatologists [and psychologists and psychiatrists] who will track you down the rest of your life, to determine the long term effects of the trauma upon your psyche. (Hacking, 1998, p. 83)

As I outlined in previous sections, the movement of grief from a moral, or religious phenomena into the psychological realm is accompanied by the need of therapeutic interventions that involve the proliferation and construction of endless interventions in the lives of the bereaved. The motivation for the psy-professions to pathologize grief exists regardless of whether the interventions actually work. This tautological logic stipulates that if the interventions don't work, more research is necessary to find a good treatment for grieving; if the treatments do work, then it is evidence of the necessity of psychological intervention to aid in the grieving process. Regardless of which line of argument one follows, the outcome is the same: psychologists, their interventions, their research and their wisdom are necessary to 'aid' the bereaved.

Pharmaceutical industry. The fourth, and perhaps most powerful discourse in pathologizing mental disorders is the pharmaceutical industry. The development of psychiatric categorization in the DSM had a powerful effect on the perception of mental

disorders as medical problems to be solved, and vice versa, the development of drugs to treat mental disorders further increased the perception that mental disorders are akin to diseases.

Psychotropic medications first came on the scene during the 1950s and 1960s and mostly involved tranquilizers such as Miltown, Librium, and Valium. They were extremely popular at the time, especially for women who were experiencing 'anxiety' and a general sense of 'malaise' (Barber, 2008; Healy, 2003).[29] By the 1970s, drugs were being used to control all mental disorders including schizophrenia and bipolar disorders, and a wide variety of anxiety and affective disorders like depression and social phobia (Barber, 2008; Lane, 2007).

Today the figures for pharmaceutical drugs to treat mental disorders are staggering. In 2007 alone, Paxil, an antidepressant/anti-anxiety drug, racked up sales exceeding 2.7 billion dollars worldwide. In 2005, 8 out of the 20 of the most prescribed medications (for *all* medial conditions, not just mental disorders) in the United States were antidepressants or anti-anxiety medications with Paxil topping the list (RX list, 2007). In 2006, 227 million antidepressant prescriptions were given out in the United States, more than any other kind of medication in its class (Barber, 2008).[30] Moreover,

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[29] For a thorough examination of gender and psychotropic medications during this time, see Metzl (2003).

[30] In making the point about how pervasive antidepressants have become in North American, Barber (2008) noted the following facts: "33 million Americans were prescribed at least one psychiatric drug in 2004, up from 21 million in 1997. The third best selling antidepressant, Lexapro, has been on the market only since 2002. But 15 million Americans have already taken it. Nine percent of American teens have been prescribed drugs for depression. Zoloft's American sales - 3.1 billion in 2005- exceeded those of Tide detergent that same year" (p. 8).

North America accounted for 66% of the global antidepressant market (Barber, 2008). Eli Lily, the makers of Prozac, indicate on their website that:

> PROZAC is the most *widely prescribed antidepressant medication in history.* Since its production in 1986, PROZAC has helped over 54 million patients worldwide, including those suffering from depression, obsessive compulsive disorder, bulimia nervosa and panic disorder. (Ely Lily, 2007) (Italics added)

Putting aside the questionable act of using one drug to treat such a vast array of disorders, these numbers clearly show that the pharmaceutical industry has a vested interest in producing disorders that require medications in order to be resolved. Indeed, the push to market diseases to be treated with medications is so strong that information about the efficacy of these drugs is often misunderstood or overlooked (Barber, 2008; Healy, 1997; Lane, 2007).[31]

Estimates of the efficacy of antidepressants and anti-anxiety drugs are controversial and range from 15% to the highest estimate of 45 % in treating symptoms of depression and anxiety (Barber, 2008; Breggin, 1991, 1998, 2001; Breggin & Breggin, 1994; Glenmullen, 2000; Healy, 1997, 2003; Solomon, 2002; Stoppard, 2000).[32] Despite

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[31] Social critics like Barber (2008) and Healy (see citations throughout) have been arguing for years that pharmaceutical companies withhold negative data about the side effects of psychotropic drugs in order to inflate the perception of their efficacy and thus increase sales. Recently, an article appeared in the prestigious *New England Journal of Medicine* conclusively noting that selective publication of clinical trials is widespread, and that clinical trials that have adverse consequences for patients were withheld from publication in medical journals (Turner et al., 2008). Turner and colleagues (2008) noted that this practice can "lead to unrealistic estimates of drug effectiveness and later the apparent risk-benefit ratio" (Turner et al., 2008, p. 252).

[32] The way psychotropic medications are tested for efficacy is even more problematic in coming up with these statistics. Dr. Joseph Glenmullen (2001), a clinical instructor in psychiatry at Harvard Medical

the controversy over the efficacy of these drugs, and despite the clear evidence that placebos are often as effective as antidepressants, the drugs are still widely used and are the most common treatment for disorders like depression and anxiety today (Barber, 2008; Healy, 2003).

The implications of using antidepressants cannot be understated; there are physical, psychological, and emotional repercussions, which include a host of side effects. Numerous research studies have indicated that the side effects of antidepressants can include brain damage (Hoehn-Saric, Lipsey & McLeod, 1990); neurological disorders (Berk, 1993; Chong, 1995; Dave, 1994; Esselink, 1993; Jimenez et al. 1994; Reccoppa et al. 1990); sexual dysfunction (Modell et al. 1997; Montejo-Gonzalez et al. 1997 Patterson, 1993); suicidal and violent behavior (Arya & Szabadi; Sandler, 1996; Budman & Bruun, 1991; Fallon & Loebowitz. 1991; Fishbain et al., 1992); and severe addiction, dependence, and withdrawal symptoms (Black et al. 1993; Coupland et al. 1996; Frost & Lal, 1995; Giakas & Davis, 1997; Keuthen et al., 1997; Kent & Laidlaw, 1995; Lejoyeux & Ades, 1997; Pyke, 1995; Schatzerg et al.,1997; Zajecka et al.,1997). The side effects of these drugs are so significant and pronounced that there is now a specific category in the DSM-IV recognizing and describing disorders caused *exclusively* by the side effects of antidepressants (DSM-IV, 1994).

Healy (1997, 2001, 2003) argued that the perpetuation of antidepressants is the

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School, stated that, "The efficacy and safety of serotonin boosters [the most commonly used anti-depressants] is anything but "scientifically proven", given the many problems with their clinical testing: the short duration of clinical trials, the lack of objective criteria, the use of subjective rating scales, the acceptance of partial drug "responses", the use of inert placebos, questionable double blinds, high placebo responses rates, and statistical manipulations" (Glenmullen, 2001, p. 211).

economic driving force behind research conducted at universities and hospitals dependent on the pharmaceutical companies funds to survive.[33] He argued that this kind of science is biased, dangerous, and misleading for the public in addition to being unethical. In addition to the fact that antidepressants, such as Prozac, can actually increase the number of suicides,[34] and the fact, that, as Healy stated, the treatment effects are minimal, if not non-existent, as evidenced by the low efficacy rates and the indistinguishable success of placebos in treating depression and anxiety, the justification for using antidepressants is ambiguous. Despite this compelling evidence, however, the bid to make money and produce disorders that need to be treated takes precedence over the well-being and health of the consumers (Barber, 2008; Lane, 2007).

The treatment of grief has been no exception to this trend. While I have offered several interpretive frameworks to understand the increasing pathologization of grief in this chapter, including the need for psy-professions to have an identity, the rise of managed care in North America, and the proliferation of psychological grief counselling, as motivating factors to construct grief as a disease, the influence of the pharmaceutical approach has taken this pathologization one step further.

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[33] The relationship between government, industry, science, profit, and the academy is a serious issue that has emerged in the 21st century due to the power and size of the pharmaceutical companies. Because of the already large scope of this thesis, it is not possible to elaborate on this serious issue. For further reading see *The Antidepressant Era* by David Healy (1997).

[34] In a talk at York University, Healy described study after study in which normal, healthy non-depressed people were put on anti-depressants and within days were reporting suicidal thoughts and suicidal ideation. This finding, therefore, dispels the criticism that the suicides completed on antidepressants are due to the depressed mood of the patients and not to the drug itself. It should also be noted that because pharmaceutical companies have such power and control over the studies they sponsor, information about the damage anti-depressants cause are unavailable to the public or to other researchers. For a review see Barber (2008).

The number of people who are given pharmaceuticals to treat their grief is difficult to measure. Even though grief is not an official disorder, some psychiatrists have explicitly prescribed medications to treat grief, and, as with counselling, have had poor results. While these psychiatrists have focused specifically on grief treatment, countless other bereaved people have been put on antidepressants and anti-anxiety medications to treat Major Depressive Disorder (MDD) which can be diagnosed in the grief stricken only two months after bereavement (APA, 1994). As I outlined earlier in this chapter, the diagnostic system is decontextual, making it impossible to glean *why* people are depressed and put on antidepressants (Horwitz & Wakefield, 2007). It is highly plausible that many of the 54 million patients put on Prozac, for example, could have been suffering from context specific depression that may have had to do with a loss.

For example, in a recent study Wakefield, Schmitz, First and Horwitz (2007) looked at a national co-morbidity survey of 8098 people aged 15-54 in America. Of those who were diagnosed and treated with MDD, 90% attributed it to either a bereavement-related loss or another type of loss such as losing a job or a relationship. While the authors used this data to advocate for more stringent criteria for MDD that takes into account the social context of why people are depressed before making a diagnosis, their research is relevant to this argument. The authors found that those who were grieving looked almost identical in terms of symptom presentation (i.e., appetite and weight problems, sleep problems, lack of energy, etc.) to those who were depressed for other reasons. The conflation of grief with MDD is significant problem as one is context

specific and should be non-pathologized, while the other is a clinical diagnosis, and is considered to be a pathology. (Also see: Robinson & Fleming, 1989).

The correlation between depression and loss has been robustly documented in the psychological literature (Beck, 1982; Gilligan, 1982; Jack, 1991; Kirsh & Kuiper, 2002; Monroe et al., 1999; Seligman, 1975; Stoppard, 2001, 2003; Thompson, 1995). Earlier in this chapter, I alluded to the fact that MDD and grief are often conflated since their presentation is so similar. Freud (1917), in fact, talked a great deal about the similarities between mourning for a loss of a loved one, and depression or melancholia, as a result of the loss of a relationship. While I talked about this in chapter one, it is worth noting again that for Freud, loss and depression were intimately connected, but not pathological. In fact, pathological melancholy was the kind that was experienced *out of context,* or for *no discernible reason* (Freud,1917).

Similarly, two British sociologists have asserted that loss (whether imminent or expected) and disappointment are the central features of most events bringing about depression (Brown & Harris, 1978). Since then, many researchers have supported this theory (Beck, 1982; Gilligan, 1982; Jack, 1991; Kirsh & Kuiper, 2002; Monroe et al., 1999; Seligman, 1975; Stoppard, 2001, 2003; Thompson, 1995).

Bereaved people commonly present with symptoms including a depressed mood, inability to feel pleasure, loss of appetite, anxiety, inability to concentrate, and difficulty sleeping that could easily be diagnosed with MDD (See Appendix C). While, the bereaved rarely show other symptoms of MDD such as low self esteem or feelings of

worthlessness that are part of the DSM criteria for depression, they often report more than enough symptoms to meet the diagnosis. Indeed, most people grieving will meet at least some of the symptoms of MDD. Horwitz and Wakefield (2007) noted:

> Over three-quarters of the bereaved report crying, sleep disturbance, and low mood, and over half also indicate loss of appetite in the first month following the loss. Without the bereavement exclusion [waiting two months before diagnosing the bereaved with MDD], between one-third and one-half of bereaved people could be classified as having a depressive disorder during the first month after the death. Among people who have lost spouses, most studies find that between 20 and 40 % - and some find that more than half - experience symptoms comparable in severity to MDD criteria over the first few months. Rates of depressive symptoms in patients' reactions to the death of their children or adolescent's reactions to the deaths of their parents are even higher, more intense, and longer lasting than those that follow the deaths of spouses. (p. 31)

The fact that large numbers of grieving people meet criteria for MDD does not mean that they are disordered. Indeed, these people are responding in an expected way to the transient condition of bereavement, and the majority recover with the passage of time (Clayton & Darvish, 1974). This is another example of the distinction I made earlier between reliability and validity. While bereaved people may reliably meet criteria for MDD based on DSM criteria, it is not a valid indicator that they have a mental disorder because it is context specific.

The conflation of grief and depression and the overuse of medications to treat the former makes it significantly more likely that a person grieving will be given an antidepressant to deal with their sadness. Most bereaved people meet the criteria for MDD well after the DSM's exclusion criteria for two months post loss. Further, psychiatry's jurisdiction over depression as a decontextualized psychiatric disorder makes it almost inevitable that grief in itself will become a disorder that needs to be medicated, and indeed, that is the path that grief research seems to be taking.

One trial that used antidepressants to treat 'bereavement related depression' was published by Jacobs and his colleagues in 1987. Ten subjects were treated with desipramine, an antidepressant that sells under the brand name Norpramin and Pertofrnae. At the end of four weeks, four out of the ten subjects had reduced their score on the Hamilton Depression Rating Scale. Furthermore, three out of the remaining seven subjects (after attrition rates) experienced a reduction 'of major proportion' in their grief scores (Jacobs, Nelson, & Zisook, 1987).

Pasternak and her colleagues (1991) treated thirteen widows and widowers with nortriptyline, an antidepressant that goes under the label Aventyl, Pamelor, and Nortrilen. The subjects were on the medication for sixteen weeks and the authors report that all thirteen subjects improved on the depression scales including the Beck Depression Inventory and the Brief Symptom Inventory. The Texas Revised Inventory of Grief (TRIG) scale was used to measure grief, and while there was a modest decline in intensity in eleven of the thirteen subjects in ratings of grief, the authors noted that grief

intensity seemed to decrease less than depression as a result of the antidepressants, and went as far as to conclude that antidepressants did not help with bereavement symptoms (Pasternak, Reynolds, Schlernitzauer, & Hoch, 1991).

Zisook et al. (2001) treated 22 widows and widowers with bupropion (Wellbutrin SR, Budeprion SR) for eight weeks. While the participants had an improvement in their depression scales as measured by Hamilton Depression Rating Scale, they showed little improvement in their grief scores as measured by the TRIG. While the intent of this study was to treat grief, the authors perplexingly give a positive spin to their results by suggesting that the treatment with antidepressants does not interfere with the grieving process (as evidenced by the modest changes in the grief measurement). They even go so far as to state that treating depression symptoms freed up their patients so that they could begin the grieving process. In other words, the authors claimed that even though there was no improvement in the grief scores of their participants, the antidepressants still work by reducing depression scores, and therefore, allow people to grieve. This is a surprising interpretation. To conceive of the grieving experience without the depression and the sadness is puzzling. What is involved in the 'grieving process' if one takes out the sadness and depression piece is never explained (Zisook & Shuchter, 2001).

While the above studies were published with the intention of treating 'bereavement-related grief', other studies have attempted to treat CG with medications. Zygmont and colleagues (1998) conducted a study with 21 patients with 'traumatic grief'. Six patients dropped out before the end of the study due to side effects and fifteen

subjects went on to complete the 16-week trial on Paroxetine. The subjects also received 'traumatic grief psychotherapy' concurrent with the medication treatment. The authors found a decrease in depression symptomatology, but only a modest decrease in bereavement symptoms (Zygmont et al., 1998).

The finding that depression symptoms decreased, while grief symptoms remained the same, or only modestly declined, is a common finding in the studies outlined for both bereavement related depression and CG. In addition to the study just described, several other trials and reviews have come to the same conclusion (i.e., Hensley, 2006a, 2006b; Reynolds et al., 1999). While the 'take-home' message of these studies is often that the "treatment of bereavement related depression supports the use of antidepressant medication" (Hensley, 2006, p. 626), the actual results from the studies present a more ambiguous state of affairs. First, there were no control groups used in any of these studies, which means that we do not know if the slight improvement in depression scales was because of the intervention, or as a result of a natural decline in symptoms over time. Second, the finding that depression-related symptoms abate while the grief intensity stays the same presents a rather complicated picture. While, it may be true that certain symptoms of grief related depression are reduced with antidepressants, this may not mean that one's mood improves, or that grief is alleviated. Many of the symptoms of depression, as defined by the DSM, and as constructed in the depression measures, are physical, including loss of appetite, difficulty sleeping, and feeling agitated. Antidepressants may help in alleviating some of these symptoms, but as other research

has indicated, they will also affect these symptoms in 'normal' people who are not clinically depressed (See footnote # 33 and Barber, 2008; Healy, 2003). The treatment of bereavement-related depression with medications and the new trials to test antidepressants for CG are the extreme result of the medicalization of grief.

Despite this, the pharmaceutical industries, and the psychiatrists who are dependent on them for their funding, have a vested interest in turning grief into as pathological a condition as possible. Part of this is illustrated through the conflation of grief and depression, and the inability to distinguish one from the other when it comes to treatment with medications. While some researchers have staked their careers on adamantly making these distinctions when proposing the category of CG, they are not decrying the fact that grief is medicalized when it is 'wrongly treated as MDD', but rather they are advocating for further medicalization by giving it its own distinctive psychiatric category (Prigerson & Maciejewski, 2005-2006; Prigerson & Jacobs, 2001; Stroebe & Schut, 2005-2006).

Medicating people who are grieving not only puts them at serious physical risk including increased suicidal thoughts (Barber, 2008; Healy, 2003), sexual problems, (Modell et al. 1997; Montejo-Gonzalez et al. 1997; Patterson, 1993), and severe addiction, dependence and withdrawal symptoms (Black et al. 1993; Coupland et al. 1996; Frost & Lal, 1995; Giakas & Davis, 1997; Keuthen et al., 1997; Kent & Laidlaw, 1995; Lejoyeux & Ades, 1997; Pyke, 1995; Schatzerg et al.,1997; Zajecka et al.,1997) but it also affects their self understanding and how they make sense of their grieving

experience.

The pathologization of grief involves not only a diagnosis, it is a narrative that the psy-disciplines have constructed in which people learn how to understand themselves, and in the process experience their grief in a new way. The pathologization narrative is a prime example of a shift from understanding grief within a religious, existential, and communal frame, to understanding it within a psychological, individual, and private one. In the next chapter I will expand on the influence of the abnormality paradigm and the psychologization of grief on people's understanding of their own grief in contemporary North America.

Chapter Three: Looping

Looping

To begin to understand the impact of the psy-professions on people's self understanding, it is necessary to begin with the concept of looping. In chapter one, I introduced Hacking's concept of *human kind* classifications in the social sciences and proposed that grief has been made into a *psychological kind* (Hacking, 1995). While the first chapter focused primarily on showing *how* grief became categorized in psychology, and chapter two focused on *why* psychologists were motivated to construct grief in these ways, this chapter will examine the impact of this classification on people's experiences of grieving. Hacking (1995) described the process by which academic classifications shape people's self understandings as looping. He wrote:

> There is a looping or feedback effect involving the introduction of classifications of people. New sorting and theorizing induces changes in self conception and in behaviour of the people classified. Those changes demand revisions of the classification and theories, the casual connections, and the expectations. Kinds are modified, revised classifications are formed, and the classified changes again, loop upon loop. (p. 370)

In another article entitled *Making Up People*, Hacking (2006) expanded on the concept of looping and introduced the concept of 'moving targets'. He wrote that people:

> are moving targets because our investigations interact with them, and change them. And since they are changed, they are not quite the same kinds of people as

> before. The target has moved. I call this the 'looping effect'. Sometimes our sciences create kinds of people that in a certain sense did not exist before. I call this 'making up people'. (p. 1)

In other words, when a classification is introduced in the social sciences it functions as both a *descriptor* of a phenomenon and as a *construction* of one at the same time (Danziger, 1997) . Once a classification is taken on by a group of people, it begins to change as people appropriate it, and as new knowledge is generated about its nature. This, in turn, functions to alter, and expand the boundary of what it means to be defined within that category, and in turn, changes the category or classification itself ("loop upon loop"). Psy-science not only observes 'natural' human behaviour, but actively constructs it and shapes the reality in which people live.

It is pivotal to understand that the looping process is not unidirectional when it comes to the classification of people. Smith (2005) wrote that "knowledge of people changes the subject matter; whatever knowledge 'touches it immediately causes to move'. When we develop our knowledge of human begins, we do not just change knowledge but potentially change what it is to be human" (p. 56). Danziger (1997) similarly noted that "identifying experiences, actions, [categories], and dispositions is not like sticking labels on fully formed specimens in a museum. Psychological objects assume their identity in the course of discursive interaction among individuals" (p. 190).

Grief is a prime example of this looping phenomenon. In the previous two chapters, I described the development of the abnormality paradigm as a prerequisite for

the development of the pathologization of grief as a *psychological kind.* Up to this point, I have described the active construction of the classification of grief by the psy-disciplines that involved not only pathological grief, or what I described as CG in the previous chapter, but also the construction of the very idea that there is a normal or abnormal way to grieve. In this sense, psychological sciences do not express a reality that is not 'out there' in the world that is waiting to be described, but rather actively construct it. This invention is then co-opted by the public and understood as a kind of 'truth' about the self, and in the process of learning about the classification, begin to embody it and subsequently change it in the process.

There are several processes that need to occur for a concept to become looped from the psy-disciplines into public consciousness, at which point it will begin to change as the 'moving targets', or the people classified interpret and embody the category in myriad ways. When a concept has become thoroughly looped in the culture it becomes so pervasive and widespread that it appears to be an unquestioned and natural reality (Mills, 2003). Once a classification is introduced by the social sciences, it must become known by the people who have been classified in order for the looping to begin. The first element of looping, is thus, awareness about the category.

Once a classification becomes known, it enters into the abnormality paradigm where the people evaluating themselves begin to become self-conscious about whether they are meeting the criteria for normalcy as stipulated by that category. The second element, therefore, is the evaluation stage and has to do with self-monitoring or a kind of

surveillance of the self in order to assess whether one is 'fitting in' to the cultural standards of what is deemed to be normal. The very act of evaluating the self is a construction of the psy-disciplines, and, regardless of whether the conclusion of this assessment is positive or negative (i.e., whether one deems oneself normal or abnormal), once a person has entered this evaluation phase, they are participating in the looping process.

The third phase of looping has to do with self-discipline. This is the point at which a person actively works at either avoiding or getting out of the classification in question. A person who is introduced to the concept of clinical depression, for example, will first have to know the criteria for clinical depression, and *then* be introduced to the notion of normal or abnormal states of this condition. After having met the first two criteria, the person will then begin to self-discipline, which could involve either trying to 'treat' their own depression by reducing the symptoms, and thereby, getting out of the depression category, or may take on the classification thoroughly and decide to seek professional help for their condition.

The fourth element of looping, then, has to do with taking the classification on as an identity. This involves seeking treatment from the psy-professionals and could also involve actively maintaining, and further perpetuating the construction of the classification. Indeed, the reactions people have to these categories is diverse and unpredictable, and functions to change the classification itself. The reactions may range "all the way from passive acceptance to militant refusal. In other words, the meaning of

human kinds [or *psychological kinds*] develops and changes in the course of interactions among those affected" (Danziger, 1997, p. 191). By the fourth stage, then, the loop is complete. For, as people acclimatize to the classification and begin to alter it, the social sciences gain new knowledge about their invention, which then becomes further evidence of its reality. This, in turn, starts the process again and as Hacking noted, the "classification evolves again loop upon loop" (p. 370).

Grief is a particularly interesting classification to study at this point in its historical trajectory, for it is not yet an official diagnostic category. As has been illustrated thus far, and as will be illustrated in subsequent chapters, grief is on the cusp of becoming a fully accepted mental disorder by the psy-disciplines. While it has not yet been officially announced, it seems that if the classification continues to follow the path of other categories that have been included in the DSM in recent years, grief will almost certainly be added in the next version of the DSM-V set to come out in 2011. Part of the purpose of this project is to show the historical development of the category of grief to its present state as being on the verge of becoming sanctioned as a mental disorder. Due to its nascence, however, at this point in the looping process it is only possible to see how psychology has constructed grief, and how it has been taken up, embodied, challenged, and ultimately changed by the public. What is less clear is Hacking's (1995) fourth stage of the looping process, whereby the public's experience of grief that was shaped by the psy-disciplines, goes on to change the discipline's classification and knowledge about the category.

Nonetheless, the discipline of psychology is a particularly interesting academic field to examine in the context of looping at this point in time. Its content consists of *both* a body of texts, and theories that are produced and disseminated in formal organizations such as the academy and professional organizations, *and* consists of a body of knowledge that becomes known and enacted in the popular sphere through television, self-help books, films, radio programs, and novels. Illouz (2008) noted that knowledge systems like psychology:

> have come to shape who we are because they are enacted within social institutions that bestow authority on certain ways of knowing and speaking and routinize them so that they may become the invisible semiotic codes that organize ordinary conduct and structure the interaction rituals of the self. (p. 7)

While chapters one and two dealt with the 'social institutions that bestow authority on ways of knowing and speaking' by illustrating the way that grief has been constructed within the psy-disciplines, this chapter will focus on the 'invisible semiotic codes that organize conduct', or the second half of the looping process when applied to grief; this is the point at which the psy-construction of grief becomes known, and, therefore, acted on, accepted, and changed by the public. The looping of grief begins with the psy-disciplines construction of it as an individualized, psychologized, and private event that was described in previous chapters. This construction then gets relayed to the public through various representations in mainstream media including film, television, newspapers, magazines, self-help books, and memoirs.

The relaying of psychological messages about grief in these mediums illustrates two interlocking features of the looping process. First, the representation of psychological constructions of grief in media is reflective of how these classifications became interpreted, and changed by agents in the public who themselves are immersed in, and responsive to North American culture. In other words, people who direct films, write newspaper articles, memoirs, and self-help books, are in and of themselves immersed in the culture, and are thus, excellent examples of how the psychological classification of grief is understood, interpreted, and experienced by the public. These people are receptors, interpreters, perpetuators, changers, and ultimately also co-constructors of the psy-disciplines classification of grief. Second, these media examples illustrate how psy-classifications become further looped to the lay public by serving as disseminators of psychological messages about grief that have been mediated by the aforementioned North American cultural agents.

The looping of the psy-construction of grief into public consciousness is part of the general trend of psychology becoming more widely known and represented in mainstream media. Barber (2008), writing about the pervasiveness of psychological constructs in the American media noted:

> Tony Soprano takes Prozac, Lithium, and Xanax (and his mother, Livia, took Prozac, and AJ, his son, is put on Lexapro, a newer antidepressant, in the show's last season). Dr Phil is a star. Eminem is on antidepressants. Lorraine Bracco (who happens to play Tony Soprano's psychiatrist) and Halle Barry suffer from

> depression; Brook Shields from postpartum depression; and David Beckham, from obsessive compulsive disorder. Hardly a week goes by without a celebrity revealing...their long-secret psychiatric disorder. (p. 9)

Barber (2008) pointed out that "images and descriptions of mental illness are now omnipresent in the American media" (p. 13). As will be illustrated shortly, grief is an excellent example of this looping phenomena and the general omnipresent image of mental illness in the media. As it becomes known in the public, it begins to take on a life of its own and people who may never have had any knowledge of psychology or psychiatry begin to understand their own, and other people's experiences of grief through a psychological lens. One of the most pervasive media outlets in which this process begins is through film and television (Sedney, 1999, 2002).

Representation of grief in film and television. The representation of psychological concepts and theories in television and film have hardly been limited to the representation of grief (See appendix D for several examples of mental illness in film). Hollywood has been a central arena for the propagation of psychological concepts such as depictions of psychologists, psychoanalytical story-lines, and films that emphasize therapeutic narratives about the self (Illouz, 2008). In the introduction I noted that critical psychologists acknowledge the reflexivity of agents when examining their knowledge products. Films portraying psychological themes are an excellent example of this phenomenon. Friedrich (1997) noted that Hollywood producers and directors were often undergoing therapy themselves, and therefore, tended to incorporate psychological

themes in their films. *Spellbound* (1945), a film dealing with psychoanalytic concepts (i.e., the unconscious, dreams, and repression), for example, was produced by David Selznick, who had commissioned Hitchcock to direct the film as a result of undergoing analysis (Illouz, 2008). Similarly, the famous film producer, Sam Goldwyn solicited Freud's input to assist in writing the psychoanalytic film *Secrets of the Soul* that came out in 1926 (Zaretsky, 2004). By the 1940s, psychological discourse was a major part of motion pictures. *The Dark Mirror,* released in 1946, featured a psychologist who solved crime using psychological techniques such as the Rorschach Test. Other films that included psychological theories and literature were *The Snake Pit* (1948), and *All About Eve* (1950). In 1947, there were close to 30 films that featured prominent psychological themes; by 1951, at least 20% of the major films produced had significant psychological elements in the content (Ward, 2002). "These films...shared both a fascination with psychological pathologies and a notion of a deep, and often fragile, interior self" (Ward, 2002, p. 155). Today, psychological discourse is so pervasive in films that there are dozens of books devoted to listing and examining mental illness in the movies (See: Hesley, 1998, 2001; Solomon, 2001: Wedding, 1998, 2005).

In contemporary North American culture, television and film are mediators in which people get introduced, immersed, and identify with narratives and themes of their culture (Bell, Haas, & Sells, 1995). Seale (1998) noted that in late modernity, personal experience is increasingly mediated by mainstream media such as television, newspaper, magazines, and film. Sedney (2002) has pointed out that popular films are one of the

major texts though which children (and adults) are educated about death, bereavement, and grief.[35] Indeed, one of the primary ways in which the psychological construct of grief got introduced into public consciousness is through the medium of film (Sedney, 2002). One of the most well-known films dealing with grief in North America is Robert Redford's *Ordinary People* released in 1980.[36] This film was so popular with audiences that it won four Oscars, five Golden Globes, and several other prestigious film awards (IMDB, 2007).

The film follows a family named the Jarrett's. The family is trying desperately to return to normal life after the attempted suicide of their teenage son, Conrad, who had recently come home following a long stay in a psychiatric hospital where he received electric shock therapy and psychoanalysis. Alienated from his friends and family, Conrad's parents push him to seek help from a psychiatrist, Dr. Berger, who coaxes out of him that he had been involved in a sailing accident that killed his older brother, Buck. Calvin Jarrett, the father, awkwardly struggles to connect with his surviving son, who is depicted as clinically depressed and suffering from what Dr. Berger calls "survivor guilt" and "post-traumatic stress disorder". Beth Jarrett, the matriarch of the family, struggles to maintain a sense of 'normalcy' and has become obsessed with maintaining the appearance of perfection in the family.

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[35] Children may experience death and bereavement in their lives through the loss of a pet or a grandparent, but Sedney (2002) noted that they learn how to understand and negotiate the *meaning* of the experience through film.

[36] In an informal email survey that asked approximately 200 people that I know about movies dealing with grief, the majority named *Ordinary People* first.

This film effectively depicted the psy-disciplines construction of grief and introduced the public to the relationship between grieving and psychology and psychiatry. Conrad's attempted suicide as a reaction to his brother's death necessitates psychiatric intervention, including shock therapy and regular sessions with a therapist. As Conrad successfully works with his psychiatrist and learns to express his feelings, he has major, dramatic breakthroughs in therapy that help him do his 'grief work' including the recognition that he shouldn't feel guilty for surviving and that it is okay to be angry.

Meanwhile, Calvin, Conrad's father, begins to go to therapy too and finds ways to connect with his son, and, in the process, feel the pain of his own grief. While Calvin is an essential figure in the movie, the true hero of the film is Dr. Berger. He is patient, compassionate, emotionally and physically available, and always perceptive and analytic in his interpretations of what is happening with Conrad and Calvin as they struggle through their grief work. He is the catalyst and the container in which the men work through their grief, and he is the kind of psychiatrist that is so warm and so perceptive, it is impossible not to love him.

If Dr. Berger is the hero, then Beth, the mother, is perhaps portrayed as the villain. In reaction to one son's death and the other's attempted suicide, she shuts off emotionally. She wants to go back to normal as fast as possible and throughout the film expresses her desire to "keep grief a private matter" to be solved within the family. Beth is depicted as being in denial about her pain and refuses to talk about Buck's death, or show any emotion or vulnerability to her remaining family members. Out of all the

characters, Beth is depicted as the least likeable and appears to be stubborn, heartless, and downright mean for withholding her feelings and refusing to go to therapy to work it out with her husband and son. Indeed, the end of the film has Beth abandoning her family to fulfill what her husband calls her "selfish desires".

Although the primary goal of the film may have been to portray an ordinary family going through extraordinary stress, there is implicit messaging about grief and grieving that is revealing in terms of what it tells us about the psy-disciplines' construction of grief at this time and how it was woven into popular representations. The audience learns that the grief of ordinary people can lead to suicide, hospitalization and shock therapy, can go on too long (Conrad suffers from chronic mourning accompanied by numbing); can lead to major psychiatric problems (Conrad suffers from 'survivor guilt', 'clinical depression' and 'post traumatic stress disorder'); and can break up families and tear people apart. The film further suggested that grief *must* be treated in order to avoid these problems. Conrad shows significant improvement in therapy and even gains the courage to ask a girl out on a date as a result of his therapy.

Furthermore, Conrad and his father become closer and bridge the emotional distance between them after they both attend therapy to talk about Buck's death, while Beth, who refused to see the psychiatrist, is alienated and ex-communicated from the family. Her refusal to show her feelings and deal with her grief, accompanied with her 'unconscious displacement of anger towards Conrad' instead of Buck, is presented as a consequence of being unable to cope with her grief and being unable to ask for help.

Therapy for grieving, therefore, is not only "necessary," as Conrad's father tells his son in the first five minutes of the film, but one wonders whether without it, one will end up like Beth: a selfish, cold and self-absorbed person.

While the psychological depiction of grief is pervasive, it is important to note that the movie also represents typical responses to the grieving person. As the family struggles to deal with their loss, the people around them - friends, family, Conrad's teachers and coaches - are depicted as insensitive to, and embarrassed by the Jarrett's mourning. Everyone wants them to move on as quickly as possible, "to be normal" and "happy again", and to "stop messing up their lives" with all their sadness. They are told to "cheer up", "to have fun", and "to move on" already. While I will discuss the cultural discourses around grieving in the next chapter, it is important to note here that this too, is part of the looping of grief. The Jarrett's, and indeed many people living in the West today, turn to therapy in part because few people want to hear about their pain or can tolerate their sadness.[37] The idea of therapy being almost mandatory, or the only outlet to deal with one's issues, coincides with Western ideas about self care. Seale (1998) wrote:

> care of the self is seen primarily as an individual project in the Western, or at least Anglophone, medico-psychological discourse. This differs considerably from cultures where there is both greater trust in authority and willingness to allow others (such as family members) to care for the self. (p. 5)

[37] Working part time in a psycho-oncology unit of the hospital, I often hear from clinicians and from people I interview about how few places there are to talk about one's grief or about one's fear of dying. In subsequent chapters I will address the cultural dilemma of having nowhere left to grieve.

In some ways, what the movie *Ordinary People* reinforces is the view that therapy is the only place where it is legitimate to talk about one's grief without feeling like a leper. It is a private place where one can confess to weakness, vulnerability, sadness, and the sense of falling apart. While the cultural discomfort of dealing with grief and death is not solely a psychological invention, it is partly a result of the increasing intolerance of sadness and the message that one should seek out help and deal with one's problems in a pro-active way by going to therapy and working through one's issues. As more and more people go to therapy, in turn, the psy-professions increasingly medicalize and psychologize every-day problems that used to be managed in more informal communities.

Finally, the film depicts looping of the psy-classification of grief in other ways as well. As with the movie directors introduced earlier, Redford was influenced by the psy-disciplines in making his film. In an interview with the *New York Times* that was published in July of 1980 (Terry, 1980), Redford noted that he cast Mary Tyler Moore as Beth Jarrett (despite the actor's propensity to take on generally upbeat and cheery roles) because "as Freud said, you should look in the other corner, too, and I became interested in the dark side of Mary Tyler Moore" (pp. 17-18). Redford's desire to parallel Freud and 'look at the dark side' led him to cast Timothy Hutton in the role of Conrad. Hutton's father had died just prior to the beginning of filming and Timothy Hutton was grieving intensely at the time. Another interesting development related to this film was the suicide of Mary Tyler Moore's only son a month after the film was released. In what

can only be described as a cruel irony, Moore's onscreen character of the grieving mother infiltrated reality when she had to deal with grieving her only son, who was 24 at the time of his death (No author, NY Times, 1980).

While both of the main characters were dealing with untimely deaths and grief over their losses (Timothy Hutton was only 19 when his father died, and Mary Tyler Moore's son, Richard Meeker, was 24 when he took his own life), what is interesting is that neither of them are asked to speak about the effect of their own grief in relation to the film. In a thorough search of the literature including newspaper articles, magazines, and websites, there were no articles or interviews that I could find that addressed these losses in the context of the film. One way to interpret this silence around the actor's grief, ironically parallels the film's emphasis on the privatization of grief and the silence around their suffering. The film depicts the general discomfort people have around death, dying, and grieving people and the tendency of friends and family to push the grievers to 'move on' and to stop 'wallowing in the past'. In many ways, the actor's reception in the media, and the silence around their own personal losses depicts the looping of the psy-discipline's privatization of grief in the film and in the real lives of the actors in the film.

Less obvious portrayals of grieving and psychology are also popular in other mainstream films. Two recent examples include *Under the Sand* that came out in 2001[38]

[38] *Under the Sand (2001)*, a French film, was extremely popular around the world. It was nominated and won 8 distinguished international film awards and grossed $1,450,106 in the United States, which is an abnormally high sum for a foreign film in the U.S.A. (See: http://www.imdb.com/title/tt0240913/awards)

and *Reign Over Me* in late 2007.[39] Both films are extremely psychological and both depict, and simultaneously warn about pathological grief.

While *Under the Sand* (2001) depicts a woman in complete denial about her husband's death to the degree that she still speaks of him in the present and continues to make him breakfast every day, the main character in *Reign Over Me* (2007) is so far removed from reality that he is in a state beyond denial. In his grief he has regressed into a kind of preadolescence where he travels around Manhattan on a scooter and retreats into a world of video games, compulsive late-night kitchen renovations, and classic rock, which he listens to on oversized headphones. His grief at losing his three daughters and a wife in the September 11th terrorist attack in New York City is so incapacitating and so extreme, it seems he is suffering from some kind of psychotic disorder. (Indeed, part of the plot line in the film is the debate about whether he should be institutionalized in a psychiatric hospital.) Any mention of his dead family sends him into extreme rages where he throws and breaks furniture.

While these kinds of grief reactions are rare, these two popular films give the impression that grief is a dangerous and out of control condition that necessitates therapy. One of the main plot lines in *Reign Over Me* (2007) is the urgent need of the bereaved man's friend to get him into therapy to deal with his loss. The psychiatrist, played by Liv Tyler, resembles Dr. Berger in *Ordinary People*, she is such a good therapist, she seems almost angelic. As with *Ordinary People,* the message in these films is that grief needs

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[39] *Reign Over Me* was also a popular film that grossed a domestic total of $19.7 million in the U.S.A and an international total of $1.2 million, making a total gross of the film $20.9 million (See: http://www.boxofficemojo.com/movies/?id=reignoverme.htm)

to be treated and resolved, or else one is at risk of being psychotically in denial about the death of loved ones, or go on violent rampages to avoid talking about them.

While grief is almost always depicted as pathological and requiring therapy in the movies, television programs also use psychological constructs in their portrayal of grief. The incorporation of psychological themes in television is said to have taken off in the fall of 1955, when Dr. Joyce Brothers, a psychologist, appeared on the quiz show *The $64,000 Question* and won. The next year, she won *The $64,000 Challenge* and became a celebrity in American culture. By the end of the decade she was hosting a new program entitled *Dr. Joyce Brothers* on NBC, one of the largest broadcasting companies in the United States (Ward, 2002). By the 1980s, Brothers was writing a weekly column that was read by 20 million people and was making regular appearances on the growing TV talk show circuit including *Oprah*, *The Today Show,* and *Hollywood Squares* (Ward, 2002). Ward (2002) noted that Brothers "set the stage for the introduction of psychologists on TV talk shows and for the emergence of the psychologically-inspired, therapeutic discourse of TV talk shows. By the late 1970s psychologists had become some of the "most favoured guests on radio and television talk shows" (p. 156).

One of the most successful talk shows today is the *Oprah Winfrey Show*. The show is hosted by Oprah Winfrey and is aired in 135 countries worldwide. Close to 9 million viewers tune in to her show every day (Winfrey, 2007a). Her influence on the American public is so profound that any endorsement from her (whether a recommendation of a new book, a product, or a political candidate) is met with

overwhelming enthusiasm.[40] She has succeeded in influencing Americans to change their lifestyles including what they think, how they feel, what they consume, eat, do, and read.

Oprah's views are psychologically oriented. Illouz (2008)[41] has noted that:

> Oprah Winfrey has notoriously used a therapeutic style of interviewing and has intensely promoted a therapeutic style of self-improvement... Moreover, her show has been a platform for the performance of problems and struggles of ordinary guests who, in the act of their self, use the therapeutic narrative. (p. 179)

Indeed, two of her most popular guests are Dr. Phil McGraw and Dr. Robin Smith, two psychologists that started out as guest experts on the show and have now expanded to have their own spin off shows that teach 'life skills' and coach people on 'relationship issues' worldwide (Winfrey, 2007a). Because Oprah is so popular, and because her influence is so pervasive in North America, she is a good source to examine as an example of how mainstream media depicts grief.

A general search on Oprah's popular website targets all of Oprah's media outlets, including her magazine, her show, and the radio programs hosted by Oprah herself, Dr. Phil, and Dr. Robin. The keyword search 'grieving' yielded 140 hits that had to do with grief caused by the death of a loved one. While it is impossible to describe all of these

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[40] Oprah's influence is so pervasive in the United States that she was sued by Texas Cattle Farmers in 1996 for talking about Mad Cow Disease on her show. The farmers argued that her comments cost them millions of dollars in meat sales simply because she mentioned off hand that she never wanted to eat another hamburger again due to Mad Cow Disease. Another example is with her book club, when Oprah recommends a book on her show, it immediately becomes a best seller.

[41] See also Illouz (2003) book entitled, *Oprah Winfrey and the Glamour of Misery: An Essay on Popular Culture* for a thorough analysis of Oprah's impact on popular views of the self.

sources, a look at a few key examples will provide an illustration of the way grief is conceptualized on these shows. The psy-disciplines construction of grief as a psychological disorder or condition that needs to be treated by seeking professional help is a common theme in these sources (See: Winfrey, 2007b).

The first source that came up in a search on grief was a show entitled *9/11 Widow Stuck in Her Grief* that aired in October, 2005 (Winfrey, 2007b). On this show, Dr. Phil outlined the four stages of grief and gave several suggestions on how people can move on with their lives after a death. In Dr. Phil's view, the four stages of grief include shock, denial, anger, and resolution, and in order to reach closure and resolution, one must "define success differently, change the form of your relationship with the deceased, ask for help, set up a support system, and work actively on your grief process" (Winfrey, 2007c; the stage model of grief, originally introduced by Elizabeth Kubler- Ross (1969) is one that is enormously popular with the general public. I will discuss the origins of this theory in the next section). Dr. Phil goes on to give several more suggestions in a time of crisis that include "giving oneself permission to grieve", "voicing of one's feelings", "maintaining a normal routine", and avoiding "being in denial" (Winfrey, 2007c).

Several strong messages about grief are evident in this show that was so popular it was aired several times and eventually expanded to include a series on grieving and loss of loved ones. The title of the show *9-11 Widow stuck in Her Grief* conveyed quite a bit about the premise of the program. While the show was about 'helping' widows "heal from their grief", a large part of the program was about differentiating what is normal

versus what is pathological when it comes to grieving (i.e., who is still 'stuck' and who has 'moved on') (Winfrey, 2007b). The bereaved widows were characterized as being addicted to spending money after their losses, were pathologized, and were told that this was not the right way to deal with their grief. On this show, both the grieving widow, and the 9 million Americans (as well as the many others who watched the repeats or read about it on the website), learned that there is a 'right' and a 'wrong' way to grieve.

The second message transmitted on the show was Dr. Phil's emphasis on grief occurring in an orderly progression of stages (Winfrey, 2007c). Despite the fact that some research in the psy-disciplines now dispels the notion of the stage theory of grief (Corr & Doka, 1994; Folkman, 2001; Littlewood,1992; Maciejewski, Zhang, Block, & Prigerson, 2007; Walter,1994; William, 1996; Wortman & Silver, 1989), it has remained immensely popular in the public imagination and has been disseminated widely through mainstream media outlets.

The stage theory of grief is based on the assumption that there is an orderly progression to this condition, and that eventually, one will reach resolution of their grieving process (Kubler- Ross, 1969). The outcome of this model is that people begin to evaluate themselves on this continuum to determine whether or not they, or their bereaved friends and family, are 'grieving properly' or 'are on schedule'. An interesting example of the looping process and the ways in which people co-opt, resist, and/or change psychological categories is evident here. While most people do not grieve in

stages, the majority do hold on to the belief that they *should* be grieving this way. The idea that there is a 'right' way to grieve is one part of the psy-classification of grief that has been co-opted by the public. While this part of the message has taken off, what is apparent through shows like Dr. Phil's is that although there is a public *perception* of grief occurring in stages as dictated by the psy-disciplines, it rarely materializes that way. I purposely use the word *perception* here as the stage theory of grieving has been discounted in some contemporary empirical and theoretical psychological studies (See: Corr & Doka, 1994; Folkman, 2001; Littlewood,1992; Maciejewski, Zhang, Block, & Prigerson, 2007; Walter, 1994; William, 1996; Wortman & Silver, 1989). Nonetheless, while mainstream, contemporary psychology now discounts orderly stages of grieving, the public has still held on to the *expectation* that their grief will happen in this way. This is one clear example of the ways in which the public can mould a psychological classification in ways that resonate with them, regardless of what is happening within the psy-disciplines themselves.

Ironically, one of the themes that runs through most writing on grief theory, in both the academic spheres and the mainstream media, is the paradox that "there is no right way to grieve" and that "everyone is different" juxtaposed with the notion of pathological grieving depicted in the movies or with the proliferation of theories such as the stage model advocated by Dr. Phil. The result is many people who either self-diagnose as needing help, or push other people to seek help who they think may not be grieving properly, or on course.

The resolution of grief, according to Dr. Phil, is to take action in a number of ways. One of the main things Dr. Phil advocates is asking for help when doing one's grief work. Dr Phil is quoted on the website as saying, "You must be willing to ask for help" and "time heals nothing. It's not the passage of time; it's what you do with that time. One day of doing the right thing can replace a year of doing the wrong thing. Don't let yourself spend days and weeks in denial and withdrawal" (Winfrey, 2007d).

The 'right' thing according to Dr. Phil, means seeking therapy and the 'wrong' thing means being in denial, withdrawing, and not doing one's 'grief work'. Other suggestions include "giving yourself permission to heal". Dr. Phil said, "Don't fight your emotions; work though them. If you don't, you will have unfinished emotional business" (Winfrey, 2007d). Much like the message transmitted in *Ordinary People (1980), Under the Sand (2001),* and *Reign Over Me (2007),* the implicit message is that one must do one's grief work or else there will be "unfinished emotional business" that could make one go mad. The message to the bereaved here is not a suggestion that doing one's 'grief work' may help, but rather a very threatening warning that one *must,* one is *obligated* to seek help or else there will be dire consequences

Perplexingly, while one is expected to do all of this grief work, Dr. Phil also demands that one should continue to "maintain a normal routine". "Take each day at a time. Even if you don't feel like doing your regular activities, do so anyways. Behave your way to recovery" (Winfrey, 2007d). Here the message seems to be that while one should do their grief work in the privacy of a therapeutic relationship, they should also

continue to put on a happy face and go back to normal as quickly as possible. The pathologization of grief in a therapeutic culture leads naturally to privatization; when one is 'stuck in grief', or is suffering from pathological grieving, the onus of responsibility is on the bereaved to seek help for their sadness rather than inflicting it on others. The job of the mourner is to go back to normal and "go back to regular activities" even if they don't feel like it. Finally, while the undercurrent of all this advice is to turn one's sadness into something positive, Dr. Phil explicitly says this only at the end:

> releasing negative energy will allow you to feel better. Channel this energy into positive situations. Become active in your community, be a role model for your children or voice your opinion to representatives in Washington - just do something positive with this negative energy. (Winfrey, 2007d)

In summary, the message for people who are grieving is that one should seek help for their sadness; they should move on with their lives and go back to normal as soon as possible; they must do their grief work or else they will go crazy; they should avoid being 'in denial' or 'withdrawing from life'; and finally, and perhaps most importantly, they should stop wallowing in their sadness and do something positive with their negative energy.

The inability of most people to follow through with these multiple injunctions and demands is inevitable. The majority of those who are bereaved do not become heroes by doing something positive with their sadness. Indeed, the majority just feel very sad for a very long time. The disparity between what people experience and what they are

told they *should* experience or do with their grief is likely what leads many people to seek professional, psychological help for their sadness.

A good example of this disparity was illustrated on another Oprah show where she interviewed Russell Yates, a man whose five children were murdered by his wife. (Winfrey, 2007e). In 2002, she interviewed the bereaved father and asked him "How are you carrying on? You're still standing. You're still talking". The question that follows immediately after is "Have you grieved yet? It seems like you missed the first four or five stages" (Winfrey, 2007e). While Yates' response is telling in his reiteration of the psy-disciplines' construction of grief (he replies "I know that there are stages of grief... I don't want to dwell on it, because I want to remember the children for their lives and not for their deaths") (Winfrey, 2007e), Oprah's questions are even more indicative of the co-option of this approach to grief. Her first question about how Yates is carrying on, and the surprise that he is able to keep standing and talking is the reiteration of the expectation that people grieve in the extreme and are so distressed, they are unable to talk or stand. While losing five of your children to murder by your own wife is devastating beyond comprehension, not everyone, as Oprah implies, goes mad like Charlie Fineman in *Reign Over Me (2007).* Her next question is even more presumptuous and judgemental. She asks Yates if he has grieved yet and challenges him on missing the first "four or five stages" of grief (Winfrey, 2007e). In asking this question, she is reiterating Dr. Phil and the popular conception of grief happening in stages and further, that if it

doesn't progress in this way, then one must not be grieving at all or grieving in the wrong way.

If Oprah's questioning appears to be in line with the perceived psy-classification of grief,[42] Yates' response is also telling in relation to the looping process. As noted in the introduction to this chapter, reactions to psychological classifications can range "all the way from passive acceptance to militant refusal" (Danziger, 1997, p. 191), but all are examples of looping. Illouz (2008) has similarly noted that:

> Resistance to cultural outlooks can and often does end up strengthening the very outlooks it opposes because resistance implies recognition of their centrality. Thus cultural dominance is not necessarily produced by gaining assent; rather it is produced by gathering cultural activity *around* a particular cultural object, an activity that may well take the form of a controversy. (p. 30)

In other words, Yates' simultaneous acknowledgment and rejection of the stages of grief (the 'cultural outlook') functions to reinforce the classification in much the same way as Oprah's reiteration of it. Both generate activity around the cultural object and thus, both reinforce the centrality of the psy-classification of grief.

Representation of grief in newspapers and magazines. Popular magazines and newspapers are other media outlets through which the psy-disciplines construction of

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[42] It is worth noting here again that although Oprah is reiterating a discounted psychological notion of grief happening in progressive stages, the underlying message of *all* psychological models/classifications of grief is that there is a 'right' and 'wrong' way to grieve and that if one is not grieving properly, psychological intervention is necessary. This idea harks back to the abnormality paradigm discussed in the previous chapter. While the content of psychological models on grief will inevitably change, the underlying assumption of grief being a potential pathology is constant. That is the main crux of what Oprah and Yates are experiencing and expressing in this televised vignette.

pathologized grief are transmitted and interpreted by the public. Baugher (2001) noted that no matter how tragic a story is, or how many people have died, or how many are grieving, the message in mainstream American media outlets is that grief will soon be over (Baugher, 2001). In a two-year study looking at how newspaper outlets portray grief, Baugher (2001) found that many articles have headlines about how long grief should last and convey the implicit message that one should move on. For example, he noted that many headlines include the world 'still' in their titles implying that one is 'still stuck' grieving their losses several years later (i.e., "Father Still Mourns Loss of His Son, 16, Ten Years After the Attack" or "Still Mourning Her Son's Death after Eighteen Years" in Baugher, 2001).

Another point Baugher (2001) made that is in sync with Dr. Phil's philosophy, is that in newspapers, grief is often written about when people turn it into something positive in the form of activism or personal growth. "Another message from the media is the belief that people who experience the tragic death of their loved ones need to get through it, accept it, recover ... Now you see grief and voila - it turns into action!" (p. 58). The message is that grief should be productive and enlightening rather than just sad and depressing. This seems a very tall order for most people in the throes of grief. Walter (1991, 1995) has similarly argued that news coverage after disasters where many deaths have occurred tends to affirm the value of human attempts at rational control. People who are expressively grieving are often displayed as heroes brave enough to speak about their sadness in the news. Walter suggested that these displays of grief enforce the psy-

conception of expressive grieving as the normal and right way to cope with loss, and to reach a good and healthy resolution (Walter, 1991, 1995).

A recent example of this depiction of grieving was evident in the news coverage about the sudden death of Tim Russert, the famous host of the popular show *Meet The Press.* Some of the media coverage focused on his son, Luke Russert, who had spoken at his funeral, and gave several television appearances to discuss his deceased father. In June of 2008, only a few days after his father's death, Luke was interviewed by *The Today Show,* which was transcribed on to an online article at *Today.com* (Celizic, 2008). Celizic (2008) wrote:

> Luke spoke for 15 minutes about his dad with remarkable poise. He never lost his composure, not even when he was talking about being on the set of "Meet the Press" on Sunday and touching his dad's empty chair... Luke shed no tears. There were too many happy memories, too much that was good about Tim Russert to talk about. (no page number available)

The emphasis on rational control over one's emotions and the ability to take away something positive from the experience of grief is evident in this passage. Luke Russert is extolled for keeping his composure and holding back tears even when on the set of his beloved father's show. In addition to press coverage adulating on how strong, composed, and put together Luke appeared on television, other media focused on whether Luke could potentially replace his father in political reporting. The emphasis of focusing on the positive and 'moving on' as quickly as possible is evident in an interview with Larry

King on CNN. Luke was told by a viewer that he had "shown great strength and character in recent days" and was asked, "any chance we'll see you reporting or doing commentary about the 2008 election?" When Russert showed interest in getting involved in his father's line of work, King stated, "...You could come to work for us [at CNN]. I think I can speak for management. In fact, they'll probably talk to you tomorrow based on just how well you're handling yourself tonight" (CNN, 2008, no page numbers available). The push to get Luke working and replacing his father as fast as possible and further, the idea that he would be eligible for such a position because of the way he 'handled himself' by holding back his feelings of grief, is an example of the psy-classification shaping people's experience of grieving.

Like movies and television, newspapers also have a profound influence on people's ideas and understanding of modern grief. *The New York Times* is a daily newspaper published in New York City and distributed internationally. Founded in 1851, the newspaper is known as the authoritative reference for modern events and is one of the the most well read papers in North America and the world today. In March 2007, the paper reported a circulation of roughly 1,120,420 copies on weekdays and 1,627,062 copies on Sundays (New York Times - NYT, 2007). *The New York Times* also has an extensive website that is accessed by 13 million people per month (NYT, 2007). The combination of their daily and weekend newspapers and their website makes *The Times* a particularly relevant media sources to examine for its impact on people's understandings

of grief.[43]

A keyword search of grief and grieving on *The Times* website, which accesses the archives since 1981, yielded close to 700 results. While not every article was necessarily about grief, many of the publications dealt specifically with research being done in the psy-disciplines. In the 1980s, Daniel Goleman, the psychologist who invented the construct of *Emotional Intelligence,* wrote several articles about grief for *The Times.*

In an article entitled *Mourning: New Studies Affirm Its Benefits* (1985), Goleman introduced the public to the research of psychologists doing work on bereavement and grieving. Although the title is misleading in that it suggests the piece would be about the benefits of mourning, Goleman (1985) spent the majority of the article talking about how grieving can go wrong. As with the messages given on Oprah, and in many newspaper articles, Goleman (1985) reiterated the point that while people's responses to grief differ widely, and most people don't follow a set of stages when grieving, there are nonetheless patterns of grieving and the possibility of pathology in the process. He wrote:

> *Mourning, when successful* removes one from the stream of life to ponder one's own place in the world and one's relationship with the dead person, and finally to return to that stream having *adjusted to living with the loss.* Mourning entails a spontaneous, sometimes *overwhelming process* in which the bereaved is preoccupied with thoughts of the dead person, even in dreams. *As the mourning*

[43] While *The New York Times* is a very popular newspaper, it should be noted that it is read by an educated audience, and may not reflect the general public in America. While the audience may be self-selected, it is a particularly potent media resource to examine because it is used frequently in classrooms across the country. In addition, the readers of the newspaper tend to be professionals such as professors, health care professionals, and educators, making them more likely to pass the information they read onto other people.

> *proceeds*, the obsession passes, leaving behind it a realistic assessment of life and death - *and the ability to go on. When mourning goes awry*, the rest of the life suffers. Over a protracted period, perhaps years, the mourner is so overwhelmed and obsessed that *the grief is debilitating and distorts many aspects of life.* (Goleman, 1985, p. C1) (Italics added)

Several psy-disciplinary themes are evident in this statement. First Goleman (1985) introduced the abnormality paradigm in relation to grief when he refered to "successful" mourning in the first sentence. The idea that mourning can be successful implies that mourning can also be unsuccessful, and indeed, Goleman discussed the possibility of debilitating and obsessive pathological grief towards the end of the paragraph. Goleman also reiterated the idea that grieving is a process, and that there is work to be done that goes in successive stages in order for one to "adjust to the loss" and "move on" (Goleman, 1985).

The psy-construction of grief is also evident by Goleman's interview with Mardi Horowitz, the psychiatrist I introduced in the previous chapter, who is an advocate for the inclusion of Complicated Grief in the DSM. "For some people" said Horowitz, "mourning the loss involves a process so unbearably painful, protracted or tenaciously blocked that it can be described as pathological grief" (Goleman, 1985, p.C1). Horowitz's solution is therapy to deal with the problem.

In 1988, Goleman wrote another article for *The Times* entitled the *Study of Normal Mourning Process Illuminated Grief Gone Awry*. While the last article was about

grieving in general with an introduction to pathological grief, this article dealt specifically with CG. Again, Goleman (1988) interviewed Dr. Horowitz at length, but also included a short quote by Dr. Volkan, another researcher advocating for CG's inclusion in the DSM. Goleman (1988) quoted Horowitz who stated, "the death of a loved one is the prototypical psychological catastrophe, a blow to the unconscious sense of personal inviolability that most of us carry". Goleman (1988) wrote:

> Mourning a loved one is always painful, but some people find the process more difficult than others, either *becoming too distraught or holding too much emotion in.* In studying these extreme reactions, researchers are coming to a sharper understanding of the *normal course of mourning*, and of signs that it has gone awry. The research is also spawning new *psychological treatments for those who have trouble grieving.* Most of the treatments focus on *helping mourners follow the normal path,* moving past a point where they might have become frozen. (Goleman, 1988, p.C1) (Italics added)

While I discussed the concept of grief as trauma in chapter two, it is worth repeating here that death in itself, and grieving for a loved one, is not an unusual trauma or a catastrophe in the way that Horowitz implies. Death is constant and expected. While it is emotionally straining to cope with loss, it is not out of the ordinary to grieve. The idea that grief is a "psychological catastrophe" is part of the psy-disciplines construction of grieving.[44] If the loss of a loved one can be considered a psychological problem, it can

[44] The famous writer, Jamaica Kincaid, made a similar point in her memoir describing her brother's death. She wrote "If it is so certain, death, why is it such a surprise, why is everybody who is left behind, who is

also be treated as one. Indeed, as Goleman's (1988) statement implied, grieving can go awry by either the person becoming too distraught, or not distraught enough. The role of the psychologist, therefore, is to aid the mourner to "follow the normal path" of the grieving process with their new treatments.

Jane E. Brody (1999a), the health columnist for *the Times,* wrote a piece about 'unresolved loss' where she discussed the role of therapy for ambiguous deaths or losses where no body could be found. Later that year, she wrote another piece entitled *Mourning, A Time When Words Often Fail; A Gift of Comfort* (1999b) about the public's discomfort with grieving people and the recommendation of a book written by a grief therapist to cope with one's losses.

Following the terrorist attacks on September 11th, 2001, a series of articles about grieving were published in *The Times.* Robert Klitzman (2002), a psychiatrist, wrote about using antidepressants to deal with his grief over his dead sister and suggested that this might be a good solution for others too (Klitzman, 2002). Another article written by Erica Goode (2001) was entitled *A Nation Challenged: Psychological Trauma: Stress Will Chase Some into Depths of their Minds.* The piece was about grieving after 9/11 and the development of treatment for survivors who suffered from post-traumatic stress disorder and pathological grieving (Goode, 2001). Similarly, in 2006, Anthony DePalma

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not dead, in a state of such shock, as if this thing, death, this losing forever of someone who means something to you has never happened before. Why is it so new, why is this worn-out thing, death, someone dying, so new, so new?" (Kincaid, 1997, p 193). While Kincaid wrote this in good faith, expressing how she felt about her brother's death, I think her inquiry is a reflection of a modern culture where death has been constructed as surprising, and therefore, has made mourning into a psychological catastrophe in need of therapy. More will be elaborated on this in chapter four.

wrote about grief assistance available to those who lost a relative in the World Trade centre attacks. He noted:

> The American Red Cross shows that for many of those directly affected by the Sept 11 attacks, grief remains a constant companion nearly five years later. The report shows that two-thirds of the responders, survivors, and victim's relatives who sought help from the Red Cross to deal with their emotions in the aftermath of 9/11 believe that grief still interferes to a large or moderate extent with their lives. Overall, just over 40% of the 1,500 adults surveyed said that they still needed additional services to help them recover. Foremost among the services needed, according to the survey, were mental heath treatments. (p. B3)

While each of these articles differs in content and purpose, they all share the same underlying message for the public. Whether it be grief resulting from a personal loss, or grief resulting from a national one such as 9/11, all conclude that grief has a normal path that can go awry, and that help is not only available, but necessary, either in the form of psychological therapy or medication.

The looping of the psy-classification of grief is evident in (what I consider to be) the non-critical reporting on these issues. Interestingly, none of the newspaper reporters questioned the validity of pathological grief, which, is likely an indication of its widespread acceptance in the culture. Further, as is evident from reports like DePalma's (2006), where the majority sought psychological help for their grief, and almost half reported still needing psychological or psychiatric intervention five years after the

attacks, the public clearly experiences their grief as abnormal and in need of help. Moreover, both the reporter and the people being written about seem to be surprised that grief should remain present nearly five years after 9/11. The evaluation of how long grief should last, the very idea that grief should be 'over and done with', can also be interpreted as the incorporation of the psy-classification of grief into people's understanding of their experiences.

Popular magazines tend to portray similar themes as the ones in newspapers. For example, an article published in *Newsweek* in 1995 entitled *The Stages of Grief* (1995) spoke about the survivors of the Oklahoma City bombing. Six years before 9/11, where grief counselling took off exponentially, grief therapists appeared on the scene to help the bereaved cope with their losses. The article cited the psychologist Allen Wolfelt stating, "there's a plague of unmet grieving needs" (Woodward, 1995, p. 62). The author of the article concurred, and wrote that although grief is a universal emotion, "coping with it is a skill that must be acquired" (Woodward, 1995, p. 62).

Another article published in *Newsweek* (2005) was written by the bereaved actress Marilyn Snyder. In memoir style, she noted that "nearly a year later, I think I may have moved from numbness and denial into acceptance" (Snyder, 2005, p. 20), thereby, reiterating the stage theory that is so popular in mainstream North America.

Other examples expounding similar themes included an article in *U.S.A Today* written by a psychiatrist and a psychologist entitled *When Tears are not Enough* (2006). Both psy-professionals wrote about things that people can do to support mourners in

order "to help the grieving person engage in the process of mourning in the healthiest way possible" (Jeffreys, 2006, p. 66). Similarly, *Sports Illustrated* featured an article called *Coaching the Grief Stricken* on how to support mourners in the spring of 2007.

The Atlantic (2007) published a half page summary of a recent study in the *Journal of the American Medical Association* that offered empirical data to support the stage theory of grieving, albeit in a modified form. The short feature was complete with a scientific chart labeled "frequency of emotions reported after the death of a loved one showing a decrease in disbelief, yearning, anger and depression and an increase in acceptance of the loss" (The Atlantic, 2007, no page number available).

Even *Golf Digest*, a magazine devoted almost exclusively to the sport, had a four page spread profiling Tiger Woods in 2008. The majority of the article was about Woods dealing with his father's death. A psychologist named Chethik is cited as saying "...Part of the grieving is integrating the father inside himself, so he can still be with him" (Golf Digest, 2008, p. 79).

While each of these articles approached grieving in different ways, all of them are like the newspaper articles in enforcing the idea that there is a normal or healthy way to grieve that usually happens in stages; they also reiterate the notion of having to do grief work in order to acquire the skills to mourn and get through the process to recovery.

Representation of grief in self-help books and memoirs. The self-help and memoir genre is one of largest literary genres of the 20th and 21st centuries. McGee (2005) noted that the "trade publication American Bookseller reports that self-help book

sales rose 96 percent in the five years between 1991 and 1996. By 1998, self-help book sales were said to total some $581 million, where they consisted of a powerful force within the publishing industry" (p. 11). Furedi (2004) has suggested that the "illness memoir became one of the most distinct literary genres of the 1990s" (p. 41). A search on Amazon.com (2007) with the keywords 'Self-Help/ Death, Grief, Bereavement', yielded close to 1000 hits. All of these titles are self-help books intended to aid the bereaved in coping with their grief. These books are written by people from a variety of backgrounds, including professional authors, psychiatrists, psychologists, and lay people alike, and are intended to be read by a general audience (e.g., Bolton, 1999; Jenkins, 2005; Martin, 1999).

While the next chapter will look more closely at why discursive sources like self-help books have exploded in the last century, it is worth pointing out that these books continue to be published because people keep buying them. The lack of grieving rituals, and the helplessness that North Americans feel in the face of death in the 21st century, is, in my view, one of the driving forces behind this exploding industry.[45] People buy these books because they do not know how to manage their grief. Whereas religious institutions and social communities used to fill this gap, grieving today has become psychologized and individualized. The self-help-book genre for grief is partly a *result* of the psychologization of grief and partly the *cause* of it.

As will be illustrated shortly, the content of these books is thoroughly

[45] Chapters four and five will deal more explicitly with the lack of grieving rituals and the alternative grieving practices that have arisen in response to the dearth of protocol around bereavement.

psychological in orientation; it is also important to understand that the very existence of the self-help genre and the act of buying these kinds of books is also the outcome of a psychological worldview (Illouz, 2008). The inclination to buy a book to learn how to cope with one's grief is a solitary endeavour that takes place behind closed doors, and is an activity that is done individually in order to help oneself 'grow' and treat one's sorrow. The idea that one is responsible for one's emotions, and proactively seeks an aid to help oneself cope with the grieving process, is akin to the person seeking therapy in order to deal with their 'issues'. The very notion of the self-help genre is a product of the psy-disciplines and the psychologization and privatization of every-day problems.[46]

One of the most famous examples of the self-help genre in psychology in relation to grief, and the one I have been alluding to throughout, is the stage model of grieving introduced by Elizabeth Kubler-Ross in the late 1960s. In 1969, Kubler-Ross, a psychiatrist working at the University of Chicago Medical School published *On Death and Dying* (1969) to wide acclaim. Kubler-Ross quickly became a best selling author and was featured in both *Life Magazine* and *Time Magazine* in 1969 (Time, 1969; Wainwright, 1969).

In her book, she outlined five psychological stages - denial, anger, bargaining, depression and acceptance - that have become widely known and reiterated in North

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[46] Advice manuals did exist prior to the creation of the self-help genre, but they had a different flavor. Advice books were popular among the middle classes in the second half of the 19th century, however, rather than focusing on 'self-help' advice, they tended to emphasize moral character. These manuals advocated moral integrity that could be developed through self-discipline, hard work, and religious instruction. The self-help genre I refer to as being a construction of the psy-disciplines focuses instead on self-exploration, self-development, and self-healing that is markedly different than advice manuals of the past. See Lears, (1983), and Sussman (1973), for elaboration. Rose (1989, 1996) has similarly remarked that the psychological 'self' as a marker of identity is a distinctly modern invention of the psy-disciplines.

American culture. Her theory, which was popularized and outlined in detail in both *Time* and *Life* Magazines, was that dying people moved sequentially through these stages until they reached acceptance of their death. As should be evident by contemporary examples in film, television, newspapers, and magazines, this stage model of grieving has been completely co-opted into public consciousness and it seems that familiarity with this theory is widespread. Her ideas have become so ingrained in popular culture, they have changed the way in which modern people grieve, or at the very least, *expect* to grieve. (See appendix E for several prominent examples.) Kubler-Ross' work is a particularly clear example of the looping process of the psy-classification of grief. While Kubler-Ross intended the stages to apply to the terminally ill who were dying, her stage model was quickly adapted and experienced by people as applying to every kind of loss, including bereavement, separation, miscarriage, losses on the stock market, and divorce (Konigsberg, 2007).

The introduction of the five psychological stages of dying was revolutionary at the time. While her ideas are fully integrated and ingrained in popular culture today, Kubler-Ross was one of the first to speak publicly about death and dying in the early 1970s, and was instrumental in introducing the public to both the theory itself - the notion of orderly stages - and to the idea that the psy-disciplines had something to contribute to a domain that had been dominated by medicine. While my project is about grief, and not about death, it is worth noting that Kubler-Ross' success was partly based on her ability to capture the public's growing dissatisfaction with modern dying that was being

relegated almost entirely to hospital settings in the 20th century (Gilbert, 2006).[47] Illouz (2008) has argued that the most successful cultural ideas take hold if they can satisfy three conditions:

> they must 'somehow' fit social structure, that is, must make sense of actors' social experience (e.g., rapid economic transformation, demographic patterns, immigration fluxes, downward mobility, status anxiety); they must provide guidance about uncertain or conflict-ridden areas of social conduct (e.g., sexuality, love, or economic success); and they must be institutionalized and circulated in social networks. (p. 20)

Kubler Ross' ideas fit all three of these conditions. Her ideas were institutionalized by virtue of coming out of a scientific discipline and arrived on the scene at a time where there was a lot of confusion and anxiety around death and dying. Indeed, just like grieving shifted from a communal and religious affair in the past, dying was also revolutionized in the 20th century and changed from a spiritual, home-and-family based experience, to a depersonalized, highly technological, privatized death in the hospital (Gilbert, 2006). Kubler-Ross' (1969) theory explicitly addressed this kind of death and described the five stages that people go through within this context.

Kubler-Ross did not conduct research with grieving people and worked her whole life with the terminally ill and the dying. Her theory was about people who were themselves *dying,* not people who were grieving the loss of someone they loved. Earlier

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[47] On this Elias (1985) noted, "never before in the history of humanity have the dying been removed so hygienically behind the scenes of social life... never before have human corpses been expedited so odorlessly with such technical perfection from the deathbed to the grave" (Elias, 1985, p. 23).

in this chapter I noted that because grief as a psychological category is a fairly new invention, it is difficult to trace the looping of the construct back to the discipline's reclassification of it. One place where this process *is* visible is with Kubler-Ross' ideas. In response to the public's co-option of her stage theory of dying to grieving, Kubler-Ross co-published her last book *On Grief and Grieving* in 2004 with David Kessler. This international best seller subtitled, *Finding the Meaning of Grief Through the Five Stages of Loss* described the grieving process as occurring in the same five stages that the dying go through. Although Kessler and Kubler-Ross were more careful in this book about distancing themselves from the idea that the stages happen sequentially, the use of the word "stage" and the modeling of their theory on the first book, implied that the bereaved go through the same progressive sequence that the dying go through. In many ways, the writing of this book and the application of the stage theory of dying to grieving was a direct response to the public's understanding of Kubler-Ross' ideas than what were the author's original intentions. It is thus an excellent example of looping and the ways in which psy-classifications are continually evolving and being re-constructed by scientists and the public alike.

The idea that 'acceptance' is the final and preferable stage for everyone's experience of death was also conveyed by Kubler-Ross' brand of self-help. In *On Death and Dying* (1969) she described 'acceptance' as a return to a peaceful, womb-like state where one will finally reach ecstasy and be free from pain and suffering. Seale (1998) has suggested that part of the appeal of this book was this idea of transcendence that was

linked to the "sanctification of peak experiences, achieved through drugs, meditation or sexual abandon, in the American counterculture of the late 1960s" (p. 106).

In another book entitled *To Live Until We Say Good-Bye*, Kubler-Ross (1978) advocated that religion help the dying patient reach death with peace and equanimity, and that when someone has reached the acceptance stage, they understand that death in itself is merely a transition into an afterlife (Kubler-Ross & Warshaw, 1978). Kubler-Ross used the term 'transitioning' to refer to the shift between accepting one's death and moving into a new reality in the afterlife. In *On Grief and Grieving (2004)*, her co-author, Kessler, wrote, "She always said that when she transitioned and graduated it would be cause for celebration since she would be 'dancing in the galaxies among the stars' " (p. xiii). Lofland (1978) has termed this kind of approach to death and dying as the 'happy death movement', which Kubler-Ross had a significant part in creating and promoting.

Part of Kubler-Ross' success was the use of this kind of terminology that shrouded the finitude of death and turned it into a cause for celebration. Her use of words like 'transitioning' or 'graduating' as euphemisms for the cold hard reality of death, was immediately well received in North America where death was increasingly becoming feared and hidden in hospitals and nursing homes in the 20th century (Gilbert, 2006). As I alluded to earlier, cultural ideas seem to take hold and become particularly popular at times of uncertainty. Illouz (2008) wrote:

> cultural activity is particularly intense during unsettled periods, a vague term that includes such diverse phenomena as the collapse of traditional social roles and role uncertainty, the demise of established patterns of life, the multiplication of values, and the intensification of social anxiety and fear, all of which can explain why individuals search for ways to explain the behavior of others and shape their own behavior. The twentieth century was marked by much greater normative uncertainty, generating intense ideological and cultural work, a significant part of which has been the prerogative of psychologists, at least in the American context. (p. 57)

The massive changes happening around death, dying, and grieving in the 20th and 21st centuries are excellent examples of shifts in ideology and culture, and as, Illouz (2008) noted, left an open space for psychologists to step in and provide guidance amidst this uncertainty and ambiguity. The use of religious symbolism in Kubler-Ross' theory, for example, had an interesting relationship to her popularity. While religious beliefs used to provide the narrative frameworks for the mysteries of death (Bowker, 1991), death has become secularized in contemporary 21st century North America, leaving people to cope with grief in a cultural vacuum (Gilbert, 2006).[48] Seale (1998) has suggested that psychology has replaced religious institutions in giving explanations and rituals for dealing with death and grief. He wrote:

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[48] The secularization of death in contemporary North America will be discussed at length in the next chapter.

> If psychology is like religion in its effect, then we can begin to understand its institutional practices as being akin to religious procedures. It is productive, then, to equate the rituals of psychotherapy with those of the church, to note the confessional as a shared technique for bringing the self into discourse, and to identify the sacred objects and creeds of psychotherapy as having their parallels in religion. Psychology, too, offers a framework for understanding the dying self, and gives guidance on how to die [and grieve] well, and gain a form of 'redemption' through reparative work. (p. 62)

Kubler-Ross clearly drew on this discourse in her theories. However, while she did make reference to religion in her writing, she also provided a secular version of religious beliefs in the afterlife and the idea of 'reparative' work that was digestible and easily consumable for the public. To think about death as merely a transition into another life is comforting regardless of whether you are religious or not. As a result of its palatability, it immediately became popular in the public imagination. The discourse of modern, scientific psychology became a substitute for the religious narrative around death. Both narratives achieved the same goal of easing anxiety about death, dying, and grieving, and further, it gave people something to 'do' when someone died. While Kubler-Ross intended these theories to apply only to those who were dying, they quickly became superimposed onto the grieving process as well, both because the public understood, and experienced her theories that way, and because she herself responded to that interpretation and further perpetuated the construct. Indeed, in addition to grieving

in stages, grieving people were also admonished to do their 'grief work' and reach the acceptance stage since their loved ones were not really dead, but were merely transitioning into another life.

Kubler-Ross' influence has extended to subsequent generations of self-help writers. In *A How-to Healing Handbook: You Can Help Someone Who's Grieving* published in 1996, (Frigo, Fisher and Cook, 1996),[49] the authors wrote, "everyone grieves; it is part of our human experience to do so. Our goal must be to grieve wisely, honestly, and consciously" (Frigo et al., 1996, forward). In the preface that follows shortly afterwards, the authors wrote, "death is only of the physical body and... after death, the spirit continues on its journey" (Frigo et al., 1996, preface). In just the first few pages of the book, the message that there is a right way to grieve (i.e., "wisely, honestly, and consciously"), and that one should be goal-oriented in one's sorrow, is evident.

Kubler-Ross' ideas are so pervasive in this book that in the section on how long grief should last, the five stages of dying are reprinted wholesale as the five stages of grieving. The authors wrote, "most experts say that the normal phases of grieving include denial, anger, bargaining, depression, and acceptance" (Frigo et al., 1996, p. 59).

A more recent example is *The Art of Saying Goodbye: How to Survive the Loss of a Love* written by a physician (Samuels, 2003). The first chapter entitled "Good Grief!"

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[49] Because there is such a large selection of self help books on grief, I wanted to pick a representative sample for this chapter. My method was to go to the reference library and ask for a list of the most checked out self-help books on grieving. I took out ten well read titles and piled them in order of publication on my desk as I was writing. While I had no previous knowledge of these books, all of them reiterated Kubler-Ross' ideas, an indication of how prevalent her influence is in the general public.

has several sections including "rites of passage", "creating a new self", and the "opportunity for a new life". Samuels (2003) began the chapter with this epigraph: "grief has many positive aspects to it" (p. 1). The "positive aspects" of grief include many possibilities for self-growth and renewal according to the author who echoed Kubler-Ross' idea of death being a 'growing experience'. Chapter two is dedicated to distinguishing the difference between grief and depression. Samuels (2003) wrote:

> There are two common causes of depression associated with grief. One is the result of dysfunctional thinking patterns. For instance if someone dies and you tell yourself "I will never be happy again", you are compounding the fresh pain of grief by projecting it into the future. You are engaging in negative fortunetelling. You are also generalizing by saying, "since I am unhappy now, I will always be unhappy". Another source of depression comes of the habit of making yourself sad when something unwanted occurs. This represents the inner child saying, "I am going to stay sad until someone comes along and makes me feel better". In this instance, "I will stay sad until my love comes back. (p. 11)

In addition to clearly drawing on Kubler-Ross' ideas (that were modified, or perhaps, more appropriately, expanded, based on the public's understanding of her work), Samuels (2003) also drew on the language and concepts of cognitive behavior therapy in his exposition on grieving. The notion that one's grieving is maintained by irrational thoughts and cognitive distortions, and that one can help oneself by becoming aware of these issues (presumably by going to a therapist), is rooted in psychological ideas about

the self. Reminiscent of the films discussed earlier in this chapter, the message here is that grieving can become pathological if it morphs into depression, which, according to this author, is a result of dysfunctional thinking patterns such as over-generalizing. This self-help book places enormous demands on the griever. Not only does the mourner learn that their grief should be a positive, life changing, and growth-inspiring experience, but one is also to make sure that they do not allow themselves to become too sad lest it lead to dysfunctional thinking. To 'stay sad' is childish. One is obligated to 'move on' and accept the death in order to grow.

As with the previous self-help book, Samuels (2003) entitled chapter 5 *The Stages of Grief*; the epigraph cited Kubler-Ross' book, *On Death and Dying* (1969) as the inspiration for what is to follow: the five stages of grief leading to the point where "you can experience happiness and security and none of those require the presence of the one you love. Your new life can embody and represent a living endorsement of their preciousness" (p. 41).

Finally, a third example written by Allen D.Wolfelt, a psychologist, is entitled *Understanding Your Grief: The Ten Essential Touchstones for Finding Hope and Healing Your Heart (2003a)* that comes with a companion volume called *The Understanding Your Grief Journal (2003b).* Wolfelt proposed that there are 10 essential touchstones that each person goes through when they are grieving including "recognizing normal grief behaviors", "reaching out", "seeking reconciliation", and "appreciating transformation". Throughout the book, the author offered several checklists for the

mourner so that they can understand their grief. These lists include distinguishing between 'normal grief' and clinical depression, a list of what to expect in the grieving process, and a list that helps determine whether a grief counselor is a good match for the mourner. The checklists are good examples of discursive sources of information about grief. The abnormality paradigm is enforced through making a distinction between normal and abnormal grief, and the checklist on assessing your therapist is a message in of itself that therapy is the right way to cope. The question is never *whether* therapy is helpful, but rather *which* therapist is most appropriate for you. Wolfelt's emphasis on personal transformation and seeking reconciliation, as well as the provision of a grief workbook, enforces the necessity of doing one's 'grief work' as well as Kubler-Ross' transformational and celebratory approach to death (Wolfelt, 2003a).

While self-help books tend to emphasize a psychologized approach to grieving and enforce psy-conceptions such as the five stages and the idea that grief can be transformational and life changing if one does their grief work, the memoir genre is slightly different in its approach. The grief memoir is usually a biographical account of both the mourning process, and a meditation on the dead and what they meant in the lives of the writer (Fowler, 2007). The memoir can be written by anyone, not just a health professional or an established author, and can be about any kind of loss including the death of a spouse, parent, child, lover, or friend. Grief memoirs do not usually include theory and rarely describe the grief process as occurring in stages. They are normally about the pain of the mourner and they attempt to describe what it's like to try and live

without the ones they have loved and lost. As a result of this democratic nature of grief memoirs (in the sense that they can be written by anyone), they are a particularly poignant source to examine the looping of the psy-classification of grief. Specifically, they provide a window on the second half of the looping process - how members of that category relate to, and experience the classification, and how, in turn, they change it, and revise it in the process.

While film, television, newspapers, magazines, and self-help books are easy to deconstruct for their implicit and explicit messages about grief as a psychological kind, the memoir genre is more complicated. The rise of the grief memoir, paradoxically, coincided with the increased public discomfort around death, dying, and grieving. At the same time, there is also a corresponding explosion of interest in the field of the psy-disciplines that wish to individualize and privatize the experience. As I noted in an earlier chapter, the resistance to a classification is as much evidence of its import as is passive acceptance of the category. The act of writing a memoir simultaneously incorporates the psychological emphasis on expressing grief in order to 'work through it', while rejecting the notion of doing so in a private office of a professional. To further complicate the looping process, as will shortly be discussed, the grief memoir is an intensely psychological act that both reiterates and rejects the discipline's mores around 'telling one's story' in order to heal.

Fowler (2007), writing about the memoir, noted that that while "psychologists envision the audience of narrative of loss as private (and perhaps, *necessarily* private)"

(p. 546), the grief memoirists bring their account into the public sphere and share their stories with many people they do not know. Fowler gave a feminist interpretation to this paradox of private versus public, arguing that this has "more to do with the persistence of the image of the male therapist as a change agent and the female patient under treatment... the concern that the memoirists seizing of agency (authorship) ultimately challenges the authorship of the professional" (Fowler, 2007, p. 546). In Fowler's (2007) view, the psychological imperative towards privatization is about gender relations and the threat of women being empowered through their writing and replacing the professional male psychologist.

While this is a compelling argument, and one that I would concede is part of the equation, I believe the grief memoir has the *potential* to be a rebellion against the psy-disciplines psychologization and privatizing of grief while at the same time, the memoir also uses the tools of the discipline in reiterating its norms. In this sense, it is an excellent example of the looping process for it depicts how the psy-classification of grief gets interpreted, understood, and subsequently modified by the lay public. In writing a memoir about one's experience, the writer is publicly making visible something that is usually kept hidden and silenced. In her article, Fowler (2007) noted that a significant part of the grief memoir is the 'grief community'. This refers both the individual writer's immediate social circle of supporters *and* a creation of a wider grieving community; the readers of the memoir who can emphasize and share in the suffering. An example can be

found in the famous novelist, Isabelle Allende's (1995) grief memoir for her dead daughter, Paula. She wrote:

> It came to me how for countless centuries, women have lost their children, how it is humanity's most ancient and inevitable sorrow. I am not alone, most mothers know this pain; it breaks their hearts but they go on living because they must protect and love those who are left. (Allende, 1995, pp. 291-292)

The creation of community through the writing of the grief memoir is one way in which I believe the public is responding to the increasing psychologization, privatization, and silencing of their grief. Since a 'live' grief community no longer exists in the form of religious communities, and since there is no longer social etiquette about how to grieve, or how to support someone who is in mourning, memoirs create a kind of pseudo-community of writers and readers that challenge the psy-disciplinary imperative to seek private, professional, help.

The other *potentially* rebellious piece of the memoir is that writers can describe their grief on their own terms - they can tell their story anyway they like regardless of whether it fits into any psy-disciplinary narrative of what grief should look and feel like, or how long it should last. This can be empowering for both the writers and the readers. At the same time, however, the very idea of 'telling one's story', especially a sad one, is a product of the psy-disciplines themselves. While memoirs have existed in the past, (see footnote 45 for elaboration of a similar point in the context of self-help manuals), the modern, psychological memoir has the peculiar duality of acting both as a source of self-

expression for the 'diseased' or 'disordered', and simultaneously acting as at therapeutic, or self-help trope for an external audience. Illouz (2008) noted that:

> the therapeutic narrative schema makes it possible to emplot the self in ways that turn the narration of the self into a public performance... the mechanism that enables the translation of the private into public discourse is therapeutic: it is the therapeutic narrative code that dictates how private stories can be shared, the motivation in telling them in public, and how the audience should interpret them. (p. 187)

In other words, while the memoir breaks out of the private professional sphere, it still functions to reiterate the psy-disciplines emphasis on cathartic story telling and the value in sharing one's story in order to reach personal resolution. Paradoxically, then, the grief memoir also reiterates the notion that there must be an audience with which to share one's grieving, which is a construction of the psy-disciplines when it comes to grief. Presumably, the cathartic benefit of writing one's story could be just as healing as if it were kept privately in one's drawer; the notion that there must be an audience that receives the story and acknowledges it, is an invention of the therapeutic milieu (Illouz, 2008).

While I referred briefly to psychology and religion earlier, it is worth noting that parallels exist here as well. Foucault (1976) has noted that the act of confession in order to be absolved of one's sins was a religious practice, which was co-opted by the psy-disciplines in the form of a therapeutic civil code that prizes self-reflection and

confession of one's issues. One could argue that the need for an audience, in this case, a community of readers for these memoirs, is not a psychological invention but a religious one. While this may be true for 'confessing one's sins/issues', I believe the act of telling one's sad story in order to reach its resolution is a peculiar invention of psychology. Rose (1989) has made a similar argument using Foucault's theories. He cited the example of the confessional interview of the therapist, which he juxtaposed with the confessing of one's sins to a priest. While church confession was about being absolved of sin, the psychotherapeutic confession is an opportunity for people to become 'entrepreneurs of themselves'. People construct themselves as consumers shaping their lives through choices that they have made. These choices are heavily mediated through cultural expectations and pressures, but they *appear* to be the unique selections of the acting agent. The grief memoir is a prime example of this kind of confessional. While the content of the memoir can take many forms and, therefore, has the *potential* to rebel against the psy-disciplines policing of 'proper' grief, the writers are also products of this culture and, therefore, cannot transcend it. Indeed, the very rejection of the privatization of grief is a reinforcement of its centrality within the culture.

One excellent recent example is Joan Didion's highly acclaimed memoir *The Year of Magical Thinking* (2005). It won the National Book Award in November, 2005, and was a finalist for the National Book Critic's Circle Award. It was also short listed for the Pulitzer Prize for the Biography/Autobiography section in 2007. It was an international best seller and became a Broadway play (starring Vanessa Redgrave in the lead) that was

sold out every night (Didion, 2007). Due to the high volume of its sales and its widespread coverage in the media, it is a good example of a recent grief memoir that can illustrate the impact of the psy-disciplines constructions on contemporary writers expereince of grief. A memoir like Didion's is both a window into the experience of modern grievers and an excellent illustration of how these experiences further get looped into the consciousness of other readers.

The memoir is a sparse and detached re-telling of the year after Didion's husband died suddenly at the dining room table. Unlike other grief memoirs, Didion does not spend much time describing her feelings, but rather focused mostly on detailing her cognitive irrationalities as a result of her grief. She wrote:

> it was deep into the summer, some months after the night when I needed to be alone so that he could come back before I recognized that through the winter and spring there had been occasions on which I was *incapable of thinking rationally.* I was thinking as small children think, as if my thoughts or wishes had the power to reverse the narrative, change the outcome. In my case this *disordered thinking* had been covert, noticed I think by no one else, hidden even from me, but it had also been, in retrospect, both urgent and constant. (Didion, 2005, p. 35). (Italics added)

Her "disordered thinking" included wanting to avoid the obituaries, wanting to keep some of her husband's clothes, and wanting an autopsy to understand the cause of his death. While these thoughts are entirely understandable in the context of such a

sudden, devastating, and unexpected loss, Didion's understanding of herself as irrational, and 'out of her mind', is a reification of the psy-conception of grief as making people crazy and in need of help. The above cited paragraph describes Didion's thinking only a few months after her husband had suddenly died. This phase also coincided with her daughter being ill in the hospital (who died later that year). When understood in context, Didion's thinking and her experience of grief does not seem magical or irrational at all, but rather a reasonable response to protect herself from the overwhelming pain of losing both her husband and only child within such a short time.

Didion wholeheartedly embraced the psychologized version of grief in her memoir in other places as well. She cited Lindemann's 1944 paper which I described in detail in chapter one. Lindemann (1944) was one of the first to advocate for a psychiatric view of grief and urged psychiatrists and doctors to get involved in treating the 'grief stricken'. In the next chapter, she begins with this paragraph: "The power of grief to derange the mind has in fact been exhaustively noted. The act of grieving, Freud told us in his 1917 Mourning and Melancholia 'involves grave departures from the normal attitude to life'" (Didion, 2005, p. 34). While she goes on to include the rest of Freud's quote which stated unequivocally that grief *is not* a pathological condition, the reader is left with the feeling that this somehow an oversight and that Freud meant the opposite.

She also incorrectly cited Melanie Klein's *Mourning and It's Relation to Manic-Depressive States* (1944) as evidence of her argument that grief "deranges the mind" (Didion, 2005, p. 34). As I noted in chapter one, Klein (1944) was referring to the

developmental process of babies, and when she spoke of mourning, it was about losses in childhood, such as when the infant is weaned and is mourning the loss of the mother's breast. The power of grief to derange the mind, has in actuality, not been "exhaustively noted" and as I showed in the previous chapters, is a recent invention of 20th century psychology and psychiatry.

This does not stop Didion from continuing to understand herself within this paradigm. She turns to the National Academy of Sciences 1984 publication entitled *Bereavement: Reactions, Consequences and Care* which outlined the five stages of grieving that Didion immediately recognized in herself. She also referenced *The Merck Manual,* that described two kinds of grief. Didion (2005) wrote:

> the preferred kind, the one associated with "growth" and "development", was "uncomplicated grief", or "normal bereavement". Such uncomplicated grief... could still typically present with anxiety symptoms such as initial insomnia, restlessness, and autonomic nervous system hyperactivity but did "not normally cause clinical depression, except in persons inclined to mood disorder". The second kind of grief was "complicated grief", which was also known in the literature as "pathological bereavement" and was said to occur in a variety of situations. (Didion, 2005, p. 48)

In a demonstration of the looping phenomenon, Didion begins to question whether she has pathological grief and asks herself the diagnostic questions she reads in *The Merck Manual* to determine whether she is grieving correctly. While she does not

conclude anything definitive about her own status as a pathological griever, she begins to consider "these questions" (p. 49) about whether she is suffering from pathological grief. Interestingly, Didion then begins to engage in a heated dialogue with the literature on complicated grief. After being introduced to the concept, she comes across a professor of psychiatry named Volkan (who I mentioned in previous chapters) in her research. Volkan engineered 're-grief therapy' to treat 'established pathological mourners'. Didion (2005) cited Volkan as writing:[50]

> We help the patient to review the circumstances of the death - how it occurred, the patient's reactions to the news and to viewing the body, the events of the funeral. Anger usually appears at this point if the therapy is going well; it is at first diffused, then directed towards others, and finally directed towards the dead... using our understanding of the psychodynamics involved in the patient's need to keep the lost one alive, we can then explain and interpret the relationship that had existed between the patient and the one who had died. (Volkan, in Didion, 2005, p. 55)

Following this passage, Didion's writing takes on an enraged tone that is directed at Volkan. She questioned where he derived his "unique understanding of the 'psychodynamics involved in the patient's need to keep the lost one alive', their special ability to 'explain and interpret the relationship that had existed between the patient and

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[50] I purposefully use Didion's book here to cite Volkan (as opposed to using his original research) for this chapter. My aim is not to deconstruct Volkan's work (this is partly accomplished in previous chapters), but rather to illustrate looping, or how contemporary grievers take up psychological works and incorporate them into their own understandings of grief. As such, I use Didion's lens here to examine what *she* picked up from Volkan's work.

one who had died'?" (p. 56). She goes on to state, "I don't need to 'review the circumstances of the death.' I was there. I didn't get 'the news', I didn't 'view' the body. I was there" (p. 56).

Interestingly, while it appears at first that Didion will reject the diagnosis of complicated grief, she silenced her own anger at being pathologized by further interpreting her experience within the context of the psy-disciplines. She continued, "I catch myself, I stop. I realize that I am directing irrational anger toward the entirely unknown Dr. Volkan in Charlottesville" (p. 57). Indeed, Didion realized at this point that her 'irrational anger' was as a result of her pathological grief. The next few lines in the memoir cite Volkan again, who wrote, "Persons under the shock of genuine affliction are not only upset mentally but are all unbalanced physically. No matter how calm and controlled they seemingly may be, no one can under such circumstances be normal" (Volkan, in Didion, 2005, p. 57).

The looping of the psy-classification of grief as pathological and the impact it has on Didion's understanding of herself is clearly evident in these passages. First, her initial resistance to the category of pathological grief is an indication of its significance within the culture. The engagement with the classification is a reinforcement of its reality, and an illustration of how it is only necessary for a category to be part of the abnormality paradigm for it to shape people's understandings of themselves. The further dialogue she had with the construct, and the process by which she concluded that her own angry reaction to being pathologized is a *symptom* of the very diagnosis she resisted is a clear

example of a negotiation with the psy-classification of grief, ultimately co-opting it as part of her identity.

Ironically, the very reiteration of these ideas in her widely-popular memoir also has a kind of looping effect. As people read the memoir, they learn about the ideas of complicated grief and take their cue from Didion and begin to self-evaluate on these continua as well. This is especially true for a memoir that is as widely read and well received as this one, written by a prize winning author whom people respect and admire.[51]

Outcome for the Grievers

What then is the outcome of these representations on people's experience of grieving? How do these experiences then feed back and change the classification itself, loop upon loop? A documentary entitled *Selling Sickness* (2004) was recently aired on television. It was about pharmaceutical companies selling the concept of mental disorders in order to then make a case to treat them with medication. As I explained in chapter two, a mental illness must be constructed first within the abnormality paradigm in order to make a justification for treating it with either therapy or drugs. David Healy, whose work I discussed in chapter two, was interviewed about this phenomenon. While

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[51] Didion's (2005) book has become so popular, it has also been featured in several popular media outlets. Some examples retrieved from Wikipedia (2007b) and confirmed by doing additional research include the following: The book appears in the ninth episode of *Commander in Chief (TV series), The Mom Who Came to Dinner:* president *Mackenzie Allen's* mother, *Kate Allen*, has fallen asleep while reading it; The book appears in an episode of *Gilmore Girls*. (Season 6, Ep. 15, *A Vineyard Valentine*); The book is quoted by Del.icio.us founder Joshua Schachter in an interview with *John Heilemann* of CNNMoney.com; *Gore Vidal* refers to the book helping him through the loss of his partner Howard Auster in 2005; During a 2007 interview with pop-star *Madonna* and husband *Guy Ritchie* at the premier of Guy's movie *Revolver*, Madonna was asked what book she was currently reading. Her answer was *The Year of Magical Thinking* by *Joan Didion*. (see: *http://en.wikipedia.org/wiki/The_Year_of_Magical_Thinking*)

he warned about the over prescription of antidepressant and antipsychotic medications, his concern was also with the fact that pharmaceutical industries "are changing the very meaning of what it means to be human" (Scott et al., 2004).

While Healy did not talk explicitly about the looping phenomena in the documentary, his comment brought home the impact of what looping can achieve in the 21st century. The power of the psy-disciplines to construct categories of human experience not only give people a new frame in which to understand themselves, but as has been evident throughout this chapter with the example of grief, construct new ways of being, thinking, and feeling. As Healy eloquently noted, when psy-kinds become looped into public consciousness, they change the very meaning of what it means to be a human being (Scott et al., 2004). On this, Hacking (1995) noted:

> To create new ways of classifying people is also to change how we can think of ourselves, to change our sense of self worth, even how we remember our own past. This in turn generates a looping effect, because people of this kind behave differently and so are different. (p. 369)

Foucault's theories are instructive here. In the previous chapter, I described the move from internment houses in the 18th century to mental institutions in the 19th century, where the mentally ill were freed from the material bonds of chains and shackles but were subject to a new kind of discipline. Foucault (1976), described Pinel as "reconstituting around them [the mentally ill] a whole network of moral chains that

transformed the asylum into a sort of perpetual court of law...sanctions were immediately applied to any departure from normal behaviour" (Foucault, 1976, p. 71).

In the 20th century, these 'moral chains' became further internalized, and while mental institutions have almost entirely disappeared, Foucault described a new kind of social discipline introduced, and imposed by the psy-disciplines that becomes self - fulfilling and self-enforced. The 'institution' moved from an external, imposing figure to an internal, self-regulating mechanism so pervasive it had become innate and invisible.

In *Discipline and Punish* (1977) Foucault used the metaphor of the panopticon to describe this process. The panopticon is an architectural metaphor that described a way of arranging people so that they seem to be continually observed, but they themselves cannot see the observer. In the example of a prison, the guard has visual access to all the prisoners, while the prisoners themselves cannot see the guard. What this achieves is a sense that one is continually being watched (regardless of whether the guard actually exists) and, as a result, the prisoner will begin to self-discipline and monitor themselves in order to avoid punishment (Foucault, 1977). In a thorough explanation of this, Mills (2003) wrote:

> Discipline consists of a concern with control which is internalized by each individual: it consists of a concern with time keeping, self control over one's posture and bodily functions, concentration, sublimation of immediate desires and emotions - all of these elements are the effects of disciplinary pressure and at the same time they are all actions which produce individuals as subjected to a set of

> procedures which come from outside of themselves but whose aim is the disciplining of the self. These disciplinary norms within Western cultures are not necessarily experienced as originating from institutions, so thoroughly have they been internalized by individuals. Indeed, so innate and 'natural' do these practises appear that we find it hard to conceptualize what life would be like without [them]. (pp. 43-44)

Grief, as has been illustrated throughout this paper, is a prime example of this kind of disciplining. The discipline involved with the psy-construction of grief, which becomes thoroughly looped through mainstream media, consists of all the things I have described throughout - the obligation to be 'normal' in one's expression of grief; the evaluation of oneself on psychological terms of what normal versus pathological grief looks like; the attempt to follow the orderly five stages of the grieving process; the pressure to turn one's grief into a celebratory experience for personal growth; the pressure to do one's grief work; and the obligation to seek professional, psychological help if one cannot do this on one's own.

Not only does this process result in this kind of behavioural discipline, but it also changes the meaning and experience of grieving for the individual. To conceptualize grief as an illness or a disease that can be cured with therapy or medication is to individualize and privatize what used to be a communal responsibility of grieving the dead. The result for the grieving person is profoundly felt on an individual level as is

evidenced by all of the things grieving people *need,* and s*hould* do, but is also felt by the society in which the grieving person lives.

One of the primary outcomes of the psy-construction of grief is the creation of a culture where these kinds of expectations and scripts around grief become the norm regardless of whether they are viable or helpful for those who are grieving. Indeed, as I have been indicating throughout, much of this kind of grief discipline is untenable and places enormous demands on the mourner. As a result, people who believe they *should* meet these grieving milestones feel they need professional help to achieve these goals. The psychological imperative of accepting and resolving one's grief is a good example of this pressure. Many people will never accept or resolve their sadness over losing someone they have loved. The pressure on them to do so, however, not only makes them self conscious about whether they are doing their grief work properly, but also infuses them with a sense of guilt and failure over being unable to meet these enormous demands. The outcome for the mourner is a sense of shame and embarrassment over both their sadness and their inability to overcome it. The next chapter will be devoted to examining the shame and embarrassment of the mourner as a result of the psy-construction of grief and its relationship with a culture that denies and fears death.

Chapter Four: Diffusion

The last chapter looked at the effects of the psy-construction of psychologized grief on the individual mourner. I argued that the understanding of grief as a therapeutic endeavor that gets represented and conveyed through media outlets puts untenable demands on the mourner. As a result, they follow the cultural script of seeking professional help for their grief, and then further modify the classification as they begin to take it on as an identity. I also illustrated how the psy-disciplines have come to replace religious institutions in the 21st century as the experts in constructing narratives around death, dying, and grieving for the public. While the last chapter examined the effects of psychologized grief on the individual, and the ways in which the individual, in turn, changes the classification, this chapter will focus on the collective repercussions of grief being constructed and subsequently experienced as a disorder.

In this chapter, I argue that the language of death, and subsequently also the language of grief has been denied in Western culture; when it is addressed, it is understood as a psychological problem necessitating therapy or medication in order to get the grieving person back to 'normal' as quickly as possible. The pressure on the griever to appear normal has resulted in a new experience of contemporary mourning that includes shame and embarrassment at one's bereaved condition. I examine three intertwined cultural discourses that support and enforce this psy-construction of grief including fear of the body and emotions, the denial of death, and the contemporary progress narrative that does not allow for expressions of prolonged sadness. A significant

outcome of all three of these discourses, which set the foundation for the psy-construction of grief as pathological, is the shame of the mourner that I began to talk about at the end of chapter three.

Shame

To understand grief as a disease, or a mental disorder, or to think of oneself as in a condition requiring psychological help, is embarrassing (Gilbert, 2006). The connotation of disease, disorder, or illness is contrary to the Western ideal of being healthy and taking care of oneself (Seale, 1998). While it is now more acceptable to have mental illness than it has been in the past, there remains a stigma around mental disorders that makes one feel inadequate (Horwitz & Wakefield, 2007). The psychological construction of grief as a diseased state has had a similar effect on contemporary mourners.

It was not always this way. Up until the late 19th century, grieving in North America was a public affair, a clearly visible marked process that involved community and a network of public rituals and ceremonies elaborately constructed to support the mourners (see: Ashenburg, 2002). Aries (1981) has argued that dying and mourning have been constructed as scandalous in 20th century Western culture. We have, according to Aries, on the one hand, "eliminated [death's] character of public ceremony, and made it a private act, and on the other hand, associated with this privatization of death was the second great milestone in the contemporary history of death: the rejection and elimination of mourning" (p. 575).

On this topic, Gorer (1967) has suggested that death, and subsequently mourning is treated with the same prudery as sexual impulses and sexual expression were a century ago. The idea that grief is shameful or embarrassing is a phenomenon that others have written about. In his now famous book, *A Grief Observed*, C.S Lewis (1961) wrote of his 'embarrassing' state as a grieving man. Writing about his desire to speak of his dead wife, Lewis (1961) described the reactions of those around him. "The moment I try [to bring up his wife] there appears on their faces neither grief, nor love, nor fear, nor pity, but the most fatal of all non-conductors, embarrassment. They look as if I were committing an indecency" (p. 21). He goes on to suggest that perhaps the bereaved "ought to be isolated in special settlements like lepers" (p. 23).

The leper analogy is a good one. In the old testament, one became afflicted with leprosy as a result of gossiping or speaking badly about someone behind their backs. The 'punishment' was visceral and visible (Stone Chumash, 1993). One would be separated and ex-communicated for a period of time causing a deep sense of embarrassment and shame for the person afflicted. When Lewis (1961) mused about being "isolated in a special settlement like a leper" because of his bereavement, he was talking not only about the interpersonal isolation that happens when one is grieving, but also about the shamefulness, embarrassment, and sense of personal responsibility for his sadness.

The Oxford dictionary defines embarrassment as "a feeling of self-consciousness, shame, or awkwardness" (Thompson, 1998, p. 282). The English word "embarrassment" comes from the French root 'embarasser' which means to "encumber,

hamper or impede". To be embarrassed at one's mourning's is to feel shame and awkwardness; it is to feel like one is impeding or hampering others. In chapter three, I spoke briefly about care of the self being an individual project. In contemporary North America, one is obligated to care for oneself by seeking professional help for one's problems or one will be viewed as an imposition on others (Seale, 1998). The state of grief is a shameful state, primarily because one is considered to be diseased or at the very least *potentially* diseased or disordered. While the psychologization of grief affects the individual mourner and changes their experience of what it means to be a griever, it also affects, and simultaneously is affected by the society in which they live. In addition to the stigma already discussed surrounding mental illness, I propose that three other discursive factors interact with the psy-conceptions of grief to produce shame for the mourner.

Fear of the Body and Fear of Emotion

The meaning of embodiment. Embodiment theory offers another way in which to understand the shame of the mourner. Embodiment rejects Cartesian duality in favor of a philosophy of phenomenology. Phenomenology, in turn, emphasizes both the cerebral and the sensual subjectivity of the agent as foundational elements to one's psychology, epistemology, and ontology (Birke, 2004; Grosz, 1994). Postmodern thinkers have critically examined *how* embodied subjectivity is discursively constructed within and across cultures. Theorists in this genre argue that embodiment as a source of knowledge cannot be denied and that, further, it is necessary to deconstruct the discourses

surrounding the body in order to understand the totality of any human experience (Bordo, 1987; Butler, 1997, 1999; Minh-Ha, 1989).

On this matter, Csordas (1994) distinguished between the objective physiological body and the phenomenological body to argue that the body is "the existential ground of culture and self" (p. 4). Csordas contends that the body is a matrix for the "production of personhood and social identity..." (p. 13) and it is dual in that the body is phenomenologically both "a set of individual psychological or sensuous responses and a material process of social interaction" (Csordas, 1994, p. 13). Although this phenomenological account claims there is no inherent gap between the mind and the body, it also argues that the way in which this phenomenology is experienced will be heavily influenced and inscripted by cultural processes (Csordas, 1994).

The shameful body and outlaw emotion. Theorizing in the Western philosophical tradition has a long history of being disembodied. Based on the Cartesian dissassociative split between mind and body, the Western intellectual tradition has considered the body irrelevant and thus easily dismissible. "The processes of theorizing and theory itself have proceeded as through the body itself is of no account, and that the thinking subject is in effect disembodied, able to operate in terms of pure mind alone" (Price & Shildrick, 1999, p. 1). The assumption in this ontology, which has dominated the patriarchal academic tradition, is that knowledge cannot come from or through the body.

One of the ways in which fear or shame of the body in psychology is practiced is in the notion that emotions are embodied and subsequently irrational and out of control.

Jagger (1992) noted that within the western philosophical tradition, the rational has been contrasted with the emotional as acceptable modes of acquiring knowledge and this dichotomy has been linked with other dichotomies connecting reason, mind, and objectivity with masculinity, and emotion, body, and subjectivity with femininity.

Jagger (1992) traced the history of emotion from the Greeks, who viewed emotions as necessary for reason (but argued that they needed to be harnessed and directed in order to be productive), to the rise of modern science, where the realms of nature and value were separated. In the process of re-conceptualizing reason as separate from human values, "the validity of logical inferences was thought independent of human attitudes and preferences; this was now the sense in which reason was taken to be objective and universal" (p. 146).

In order for reason to be considered objective and universal, it was necessary to also re-conceptualize emotion. Whereas it was once the case that emotion simply needed to be directed, it was now necessary to conceptualize emotion as being out of control and irrational in order to justify their eradication from scientific inquiry. On this, Jagger (1992) pointed out that the modern re-conceptualization of rationality portrayed emotions as:

> nonrational and often irrational urges that regularly swept the *body*, rather as a storm sweeps the land. The common way of referring to the emotions as 'passions' emphasized that emotions happened to or were imposed on an individual, something she suffered rather than something she did. (p. 146)

Emotions were seen as nonintentional, primal, and physical/embodied forces that were in constant war with the rational, logical, reasonable, and 'in control' minds. Within this process of re-conceptualizing rationality in modern science, the body and emotions become inexorably linked and both were seen as being out of conscious control, and thus, untrustworthy as sources of knowledge; fear of both, according to Jagger, is what characterized the ontology of positivism that subsequently ensued (Jagger, 1992). This epistemology, which is the basis for modern psychological inquiry, is rooted in empirical testability and emphasized that 'true' scientific knowledge must be able to be inter-subjectively verified and thus should be free from emotional/embodied 'contamination'. The only way to achieve this kind of 'objectivity' was to establish scientific methods that neutralized and eradicated all values and emotions of the scientist, effectively disembodying them from their own subjectivity (Jagger, 1992).

Within the Western philosophical tradition, disembodied reason is preferred to embodied emotion and those who are deemed the most reasonable and the least emotional are also those that hold the most political, social and cultural power. The relationship between this dichotomy and our modern ontology has a profound influence on the way in which we are taught to act in day to day life. On this Jagger (1992) related, "In these circumstances, where there is a differential assignment of reason and emotion, it is easy to see the ideological function of the myth of the dispassionate investigator" (p. 158).[52]

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[52] For other accounts of the bifurcation of emotion from reason in the history of philosophy, see: Damasio, (1994) and Lloyd (1993).

Whereas Jagger, a feminist philosopher, was speaking within the context of the 'outlawing' of gendered, embodied emotions within scientific practice, her ideas can be extrapolated to the way grief has been constructed in psychology and the kind of influence they have on the way people grieve.

Shameful grief and the shameful body. The modern, scientific epistemology outlined above that dichotomizes, and privileges reason over emotion, and the mind over the body, has infiltrated the understanding and construction of grief in modern society. The shame associated with the body, and the emotions that 'erupt' from it, have led to a shaming and silencing of the emotional pain that accompanies grief. Subsequently, people are expected to take control of their grief so that it does not become too expressive, too overwhelming, or too visible. The messiness of grief is unattractive and even threatening in a culture that prizes control, order, and rationality (Bauman, 1992).

These discourses are heavily intertwined within the psy-construction of grief. The demand that people deal with their grief behind closed doors, in a rational manner, with a professional who can help them cope with it privately, is situated within an ontological frame that privileges the rational and the disembodied, over the emotional and expressive.[53] As discussed in chapter two, grief is heavily policed by the psy-disciplines to ensure that it stays 'under control'. An over-expression of grief, or grief that goes on too long, is considered pathological and in need of immediate intervention such as therapy and medication. The point of these intrusions is to make sure people 'stay on

[53] For a historical review on how rationality and emotional control became central to psychological narratives of the self see: Illouz (2008).

track' and get back to normal as soon as possible. As was illustrated in chapter three, these messages get taken up and experienced by the public as new norms around grief. People who keep can keep their grief under control are lauded, celebrated and held up as models of having 'good character'. Moreover, the message in the public sphere is that one should be diligent about screening oneself for pathological grief (i.e., Didion's self-diagnosis of CG), one should "maintain a normal routine" (i.e., Dr. Phil) and, one should seek help for their grief so that they could "stop messing up their lives" (i.e., the film *Ordinary People*).[54]

While the embodiment theory I described above has to do with the association of the body with emotion, and the subsequent fear of both, I also contend that the vulnerability of the physical body is another anxiety particular to 21st century North American culture. The obsession with healthiness, youth, eating right, and exercising are just a few contemporary practices that are illustrative of the fixation with developing and maintaining the strength and youthfulness of the body. All of this hard work is in the hope of avoiding the disintegration and illness of the body and ultimately is an attempt to prolong one's life (Bauman, 1992). Hence, fear of the body has to do with the fear of the uncontrollable emotions that come out of it but it *also* has to do with the fear of the

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[54] Illouz (2008) wrote, "In its therapeutic version, self control must be manifested in an upbeat, smiling, agreeable attitude. From the 1930s onwards, almost all guidebooks on successful management emphasized the value of positive talk, empathy, enthusiasm, friendliness, and energy, with the more recent guidebooks advocating a blend of spirituality with a therapeutic call to dispel performance anxieties, to nurture oneself, and to entertain positive thoughts about oneself and others" (p. 81). While Illouz referred here to corporate culture and the management of emotion within the workplace, I believe that this psychological worldview has become an epistemological ideal that has influenced the way in which grief is experienced. To 'stay in control' is to deny, or at the very least, to manage one's grief in the privacy of one's own home, and to retain an upbeat and cheery demeanor when in public. This point will be elaborated on in the section on the 'progress narrative'.

materiality of the body itself.

In his book, *Constructing Death,* Seale (1998) made a useful distinction between the biological body, which, in the case of death, refers to the actual ending of a person's physical life, and the social body, which has to do with the death of a certain way of living. He wrote, "the material realities of the ageing, diseased and dying body exercise a determining influence on participation in culture" (p. 49). Participation in culture includes being able to contribute to the economy, eating with others, and participating in social relationships. The dissolution of the body, or what Seale called "the material realties of ageing and disease" hinder the possibilities for these contributions. This social death can be even more frightening than biological death. Seale contended that fear of the body (and subsequently, in my view, fear of mourning which is a reminder of our impeding vulnerability and mortality), or what he called fear of embodiment, is in actuality the fear of death. In other words, we fear the vulnerability of our fragile bodies because we don't want to die, either in the social sense or the biological one (Seale, 1998).

Denial of Death and Denial of Grieving

In the recent, award-winning novel, *The History of Love* (2007), the young boy who narrated the story told of his first experience of death. In this passage, he is left to watch over his uncle's corpse.

> My uncle was laid out on a slab of stone the color of raw meat with white veins. Once I thought I saw his chest rise a fraction and almost shrieked. But. It wasn't

> only him I was afraid of. I was afraid for myself. In that cold room, I sensed my own death... One day it would all be gone... the fear of death haunted me for a year. ... It wasn't that something new had happened. It was worse; I'd become aware of [death] what had been with me all along without my notice. (Krauss, 2007, p. 125)

According to Seale (1998), the fear of the vulnerability of our bodies is, in actuality, the fear of death. The idea that people fear, and thus, deny death in the 21st century West is called the 'the denial of death thesis' and has been expounded on by several contemporary thinkers who have written extensive histories of death (see: Aries, 1974, 1981; Glennys, 2007; Kellehear, 2007b; Ufema, 2007). While this paper is not about death, it is important to speak about the death denial thesis because it is related to the way grieving is conceptualized in the contemporary West. The denial of death[55] has also partly led to the denial of grieving. I say 'partly' because it is impossible to disentangle the many threads weaving the tapestry of 21st century Western culture when it comes to grief. For example, the psy-disciplines construction of grief as a disease to be treated is partly a *response* to the denial of death phenomena, but also partly a *result* of it. While fear of the body and fear of death in relation to grieving are part of the 21st century cultural scripts of personhood, for most people they become known through psychological representations of grief (see chapter 3 for examples) and not through the theories that are discussed in this chapter.

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[55] For a thorough review of the denial of death thesis, see Ernst Becker's *The Denial of Death* (1973).

Kellehear (2007a) aptly noted that the historical experience of death has yielded one consistent finding when it comes to the sociological response to death:

> Wherever and whenever there has been a clear social picture of death - one populated by afterlife images of social life and other beings - there has also been a corresponding clear social role and reaction for grieving and dying people. Wherever and whenever death has been asocial - a content-free nothingness, an extinction, or a disappearance - the roles of dying and grieving have also been hidden, embarrassing, and lacking social direction and legitimacy. (p. 72)

In other words, when death is an integrated, visible, and accepted part of the culture, grieving is as well. When death is denied, avoided, or relegated to the margins, grieving also becomes silenced and hidden. Gorer (1967), whom I mentioned briefly in the introduction of this chapter noted the decline of mourning rules and rituals in England and North America in his anthropological studies of the bereaved. He argued that both cultures no longer know how to treat death or mourning because the rules for both have been eradicated, and therefore, people no longer know how to handle grief either. He noted several trends that support the denial of death thesis as being related to the denial of mourning. One of these included the rise of modernism that coincided with the decline in religion and the belief in science instead of God (Gorer, 1967; also, see, Lewontin, 1993).

The main tenets of modernism are an emphasis on scientific rationality, reason, observation, and a belief in continuous progress (Gergen, 1991, 1992). Modern life emphasises goal directedness, functionality, scientific evidence over religious belief, and

rationality and efficiency in all areas of living. Science values empirical evidence and believes only what it can see and prove (Bordo, 1987). In the case of death, science can only claim that it is the end of the physical body and for all intents and purposes means that it is the end for the person. It is understandable why death is so overwhelmingly frightening within this paradigm. If one believes that it is really the last stop and nothing continues on afterwards, then there is nothing we can do to plan for it and nothing to hope for (Kellehear, 2007b).[56]

Bauman (1992) noted that in this scientific and secular culture where death has no meaning other than the end of life,[57] "we may offer the dying only the language of survival; but this is precisely the one language which cannot grasp the condition from which they can hide no more" (p. 130). The language we do have is what Bauman called the "instrumental language" of survival; this is a language of production and of doing, it is the language of advice, therapy, and self-help books, which cannot help the dying since, no matter how hard the culture tries to avoid death, no one is exempt from it.[58]

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[56] *Everyman*, the well- known medieval mortality play poignantly depicts humanity's encounter and fear of death (Everyman, 1917). Everyman is visited by Death and told to prepare for his own demise and to meet God. Everyman becomes anxious and frightened and searches for help from his 'friends' including 'Fellowship', 'Worldly Goods', 'Knowledge', 'Beauty', and 'Strength'. The moral of the play is that while none of these traits will go with him, 'Good Deeds' is willing to accompany him to the grave. The Christian message in the play is clear: religion and good deeds give meaning and context to one's suffering and death. Today's Everyman, however, is mostly secular and does not have the religious buffer to assuage his/her anxiety about death.

[57] Bauman (1992) wrote, "Death is nothing but waste in the production of life; a useless leftover, the total stranger in the semiotically rich, busy, confident world of adroit and ingenious actors. Death is the *Other* of modern life" (p. 131).

[58] In the recent memoir of his famous mother's death (Susan Sontag), David Rieff (2008) gave an excellent example of this instrumental language that results in euphemisms about death and dying. He and his mother (who had been diagnosed with a lethal form of blood cancer) peruse the medical brochures about her

Bauman (1992) also noted that since this instrumental language does not allow one to communicate with the dying, people remain silent and refuse to acknowledge death at all.

> It is the impossibility to communicate, the silence between us, the cowardly silence that hides the impotence, that is the deepest cause of embarrassment. Our usual resourcefulness and industry have failed us, and this is something to be ashamed of in the world that measures human quality by the amount of know-how demonstrated in the efficiency and effectiveness of action. (p. 131)[59]

Indeed, death is mysterious and unknown and, therefore, frightening and out of control. The finitude of death in this paradigm means that there is little room for the person grieving to express their sorrow. The grieving person is a reminder of death and death, as Bauman (1992) noted, is too scary to contemplate within this worldview.

The scientific paradigm also supports the use of technology to solve all of one's problems. The technological imperative supports the belief that if something can be done, it should be done (Callahan, 1993; Cassell, 1991). Turning to psychological services to cope with one's grief is a prime example of how the scientific paradigm deals with grief;

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disease. He wrote: "In the end, what is really unconscionable is the way in which the brochure is written in the language of hope, but in fact offers almost none to anyone reading with care" (pp. 55-56). Several pages later he continued, "the gap here between language [of hope and euphemisms about death] and reality [that one is going to die and there is nothing to do about it] is simply too great" (p. 58). Rieff's memoir can be read as a particularly adept and poignant text that reflects contemporary North American fear of death. The memoir primarily examines Sontag's intense fear of her own demise and the extreme measures she and her physicians were willing to take to attempt to prolong her life. The memoir also serves as another example of one stage of the looping process: how societal understandings of death, and psychological notions of dying, are taken up and understood by cultural agents such as Sontag and Rieff.

[59] On this Rieff (2008) asked, "How to reconcile the reality of human mortality with the reigning assumption in the rich world that every disease must have a cure, if not now then sometime in the future? ... the logic is that death is somehow a mistake, and that someday that mistake will be rectified" (p. 61).

as outlined in chapter three, the psy-disciplines co-opted what used to be a religious narrative to explain, and deal with death. The use of 'empirically validated therapies,' for example, can be considered an attempt by the psy-disciplines to try to control, and make order out of the chaos and mystery of death and grieving. The idea being that since we cannot empirically prove that there is an afterlife, at least we can control the grieving process. The popularity of Kubler-Ross' (1969) stage theory of grieving that I discussed in chapter three is a prime example of the contemporary scientific paradigm that produced a set of orderly stages and supports the illusion that one can predict and control what is happening because of the *perception* of good science.[60] As I noted in the previous chapter, Kubler-Ross' stage theory of death was constructed from interviewing people at the end of their lives. As her theories got looped into to the public sphere, however, they were picked up and modified to adapt to all losses. Regardless of how 'scientific' her work actually was, what is relevant in the context of understanding her immense popularity is the *perception* of her research being based on sound, empirical and scientific evidence.

Gorer (1967) connected the denial of death to the denial of mourning when his participants reported hiding their grief in order to avoid imposing their sadness on others

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[60] Similarly, and perhaps ironically, the person who does believe in God and an afterlife is also discouraged from grieving. I wrote about this in chapter three when I outlined the messages in self-help books about celebrating death and rejoicing in it because, as Kubler-Ross claimed, it is simply a 'transition point' or a 'graduation' to a higher level of consciousness. In this way of thinking, one does not mourn because death is just the next step in the journey and the dying person has moved on to a 'better place'. This too is a kind of denial of death; no matter what one believes happens to the dead person, the reality is that they no longer exist in the same way they did before. Denying one's grieving because the person is in 'a better place', is a denial of the fact that while they may have moved on to another realm, they are still not present to talk too, touch, and be with, in the same way as before.

or appearing psychologically ill. Here, it seems that the psy-conception of grieving as pathological had an effect on a person's wish to avoid speaking of death and subsequently showing their grief. Gorer wrote:

> [hiding grief] has several components. One is the generous wish not to make others unhappy in one's misery, particularly to protect children from the infection of grief. Frequently coupled with this is what might be described as pathological hypochondria, a belief that giving way to grief and mourning is 'morbid' and 'unhealthy', and that psychological health will best be maintained by endless trivial distraction - by continuing to be as active as possible...the only way to cope with grief is to keep busy, to keep going out and see a lot of friends and so on. (p. 73)

Several important themes of the death denial thesis are highlighted in this paragraph. Gorer's referral to grief as an infection is purposeful and, as I outlined in the introduction to this chapter, the idea that grief is a contagious disease that can be passed on like an infection is part of the underlying cultural script about public expression of grieving. The diseased are cordoned off, or to use Lewis's analogy, are like lepers that are isolated in order to avoid infecting others with their sadness.[61] Robert Fulton (1965) used

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[61] The cordoning off of death and grief into a private, gated sphere so as to control it, and have order over it, happens on a micro-level with the individual (i.e., seeking grief counseling) and on the meta-level with societal expectations of who should deal with death and grief. The mortuary industry, palliative care units, and grief counselors (all to be discussed in the next section) have taken over the role of mediating and handling grief and death so that no one else has to deal with it. The fear of death and grief is so pervasive and so wide-ranging it has even disappeared from the general education of health professionals who deal with death and grief daily. Wass (2004) reviewed the current state of death education for health care service providers and found that less than a fifth of the students in health-related professions have exposure to death education. In American and British surveys of medical, nursing, pharmacy, and social work

the same contagion analogy to show the relationship between fear of death and fear of mourning.

> We are beginning to react to death as we would communicable disease...death is coming to be seen as the consequence of personal neglect or untoward accident. As in the manner of many contagious diseases, those who are caught in the throes of death are isolated from their fellow human beings. (p. 4)

The second important point Gorer made is with the idea of putting on a happy face in order to avoid imposing on others and meet the needs of the culture to deny death and grief. While I will talk about this in the next section when I discuss the progress narrative, it is related to Gorer's third point, which is the cultural belief that psychologically healthy people are not sad or morbid; in an attempt to be 'normal' and in their fear of being pathologized, the grieving person is expected to appear as if nothing is wrong and go on with their life. This pressure creates a new experience for the griever. While some people may feel pride at their ability to keep their feelings under control (e.g., the accolades for Luke Russert in the media may have been a source of pleasure for him and his family), for most people, these demands are untenable. The griever then, experiences a sense of shame and embarrassment at being unable to meet the explicit and implicit messages around handling their grief in a 'rational' way. Indeed, Luke Russert is a cultural signifier. He served as both a model of the 'right way to grieve' and a

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schools, Dickenson and colleagues found that while there was some education on grief, it was minimal and not very helpful for the service providers (Dickinson & Field, 2002; Dickinson, Sumner & Frederick, 1992).

barometer of what this culture considers to be normal when it comes to the expression of sadness. The modern griever has now become one who questions and assesses their sadness within the abnormality paradigm, and often feels shame and embarrassment as part and parcel of their experience of grief. On this Gorer (1965) wrote, "mourning is generally denied... [people] tend to treat mourning as morbid self indulgence, and to give social admiration to the bereaved who hide their grief so fully that no one would guess anything had happened" (p. xiii).

Aries (1974) made similar points in his widely read book, *Western Attitudes Towards Death.* In it, he traced the history of attitudes towards death from the Middle Ages to the present and outlined the historical changes in cultural understandings of dying and grieving. While death was omnipresent in the nineteenth century with funeral processions, mourning clothes, the spread of cemeteries, the visits to tombs and gravesites, the twentieth century saw a radical shift and a denial of the existence of death (Aries, 1974).

Aries (1974) wrote that the end of the eighteenth century saw a shift from the dying person themselves to a focus on his or her family to take care of them in their hour of death. Today, he, argued, the "initiative has passed from the family, as much an outsider as the dying person, to the doctor and the hospital team" (p. 89). This shift marked the transition from dying at home to dying in the hospital and being presided over by a medical team instead of one's family or one's priest. While Aries does not make the connection I spoke about earlier regarding the fear of the body and its relationship to fear

of emotion, he noted that the shift to the hospital has resulted in the focus being on what he calls an "acceptable" death. He wrote:

> an acceptable death is a death that can be accepted or tolerated by the survivors. It has its antithesis: "the embarrassingly graceless dying," which embarrasses the survivors because it causes too strong an emotion to burst forth; and emotions must be avoided both in the hospital and everywhere in society. One does not have the right to become emotional other than in private, that is to say, secretly. (p. 89)

An 'acceptable death', then, is one that is clean, orderly, and hidden in the hospital where it is private and medically supervised. The inability to express emotion, which I argue is connected to the fear of the body, is evidenced by this sequestering of death in the hospital (as well as other practices which will be described shortly), is what leads to a denial of mourning. Aries continued:

> too evident sorrow does not inspire pity but repugnance, it is a sign of mental instability or of bad manners; it is morbid... One only had the right to cry if no one else can see or hear. Solitary and shameful mourning is the only recourse. (p. 90)

Here Aries (1974) reiterated Gorer (1967) in outlining the public intolerance for grief and the fear of the mourner that they will be considered mentally unstable or pathological for showing their grief. Moreover, as I have been arguing throughout, this creates a new experience for the grieving person who now also fears imposing

themselves on others, and of having 'bad manners', so they turn their grief into a private affair. While Aries wrote about having the right to cry only when no one else can hear, the 21st century has turned this 'private space' into a psychological one where one goes to be healed from their sorrow.

Aries noted that several other practices have been both a result of, and a contribution to, the denial of death in the West. Embalming, for example, is the practice of preserving the human body to forestall decomposition so that it appears 'real' and 'human' at the funeral service.[62] Aries (1974) pointed out that while the meaning of embalming is a kind of refusal to accept death (the beautification and attempt to keep the body looking as alive as possible is a reflection of a culture that wishes to preserve the belief that the body is not really dead, but merely sleeping), he also noted that the wish to preserve the body so as to show it is a reflection of culture that is ambivalent about its denial. While Aries (1974) argued that part of the practice of embalming has to do with commerce and capitalism and the need to make death friendly in order to sell it, it is also because Americans are "very willing to transform death, to put make-up on it, to sublimate it, but they do not want to make it disappear" (p. 100).

The ambivalence about death is interesting to compare to the ambivalence about grief.[63] Just as with Aries' example of death being only partly denied and transformed

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[62] Embalming is a distinctly North American phenomenon. In some European countries, embalming is not allowed because of public health rules around corpses and burial.

[63] The ambivalence about death extends to other spheres as well. Gilbert (2006) noted that while death and grief have become increasingly sequestered to private spaces like hospitals and psychologist's offices, there simultaneously has also been a proliferation of images of death in the media. In addition to seeing more and more violent murders on TV and in the movies, we also have more access to images of war and

with 'make-up' and 'sublimation', in the West grieving has also shifted from a public ceremonial ritual to an elaborate private one. If grieving had been completely denied, we would assume that there would be no discourse at all about it, but as was illustrated in chapters one through three, this has not been the case. Grief has indeed been privatized, psychologized, and hidden, but it is still dealt with and spoken about within the professional sphere. In the same way that dying people have been evacuated from their homes to the hospital, embalmed, and buried by medical and mortuary professionals, grieving has also moved from the public to the private office of the psychologist or the psychiatrist. Another obvious parallel is the connection that Aries made between embalming practices and commerce; as I outlined in chapter two, the creation of certain concepts such as the pathologization of grief (or the need to embalm a body), is related to the need to make money and to professionalize a group of people who offer these services.[64]

While Aries (1974) did not make these parallels, he did connect the embalming process to the denial of death that is evident in the body that looks like its sleeping, which in turn, is connected to the denial of grief since the person is not *really* dead, and therefore, does not need to be mourned.

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subsequently see more dead people on our screens. While it is beyond the scope of this project dealing with grief to elaborate on this (see: Gilbert, 2006, chapter 9 for a thorough review of this thesis), it is another example of the ambivalence North Americans have about death. Other examples of media images of death include recent shows such as *Six Feet Under,* which deals with the funeral industry. It is necessary to note that while this show has been popular, it is not as widely accessible to the public since one must pay for specialty cable services to see it, and therefore, it cannot be considered to be mainstream.

[64] For an overview of the relationship between commerce and death, see Mitford (1963).

> In reality they [the mourners] are not visiting a dead person as they traditionally have, but an almost living one who, thanks to embalming, is still present, as if he were awaiting you to greet you or to take you off on a walk. The definitive nature of the rupture has been blurred. Sadness and mourning have been banished from this embalming reunion. (p. 102)

Interestingly, Seale (1998) observed a different kind of ambivalence regarding the death denial thesis that came to the same conclusion. He argued that social organization in the form of hospice, palliative care, and hospital preparation for death in late modernity is realistic and accepting of death in terms of how to manage the physical aspects of the body's decomposition. Seale (1998) called this institutional organization for death *sociological*, while he referred to death denial in the way I have been conceptualizing it throughout this section as the *psychological* problem of death. "At the psychological level, the construction of a meaningful approach to social life is rooted in 'denial', or at the very least a turning away form the problem of death" (Seale, 1998, p. 3).

This psychological denial of death, is what leads people to deny grieving. Like all the other theorists discussed, Seale made the connection between fear of death (which, as noted earlier, has roots in fear of embodiment), to fear of grieving which is a reminder of all the things people are working so hard to eradicate from their minds (Seale, 1998).

Finally, Bauman (1992), elaborated on all of these ideas in his highly acclaimed book, *Morality, Immortality and Other Life Strategies.* Bauman (1992), wrote about the relationship between the denial of death and the denial of grief:

> Death was an empathic denial of everything that the brave new world of modernity stood for, and above all of its arrogant promise of the indivisible sovereignty of reason. The moment it ceased to be 'tame', death has become a guilty secret; literally, a skeleton in the cupboard left in the neat, orderly, functional and pleasing home modernity promised to build...death had become unmentionable. One did not speak of death - not willingly, at any rate, and never without embarrassment. (Indeed, bringing a secret into the open is always embarrassing, as it calls for a publicly acceptable reaction for which no publicly accepted rules or guidelines may, or should be established.) Prolonged silence has resulted in a collective inability to discuss death meaningfully and behave sensibly towards those whom death affected in a fashion impossible to hide - toward the terminally ill, the bereaved, the mourners. (p. 135)[65]

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[65] A good example of the pervasive fear of death in contemporary, modern North America is illustrated by the *Fuck Death Foundation* (see: Fuckdeath.org). While it is difficult to tell if this website and organization is a parody or not, they do collect donations and appear, despite the abrasive language, and absurd suggestion to eliminate death, to be quite serious about their goals. The website mission statement indicates: "The Fuck Death Foundation is an organization dedicated to the elimination of death through the generation and distribution of funds to strategically selected causes and initiatives worldwide. Not only does the FDF effectively address the major precipitants of human demise worldwide, it also takes into consideration the most ruthlessly indiscriminate killer of all — oldness" (See: http://www.fuckdeath.org/main.htm). The goal of the foundation is to collect money and distribute it among the various causes of death such as cancer, old age, and heart disease with the goal of eventually prolonging or eliminating death completely.

This passage highlights all of the of the themes I have discussed throughout this chapter: the notion of the modern emphasis on reason, control, and order; the fear of untamed death and subsequently the silencing of it in order to keep it under control; the notion of embarrassment and shame of the mourners who are transgressing these rules around silence when expressing their grief; and the culture-wide loss of rules and rituals around death, mourning, and grieving which have further marginalized the bereaved into the hands of private institutions like the hospital or the psychologist's office.

Progress Narrative

Moller (1996) wrote that the absence of communal "rituals for grieving is reflective of a society that seeks to disengage [pain and suffering] from the fabric of every-day social activity" (p. 134). Similarly, Gorer (1967) described the relationship between society's values surrounding death and grief and the impact on the individual's understanding of how to mourn. Gorer (1967) wrote:

> one reason for the disavowal of mourning in the United States over the last forty years may have been the increasing pressure of what Leites and Wolfenstein called 'fun morality', the ethical duty to enjoy oneself (to prove that one is psychologically well-adjusted) and the generous imperative to do nothing which might diminish the enjoyment of others, so that the right to the pursuit of happiness has been turned into an obligation. Public and even private mourning may be felt as contravening this ethic. (p. x)

Another reason why grieving may be denied in Western culture is because the expression of such intense sadness flies in the face of the Western ethic to be constantly happy and productive (Barber, 2008). This is so ingrained in American culture that the "pursuit of happiness" is part of the American constitution. Barber (2008) called this pressure to be happy part of the American phenomenon of "emotional entitlement" (p. 129). He wrote:

> By emotional entitlement, I mean a very recent but endemic belief on the part of vast swaths of Americans that we should feel happy all the time, or at the very least most of the time, and that the conditions of life/society/the very existence of drugs/ fill in the blank should allow us, as much as possible, to maximize our feelings of happiness. In some ill-defined but nonetheless pervasive way, we have come to feel that we are entitled to – *no - we are owed* - happiness. (p. 129)[66]

The 'right' to be happy, as Gorer (1967) noted, has turned into an obligation that has no tolerance for the time and space required of mourning and the emotional intensity that grief entails.

Aries (1974) argued that this peculiar Western attitude, which involves the denial of death and grieving in order to preserve happiness, or at the very least the *appearance*

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[66] The relatively recent explosion of books on happiness is evidence of this phenomena. A search on Amazon.com with the keyword "happiness" yields close to 300 hits. Sample titles written and published within the last year include: Ben-Shahar's (2007), *Happier: Learn the Secrets to Daily Joy and Lasting Fulfillment;* Lyubomirsky's (2007), *The How of Happiness: A Scientific Approach to Getting the Life You Want;* Ricard's (2007), *Happiness: A Guide to Developing Life's Most Important Skill; and* Holden's (2007), *Happiness Now!: Timeless Wisdom for Feeling Good FAST.* Barber (2008) adds to this list the birth of positive psychology focusing on what makes people happy. This field is so popular and is growing so rapidly, it now has its own journal, aptly named *Journal of Happiness Studies.*

of happiness, was born in the United Sates around the beginning of the twentieth century. Although Aries (1974) did not provide a context for this statement, the emphasis on happiness, progress, and order in American culture around this time is situated in the context of a larger cultural trend focusing on the "new look" and "better living" (Rutherford, 2003). The "new look", which became popular in the late 1940s and early 1950s, has been described by historians as a shift from an emphasis on functionality in areas of fashion, architecture, and general design of every-day products, to a focus on aesthetics and making things beautiful. Writing about 1950s America, Rutherford (2003) noted:

> The "New Look", was a reaction against the frugality, efficiency, and austerity of the war years, expressed the postwar optimism and ebullience of a new era of peace and increasing economic abundance. It emphasized appearance and glamour...how things looked, not necessarily how they worked...In addition to the aesthetic of the "New Look," a palpable trend towards better living also characterized the late 1940s and 1950s... This better living campaign focused on claims of "new," "more", and "better" as business attempted to reclaim the public's confidence and its consumer market. (pp. 2-3)

Both the "new look" and the "better living" campaigns are reflective of what Gorer (1967) called the "fun morality" in relation to mourning. The mentality that things could only get better, that everyone *could*, and therefore, *should* constantly be happy, that improving one's life and aesthetics was essential, and that everything was possible if one

just worked hard enough at it, does not leave room for the despair that comes when one grieves. Indeed, not only does the contemporary mourner end up feeling like they are failing to live up to the ethic of constant happiness, but they are also poor consumers, since in general, they don't care very much about anything (at least for a short while) and may not be quite as motivated to go out and buy something in order to fill the void of their loss.

The emphasis on aesthetics as part of the "new look" is also interesting to point out in relation to grief. While the focus on "better living" implies that people generally strove towards an improved life including feeling better, the focus on appearance made it mandatory to *look* as if one was achieving the "better living" expectation regardless of what one felt inside. For the grieving person, this is felt by the pressure to look "normal" and "productive" no matter what one's internal state may be. On this Aries (1974) noted:

> The cause of [death and grief denial] is at once apparent: the need for happiness- the moral duty and the social obligation to contribute to the collective happiness by avoiding any cause for sadness or boredom, *by appearing to be always happy, even if in the depths of despair.* By showing the least sign of sadness, one sins against happiness, threatens it, and society then resists losing its raison d'etre. (p. 94) (Italics added)

Cable (1998) similarly noted, that as North Americans, "we live in the days of fast food, high speed modems, supersonic transports, and cellular telephones. Everything and everyone must operate at top efficiency. Mourning is seen as serving no useful purpose

and simply getting in the way of our progress" (p. 63). The expression of grief in this paradigm is considered a failure to adapt to this modern, happy, and productive society. The only solution to this problem of adjustment is to seek professional help to get back on track.

Finally, much more recently, Horwitz and Wakefield (2007) have noted that North America is experiencing a general, but pervasive "loss of sadness" in the culture. They argued that sadness, including grief, is no longer tolerated in society and the pressure to be 'up to speed' and 'on track' is so immense people are medicating themselves in the millions in order to appear normal. While I have focused on the progress narrative in this section, it is important to note that it is intertwined with capitalism and an economic bid to make money on people's sadness and grief. The Western world economy based on capitalism and individualism promotes consumption of goods and experiences in order to keep the economy and society running efficiently.

When Horwitz and Wakefield (2007) wrote about the influence of the pharmaceutical industry in turning normal sadness into depression, or when Aries referred to society's "raison d'être", they are speaking about the consumption piece of the progress narrative. It is beyond the scope of this paper to deconstruct North American culture in relation to the happiness ethic, for the purposes of this chapter, however, it is instructive to note that in North America the solution to the demand to be constantly happy (the progress narrative) is to consume products (or people) in order to reach that goal.

Contemporary theorists such as Cushman (1990) and Gergen (1991) have argued, for example, that people in North America are distracted from their unhappiness and sadness by being encouraged to fill up on various diversions that can be purchased. Barber (2008), writing about the pharmaceutical industry, interestingly noted that:

> the enduring legacy of the Serotonin Empire may not be the pills themselves but their allegorical value. Like nothing else before in American history, the SSRI's instilled in the public the idea - entirely independent of the clinical utility of the pills - that here exists something 'out there' that can make them happy. (p. 129)

In other words, the immense popularity of antidepressants (see chapter two) contribute to the narrative of the happiness/progress discourse *regardless* of whether one takes medication or not. Just like the abnormality paradigm serves to co-opt a phenomenon into the psychological purview regardless of the criteria involved, the very *notion* of a pill that can cure unhappiness is enough to enforce the idea that one should be happy all the time and, further, that one can purchase a product to achieve this goal. The sheer amount of things that people consume, from food, to people (including empathetic therapists), to goods (such as antidepressants), to images, all contribute to the smooth running of the economy. The progress narrative, therefore, is not only about being happy; it is also about the encouragement to strive towards that goal, to pursue happiness in order to be 'normal' and 'to fit in'. As has been noted throughout, in the context of grieving the pressure to be happy means that there is no room for one's sadness, and since this is not a request that most bereaved people can accommodate, they feel a sense

of shame and embarrassment at their inadequacy. Indeed, in my view, this is the quintessential experience of contemporary grievers. Embarrassment at one's inadequacy, or feeling like one is not functioning up to speed has now become part of the grieving experience, leading many to seek professional help.

Mourning in the 21st Century

Gilbert (2006) has stated that the shame of the mourner and the "embarrassment of the comforter is the sign of a wound for which neither mourner nor comforter has proper language" (p. 254). In this chapter, I argue that the language of death and, subsequently also the language of grief, has been denied in Western culture; when it is addressed, it is understood as a psychological problem necessitating therapy or medication in order to get the grieving person back to 'normal' as quickly as possible. The shame of the mourner and the embarrassment of the comforter is the societal outcome that resulted from the construction of grief by the psy-disciplines as a disease necessitating treatment; it is also a product of a culture that fears the body, and thus emotion, that denies death, and therefore, denies grief, and that focuses so heavily on the progress narrative of happiness and production, that it leaves no room for grieving, loss, and sadness.

Despite these discursive forces, however, people still find ways to grieve in contemporary Western society. While I spoke about Foucault in the context of self-discipline in chapter three, his ideas are relevant here again. One of Foucault's most revolutionary contributions to Western thought was his conceptualization of the

dispersion of power. In *Power/Knowledge*, he wrote, "Power must be analyzed as something which circulates, or as something which only functions in a form of a chain... individuals are the vehicles of power, not its points of application" (Foucault, 1980, p. 98).

Foucault overturned the popular Marxist theories of the 19th century emphasizing the oppressed and the oppressor to focus on the dispersion of power throughout society, and the ability of individuals to be both *recipients* of power and *actors* of it. In other words, rather than power being located in someone, it is instead located in a kind of third space, where it can either be resisted or accepted (Foucault, 1980). Thus, instead of the Marxist idea of power being located in some kind of centralized agent that is enforced on others such as the army, the police, or in the case of grief, the psy-disciplines, power is dispersed and negotiated by all individuals within their social contexts.

In chapter three I described Hacking's (1995) conception of looping. He argued in *Making Up People*, that "sometimes, our sciences create new kinds of people" (Hacking, 2006, p. 1), and that once that category is introduced, the classified are "changed" and "are not quite the same kinds of people as before" (p. 1). These changed people, or what he termed 'moving targets', then function to change the classification itself as they adapt, relate, and modify it to fit their own experiences. In other words, as Foucault, suggested, power is dispersed among cultural agents making the examination of psychological categories more complex than they first appear. Grieving in the 21st century is a good example of this diffusion of power. While the institutions such as the academy (and the

psy-professions in particular) have a profound influence on the ways in which people grieve (chapter one through three are illustrations of *how* this power is enforced), there are those who find other ways to express their sadness at their losses.

In the absence of any communal grieving rituals and the total dispersion of rules of how to express one's grief in any other way but the psychological, there has been an explosion of spontaneous, public, mourning rituals in the past few decades. A few examples include the overwhelming public outpouring of collective grief at the death of Princess Diana in 1997 and the thousands of spontaneous shrines that emerged to commemorate those who died in the September 11th attacks in the United States in 2001. Other illustrations include the numerous electronic sites devoted to grieving those that have died including the world-wide cemetery and sites like *legacy.com* where people can leave a eulogy for those they are mourning for others to read and comment on. The next chapter will be devoted to examining this counterculture, or the response of contemporary Westerners to the denial of their grief.

Chapter Five: *Counterculture*

Anthropologists have long argued that while grieving rituals differ from culture to culture, every society has commemorated their dead and engaged in rituals of grief and mourning (Rosenblatt, Jackson & Walsh, 1976; Santino, 2006). In chapters one and two, I examined the ways in which the psy-disciplines have constructed grief as a pathology; in chapter three I focused on how these messages about grief get understood, incorporated, and subsequently changed by those who are classified; and in chapter four, I elaborated on the cultural context of how the death taboo in the 21st century West served as the foreground to the psychologization of grief. In this chapter I will further examine the ways in which people relate to, and sometimes reject these discourses to create their own rituals around grief, while at the same time do so in ways that reiterate, and reflect psychological discursive ways of being.

The prohibition of speaking about, or acknowledging death in day-to-day life has led to a silencing and shaming of certain types of mourning, which, as I have argued throughout, has led to a psychologization of it and the idea that one must 'cure' their grief as quickly and efficiently as possible. As illustrated in chapter two, the current trend in dealing with grief is to go to a therapist, or take an antidepressant to cope with the symptoms of sadness. While this ideology pervades popular culture (see chapter three), alternative grieving rituals have begun to spontaneously emerge in public spaces.

Within the last two decades, a new phenomena around grieving has emerged. The two cultural trends that reflect this shift include spontaneous shrines (Santino, 2001;

2006) and electronic grieving sites. Examples, which I will elaborate on shortly, include the *millions* of people who grieved Princess Diana's death and the thousands of spontaneous expressions of grief that arose in response to the 9/11 terrorist attacks in the United States.

These spontaneous shrines (sometimes called folk shrines), and the explosion of electronic grieving sites, are reflections of a growing counterculture that is seeking community in which to grieve collectively. Aries (1981) noted that historically, death and mourning have always been community affairs; the community in which one lived bore the burden of the loss alongside the family and the dying individual. Aries conceded that while the *content* of grieving rituals has changed depending on the social context, the existence of them within the community has always remained constant. This sort of traditional death and mourning, however, which was contained and expressed within the collective, began to change in the 20th century with the modernization and individualization of society. Death and mourning went from being a public affair to a private one, and people were left largely to deal with grief on their own (Aries, 1981).

If one takes the view that grieving is necessary, then the contemporary response of finding alternative ways to grieve is not surprising. The interesting question here, however, is not whether grieving is a universal need; there is no adequate way to assert or prove this point. What is more relevant for this chapter is *how*, and perhaps *why* it is that people find ways to grieve publicly and communally despite the pressure to keep it a private and an individual experience. Another relevant, and central question to be

examined in this chapter, is the ways in which grief as a *psychological kind* has changed the modern griever, creating a new identity, and new ways of experiencing, and displaying grief. In previous chapters, I noted that resistance to a classification or a cultural trend is as much evidence of its centrality within a culture as is acceptance of it. The looping process, therefore, involves all *engagement* with the classification, which can range from complete identification with the category (as in the example of Joan Didion's memoir and her conclusion that she suffered from Complicated Grief), to a rejection of the discourses (as will be exemplified in this chapter).

Elias (1985) argued that modern people distrust ritual and formality to such a degree that no communal traditions are left to mark transitions in day-to-day life. This lack of ritual leaves people bereft not only of their loved ones, but also of ways to express their sadness. Walter (1999), expounding on Elias (1985), has similarly argued that while ritual is not making a comeback as some theorists have suggested (Santino, 2001), the growing trend of spontaneous shrines is a reflection of the current cultural zeitgeist that emphasizes personal expression.

Modern grieving trends can be interpreted as new forms of rituals that have arisen in engagement with a culture that does not tolerate public grieving, and has no protocol on how to mourn one's losses. They are also simultaneously a reflection of a culture that is preoccupied with, and emphasizes individualism and personal expression. As will be shortly illustrated, while the *context* of these spontaneous shrines and electronic sites are communal and public, the *content* is often individual, and focused on

the personal. The tension between the need for collective mourning through the medium of personal expression is a reflection of an ambivalent culture on how to express grief, and is another example of the looping of psy-classifications in contemporary culture. On the one hand these grieving trends are public and collective, and thus, signify a need or a desire of the people to mourn within community. These communal rituals can also be interpreted as a form of resistance to the privatization and psychologization of grief. Indeed, these rituals may never have emerged if grief had not been pathologized in the ways described throughout this project.

On the other hand, the way in which these shrines and sites come together via the individual, is in line with the current psychological mores of self-expression, catharsis, and redemption. In this sense, these rituals further exemplify the looping of psy-classifications, and further illustrate the impact this category has had on creating a new experience for the contemporary griever. Some theorists have even gone as far as to call the spontaneous shrine a form of grief therapy (Westgaard, 2006). Westgaard (2006) wrote:

> from a therapeutic point of view the spontaneous shrine as ritual may be regarded as something that contributes to 'correct' the experience of grief. The positive experience of grief gives mourners the opportunity to deal with the loss in community with other people through evocative and beautiful ceremonies related to the death; for this, help of the therapist is necessary. (p. 156)

Modern grieving, therefore, is paradoxical. The spontaneous shrines and electronic sites have a therapeutic din to them making them less rebellious than they may first appear to be, however, at the same time, they are an expression of a desire for public grieving which has largely been eradicated from contemporary 21st century western society. Elaborating on this sentiment, Seine (2006) argued that:

> It may be precisely because cemeteries and the function they once served [a place to grieve publicly and collectively] have receded from civic consciousness that the practices of spontaneous memorials have flourished. Grieving in public expresses the need to have private loss socially acknowledged and shared. The bereaved and their community, as well as the deceased, demand recognition. (p. 45)

Spontaneous Folk Shrines: "The Voice of the People"

> They are the voice of the people. The shrines insert and insist upon the presence of the absent people. They display death in the heart of social life. These are not graves awaiting occasional visitors and sanctioned decoration. Instead of a family visiting a grave, the "grave" comes to the "family"- that is, the public. All of us. We are all family, mutually connected and interdependent. Spontaneous shrines both construct the relationship between the deceased and those who leave notes and memorabilia, and present that relationship to visitors. This is manifested in the notes and in the nature of the gifts which are brought, left, and publicly displayed: a high school jacket, a dog tag, an old report card, indicate fellow

> student, comrade solider, and bereaved parent respectfully. The gifts have personal meaning, and this is indicative of - that is they index - the nature of the relationships, real or imagined. Imagined, but no less felt. (Santino, 2006, p. 13)

Spontaneous shrines, sometimes known as 'folk shrines' or 'makeshift memorials', have arisen primarily in the last decade in North America to mourn sudden or shocking deaths (Santino, 2006). These shrines consist of notes, poems, flowers, condolence books, and other personal items such as teddy bears, or personal pieces of clothing of the deceased, that are brought to site of death. It is a place where people come to mourn their losses. Santino (1992) coined the term 'spontaneous shrines' in 1992 and since they have been described as "temporary monuments to the deceased that are created without instigation or coaxing from any church or municipal government" (Thomas, 2006, p. 19). These shrines serve to articulate the pain and grief of the mourners as well as "make the rest of us take notice of the death, consecrate the site of loss, and mark untimely deaths" (p. 19).

Haney et al., (1997) have identified seven features of spontaneous shrines. The first is that it is a private, individual act of mourning that is open for public display; the second is that these shrines often go up at the site of the death, or a site that is associated with the death, rather than more traditional places of mourning like the church, funeral or cemetery; third, these shrines are democratic. No one is automatically included or excluded from spontaneous shrines and participants are often drawn from various cultures and classes, and include a larger community than relatives, friends, and

colleagues; fourth, spontaneous shrines usually involve a wide assortment of objects that could be traditional, religious, secular, generic, or highly personalized ritual objects; fifth, objects left at the spontaneous shrines are often personally meaningful to the griever and tend to illustrate the meaning of the death for the mourner; sixth, spontaneous shrines are not limited by cultural norms such as how much time one is allowed to mourn or what rituals are appropriate to express one's grief. Haney and Davis (1999) noted that unlike traditional funeral rites, "which occur at set times and continue for a set duration, spontaneous memorization ebbs and flows as individual mourners make their pilgrimages and continue their offerings either immediately after the death, or during the weeks or months that follow" (p. 238); and finally, seventh, these spontaneous shrines often make a statement about the culture and the way in which the person has died in addition to commemorating the deceased.

Spontaneous shrines have been analyzed by cultural theorists as having a dual role (Santino, 2006). On the one hand, they are an expression of grief and sorrow at someone's death in a public space (i.e., features one though six of Haney et al. (1997) criteria). On the other hand, they are also political statements about the nature of how the person may have died, and a public expression of dissatisfaction with government and the state (Santino, 2006). While spontaneous shrines almost always carry these dual meanings, I will be focusing on their use as expressions of grief for the purpose of this chapter.

One of the first examples of spontaneous shrines emerged in response to the

Oklahoma City bombing in 1995. The Alfred P. Murrah Federal Building was bombed by Timothy McVeigh, murdering 168 people including 19 children. Within days of the bombing, a seven-foot fence was built around the rubble, which quickly became known as the Memory Fence (Doss, 2002). The fence was laden with tributes to the victims that included material objects such as flowers, stuffed animals, laminated poems, photos, pictures, religious mementos, military medals, jewelry, and baby blankets, all left by the public as an expression of their grief (Doss, 2002). Doss (2002) noted that the "memory fence became a national and international pilgrimage site for thousands of tourists" (p. 67). Notes and mementos were left by people all over the United States at the site of the bombing in order to commemorate the dead. By 1999, more than 50,000 items had been left at the fence (Doss, 2002).[67]

While spontaneous shrines may at first appear to reject the privatization and psychologization of grief by virtue of their public, and communal nature, a closer look reveals the inherently psychological character of these practices. The dominant discourse of shrines like the Memory Fence are therapeutic and cathartic in nature. "The spontaneous, often impermanent, and distinctly unofficial nature of many of these roadside shrines, grassroots memorials, offerings and ritualistic behaviors seem less concerned with producing a critique of historical moments and tragic events than in

[67] There has been criticism about the spontaneity of these shrines. Since the constructions of these memorials are covered by the media, critics noted that they may have sparked 'copycat' behaviors by the public, and therefore, are not spontaneous at all. Moreover, the critics argued that the shrines like the Memory Fence are not about public expressions of grief, but rather about wanting to participate in a public ritual that appears to be trendy (Doss, 2002; Walter, 1999). While the media do play a significant role in documenting, and simultaneously, creating the phenomena they are reporting about, I believe spontaneous shrines like the Memory Fence are still unique in that they reflect new cultural ways to express grief in a public space.

catharsis and redemption" (Doss, 2002, p. 70). Herein lies the irony and the evidence of looping that I alluded to in the introduction to this chapter. While these shrines are public and communal, and therefore, rely on the collective for their force and power, they are simultaneously also individualistic expressions of grief that arise out of a therapeutic culture that advocates a cathartic and expressive mode of dealing with feelings. These shrines are both rebellious examples of a counterculture striving for a public and communal way to grieve losses in a culture that has eradicated all protocol around death and dying, and at the same time are a reification of a therapeutic culture that emphasizes individual expression of emotion in order to heal.

Looping is evidenced by the fact that the therapeutic culture itself that has led to the construction of these shrines. As noted earlier, resistance in the form of public response to privatized grief is in itself a reification of psy-classifications. If grief were not privatized, psychologized, and pathologized in the ways described throughout this thesis, it is plausible that these shrines would never have been developed. Perhaps ironically, the counterculture's emphasis on communal grieving has been equally shaped and directed by the psy-disciplines as has been the opposite trend of seeking professional help for one's grief. Doss (2002) explained that because contemporary Westerners are:

> often insulated from death and disaster, and generally discouraged from public displays of grief, people go to these sites to see and touch real life tragedy, to weep and mourn and feel in a socially acceptable situation. As shrines to trauma, these sites memorialize the horrible events that occurred there, *and also the grief*

of relatives, survivors and complete strangers who feel kinship with those who died. (p. 70) (Italics added).

In other words, these spontaneous shrines are one response to the dearth of public grieving rituals in the West. The creation of these public spaces by the people to mourn the dead are a new way to participate in what used to be a historically common practice of expressing one's grief in the public sphere with other mourners. On this Santino (2006) wrote:

> Spontaneous shrines place deceased individuals back into the fabric of society, into the middle of areas of commerce and travel, into every-day life as it is being lived. Traditional societies have always done this[68]... it seems as if people are reacting to the mass industrialization of death and the alienation of contemporary society with new folk traditions, rituals and celebrations. (p. 13)

Since the Memory Fence, spontaneous shrines and the public marking of places where people have died has become increasingly popular (Santino, 2006). One famous example of the spontaneous shrine phenomena that baffled cultural critics around the world was the overwhelming grief response to Princess Diana's death in 1997.

Princess Diana died in a car accident on August 31st, 1997. Within hours of her death, spontaneous shrines appeared in Paris at the site of her death, and at her home in

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[68] On this Seine (2006) noted "the dead were once buried in the center of town, where they served as a daily reminder of the fate awaiting us all... Located in the center of the village, concealed by no planning, plainly visible to all, [the graveyard] was a group monument, a constant reminder to emulate the virtues of the dead and to follow the precepts of the faith... Since colonial times, for health, cultural, and economic reasons, local and national burial sites have gradually moved from plots in backyards, churchyards, and town commons to cemeteries further removed from the living" (Seine, 2006, p. 44).

England, as well as at Buckingham Palace where her family resided. These shrines, now famously documented in films such as *The Queen* (2006), consisted of mass amounts of flowers, notes, pictures, drawings, and expressions of condolences addressed to Diana and her family (Walter, 1999). The flowers covered a hectare of ground and weighed thousands and thousands of tons. People waited in line for more than eight hours to sign the condolence books that were created by the public to honour her death. The video footage of the week after Diana's death showed people gathering around the palace expressing tears, grief, and sorrow. Her funeral drew two million people who stood in silence watching the funeral procession travel through the streets of London (Walter, 1999).

While some critics have argued that the mourning for Diana was a socially constructed event whereby "in the absence of socially proscribed mourning behaviour - people received instruction by watching others, thereby learning to 'feel'" (Brennan, 2001, p. 207), others have argued that this mourning was real, and an example of a spontaneous, collective act of grieving in a society that otherwise does not tolerate overt expressions of sadness at loss (Parrott & Harre, 2001).

One of the strongest arguments made to explain the outpouring of grief at Diana's death was a psychological one. Diana was a figure who showed her vulnerability to the public and, was therefore, accessible to them as someone they could relate to (Johnson, 1999). The sociologist, Johnson (1999) noted that because Diana was a particularly good object for others to do their 'psychic and cultural work', she was a prime surface for the

public to transfer their feelings of grief that would otherwise be suppressed in contemporary culture. The spontaneous shrines erected in Diana's honour, and the overwhelming outpouring of grief at her death, were an opportunity for the public to grieve their own losses in a culture that otherwise denies their right to express their sadness in a communal and public way.

> Diana was clearly the object of many transferred feelings, feelings that had little to do with her own life and death, and everything to do with the lives of the members of her public. Many people told television interviewers, or radio chat show hosts, how they had cried for Diana, but also at the same time for some other loss, unmourned at the time. (Johnson, 1999, p. 31)

In this sense, the outpouring of grief and the construction of these shrines are examples of a culture that is struggling to find ways to mourn in public, but in particularly individual ways. As grievers assume, and act out of their new identities as fully enfranchised members of the therapeutic culture, spontaneous shrines are both a public declaration of this identity and a way to enact it. On this Greenhalgh (1999) wrote, shrines:

> may be erected by those who have suffered personal loss or be gestures of sympathy and community feeling from neighbors or even strangers. In the former case they can be both an act of loving remembrance and respect and also one of catharsis, thus in keeping with the dominant view of mourning as a therapeutic process, as the healthy discharge of grief. (p. 45)

Another famous, and recent example of communal, spontaneous grieving that had therapeutic undertones was the response of New Yorkers to the tragic deaths of thousands of people in the terrorist attacks on September 11th, 2001. Two airplanes, hijacked by terrorists, crashed into the twin towers in downtown Manhattan killing and injuring thousands of people. The response of New Yorkers was immediate. People gathered in Union Square, the closest open public space to the site of the terrorist attack (aptly named Ground Zero), and immediately began to communally grieve and reflect on their losses (Zeitlin, 2006).

While the spontaneous grieving for Princess Diana was about one celebrated person and stayed consistent throughout the mourning period, the 9/11 shrines were more flexible and changed in their purpose and content over the days and weeks that followed the attacks. On this, Gilbert (2006) noted that "more than the tributes that followed the death of Diana, these extraordinary [9/11] collages of sorrow revealed the new ways in which we display our grief in an age that is at best ambivalent about the procedures of mourning" (p. 279). Indeed, the spontaneous shrines that arose during the 9/11 tragedy differed markedly from Diana's memorials. In addition to revealing new ways in which people display their grief, they also revealed new ways in which people experienced being contemporary grievers.

To begin with, the 9/11 deaths arose out of different circumstances than Diana's death, and rather than being about one celebrity, were about ordinary people who were

more accessible to imagine as oneself. The victims of 9/11 were easy to identify with because they were normal people caught up in extraordinary circumstances.

Second, the shrines and public gatherings served different meanings at different times. Since no one knew at first who had died and who had survived, the purpose of the gathering at Union Square was initially simply about being together. Seine (2006) wrote:

> The crowds that gathered day and night at Union Square appeared intent to create a communal space, a place providing comfort in numbers in the most uncertain and frightening of times. As one young man remarked, 'you get a little hope in togetherness' (p. 48).

Later the shrines became more personal and more dispersed around the city with spontaneous memorials arising everywhere that people lived. Writing about this seemingly endless proliferation of shrines, Zeitlin (2006) noted:

> On the streets, ordinary people started the memorials, sustained them, and made them meaningful. Thousands took part. They neither asked permission from city officials nor waited for religious or civil authorities to tell them how to respond. New Yorkers showed an amazing instinct and ability to use public spaces all over the city to gather and express themselves, and in many cases, to give others an opportunity to do the same. (p. 104)

The "instinct" to gather in a public space to "express grief and allow others to do the same" is the crux of resistance against a culture that teaches people to grieve alone, and in private. Interestingly, there was little coverage of people seeking, or needing

psychological help in the first few months after 9/11 to cope with their grief. Several months later, after the public and communal outpouring of collective mourning subsided, there were more reports about people seeking psychological services to cope with the aftermath of the attacks (Rosenblatt, 2005). Initially, however, people's grief was contained in the community much like it would have been historically, and therefore, did not require additional support that is offered in the private offices of the psy-disciplines. To use the psychological terminology, there was a kind of communal container that allowed people to grieve and have hope for their future *because of their togetherness.*

At the same time, however, these collective shrines and gatherings were intensely personal and individual in nature, and therefore, have a psychological tinge to them, even when expressed in the midst of community. In this sense, they are a reflection of what Danziger (1997) called a negotiation with a psychological classification, rather than a complete identification, or rejection of it. Gilbert (2006), writing about the 9/11 memorials, noted that these improvisational shrines were personal and particularized testimonials to individual lives. She wrote:

> Often structured (like most of the 9/11 shrines) around a photographic portrait or even a collage of snapshots, they also included personal items - religious tokens, letters to the dead or missing person, poems, toys and trinkets that belong or might have belonged to the dead (p. 281).

Moreover, these shrines did not simply summarize grief in the same ways that traditional monuments do,[69] but were particular expressions of both the person who had died as just described, *and* a reflection of the person who was grieving them (Gilbert, 2006).

The shrines were constructed to memorialize the dead and were done so in prototypical modern, and psychological fashion of personal expression as evidenced by the individual nature of their construction. More importantly, however, these shrines served the living by giving the mourners a way to personally express their sorrow in a communal setting. What these shrines attest to, then, is that even in "an age when ...we're embarrassed by grief...most of us still feel the need to find modes of mourning that we experience as honest, honorable and authentic" (Gilbert, 2006, p. 282).

Electronic Mourning

The search for "honest, honorable and authentic grieving rituals" is also evident in the explosion of online memorial sites in the past several decades. Much like the recent phenomena of spontaneous shrines, electronic mourning is a product of the modern, technological world. A search on Google with the key words "grief support" yields just over 900,000 hits. Online grief resources include bulletin boards where discussions take place with other mourners; information websites where one can find various sources or

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[69] For example, the Vietnam War Memorial in Washington DC is meant to capture the losses of thousands and thousands of people in one generic, reflective wall. While individual names are engraved on the wall, the overall effect of the monument is to summarize the magnitude of the loss and the grief in a kind of communal way. No one name stands out above others and when you stand back, you see reams and reams of text that blur into the overall structure of the monument. Spontaneous shrines, on the other hand, are deeply individual and deeply personal constructions that reflect the person who has died and the person putting up the memorial.

links to grief support; memorial sites where people post pictures and stories about lives of those who have died to be read and commented on by the public; individual web pages which are set up to commemorate and memorialize a person who has died for others to view; email groups that deal with grief-specific issues; and chat rooms, where people have real-time conversations discussing the dead, and how they are coping with their grief (Online Grief Resources, 2008). More recently, social networking sites such as *Facebook*, *MySpace*, and *Xang.com* have become popular places to create online shrines to be visited, and commented on, by thousands, sometimes even millions of people (John, 2006).

In a culture where death is sequestered in hospitals and hidden from view, and where grieving is stifled and considered pathological if it goes on 'too long', the electronic grieving phenomena resembles the spontaneous shrines in their attempt to build community and find a place to mourn collectively and publicly, albeit in individual, personal, and psychological ways.

In a recent meta-analysis looking at online mourning studies, Roberts (2004) examined the results from three large academic papers that analyzed the content of web cemeteries such as *The Virtual Memorial Garden*, *Remembered Forever,* and *World Wide Cemetery.*[70] Web cemeteries, or online memorials, are sites where people post pictures, stories, and visual monuments to commemorate a person who has died. What differentiates these online shrines from private memorials that one might have in a home

[70] For *Virtual Memorial Garden*, see: http://catless.ncl.ac.uk/vmg/; For *Remembered Forever* see: http://www.remembered-forever.org/; For the *World Wide Cemetery* see: http://www.cemetery.org/

or in a real cemetery, is that other people can visit and leave virtual flowers or notes and sign the online guestbook or online condolence cards. Similar to the notes left at spontaneous shrines, online guests often leave messages that address an audience and that are as much about themselves as the person who had died (Roberts, 2004).

When asked by researchers why it is that people visit or post online memorials, Roberts (2004) found that most responses were about relationships and community. Individuals turn to cyberspace to seek opportunities to express their grief, commemorate the deceased, and to find, create, and expand their community (de Vries & Rutherford, 2004). Other reasons cited included the opportunity to share memories about the dead and discuss the deceased with others (Roberts, 2004). Further, people who have constructed the online memorials, and guests who are visiting them, come back repeatedly to check the site for other peoples' comments and postings. Online visitors are thus clearly conscious of the cyberspace community and make an active effort to contribute to it by constructing their own memorials, and by visiting and commenting on other people's sites. Interestingly, many of the comments left on these web cemeteries are posted by strangers who did not know the deceased (Roberts, 2004). On this Roberts (2004) wrote:

> Stranger messages usually acknowledged the loss and portrayed their compassion for the author (s) of the memorial. In some instances, strangers described their emotional connection to the memorial, that they had experienced a similar type of death, a similar relationship lost or that they simply were moved

> by the memorial...Almost all stranger messages were gentle caring and extending a kind word. (p. 68)

The act of acknowledging the 'loss' in a compassionate way, and offering "gentle, caring, and kind words" is, as I have been arguing throughout this project, a rare response in contemporary Western culture where grief has become privatized and psychologized. The construction of online communities to meet these needs is not surprising when understood in this context. Indeed, many of the users of web cemeteries report that they received more, and better quality support online for their grief than from their real world communities (Moss, 2004; Roberts & Vidal, 1999-2000; Roberts, 2004). Roberts (2004), for example, reported that over 80% of her survey respondents cited "sharing experiences with others" and "offering assistance and help to others in similar circumstances" as being "very important" to their decision to post a web memorial (p. 69). Web memorials seem to be a socially acceptable way to share feelings of grief and pain with others and to talk about the dead without being pathologized as morbid or strange.

In addition to being able to speak about the deceased, people reported that they were able to talk more openly online about their pain and their grief than they could anywhere else. Several studies have reported more self-disclosure and vulnerability in computer interaction than in other types of communication (Kiesler & Sproull, 1986). In a culture that is adamant about silencing grief, this phenomenon is especially apparent in online memorials. In answer to the question "why did you create a web memorial?" Roberts (2004) cited one respondent who said:

> A method of grieving (when I had the need to cry for her) in which I would not be told that 'everything would be ok'. I needed a way to let my family to know that my strong outer shell was covering up my weak inner self that was devastated. [sic] ... I think that death is so very hard for people to deal with face to face. Many of the responses I received from the website would not have been voiced had that person had come to me to offer it. For so many it is just unbearable to come in direct contact with such raw pain and grief. I understand this. This medium offers the bereaved a chance to have personal contact with others, without having any pressure of maintaining composure or trying to mask emotions. Also it gives the supporter the opportunity to offer comfort and encouragement without any awkward moments or times of not knowing what to say. A way to stay connected, no matter the distance or time. (p. 65)

The themes of silenced grief, the need to show and express one's pain, and the need for community, support, and acknowledgement are all evident in this passage. The idea that online communities afford a space where one can show their "weak" and "devastated" self is a telling reflection of a culture that has a hard time dealing with the pain and sorrow of grief. To offer support face-to-face risks having "awkward moments" or silence, which are too risky in a society that is embarrassed by death and the displays of sadness that go with it.

On this, Moss (2004) noted that web memorials are a place where disenfranchised grief can be expressed and accepted, and therefore, is one of the rare instances where the

bereaved do not feel the "social pressure to reduce or eliminate the sharing of their deep sadness" (p. 78). She aptly pointed out that "web memorials tend to allow continuing of expression of grief, offering unobtrusive access, and thus facilitating enfranchisement of grief" (Moss, 2004, p. 78) long after the mourners are told that they should have 'gotten over it already' and be 'back to normal'. The web may be the only place left where people can openly grieve for as long and intensely as they like without being pathologized. It is a place where one's grief will be normalized, supported, and acknowledged by other virtual mourners who are going through the same thing.

As with the spontaneous shrines arising out of resistance to, or as a result of, the privatization of grief, electronic grieving can also be interpreted in the context of looping. These web memorials are both ontologically and materially constructed in ways that reiterate psychological norms around grieving. These sites exist because of people's resistance to the pathologization of their grief, and yet, simultaneously, they are constructed within the same therapeutic paradigm that advocates personal expression and catharsis as a way to grieve. In a way, they may exist *because* of the pathologization of grief.

Indeed, another one of the ironies of electronic mourning is that it is collective and public in the sense that is accessible by anyone who wishes to either post a memorial or comment on one, while at the same time is also a deeply personal and individual expression of grief. de Vries and Rutherford (2004) noted that:

> Web cemeteries, as an emerging post-death ritual, celebrate *private mourning in a public place*. Web cemeteries offer unobtrusive access to *very personal and private mourning ritual and are inclusive* of all who have access to a computer. Web cemeteries borrow elements from traditional rituals and combine them into meaningful personal expression. They build (electronic) community by transforming individual loss and expression to a social context. (p. 24) (Italics added)

Santino (2006) similarly argued that "performative commemoratives", or spontaneous shrines and electronic mourning, invite participation by the public and are more egalitarian and democratic than mourning rituals of the past. While funeral processions, for example, were more controlled and usually involved only the people closest to the deceased, spontaneous shrines and electronic mourning are open to everyone. At the same time, however, these shrines and mourning sites are individual and personal expressions of one's pain that focus almost entirely on the individual person who has died or the individual person who is grieving them.

The use of technology to express and define oneself is characteristic of what some theorists have called Generation Y or the Internet Generation. This cohort, born between the mid-1970s and the year 2000, uses technology like the internet, blogs, and social networking sites like *Facebook* and *YouTube* to define and express themselves in highly

individual ways but in a public forum[71] (Junco & Mastrodicasa, 2007; Tapscott, 1997). While this generation uses technology more than any other age group, they have been instrumental in introducing the trend of using technology for the purposes of personal expression within North American culture as a whole (Junco & Mastrodicasa, 2007; Tapscott, 1997). Electronic mourning is a prime example of personal expression in a public and communal forum via the use of technology.

The second, perhaps even more ironic aspect of electronic mourning is that while it is reported as being a supportive and engaging community by the users of the sites, it is also an essentially isolating, and individual experience. Most people using these sites to post memorials or express their feelings of grief do so alone in their homes. It is a disembodied practice since one does not know who one is engaging with online, and all the markers of identity such as gender, ethnicity, and class are left out of the interaction. Paradoxically, these online communities became the only source of support for many mourners, while at the same time, leave them to grieve by themselves in their own homes. Online mourning is thus both an example of the increased privatization of grief, and a reflection of a culture that is looking for ways to reverse this trend and grieve collectively and publicly together, albeit in ways that remain rooted in psy-disciplinary

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[71] Junco and Mastrodicasa (2007) found that in a survey of 7,705 college students in the United States: 97% owned a computer; 94% owned a cell phone; 76% used Instant Messaging and 15% of Instant Messaging users are logged on 24 hours a day, 7 days a week; 34% used websites as their primary source of news; 28% owned a blog and 44% read blogs; 49% downloaded music using peer-to-peer file sharing; 75% of college students have a Facebook account; and 60% owned some type of portable music and/or video device such as an iPod.

norms.

From a meta-perspective, looping is also evidenced by the recent academic (i.e., psychologists, sociologists, and cultural theorists) interest in spontaneous shrines and electronic grieving rituals. In earlier chapters I noted that because grief as a *psychological kind* is a fairly new construct, there are few clear examples of the classification being fully looped back to the psy-disciplines themselves. While this chapter largely focused on how the psy-classification of grief has made alternative rituals like spontaneous shrines and electronic grieving possible, I have not discussed how these new rituals loop back to the social sciences. These relatively new shrines are excellent examples of looping, for, as illustrated in this chapter, they have been both *influenced* by the psy-classification of grief and have a hand in *constructing* this category as scientists begin to study these new rituals. Most of the research cited in this chapter, for example, was taken out of academic sources published within the last five years. While many of the sources were sociology journals, there is a notable increase in research within psychology looking at electronic grieving, and further, doing experiments with people who use these resources (see: Capitulo, 2004; Hollander, 2001; Lange et al., 2000; Lang, van de ven & Schrieken, 2003; Nager & de Vries, 2004; Wager, Knaevelsrud & Maercker, 2006). While it is too early to tell how the researchers examination of these grieving rituals will further change the classification, it is clear that the second half of the looping process is well underway and will result in further modifications to the grief experience in North America.

In summary, while the online mourning phenomenon is ironic, it is not nonsensical. As I have been arguing throughout, because North American culture is generally resistant to public displays of grieving, people have had to find alternative ways to express their sorrow. While both spontaneous shrines and electronic mourning have countercultural elements in them in that they demand a public recognition of their grief in a communal setting, they simultaneously reiterate the norm of Western culture in expressing their grief in private and individualistic ways, and thus, as I have suggested throughout, are further evidence of the looping of psy-classifications in creating new experiences for people grieving. Writing about the online memorials, Gilbert (2006) mused that:

> when bereavement itself is nearly as problematic as death... it's no wonder that sufferers feel freest [sic] to air their feelings of loss when they're most alone - at the glimmering computer screen. And it shouldn't surprise us either if words of consolation are easiest to utter when they are articulated in silence, on a keyboard. (p. 247)

In other words, people turn to these outlets to express their grief because there are very few socially-sanctioned ways to do so within this culture. The prohibition over prolonged expressions of grieving that is not professionally monitored by the psy-disciplines is considered abnormal and pathological. Moreover, because there are no longer communities which support the griever, mourners are left with the option of either paying someone from the psy-professions to listen to them or treat them, or turn to other

private outlets such as electronic mourning that give them a public space to express their feelings, albeit, still in an individualistic way. What is most interesting about these phenomena is that their existence is contingent upon, and grew out of grief being constructed as a *psychological kind.* Indeed, the resistance to the privatization, pathologization, and psychologization of grief is as reflective of the discipline's centrality in co-constructing new ways to grieve, as are the development of concepts such as complicated grief and the feelings of shame and embarrassment for the contemporary mourner.

Cross-Cultural Expressions of Grief in the West

Throughout this project, I have been deconstructing the psy-discourses construction of grief in North America within the past century. I have been clear that my analysis is solely focused on Western grieving norms. As I noted in the Introduction to this paper, and as should be clear by the historical trajectory of the way the construct of grief has shifted over the last hundred years, the way we grieve is very much contingent on *where* and *when* we live. Indeed, the contemporary grieving practices that I have deconstructed in this paper are peculiar to North American society. The majority (although not all) of Westerners are materially and financially privileged in comparison to people living in other parts of the world. Although there are gross inequalities between the rich and the poor in North America, and although there are *many* oppressed groups suffering in the West, there is overall, and in general, less institutionalized violence, less hunger, less poverty, and subsequently less death and grief to deal with on a day-to-day

basis. This, of course, has also shaped the way people understand and experience grief. Scheper-Hughes (1992), for example, conducted an ethnography with Alto women living in Brazil. She entitled her book Death Without Weeping, which referred to the Alto mother's seeming indifference to the death of their children. These mothers did not seem to grieve or weep when their babies died. Scheper-Hughes (1992) wrote:

> And so I maintain that Alto women generally face child death stoically... No one on the Alto do Cruzeiro criticizes a mother for not grieving for the death of a baby. No psychiatrist, pediatrician, or social worker visits the mother at home or tells her in the clinic what she is 'supposed' to be feeling at the particular 'phase' in her mourning. She is not told that crying is healthy (and womanly) response to child death or that it its 'natural' to feel bitter and resentful...or that she must 'confront' her loss and get over her unhealthy emotional 'numbness' (p. 429).

Scheper-Hughes (1992) explained that mothers do not grieve for their dead babies because they die so frequently, and are simply accustomed to losing family members to chronic hunger, poverty, and murderous violence. In particular, these mothers are less attached to their younger kin because they do not know if they will live or die in such harsh circumstances. (Scheper-Hughes made an analogy between how Westerner's might relate ambivalently to a fetus within the first trimester of pregnancy because of the precariousness of its survival). The absence of grief in the Alto women is a culturally appropriate response that makes sense within the context of their lives. This is a particularly good example of the way in which one's cultural, social, historical, and

political circumstances shape one's experience of grief. As a critical psychologist, however (and not an anthropologist, sociologist, or even a cross-cultural psychologist), my focus in this paper has been within my area of expertise. While my focus has been on the way North American norms around grief have been constructed, it is vital to note how particularly and culturally situated these emotional experiences are within a Western political paradigm.

Having said that, it is also important to examine what happens to cross-cultural expressions of grief within the West. While the psy-disciplines are dominant in shaping and enforcing how grief is expressed and understood in the West, it is necessary to note that North America is not a monolithic entity; within Western society, there exist many peoples from many different cultures that bring their own understanding of how grief should be expressed. Indeed, not only do these competing discourses on grief exist, but they differ markedly from the mainstream norm of pathologizing, psychologizing, and privatizing grief.

In other words, grief as a *psychological kind* will mean different things in different contexts. Eisenbruch's (1984) study of cross-cultural grief concluded that while grief appears to be a universal emotion, it's expression will always be culture-bound. Rosenblatt, Walsh and Jackson (1976) compared 78 different societies around the world in their expression of grief. They found that crying, fear, and anger were exceedingly common in all of these cultures to such a degree that they were "virtually ubiquitous". Indeed, in contrast to Western society where grieving rituals have been almost

completely eradicated, almost every society provides socially sanctioned ways for the expression of grief in the form of funeral rites and customs for grieving and mourning (Rosenblatt et al, 1976). Parkes and his colleagues (1997) noted on this, that "in this respect, Western cultures, which tend to discourage the overt expression of emotion at funerals, are highly deviant. They differ from most other societies and from our own society as it was a hundred years ago" (p. 5).

While it is beyond the scope of this project to examine cross-cultural expression of grief,[72] it is worth noting that immigrants coming from other societies and/or religious backgrounds may experience a clash with Western mainstream norms when it comes to how grief should be expressed. Indeed, Kissane and Bloch (2002) noted that families immigrating to a new country often risk their bereavement practices being usurped and/or shaped by the new culture. This cultural rift may have profound implications for people who do not subscribe to the psy-disciplinary construction of how grief should be experienced or treated.

For example, in cultures such as the ones found in India, Nepal, China, Pakistan, and Greece, death is a public, communal affair where crying, weeping, sobbing, and wailing in public are an accepted part of the social rituals around grieving (Laungani & Young, 1997). Further, grieving often lasts significantly longer than what is acceptable in the Western world and involves the entire community supporting the mourners. Being a 'griever' is a significantly different *psychological kind* in these cultures than it is in the

[72] For cross cultural examination of grief see: Parkes, Laungani, & Young (1997), Rosenblatt (1993, 2001) and Walter (2003).

West. While these traditions can be viewed as countercultural expressions of grieving, in much the same way that spontaneous shrines and electronic mourning are, they often are challenged when they come into contact with the dominant Western norms around the expression of grief.

In theory, one should be able to practice one's grieving rituals within a multicultural society, thereby rejecting the psy-disciplinary norms around the expression of grief. What often happens, however, is that one's cultural practices clash with the dominant norms of the mainstream and become impossible to assimilate (Kissane & Bloch, 2002). The aforementioned example of the public expression of grief by wailing, crying, and sobbing would be met with a diagnosis of pathological grief for being too intense or expressive. Grieving for several years may be diagnosed as 'chronic' or 'complicated mourning' and be treated with an antidepressant or a series of sessions with a therapist. What would be considered normal and expected in one culture, would be diagnosed as pathological, and in need of treatment in the West.

Other examples of this clash are evident within the very polices and structures of the workplace. Traditional Jews, for example, sit 'Shiva' for seven days after a person has died. During this grieving period, mourners are at home while comforters visit them in order to console and bring them meals. Sitting Shiva contrasts sharply with the idea that one should 'go back to normal' as soon as possible as it acknowledges that mourners

require *at least* a week[73] to be consoled and refrain from doing every-day activities like going to work or taking care of the household (Lamm, 2004). Most people in North America, however, only get two days off for 'bereavement needs' since it is assumed that those days will go towards planning or attending the funeral. Sitting Shiva, an essential Jewish practice when it comes to grief, is simply not possible for many people who depend on their income for their survival.

Finally, while people may have their own traditions when it comes to grieving, they are living within a broader culture whose mainstream norms impact their own subjectivity and understanding of the grieving process. The looping of the psy-construction of grief into public consciousness and back to the psy-disciplines themselves transcends the boundaries of culture and ethnicity. For example, people of all religious, ethnic, and cultural backgrounds watch the *Oprah Winfrey Show* where mainstream psychological norms about grief are reiterated and enforced to millions of people (Illouz, 2003) (see chapter three). Furthermore, the rhetoric of science and psychology, and the rational approach to grieving which I outlined in chapter two, appeals to people irrespective of religious or ethnic identity. Indeed, as discussed in chapter one, modernization is the project of rationality, and it purportedly is democratic and applies to *everyone* regardless of cultural background. While it is, therefore, *possible* for cross-cultural traditions surrounding grief to be a counterculture (i.e., resisting the psychologization of grief), most people living in North America begin to co-opt the

[73] The Jewish rituals around death and grief begin with the seven days of Shiva, then move on to the thirty days of acute grieving, and then go on to last for one full year where there are specific rituals for the mourners to partake in order to assist with healing from the grief (Lamm, 2004).

norms of the dominant culture in order to 'fit in' within one generation (Salins, 1996). Further, as I have indicated throughout this thesis, the resistance to the psy-classification of grief is as much an engagement with the category as the acceptance of it as an identity. For most people, no matter their cultural background, there is some negotiation with the category that impacts their experience and expression of grieving, which in turn, impacts and changes the classification.

Modern grief

In the absence of any communal grieving rituals, and the total dispersion of rules of how to express one's grief in any other way but the psychological, there has been an explosion of spontaneous, public, grieving rituals in the past few decades. Spontaneous shrines and electronic grieving are examples of a counterculture that has emerged in response to the psychologization of what used to be a communal and publicly-supported affair.

While these memorials go against the trend of privatizing and silencing the expression of grief, they do so in ways that reiterate psychological discursive norms of personal expression. Spontaneous shrines and electronic mourning both have a therapeutic tone in that they emphasize catharsis and personal redemption through the act of constructing these memorials. Further, these shrines tend to be highly individual, personal expressions that reflect both the person who has died and the person who is making the memorial, putting into question how communal these grieving rituals really are.

What is clear from this phenomenon is that regardless of how they are constructed, these new, almost-grassroots grieving rituals are signifiers of a culture that has lost the language in which to speak and memorialize the dead. In the absence of protocol on how to best express one's grief, and in the absence of any established community to support the mourners, these shrines and memorials are an organic way in which people experience being a new kind of griever in the 21st century.

Conclusion

In a critical reflection on the grief literature in psychology, Breen and O'Conner (2007) concluded that "there is a plethora of research on grief, including the descriptions of 'symptoms', 'risk' factors, and outcomes, without significant attendance to the context of the bereavement itself on the resulting grief experience" (p. 209). Kellehear (2007a) wrote, "notwithstanding the genuine value of psychological grief theories there are several rather startling features of them that make those theories appear socially irrelevant, medically abnormal, and publicly bizarre" (p. 75). Neimeyer and Hogan (2001) drew a similar conclusion and noted that there is an inverse relationship between the amount of research on grief that continues to grow, and the amount of new knowledge that it produces. They wrote, "although the human experience of bereavement has often been studied, it has not often been studied well" (p. 110).

In this project, I have been making similar claims. While there are volumes of literature on grief within the psy-disciplines, it has not been necessarily helpful for those who are grieving. In chapter one, I described the process by which grief became problematized and introduced into the psychological literature as a topic worthy of scientific study and intervention.

In chapter two I outlined how this problematization turned into pathologization by introducing grief into the abnormality paradigm, and subsequently addressing it as a mental disorder to be treated with medication and therapy. Moreover, I showed that 'normal' versus 'abnormal' grief as a product of the psy-disciplines created a need for

professional services, and simultaneously offered to fill it by producing research and interventions to 'cure' the problem.

In chapter three, I discussed how the psy-disciplines construction of pathologized grief is reiterated in the public sphere through media outlets like film, television, and books and thus propels the looping process.

Chapter four examined other cultural discourses that support and perpetuate the psy-disciplines pathologization of grief. Indeed, the pervasive fear of death in contemporary North American society, and the progress narrative reinforces the message that grief should be shrouded in secrecy, and dealt with in private so as to avoid the shame and embarrassment of public expression of sadness that I argued has become part, and parcel of the contemporary experience of grief.

Finally, in chapter five, I noted that while the psy-disciplines are powerful in determining the ways in which grief is experienced in North America, and have successfully created a narrative in which grief is understood as a pathology, there has been a notable trend of alternative, communal, grieving rituals that have emerged in the last two decades. These include the relatively recent phenomenon of spontaneous shrines and electronic mourning sites that are evidence of people's desire to grieve collectively, and publicly, instead of privately, and with professional help. Indeed, as with the discussion in chapter three, I further illustrated in this chapter how grief as a *psychological kind* has created a new experience of grief for contemporary mourners, and

how, in turn, these new rituals are beginning to loop back to the psy-disciplines as social scientists begin to study them.

In this, the last, and concluding chapter, I will discuss the implications of this process for the future of grief in the 21st century. To begin the discussion, I will address my perspective on the psy-professions when it comes to the construct of grief and follow by examining the repercussion for the contemporary mourner if the looping of the psy-classification of grief continues to proliferate.

Psy-Disciplines and the Pathologization of Grief

I argued in chapter two that the pathologization of grief is problematic because it takes what used to be a communal every-day event and turns it into a problem to be treated by psy-professionals with therapy and/or medication. I further noted that there are several discursive forces involved in this process, including the need for psy-disciplines to have a professional identity, the rise of managed care, the impact of pharmaceutical companies, and the development of psychological counselling services that are all motivations for pathologizing grief. Without including grief in the abnormality paradigm, grief could not be considered part of the psy-disciplines purview, and therefore, none of these services could be legitimized. In later chapters, I suggested that the combination of the pathologization of grief and North American cultural discourses around death and dying have created a new experience for the griever that includes feelings of shame and embarrassment around their sorrow.

While I remain critical of the pathologization of grief, a caveat is in order before elaborating on the implications. It is necessary to state that the psy-professions are not problematic in and of themselves. Indeed, it can be argued that the psy-disciplines serve the community by filling a need for people to have somewhere to express their grief, and further, the psy-disciplinary practitioners are themselves part of the community in which they live and work, and thus, are as influenced by societal norms around death and dying as everyone else. In a culture that has effectively silenced and shamed the griever for their sadness, therapy is often the only place left where people feel they can openly talk about their feelings of sadness and despair. As I have noted throughout, the loss of protocol around how to grieve, and how to help, or support a mourner, have left those grieving not only bereft of their loved ones, but of any community in which to understand, mediate, and express their sadness. This is not only the creation of the psy-disciplines, but as I described in chapter four, is situated within a larger cultural framework that fears and denies death, and believes that one should be perpetually happy and upbeat. In many ways, the psy-professions have filled the need of the 'listener' and the 'supporter' for the bereaved, and one could claim that has aided sufferers from falling into deeper, and more incapacitating depressions.

Illouz (2008), a cultural theorist, noted that psychological ideas become particularly popular during times of upheaval and uncertainty. She wrote:

> What has made psychologists the arbitrators and guides of the soul in so many institutional manifestations is that they have performed massive "cultural work",

> a vague term that includes such diverse phenomena as the collapse of traditional social roles and role uncertainty, the demise of established patterns of life, the multiplication of values, and the intensification of social anxiety and fear, all of which can explain why individuals search for ways to explain the behavior of others and shape their own behavior. (p. 57)

Grief is a good example of this "cultural work". The psy-disciplines were, and continue to be successful in pathologizing grief by drawing this area of human life into their purview, because they provide a framework around how to manage, control, and deal with grief in a time when there is a lot of uncertainty, anxiety, and fear around dying and mourning. In this sense, the pathologization of grief can be considered a positive outcome, for it has provided a feeling of orderliness around an area of life that is filled with chaos, and insecurity for a lot of people.

Indeed, the benefits of pathologizing grief also have to be acknowledged. It could be argued, for example, that a diagnosis of complicated grief could make it easier for people to get more than two bereavement days off from work. The psy-disciplines have tremendous power and legitimacy in modern culture. While a psychiatric or psychological label may carry a stigma, it also carries a certain validation of one's experience that may make it easier for mourning people to take more time off to grieve their losses.

At the same time, however, I remain critical of the pathologization of *all* grief. The boundary around pathological grief is ambiguous, and therefore, inclusive of almost

anyone who is grieving. As I outlined in chapter two, there is very little qualitative difference between what is deemed 'normal' grief, and what is deemed 'pathological' grief, and it seems from the literature that the diagnosis of complicated grief is arbitrary and based on the clinician's or researcher's determination of what she, or he defines as normal.

In addition to the ambiguity surrounding the definition of pathological grief, I also noted that the idea that grief could potentially go awry is situated in what I call the abnormality paradigm. While the criteria for defining grief as pathological is becoming more and more inclusive, and therefore, leading to more intervention in the lives of the bereaved, I ultimately suggest that the particulars of what defines pathology are less relevant than the idea itself that grief can be evaluated on a normal/abnormal continuum. The introduction of grief as psychological object has an allegorical value, whereby, one doesn't need to be diagnosed to be affected by the classification. The self-consciousness around grief is one example of how people may be affected by the classification without ever being diagnosed with a mental disorder. In *addition* to the sorrow and depression that often accompanies bereavement, contemporary mourners are also faced with a distinctively modern anxiety about whether they are doing their grief work properly, and whether they are on track with their progress. This new self-consciousness often comes with a sense of shame and embarrassment about mourning that has become part and parcel of the experience of grief in this day and age.

The over-inclusiveness of the criteria for pathological grief creates a new experience of grieving for people and serves to create further need for professional services. While it is true that the psy-disciplines are not solely responsible for the disappearance of grief ritual in the contemporary North America, they have, as I've argued throughout, served to fill the void created by this deterioration by creating a new narrative around grief. T3he psy-professionals have provided a new psychologized frame in which people understand themselves and their experiences. The psy-construction has enforced the idea that grief can be pathological, and that the best way to avoid this, or to cope with grief that has gone awry, is to turn to a professional who has the tools and the knowledge to help one overcome their sadness and return to normal as quickly and efficiently as possible. There is thus a closed circle whereby the psy-disciplines both problematize grief and then offer a (potential) solution to the problem.

Despite the fact that the evidence for pathologizing grief and then treating it is questionable (there is very little evidence that normal grief differs from pathological grief, and there is little evidence that any kind of grief intervention including therapy and medication works), the implications of pathologization for the griever cannot be understated. As I noted in chapter two, to pathologize grief means to enter into a paradigm where one is told to get over their grief with the aid of interventions that can be ineffective and even harmful.

Grief, the DSM and Intervention. As noted in chapter two, Bereavement is already listed in the DSM-IV-R (2000), and if it follows the course of previous DSM

disorders (i.e., Major Depressive Disorder (MDD) and Social Anxiety Disorder (SAD)), it is well on its way to be considered an official diagnosis. The logical outcome of including grief as an official pathology is to treat it as one. While I will discuss the consequences of too much intervention in the next section, it is necessary to note that the classification of grief as a disorder is the prerequisite for legitimizing and treating it as one.

As indicated in chapter two, the only way to pathologize grief so as to capture a large audience is to cast a net wide enough to be inclusive of almost everyone. This necessitates stretching the boundaries of what constitutes a disorder. One of the ways in which the psy-professions have began this process is by proposing criteria for Complicated Grief (CG). While this is not an official diagnosis, it is widely ascribed to, and it is a well known, and utilized category among researchers and clinicians. It is so popular a diagnosis that a recent conference on death education offered several workshops on how to deal with CG (see chapter two). In addition to the proposed category of CG, "bereavement" in general is listed in the current DSM-IV-R as an area that requires further exploration.

It is interesting to note that the inclusion of bereavement in the DSM has changed over the years. In the DSM-III-R, bereavement was listed in the appendix as "Uncomplicated Bereavement". In a training guide for the DSM-III-R the authors wrote:

> This category should be used to describe normal reactions to significant loss, particularly the death of a loved one. Depressive syndromes may be normal in

> such situations, but appropriate handling of feelings and situations by the individual, over time, with normal resolution of the symptoms, should preclude diagnoses of a mental disorder and suggest a V code. (Reid & Wise, 1989, p. 227)

In other words, the authors recognized bereavement, and subsequently grief, as a phenomena that happened to people, but didn't necessary view it as pathological, or automatically in need of intervention. The DSM-IV published in 1994 shifted the definition considerably. "Bereavement" in general is listed in the Appendix, indicating that all bereavement is potentially a mental disorder. The authors wrote:

> The name has changed from DSM-III-R Uncomplicated Bereavement because bereavement may cause significant impairment and complications. Guidelines relating to the duration of the symptoms and particular types of symptoms have been provided to sharpen the boundary between Bereavement and Major Depressive Disorder. (APA, 1994, p. 788)

Finally, the DSM-IV-R authors wrote conclusively that the Bereavement category:

> can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of Major Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). (APA, 2000, p. 312)

Over the years, bereavement has moved from being non-pathological, but included in the DSM, to pathological, but distinct from Major Depression, to being pathological *and* looking like Major Depression. The result is that more and more people meet the criteria for the category, and therefore, more and more people are potentially in need of psychological intervention. The inclusion of bereavement in the DSM-V main body of the text will further psychologize grief.

One way in which to imagine the impact of including grief in the DSM-V is to follow other examples of disorders that were once considered normal and then later became pathologized. One clear example is the diagnosis of Major Depressive Disorder. While it used to be the case that general unhappiness or feeling down was considered part and parcel of life, or a result of one's pessimistic, or melancholic temperament, today, even mild unhappiness is diagnosed as clinical depression and treated with therapy and medications (Barber, 2008; Horwitz &Wakefield, 2008). The psychologist Martin Seligman (2000) critically noted:

> If you're born around World War I, in your lifetime, the prevalence of depression is about 1 percent. If you're born around World War II the lifetime prevalence of depression seemed to be about five percent. If you were born starting in the 1960's, the lifetime prevalence seemed to be between 10 percent and 15 percent, and this is with lives incomplete. (Seligman, 2002 in Barber, 2008, p. 106)[74]

[74] Barber (2008) included this quote in his book that came out of an interview with Seligman on public radio.

In a book dedicated almost entirely to examining the phenomenon of increased diagnosis of depression, Horwitz and Wakefield (2007) made a similar point about the pervasiveness of the MDD diagnosis. They noted that treatment of depression had increased by 300 % between 1987 and 1997, and that by 1997, 40 % of psychotherapy patients had diagnoses that were mood disorders, and most of these were depression. They further indicated that the overall percentage of people treated for depression expanded from 2.1 % in the early 1980's to 3.7 % just two decades later. This is an increase of 76% in just under twenty years (Horwitz & Wakefield, 2007).

Considering the fact that the quality of life has improved tremendously for most North Americans since World War I, it would seem counter-intuitive that depression should rise so exponentially in the 21st century. Indeed, as Seligman (2002), Horwitz, and Wakefield (2007) argued, it is not so much that there are more cases of depression, it is that the definition of the disorder has been stretched so widely it includes egregiously large amounts of people.

The consequences of considering every-day unhappiness a depressive disorder is that many more people are treated for it with therapy and medications, and, perhaps even more importantly, begin to understand themselves within a narrative of mental illness. When it comes to mental disorders, one's understanding of what constitutes mental illness is inexorably tied up to diagnosis and treatment. According to Hillman (1983), embedded within the conceptual and literal diagnosis of what a given individual is going

through is a definition of what mental illness is, and by extension, a specific method of dealing with it. He suggested:

> The force of diagnostic stories cannot be exaggerated. Once one had been written into a particular clinical fantasy with its expectations, its typicalities its character traits, and rich vocabulary it offers for recognizing oneself, one then begins to recapitulate one's life into the story. ... A diagnosis is indeed a gnosis: a mode of self-knowledge that creates a cosmos in its image. (p. 15)

In other words, how people experience their depression (or in the case of this project, their grief), how they make meaning of their experiences, and how they then interpret these meanings largely determines the outcome. Outcome can mean length, duration, quality and context of a person's experience of depression or grief. The diagnosis, as I have argued throughout this project, not only makes the experience, but also determines the fine line between health versus sickness, and normal versus abnormal. This distinction between what is deemed "normal" and "abnormal" has profound implications for cultural understanding of what is acceptable behavior, and what is not (Granek, 2006; Kingwell, 1998).

Another example can be found in the diagnosis of Social Anxiety Disorder (SAD), or shyness. Those advocating for the diagnosis of SAD use many of the same rhetorical tools that grief researchers use to justify the diagnosis of CG. As with the inability to distinguish 'normal' grief from 'pathological grief', the authors of *Social Anxiety Disorder: A Guide* noted that "where shyness ends and social anxiety disorder

begins isn't clear. Some social anxiety is expected in everyone" (Greist, Jefferson, & Katzelnick, 2000, p. 7). In other words, despite the fact that there is a fuzzy line between shyness and social anxiety disorder (and normal versus abnormal grief), the pathologizing of it, which involves its inclusion in the DSM, has had tremendous ramifications for people's understanding of themselves. Indeed, as with the explosion of MDD diagnoses, Social Anxiety Disorder ranges anywhere from 3.7 % to almost 20 % of the population and the result is that over 200 million prescriptions of anti-anxiety drugs are given out in North America each year to treat the disorder (Lane, 2007).

As should be evident from the research presented in earlier chapters, and from the examples of these disorders, grief is already heading towards (what appears to be) the inevitable journey into the complete psychologization of the phenomenon. The explosion in the number of grief counsellors, and the preliminary clinical trials treating grief with antidepressants, is an indication of the early stages of what has happened to every-day depression and shyness in recent years. The shift from considering these emotional experiences to be a normal part of life, to a pathological disorder, has led directly to the overwhelming numbers of people seeking help and being treated by the psy-professions.

Indeed, as with the pathologization of depression and social anxiety, what becomes an even more alarming outcome of psychologizing every-day emotions is the way in which it changes the experience of being human. To be a contemporary griever is to feel shame and embarrassment at one's condition. It is to be like Joan Didion, discussed in chapter three, a person perpetually on guard, inflicted with a new kind of

self-consciousness about whether she is grieving properly. To be a modern griever, then, is to be continuously evaluating and monitoring oneself. As I noted in chapter two, turning grief into a *psychological kind* has ultimately changed the experience of what it means to be a grieving human-being by virtue of being included on the 'normal versus abnormal' continuum. In a previous chapter, I cited Barber (2008), who argued (in the context of antidepressants) that:

> the enduring legacy of the Serotonin Empire may not be the pills themselves but their allegorical value. Like nothing else before in American history, the SSRI's instilled in the public the idea - entirely independent of the clinical utility of the pills - that here exists something 'out there' that can make them happy. (p. 129)

Grief as a *psychological kind* also has an allegorical value. In much the same way that antidepressants have introduced the idea that there is a solution to the problem of unhappiness, and have, therefore, changed the experience of depression, the experience of grief has also changed radically because of the idea that it can go wrong.

The logical outcome of turning grief into a mental disorder is that it will need to be treated by mental health professionals, which will include psychological counselling and/or medication. I spent much of chapter two describing the negative and dangerous consequences of medicating grief and highlighted the fact that grief counselling rarely works and in fact, can be harmful. My concern about too much intervention is related to the aforementioned fear that turning grief into a pathology means legitimizing it as a disorder to be treated.

While the pool of potentially-disordered people with depression or shyness is large (it is common for most people to experience some form of unhappiness, and fear of others in certain situations such as public speaking), the potential patient pool for pathological grief is virtually unlimited. Since everyone will at some point in their lives experience some kind of loss, the inclusion of grief in the DSM makes it feasible for *everyone* to be diagnosed with the disorder. Indeed, many of the researchers who work on the CG diagnosis noted that there is little qualitative difference between normal grief and pathological grief and, further, that psychologists and psychiatrists do not need to wait for a diagnosis but can potentially intervene in order to *prevent* CG from developing.

One excellent example of psy-interventions is the pervasiveness of grief counsellors in almost every single public crisis involving death. While the literature clearly indicates that grief counselors and de-cathartic methods are not helpful in the aftermath of a crisis such as school shootings or mass fires, grief counselors are almost always dispatched to attend to the survivors of the crisis (see chapter two). This is a good example of a psy-intervention that is unwarranted, potentially harmful, and yet is justified as being a preventative measure to avoid the development of PTSD and CG in survivors. Including grief in the DSM will further psychologize it and perpetuate this trend towards intervention, even when intervention is potentially harmful or at least unnecessary.

Loss of grief. In the conclusion to their book, *The Loss of Sadness*, Horwitz and Wakefield (2007) wrote the "transformation of sadness into depressive disorder has the questionable effect of shrinking the range of normal emotions and expanding pathology

to ever widening realms of human experience" (p. 217). Moreover, on the last page of the book, the authors continued:

> Sadness is an inherent part of the human condition, not a mental disorder. Thus to confront psychiatry's invalid definition of depressive disorder is also to consider a painful but important part of our humanity that we have tended to shunt aside in the modern medicalization of human problems. (p. 225)

Although the aforementioned authors are referring to depressive disorder, their conclusions can also be applied to grief. The questionable act of turning grief into a disorder has further reduced the diminishing range of what is considered acceptable human emotion by the psy-disciplines. The pathologization of grief, and its potential inclusion in the DSM will lead to further restrictions on the way in which people experience their grief; this includes limitations around duration, intensity, and modes of expression.

To pathologize grief is to claim that the widespread response to feeling sadness over a loss is a disorder that needs to be treated. The outcome, which is already evident in the public sphere (see chapter three), is that people are afforded less compassion, less time, and less space to grieve their losses. Indeed, as I noted in chapter four, one outcome of thinking of grief as pathological is that the grieving person is left to feel shame and embarrassment over their sadness and are encouraged to seek professional help so as to cope 'better' with their loss. In the case of grief, 'cope' means to get over and get back to normal as soon as possible.

While a diagnosis of depression is purportedly a-theoretical (cause of depression is not necessary to make a diagnosis), the cause of grief is clearer. One grieves and feels pain and sadness at a specific loss(es). While I have been referring primarily to bereavement, or the experience of grieving a loss of a person who has died in this paper, the ability to grieve all losses (including those as a result of divorce, loss of a job, infertility, loss of an ideal, etc.) becomes disenfranchised when grief becomes a pathology. As with the consequences of including grief in the DSM, the notion of eliminating grieving, or rushing through it, has serious ramifications for the grieving person.

To begin, it is important to deconstruct the very premise of 'treating grief'. The idea that we can eliminate grief by treating it in therapy, or by medicating it away, is an illusion. Grieving loss is part and parcel of the human experience. No matter how hard one tries to avoid it by refusing to acknowledge sadness at all, or by trying to get over it quickly and efficiently, it is simply not possible to avoid all grief. The idea that emotional pain can be bypassed, or that it is possible to find solutions to every unhappiness, is a myth.

The *belief* that we can do these things, however, can potentially be harmful. As I noted earlier, grief counselling and the use of medications in order to eradicate grief has proven to be not only ineffective, but even damaging at times. I further contend that the *expectation* that one can avoid or eliminate one's grief and the reality of being unable to do so, also causes a lot of unnecessary pain for people. As I have illustrated throughout,

most people do not grieve in the way they are 'supposed to' according the psy-disciplines construction of the way grief should be experienced. Consequently, their sadness is compounded with an additional sense of self-consciousness about not grieving properly or not getting over it fast enough. The disparity between how one is *supposed* to grieve, and what happens in reality is another cause of despair and sadness for people who are mourning, and, as I have been arguing, this shame and embarrassment has become part of the new experience of contemporary grievers.

To eliminate grief, or rather the attempt to eliminate it, is to eradicate a large part of the human experience. On this Kellehear (2007a) wrote "we have been told so frequently in the academic and professional literature that grief is sad and bad for your health that we steadfastly refuse to create, much less recognize its census of positive features" (p. 75). Contrary to the Western ethic of perpetual happiness (see chapter four), there are also benefits to experiencing grief that often go unstated.

Existential philosophers have written about the benefits of death awareness and the importance of acknowledging loss and grief. Heidegger (1927/1962) distinguished between two states of mind. The first is the state of *forgetfulness,* where one lives in the world of 'things' and is immersed in every-day distractions and diversions of life. The second state, the state of *mindfulness,* often referred to as the 'ontological mode' of being, is where one remains mindful of the fragility of life and is aware of one's own death. Heidegger believed that the latter state, the state of *mindfulness*, was the only way to reach a higher level of consciousness and to live 'authentically'. He further articulated

that the awareness of death and the acceptance of one's own end was necessary in order to access, and live in this state (Heidegger, 1927/1962). Yalom (1980), an existential psychotherapist, summarized Heidegger's philosophy when he wrote, "death is the condition that makes it possible for us to live life in an authentic fashion. This point of view - that death makes a positive contribution to life - is not easily accepted" (p. 31).

While it is not an easily-accepted point of view, I believe it is an important one. Acknowledging and experiencing grief and loss is part of the human spectrum of emotion. Because it is part of the whole of human experience, it is connected to many positive feelings such as joy and gratitude. The only way in which we can learn to appreciate and know about the good things in our lives is by knowing and dealing with the 'bad' parts. In simpler terms, we cannot appreciate or know happiness, joy, gratitude, elation, and love unless we experience the opposites too. We need a point of comparison. Wilson (2008) wrote, "this quest for happiness at the expense of sadness, this obsession with joy without tumult, is dangerous, a deeply troubling loss of the real, of that interplay, rich and terrific, between antagonisms" (pp. 21-22). The ability to inhabit both poles of the antagonisms is the key, in Wilson's view, to experiencing a fuller and more fulfilling life. The eradication of one end of the spectrum, is also inadvertently, an eradication of the other end of the pole too. The same can be said for knowing the depths of our sadness and grief; they are necessary emotional experiences in order to appreciate and know the heights of happiness and joy.

A second, and related benefit to grieving, is that it allows for a fuller range of emotional experience, and thus, a more creative existence. Elliott (1999) wrote, "without mourning there can be no self development, understanding or change. Without mourning we are psychically ill-equipped for creative living. Without mourning we are hampered in preparing for our loss, as it were, in death" (p. 5). Rather than thinking about grief as a pathology to be treated, the idea here is that the experience of it can lead to a more creative existence.

Finally, and perhaps most importantly, the ability to experience grief and acknowledge loss is connected to the acknowledgment of death and endings in life. The ability to recognize that all things in life are fleeting and intangible (which comes with the experience of loss, and subsequently grief, over their absence) is what can potentially give meaning to life. This principle can be thought of in economic terms. Where there is too much of a product, it floods the market and subsequently loses its value. The inflation of the product renders it meaningless because it no longer is worth anything. The same is true for our lives. The fact that they are limited and finite, and that our years are in short supply, is what gives it its meaning and its value.

The only way to comprehend this lesson is by experiencing loss and taking the time to grieve it. The experience of grief draws our own mortality and the mortality of others into sharp relief. Whereas, North Americans are accustomed to hiding from the reality of death, loss and grief are reminders that all things must come to an end and that since time is limited, one must accomplish what one wishes to accomplish *now*. Further,

it is a reminder that one must behave in ways that one wishes to be remembered for in the present. To medicate grief away, or to try to bypass or speed through the process, is also to eliminate the potential gifts of grief.[75]

Healing versus Curing

> "Healing" and "curing" reflect two quite different perspectives concerning human health and illness... Curing finds its' modality in external sources: pharmaceuticals, radiation, and surgery. Healing draws only from inner resources, experience, faith, strength of character, and the power of the soul. The person who delivers a cure has to be proficient in scientific, technical, and intellectual matters. The person who wants to heal need not have technical know-how but must be demonstrably empathic and deeply concerned with the well-being of others. (Lamm, 2004, p. 133)

The just cited paragraph was written by Rabbi Maurice Lamm, an expert on grief and mourning rituals in the Jewish tradition. He made the distinction between healing and curing in relation to grief by pointing out that the "goal of curing is to return the diseased part to functional integrity. But healing seeks to return the whole person to health" (p.134). For example, "amputees return to health when they feel strong, positive, ready -

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[75] I use the term 'gift' here cautiously. As a person who has experienced multiple devastating losses, I want to be clear that I am not romanticizing suffering or grief. Grieving a death is heartbreaking, painful, and difficult. I would not wish what I experienced on anyone, or claim that one must grieve in order to experience these benefits. At the same time, I believe, as I have outlined in this conclusion that most people will grieve at some point in their lives. This is not optional. Rather than viewing the experience of major loss as a pathology to be treated, I think that there is a benefit in accepting it as part of the totality of human experience and glean some of the benefits that naturally arise out of it including the awareness of one's own mortality, and the subsequent urgency that can arise out of it, to live in line with one's values and accomplish what one wants to do before they die.

actually healthy - despite the fact that they will never return to complete physical intactness" (Lamm, 2004, p. 134). Lamm (2004), being a religious person, argued that healing can only come through God. I would like to use his analogy here, however, in a different way.

The psychological construction of grief as a pathology to be treated takes the curing approach, and as Lamm (2004) pointed out, requires a professional, scientific, administrator who uses external resources such as pharmaceuticals, or 'empirically validated' therapies, to cure. While it can be argued that some psychologists attempt to address the whole human being in their clinical treatment of their clients, and therefore, also aim to heal, the focus in the majority of psychological interventions for grief is to eradicate the symptoms (Horwitz & Wakefield, 2007). The point of the curing intervention is to deal with the 'diseased' or, in the case of grief, the 'disordered' parts to return them to 'functional integrity'. This is akin to statements I have been making throughout this project regarding the pressure on people to seek help for their grief so as to go back to normal as quickly and efficiently as possible.

Healing, on the other hand, is about healthiness. Lamm (2004) uses the analogy of the amputee to make his point. The amputee is someone who has experienced a serious and traumatic loss to her or his bodily integrity. The possibility of returning to health, or to feeling healed, however, is not contingent on the reestablishment of their previous body boundaries. They will never go back to 'normal' again; their bodies will never resume their original shape. Once the limb is lost, it is lost forever. According to Lamm

(2004), however, this does not preclude them from healing or becoming healthy again. They "return to health when they feel strong, positive, ready - actually healthy - *despite* the fact that they will never return to complete physical intactness" (Lamm, 2004, p. 134).

I believe it is the same with grief. No matter how many interventions psy-professions come up with, and no matter how hard they try to cure one from their sadness, a person who has experienced a significant loss (of limb, or person) will never be entirely the same again. They will never be cured from their grief completely. This does not mean, however, that they will never heal from it. Indeed, as with the amputee, the grieving person will become strong again, but in a different way than they were before and it is other 'empathic and caring' people that can help them get there.

To understand the distinction between curing and healing is to understand why the psy-professions' attempt to cure grief can be unhelpful and even damaging. Curing grief is akin to trying to convince the amputee that their lost limb still exists and that they should go back to functioning in the exact same way as they were before. It is completely absurd to imagine this scenario. Yet, psy-professionals advocate that very sentiment when they tell grievers that they should go back to their normal lives after experiencing significant losses of people who they loved and depended on so much.

Barber (2008) noted that one of the greatest insights of the recovery movement (includes recovery from addictions, mental or physical illness) is that recovery can exist within the context of illness. While grief is *not* a disease, disorder, or an illness in the

same way as some mental illness and addiction problems are, the analogy to grief resembles Lamm's distinction between curing and healing. Barber (2008) wrote, "medicine defines recovery...as the removing of all symptoms, as if they were toxic and foreign entities having nothing to do with us" (p. 184). He further noted that this definition is inadequate and does not reflect the reality of most people's lives. He wrote, "recovery then involves both a coming to terms with symptoms - one hopes in the context of their gradual moderation, but this is not always the case - and finding a meaningful life in their midst" (p. 184).

Recovery from grief happens in the same way. As aforementioned, the healing of grief means accepting that one will never be cured from it; one will always have 'symptoms' of intense sadness and feelings of loss that come and go throughout the years; and, finally, one will be forever changed by their experience. Perhaps this last idea is most radical of all when juxtaposed with the psy-disciplinary perspective on grief because it assumes that there is very little to be done about grief, but suffer through it. This idea is contrary to the very essence of the psychological worldview.

One of the central implicit principles of psychology is that all suffering must have an explanation, a trajectory, a treatment, and subsequently, a cure. On this, Illouz (2008) noted that in "the contemporary therapeutic worldview suffering has become a problem to be managed by the experts of the psyche" (p. 246). The question of why we suffer is not new. Indeed, suffering has historically been a central problem for the world's major religions (Bowker, 1970). It can be argued that people have always wondered about why

we grieve, suffer, and feel pain. In the biblical story of Job, for example, the main character, described as a pious and kind man, is struck down with devastating losses. His family, his livelihood, and his very reason for living are taken away from him, until he is ultimately left with nothing. The majority of the narrative has Job, his friends, and his community offering various explanations as to why he is suffering. The story ends with God raging at Job and his friends that suffering cannot be understood by mortal men, and that trying to do so will only lead to more suffering. Contrast the moral of this narrative to the therapeutic worldview when it comes to grieving and loss. Illouz (2008) wrote that it is a:

> discourse that views suffering as the effect of mismanaged emotions or a dysfunctional psyche... psychology is the first cultural system to dispose of the problem [of why we suffer] altogether by making misfortune the result of a wounded or mismanaged psyche. (p. 246)

The psy-disciplinary prerogative is to explain, rationalize, treat, and always eliminate suffering. What is problematic about this view in relation to grief, is that there is no explanation, no justification, and thus, ultimately, no treatment for grieving. While this idea can be applied to many psychological categories (e.g., explaining and pointing out that shyness is a problem is the first step in treating it), it is especially poignant for grief. The subjective feeling of grief, whether acutely, or years after a major loss is an exercise in helplessness. No matter how much you want that person to come back, they never will return. No matter how much you yearn to see them, hear their voice, or touch

their arm, you cannot will them or those sensations back. Finally, no matter how much you want to assuage your pain and make it stop, you are helpless in the grip of your grief in that moment. It is the one area where there really is no cure, and it is perhaps it is *this* reality that is most difficult for the psy-disciplines to accept. It also explains why the psy-disciplinary attempt to treat grief despite the evidence that these interventions are not effective has been so successful in the popular culture. In addition to the remarks I made earlier in this chapter about the psy-disciplines filling in a need to manage and control grief at a time where there is a lot of uncertainty around mourning, the psy-interventions also hold the promise that one can rid oneself of grief and pain. As I argued earlier, I do not believe that this is possible, but it is easy to understand why this idea has taken hold so successfully in the culture.

Illouz (2008) noted that "in the therapeutic ethos there is no such thing as senseless suffering and chaos, and this is why, in the final analysis, its cultural impact should worry us" (p. 247). Although Illouz is referring here to the general impact of psychology on modern culture, I agree with her statement in the context of grief. It is the insistence that grief is a phenomena that can be explained, rationalized, justified, treated, and ultimately eradicated that is worrisome. In an article on suffering, Kleinman (1997), a medical anthropologist made a similar remark.

> The claims made for high technology interventions and the growth of our scientific knowledge base... hide the reality, as do facile expectations that psychotherapy and psychopharmacology can relieve residual pain and suffering.

> In this respect, the culture of biomedicine [of which the psy-disciplines are a part]... conspires with the popular culture to treat death as the enemy. They have great difficulty coming to terms with the limits of treatment and the reality of suffering as a way of life. (p. 331)

It is the "coming to terms with the limits of treatment" that seems to be the most challenging from the psy-disciplinary perspective, and yet, as I have argued throughout this paper, the insistence that it could be otherwise has changed the experience of what it means to be a griever in 21st century North America. These changes have not always benefited the contemporary mourner. This conclusion, in itself, is enough to make this project a worthy endeavour.

To conclude, I would like to go back to Lamm's distinctions, I believe that 'recovery' from grief should mean 'healing' rather than 'curing', and that healing, in turn, means finding a meaningful life in the midst of one's losses and grief.

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Appendix A

Prigerson's Criteria for Complicated Grief Proposed for DSM-V

Reference: Prigerson, H. G., & Maciejewski, P. K. (2005-2006). A call for sound empirical testing and evaluation of criteria for complicated grief proposed for DSM-V. *Omega: Journal of Death and Dying, 52*(1), 9-19.

Criterion A: Chronic and persistent yearning, pining, longing for the deceased, reflecting a need for connection with deceased that cannot be satisfied by others. Daily, intrusive distressing, and disruptive heartache.

1. **Yearning/longing/heartache** - `Do you feel yourself yearning and longing for the person who is gone?'

Criterion B. The person should have four of the following eight remaining symptoms at least several times a day or to a degree intense enough to be distressing and disruptive:

1. **Trouble accepting the death** – `Do you have trouble accepting the loss of ___?'
2. **Inability to trust others** –`To what extent has it been hard for you to trust others since the loss of ___?'
3. **Excessive bitterness or anger related to the death** - `Do you feel angry about the loss of ___?'
4. **Uneasy about moving on** – `Sometimes people who lose a loved one feel uneasy about moving on with their life. To what extent do you feel that moving on (for example, making new friends, pursuing new interests) would be difficult for you?'
5. **Numbness/Detachment** - `Do you feel emotionally numb or have trouble feeling connected with others since _____ died?'
6. **Feeling life is empty or meaningless without deceased** – `To what extent do you feel that life is empty or meaningless without ___?'
7. **Bleak future** – `Do you feel that the future holds no meaning or prospect for fulfillment without _____?'
8. **Agitated** – 'Do you feel on edge or jumpy since _____ died?'

Criterion C. The above symptom disturbance causes marked and persistent dysfunction in social, occupational, or other important domains.

Criterion D. Symptoms must be met for at least six months.

Complicated Grief Diagnosis = Criteria A, B, C, and D are met.

Appendix B

Horowitz et al. Criteria for Complicated Grief Disorder.

Reference: Horowitz, M. J., Siegel, B., Holen, A., & Bonanno, G. A. (1997). Diagnostic criteria for complicated grief disorder. *American Journal of Psychiatry, 154*(7), 904-910.

A. Event Criterion/ Prolonged Response Criterion
Bereavement (Loss of spouse, other relative or intimate partner) at least 14 months ago (to avoid anniversary).

B. Signs and Symptoms Criteria
In the last month any three of the following, with a severity that interferes with daily functioning:

Intrusive Symptoms
1) Unbidden memories or intrusive fantasies related to the lost relationship.
2) Strong spells or pangs of severe emotion related to the lost relationship.
3) Distressing strong yearnings or wishes that the deceased were there.

Signs of Avoidance and Failure to Adapt
4) Feeling of being alone too much or personally empty.
5) Excessively staying away from people, places or activities that remind the subject of the deceased.
6) Unusual levels of sleep interference.
7) Loss of interest in work, social, caretaking, or recreational activities to a maladaptive degree.

Appendix C

Criteria for Major Depressive Episode (DSM-IV, 1994, p. 327).

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest and pleasure.

1- depressed mood most of the day, nearly every day
2- markedly diminished interest and pleasure in all, or almost all activities most of the day, nearly every day
3- significant weight loss when not dieting or weight gain, or decrease, or increase in appetite nearly every day
4- insomnia or hypersomnia nearly every day
5- psychomotor agitation or retardation nearly every day
6- fatigue or loss of energy every day
7- feelings of worthlessness or excessive or inappropriate guilt nearly every day
8- diminished ability to think or concentrate, or indecisiveness, nearly every day
9- recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for Bereavement. i.e., After the loss of a loved one, the symptoms persist for *longer than two months* or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Appendix D

Depiction of Mental Illness in Contemporary Films

Barber (2008) noted that in "recent years, one's chance of getting nominated for an Oscar are greatly enhanced by playing a character experiencing mental dysfunction. In almost every year over the last decade, actors have either been nominated for, or own Oscars for portraying a psychiatric disorder" (p. 11).

Year	Actor's Name	Name of Film	Disorder
2006	Jackie Earle Haley	*Little Children*	pedophilia
2005	Felicity Huffman	*Transamerica*	gender identity disorder
2004	Leonardo DiCaprio	*The Aviator*	obsessive-compulsive disorder
2004	Charlize Theron	*Monster*	posttraumatic stress disorder
2003	Tim Robbins	*Mystic River*	posttraumatic stress disorder; major depressive disorder with psychotic features.
2002	Nicole Kidman	*The Hours*	major depressive disorder
2001	Russell Crowe	*A Beautiful Mind*	schizophrenia, paranoid type
2001	Sean Penn	*I Am Sam*	pervasive developmental disorder
2001	Judie Dench	*Iris*	Alzheimer's disease
2000	Ed Harris	*Pollack*	bipolar disorder
1999	Angelina Jolie	*Girl, Interrupted*	borderline personality disorder
1997	Matt Damon	*Good Will Hunting*	antisocial disorder
1997	Jack Nicholson	*As Good as it Gets*	obsessive-compulsive disorder
1996	Geoffrey Rush	*Shine*	schizophrenia
1996	Billy Bob Thorton	*Sling Blade*	pervasive developmental disorder
1995	Bradd Pitt	*12 Monkeys*	schizophrenia
1995	Nicholas Cage	*Leaving Las Vegas*	major depressive disorder; alcoholism
1994	Tom Hanks	*Forrest Gump*	pervasive developmental disorder
1994	Nigel Hawthrone	*The Madness of King George*- psychotic disorder	
1993	Leonardo DiCaprio	*What's Eating Gilbert Grape* – pervasive developmental disorder	

Appendix E

Popular Culture References to Kubler-Ross

Kubler-Ross's five stages of grief are pervasive in popular culture. Below are a few examples copied from Wikipedia (2007a), the online encyclopedia. Since this website is not always reliable, I checked each episode described below for accuracy and found that the five stages of grief are indeed represented in all of these mainstream media outlets. *http://en.wikipedia.org/wiki/Five_Stages_of_Grief*

- In the episode *Acceptance* of the TV show *House,* Dr. Cameron goes through the 5 stages of grief upon learning that one of her patients has terminal small cell Lung Cancer. The title of the episode itself is the last stage of grief.

- In the *Marvel Comics* series *Fallen Son: The Death of Captain America*, each of the five issues deals with a different stage of grief following the death of Captain America: Denial, Anger, Bargaining, Depression, and Acceptance.

- In the TV show *Frasier*, when Frasier is unemployed, there is an episode where he cycles through the stages. (Season 6)

- In the TV cartoon show *The Simpsons*, the 5 stages were also shown in the episode "One Fish, Two Fish, Blowfish, Blue Fish", where Homer discovers he will most likely die after eating a poisonous fugu fish. Dr Julius Hibbert tells him the 5 stages of grief, and which Homer replies instantly with the according emotion after each one.

- In the TV cartoon show *Robot Chicken*, the 5 stages are cited by a giraffe when he is sinking in quicksand, but by the time he gets to "acceptance", he hits the bottom with his head remaining above the quicksand.

- In the TV show *Scrubs* Dr Cox and J.D. become friendly with a long-term patient, Mrs. Wilks. When her condition worsens and her death becomes inevitable, they go through the 5 stages of grief and gets help from the hospitals grief counselor, Dr Hedrick, in the episode *My Five Stages.*

- In the TV show *Dead Like Me*, George Lass noted that dead people go through the same cycle, as she does moments after her death. Her acceptance takes a little longer to accomplish than the other four which she passed through rapidly for comedic effect.

- In the Comic series *Cat and Girl*, Cat announced to Girl that a new stage of grief, Baklava, has been introduced between Anger and Bargaining in issue 144.

- In the 1979 Film *All That Jazz*, stand-up performer Davis Newman, commenting on the impending/happening death of the main character, says, "This chick, man, without the sole benefit of dying herself, has broken down the process of dying into five stages: anger, denial, bargaining, depression and acceptance.

- In an episode of *Reba,* Van claims to go through the five stages of grief after finding out his injury will not allow him to play pro football anymore. ("I went through denial, anger and unusually dry skin. But now I'm a new, moist man!")

- In the 2002 Film *Life or Something Like It*, after Prophet Jack tells Lanie Kerrigan (played by Angelina Jolie) that she will die within a week, she proceeds through the stages rather quickly. Prophet Jack takes notice of this and directly references the five stages of grief and how quickly she is moving through them.

- Anna, in Scene 14 of Paula Vogel's *The Baltimore Waltz* (1992) passes through, what are called six stages of the Ross model. Hope is the sixth stage. Anna, also adds a seventh stage: lust, where the illness of the body is fought with the health of the body. The health of the body in this instance manifests itself as sexual activity.

- Edward Albee's *The Lady From Dubuque*, and Michael Crisofer's *The Shadowbox* are noted in various academic journals and articles, and interviews, as influenced by the Kubler-Ross model.

- Darren Hayes, an Australian musician, has a song called *Unlovable*, which includes the lyric "Denial, anger, bargaining, depression, just a few stages of acceptance that it's really over" in reference to experiencing these five stages after ending a relationship.

- In the Ned's Declassified School Survival Guide episode *Backpacks,* Ned had 4 spoofs of the stages.

- In the episode *Mr. Monk Gets a New Shrink* of the TV show *Monk,* when Monk's therapist left, he went through the Five Stages of Grief, but he repeated all the stages over and over.

- In Armor For Sleep's 2nd album *What To Do When You Are Dead,* the album tells a story of a young man who commits suicide and goes through the five stages concerning his death.

- According to the Director's Commentary on the *Groundhog Day* DVD, Bill Murray's character in the film, Phil Connors, goes through the five stages.

- In *Bridge to Terebithia*, Jess accurately displays the five stages of grief.

- In the popular TV teen drama series *One Tree Hill* during episode 62 of the third season titled: *Who Will Survive and What Will Be Left of Them*, the 5 stages of grief were present, but in this particular episode, the writers of the screenplay switched bargaining with guilt and added fear before it.

Appendix F

How to Create a Community of Supporters for Grievers

One outcome of conducting this research was the creation of a workshop on why it's important to grieve one's losses and how to be with someone who is mourning. Having presented this workshop to several groups, here are a list of suggestions I have put together on how to build community and become a person who can support someone who is grieving. One important caveat is that these are *suggestions* (as opposed to prescriptions) of what might be helpful based on what grieving people have told me. I am wary of committing the same fallacy I am critiquing in this dissertation, that of prescribing a 'right' versus a 'wrong' way to grieve. I, therefore, present these ideas cautiously, and with a forewarning that these ideas may not be appropriate in every situation. I am taking the risk of including some of these notes because as I have been arguing throughout this project, part of the problem with the pathologization of grief is the lack of knowledge around grief ritual, and a discomfort around people who are mourning. My aim here is to provide simple ways in which people who wish to support the bereaved can begin to address some of their discomfort, and in the process, be present for those who are grieving.

1- **Become Comfortable With Death:** The first thing one can do to help someone who is grieving is to cope with one's own grief. We must recognize and acknowledge our own mortality before we can help anyone else cope with theirs. As I note throughout this project, the fear of death leads directly to the fear of grief. One way in which to support a mourner is to become comfortable with death, and thus subsequently, also become comfortable with grief- one's own grief and the grief of others.

2- **Accept Grief as part of Life:** Grief is normal, natural, and expected. It is not to be fixed, eradicated or medicated away. It is to be experienced.

3- **Say the 'Right' Thing:** I'm often asked about the right thing to say to someone who is grieving. To begin with, here is what might be **less helpful:**
Platitudes are not helpful. These include things like "I know how you feel" or "It's all for the best", "time heals all wounds" or "it was God's Plan". No one wants to hear these things, especially right after someone they love and care about has died or if they are in midst of coping with their loss and suffering. Other things that are not helpful include telling people that their grief is abnormal, that they should get over it, or that there is something wrong with them. All of this advice can be extrapolated too all losses. For example, telling a divorced person that it's time to move on before she or he is ready is not helpful or supportive.

Here are some things that can be **helpful to say:**

Follow the Leader: If you cannot think of anything to say, it is ok to say nothing at all, or simply to be honest and say you don't know what to say.
In the Jewish practice of Shiva, for example, there are stringent rules around visiting a mourner. When a comforter is visiting, they are to remain silent until the person grieving initiates conversation. If the person grieving talks about the weather, you reciprocate by talking about how cold or hot it is. If the griever cries over their loss, you sit and cry with them. The wisdom is to follow the lead of the mourner and to be comfortable with whatever they need at the moment.

Don't Ignore the Situation: A caveat- the saying nothing at all rule does not mean you are too ignore the person who is grieving! You still go over and acknowledge the loss by simply being there or asking the person how you can be with them at this time- but it does not mean ignoring what has happened or avoiding the conversation. One of the most healing and helpful things a person can do to help someone is grieving is simply acknowledge their loss by being there with them without trying to fix or solve the 'problem'.

Share the Pain: Finally, you can also simply tell the person how sorry you are for their loss. Another option is to say, "I share in your pain" or "my heart is with you". These simple words can be more impactful and more meaningful to a mourner than platitudes about their pain.

Know When Stay Silent: There is a right and a wrong time to express condolences to someone who is grieving. (For example, two months after my mother died I ran into a colleague in the hallway right before I was about to lecture to a class of 150 students. I had my hand on the door when she began to apologize profusely for not coming to the Shiva and started to ask me how I was doing, what could she do, how hard it must have been, how was the funeral and on and on). The right way to help someone who is grieving is as much about *context* as it is about *content.* Be sensitive to where you are and what the grieving person needs in the moment.

4- **Listen to What the Grieving Person is Saying Without Trying to Fix it:** No matter how much you want to take away the pain of the person who is grieving, you cannot do this. The mourner needs to be grieving this loss right now and the only thing you can do for them is support them in the process. This means listening to them actively, and empathically without offering solutions, advice or telling your own stories of loss.

5- **Empathize Don't Sympathize.** Listening without judgment and simply being there for the person means being empathic rather than sympathetic. Empathy means that you can identify with the other persons pain and feel their suffering in your own being. Sympathy means you feel sorry for the other person and you have pity for them. Empathizing means being egalitarian and on the same level with the other person and recognizing (back to points 1 and 2) that while you are not grieving right now, you may have grieved in the past, or you know you will in the future. Empathy means recognizing that grieving is part of the human condition and we all suffer losses. Pity, on the other hand, removes you from the situation and puts you in a superior or removed position.

6- **Be Real With Your Own Grief:** If you have experienced you own losses and you are touched by someone else's pain, cry with them. It's part of the human condition to feel empathy and it can be supportive to be emotional and real with the other person. You can say to the mourner, "I am so affected by your sadness, I feel it too and it is making me emotional" and cry together.
If you are feeling truly overwhelmed by your own grief, it may not be helpful for the person you are visiting with. In that case, you excuse yourself and deal with your own grief before you come back to support the mourner. (Think of this as the plane principle. When there is an emergency on a plane, you are asked to put on your own oxygen mask before you help anyone else with theirs).

7- **Trust the Process:** Know that your own grief or the grief of others is a long and unpredictable process and that ALL of it is ok. There are no predictable phases or stages. Whether you, or someone you know is grieving any kind of loss, recognize that it can take years to feel 'ok' again and that there will be ups and downs and that your reactions may be all over the place. All of this is simply the process of grief.

Many of the self-help books on grief and much of the professional literature spend a great deal of time talking about the 'craziness' of grief being 'normal'. The trend of talking about how what appears to be craziness is really just part of the normal grief process. I am saying the same thing here, but I am critical of this literature because I think it constructs normal grieving reactions that are common all over the world (I.e., Things like visitation dreams, or the belief that the dead person will come back) as temporarily crazy due to the 'condition of grief'.

These reactions are in fact, not crazy. They are simply grief. Just like laughter or being on a high can be part of happiness, anger or an illusion, or longing for someone to come back is part of grief. We don't judge the elation of joy as temporarily crazy and we shouldn't judge the despair of grief as temporarily pathological either.

Because we have eradicated all public displays and dialogue about mourning and grieving, we think that these behaviors and reactions are irrational, and therefore, require an explanation or require validation, but most cultures around the world recognize them as natural and normal.

8- **Be Patient and Accepting:** If you are grieving or know someone who is, be patient with the process. *It will take a long time.* It will take a lot longer than what this culture will have you believe, but it will eventually become easier to deal with. At the same time, acknowledge to yourself or to the person you are supporting that this loss may change them (or you) irreparably and that they will never go back to who they were before and that is ok.

9- **Practical Support:** One of the most helpful things one can do to support a mourner is help them with the practical aspects of living. This can include bringing over a meal, looking after their kids, helping them clean their house or doing a food shop. This can either be in the acute grief phase or well after when people may need help coping with day-to-day chores.

10- **Be There:** Some mourners may not want to talk, or may not need any practical support. Simply being there is enough to show that you care and you are available for them if they need anything either in the acute grieving stage or afterwards. One of the things that I advocate is continuing to call and be present after the first few weeks or even months of the death. The hardest pain comes long after everyone has stopped coming around and calling and it is when the person most needs your help.

11- **Know the Bereaved Person's Death Dates:** Death dates include anniversaries of death, birthdays, and holidays like mother's day, father's day or religious days. These death dates are extremely difficult for grieving people and can bring up all the emotions of grief as if the death just occurred. Simply calling and saying "Hey, I know this must be a hard day for you, lets grab a coffee" is a powerful way to show you care for the person who is grieving and you are thinking about them.

12- **Create New Rituals:** If you are grieving or know someone who is, help them create new rituals to commemorate their losses. This might include creating shrines or ceremonies to remember the deceased, planning a memorial service for them, writing out feelings or putting together a scrapbook.

13- **Get Physical:** Physical practices like meditation, deep breathing, shiatsu or acupuncture, steam room, sauna, physical exercise, eating healthy foods and getting enough sleep can have a help one cope with the pain of grief.