The discursive transformation of grief throughout history

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The discursive transformation of grief throughout history

Abstract
In recent decades, the phenomenon of grief, when you lose a loved one, has been the subject of exploration and discussion among researchers. Because of this, prolonged grief is now recognised as a possible mental disorder as the latest version of the diagnosis manual; “International Classification of Diseases” (ICD-11) being published in 2018 is featuring a new diagnosis called “Prolonged Grief Disorder”.

The commencement of this new disorder indicates a shift in the way grief is being articulated why the notion of rupture from the French philosopher Michel Foucault is applied as a philosophical approach in this paper. A Foucault-inspired discourse analysis has been prepared and by considering the issue historically and tracing how the concept of grief has been articulated in different time periods throughout history, the aim is to map out the discursive transformation that has taken place and to gain insight into how the societal context has supported and enabled this transformation.

This paper takes a historical look back from the 1800s to present and identifies when changes can be observed in the way grief is being articulated. These changes or ruptures are identified in the work of Søren Aabye Kierkegaard, Sigmund Freud and Margaret Stroebe & Henk Schut who all must be assumed to have contributed significantly to how grief is perceived in various historical time periods.

The discourse analysis identifies how prominent thinkers have articulated grief in each period and how today’s perception of grief, as a possible mental disorder, both relates to these prominent thinkers but also reflects dominant societal values and ideologies.

Keywords
Introduction

When a person loses someone close to them a grief reaction is triggered. A person grieving finds themselves in a vulnerable and painful state that requires compassionate care. Currently, we are witnessing grief appearing in a new context, since the latest version of the diagnostic manual “International Classification of Diseases” (ICD-11) contains a mental disorder called “Prolonged Grief Disorder”. The European diagnostic classification system is published by the World Health Organization (WHO), and in 2018 the 11th version of the “International Classification of Diseases” (ICD-11) was published, where the diagnosis of grief is now included as an independent diagnosis under the designation “Prolonged Grief Disorder” (WHO, 2018).

In 2013, the fifth version of the American diagnostic classification system the “Diagnostic and Statistical Manual of Mental Disorders” (DSM-5) was published by the American Psychiatric Association. In this manual, prolonged grief was rejected as an independent diagnosis, with the suggestion that there is insufficient evidence for the diagnosis. Prolonged grief is instead placed as a subcategory of “Other specified trauma and stressor-related disorders” (DSM-5, 2013).

The fact that grief is associated with a mental disorder indicates a shift in modes and thoughts in healthcare and has prompted a discussion in the media as well as in national and international research environments where researchers discuss the fairness of perceiving grief as a mental disorder and categorising it with other mental disorders. The discussion is characterised by reflecting contradictory views, where some support the diagnosing of grief and others are opposed. The discussion has included various suggestions as to what the new diagnosis should be called why different terms have been used when describing the condition. Terms such as prolonged grief, extended grief, complicated grief, pathological grief, traumatic grief, and persistent grief are used.

In this paper, the term ‘prolonged grief’ is used, which is similar to the term in the ICD-11 (WHO, 2018).
Over the past decade, researchers have advocated that a particularly persistent kind of grief should be classified as a mental disorder, with studies showing that the condition can be remedied if the right treatment is offered (Bryant, 2014; Simon, 2013).

Researchers who advocate the diagnosis emphasise that the legitimacy of the diagnosis is evident and refer to empirical studies showing that 7–10% of people grieving develop a prolonged kind of grief, and symptoms of it contribute to health problems such as depression, suicide, substance abuse, unhealthy behaviour, increased risk of developing cancer, and cardiovascular disease. Lundorff et al. found a pooled prevalence rate of approximately 10% for people confronted with a loss due to a natural cause (Lundorff et al., 2017). A recent systematic review indicates that rates are higher for people confronted with sudden, unnatural deaths (Djelantik et al., 2020).

Proponents of the diagnosis also point out that prolonged grief is more intense, more complicated, and more disabling than normal grief and that the benefits of a diagnosis outweigh the potential harmful effects as long as the diagnosis is used appropriately (Shear et al., 2011). The main argument is that a grief diagnosis makes it possible to identify those people who have symptoms of prolonged grief and to offer them appropriate treatment. It is emphasised that the benefit of this treatment is that those afflicted by it, are spared from unnecessary suffering (R. A. Bryant, 2013; Bryant, 2014; Simon, 2013).

In recent years, there have been encouraging findings that cognitive behavioural therapy is beneficial in reducing the symptoms of prolonged grief (Bryant, 2013). This is supported by a review that outlines recent advances in the treatment of prolonged grief (Boelen et al., 2007). It demonstrates that cognitive behavioural therapies designed for prolonged grief are more effective than non-specific therapies such as interpersonal therapy and supportive counselling (Boelen et al., 2007).

The intention of identifying and healing those people suffering from prolonged grief may immediately sound like an obvious and meaningful act. However, part of the international research field is reluctant to recognise grief as an independent diagnosis. They emphasise that a grief diagnosis can lead to a normal human reaction being turned into an illness.

These researchers problematise that more and more people are being given a mental disorder and associate it with a tendency to turn common human conditions and reactions into illnesses (Wakefield, 1997). Smith presents an estimate claiming that 25% of the US population has a diagnosable mental disorder (Smith, 2012). A phenomenon that Brinkmann describes as a
medicalisation of ordinary states of suffering, which can be seen as a trend in contemporary late modern society, where suffering and difficult life experiences are articulated within a medical framework (Brinkmann, 2016).

The consequences of this medicalisation of ordinary suffering are described in relation to grief by Bandini. She points out that people who respond with a common reaction as grief when they lose a loved one, are part of a group at risk of being over-diagnosed, with over-treatment being the result (Bandini, 2015). This risk is supported by a review that emphasises that clinicians should vary of over-diagnosis and mis-diagnosis of prolonged grief, as bereavement is a universally experienced life-event and symptoms of acute grief may be difficult to differentiate from prolonged grief based on duration or phenomenology alone (Doering & Eisma, 2016).

Wakefield describes that if the diagnostic criteria are formulated too inclusive, millions of normally grieving individuals could mistakenly be pathologised, because when close relationships are lost grief can naturally be extremely intense and very prolonged (Wakefield, 2012).

As with many conditions that have been medicalised, there is an opportunity for the pharmaceutical industry to take a stake in the market for a new condition by developing new drugs and earning profits. As death is a naturally occurring life event medicalising grief could potentially open a huge market for pharmaceutical companies (Bandini, 2015).

A person in grief can be perceived as a vulnerable person, which gives rise to reflections of an ethical nature (Machin et al., 2015). Among the ethical aspects is the fact that, for some, the diagnosing of grief is an opportunity to make money from people who find themselves in a vulnerable situation. Ethics is part of our common and obvious base of values. Most people agree that one of the principles of ethics is that another person’s vulnerability should not be taken advantage of (Haupt, 1995).

At present, studies in pharmacotherapy have been focusing on whether antidepressants are effective in reducing the symptoms of prolonged grief. Presently there is no evidence that antidepressants are effective for treating prolonged grief (Hensley et al., 2009; Shear et al., 2016; Zygmont et al., 1998).

In addition to over-diagnosing and over-treatment, it is emphasised that when a grief reaction is categorised in a classification system, other ways in which grief can manifest itself are underestimated, and it is emphasised that grief is a complex phenomenon that contains cultural, contextual, and individual variations, which cannot necessarily be categorised in a classification system (Bandini, 2015; Nanni et al., 2015).

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To classify a reaction as being abnormal, it is necessary to be able to describe the symptoms that separate a normal grief response from an abnormal one. Wakefield points out that there are no specific symptoms that distinguish an abnormal kind of grief from a normal one and if it is not possible to separate intense normal grief from an unhealthy reaction, the consequence could be massive false-positive diagnoses. Furthermore, he emphasises that there is no difference in the duration, since some people simply spend longer on grieving than others. He also believes that the harmful effects that are measured as consequences of prolonged grief have been measured using questionable methods (Wakefield, 2012) and brings forth the work of Prigerson and colleagues as being significant to our understanding of symptoms and trajectory of grief (Prigerson et al., 2009). However, Wakefield questions the validity of their results and claims that the aim of the study is to maximising sensitivity by reaching positive responses to certain questions. As an example, Wakefield highlights suicidal ideation which is the most cited evidence of prolonged grief pathology, but Wakefield believes that the increased suicidal ideation could be a result of the way this question is phrased combined with the greater distress and the inevitable desperate thoughts that occur during long periods of suffering (Wakefield, 2012).

The purpose of this paper is to explore how grief has been articulated in different periods of time and to show the discursive transformation that has occurred over the different historical periods. Inspired by Foucault’s notion of rupture as a philosophical attitude (Beedholm et al., 2014; Foucault, 1971, 1972b) the question is: “When and in what ways have we come to consider grief as a matter of a possible mental disorder?”

A discourse analytic approach

A Foucault-inspired discourse analytic approach is applied. Foucault never stated his philosophical position and refused consistently any categorisation. This paper rest on a social constructivist basis and build on the assumption that at any time in any society certain given conditions for thinking and speaking exist (Jørgensen & Phillips, 2010).

A discourse analysis is prepared on texts from the work of prominent thinkers from the 1800s and to present serving as the empirical material. That is, texts of work that are considered to have had an impact on the emergence of the discourse and been constitutive of dominant discourses in relation to the concept of grief at the given time.

The prominent thinkers are not considered as producing the current discourse independently nor controlling it. In accordance with Foucault’s conception, discourses are perceived as a product of
different societal conditions that have contributed shaping how we talk and think about the world. These conditions are contributing but not the cause of it (Foucault, 1972a).

A discourse analysis unfolds how reality is articulated and assumes that language allows for cognition and that language is not a passive description of reality but an active tool that puts reality into a certain way. Language is not innocent, language is not objective, language is created by something and creates something (Beedholm, 2000).

Foucault does not offer any concrete and systematic method of applicable analytical tools because he considered any analysis to be specific arguing that functional methods must be developed for the individual case (Beedholm et al., 2014; Foucault, 1972b). Instead, his books are described as toolboxes with a collection of different kinds of tools (Heede, 2012).

Since this paper unfolds the articulation of grief and its transformation related to historical societal conditions it applies concepts from both the archaeological and genealogical parts of Foucault’s authorship.

The archaeological part primarily entails the analysis of discourse (Foucault, 1972b). The first part of the analysis is close to the written words and is the smallest unit of the discourse and focus specifically on how the texts construct the discursive object ”grieving” and when changes occur in these constructions over time. Subsequently, the analysis brings forward broader patterns in which the written word can be systematised. Finally, a set of rules emerges that describe what statements are made at a given historical time and in each context and by whom. This set of rules makes it possible to deduce patterns in which grief is articulated throughout history (Foucault, 1972b, 2005).

The genealogical part reveals how a phenomenon has arisen through an elongated history of creation. How different conditions have been present at the same time in history and how their interaction form the genesis of a new phenomenon such as the diagnosis of grief. In addition, the genealogy provides a fruitful glimpse into when ruptures can be identified in the way grief has been articulated in the explored historical period (Foucault, 1971, 1984, 1991).

The rationale for the selection of prominent thinkers is primarily based on where and when ruptures are identified in the way grief is articulated. That is, when the articulation changes and the discursive signs thereby reveal a rupture with the way grief is articulated earlier in history.

The purpose is not to make an exhaustive historical review of all prominent thinkers who have contributed to the discourse of grief. Because of this, we are aware that some key authors are missed such as John Bowlby and Erich Lindemann who has contributed significantly to the discourse of grief.
The first historical point of departure focuses on the Danish theologian and philosopher Søren Aaby Kierkegaard (1813–1845), who in the 1800s was a prominent thinker concerned with, amongst other things, the concept of grief (Kierkegaard, 2000). The second point of departure focuses on the Austrian physician Sigmund Freud (1856–1939), who in the 1900s was interested in understanding the nature of grief (Freud, 1917b). The third point addresses the Dutch psychologists Margaret Stroebe and Henk Schut (Stroebe & Schut, 1999), whose thoughts on grief have been prevalent from around the year 2000 until now, where grief has been conceptualised as a mental disorder. The fourth point is the diagnostic description itself as it is stated in ICD-11 (WHO, 2018), where grief is described for the first time in history as an independent mental disorder in a diagnostic manual. This last historical point differs from the others as it is not a specific prominent thinker but the actual description of the diagnosis in the manual. The rationale for this choice is primarily due to the number of discursive signs and the assumption that this description represents the essence of today's articulation of grief and reveals a clear rupture with previous articulation as it is the first time in history grief appear in a diagnosis manual as a mental disorder.

Emphasis is placed on examining how the various thinkers articulate grief to gain insight to the basic properties and characteristics associated with grief at the given points in time. Such a look at how prominent thinkers have articulated grief at different times in history, can contribute to an understanding of when in history ruptures in the articulation of grief is observed.

Inspired by Foucault, the thoughts of the prominent thinkers must be seen considering the societal context and the values that were dominant at the given historical time. Their thoughts on grief relate to historic societal conditions why these will be unfolded at the beginning of each section of the prominent thinkers.

**Søren Aaby Kierkegaard**

Kierkegaard’s ideas were situated in a time (1813-1855) where Denmark was under political and economic pressure. In the 1800s the opposition to autocracy grew greater and greater and the political tensions became stronger and led to Denmark's first constitution in 1849 (Abrahamsen et al., 2006b). The new times required a new kind of church. In the 1800s, the urge for religious freedom and the right to think for oneself had grown greater than the allegiance to autocracy (Povl, 1977).

Kierkegaard's thoughts of grief are derived under the influence of a society that reflects an emphasis on Christianity and the relations between human beings which may have contributed to the way
Kierkegaard articulate grief. The Christian commandment of charity, which emphasises that people are dependent on each other is a dominating value. The fact that it is a time of crisis in Denmark may have reinforced the feeling of being dependant on one another.

Kierkegaard describes overall grief as an act of love and emphasises that grief is the most selfless of all acts of love, because the premise of grief is that every opportunity for reciprocation is gone. Kierkegaard writes that the deceased does not “beg like a beggar” and demand a reaction. The deceased does not require anything from the mourner, but can nevertheless fill the mourner’s thoughts. The deceased does not require any attention, but the mourner continues nonetheless to relate to the deceased. According to Kierkegaard, this testifies to how selfless an act of love grief is. Kierkegaard says:

“When one wants to make sure that love is quite selfless, then one can remove every possibility of reciprocation. But this is just removed in relation to a deceased. If then love remains nonetheless, then it is in truth selfless” (Kierkegaard, 2013, p. 433).

Kierkegaard argues that a person who loses a loved one will suffer from grief that lasts forever. He emphasises that grief will be present as long as the separation from the deceased lasts. Kierkegaard expresses this as follows:

“One must remember the deceased, weep softly, but weep long. How long cannot be decided in advance, since no recalling person know with certainty how long he must be separated from the deceased” (Kierkegaard, 2013, p. 342).

Kierkegaard equates grief with ungrateful work, since the deceased remains dead no matter how much the person left behind misses and grieves them. He also describes the grief work as being distressing and hopeless, because it does not bring the deceased back to life. On the contrary, ‘the body of the deceased decomposes more and more’ and thus becomes physically nothing, while the longing for the deceased potentially increases. Kierkegaard writes:

“Oh, it is so hopeless in a certain sense, so ungrateful a work, in the sense as the farmer says it, so depressing an occupation to remember someone deceased! Oh, it is so depressing that he so calmly
remains down there in the grave, while the longing for him increases, so depressing that there is no thought of any change without the decomposition, stronger and stronger” (Kierkegaard, 2013, p. 344).

Kierkegaard associates the Christian commandment of charity to love God and one’s neighbour as oneself unfolding grief as the essence of love. God is the supreme body of which Kierkegaard represents grief as the obligation to love the people we can see also applies to those we cannot see. The duty to love the people we see does not end because death separates them from us because the duty to love your neighbour is eternal as a grieving person and the deceased will be forever connected. To Kierkegaard it is not possible to heal grief, as grief will last until one is reunited with the deceased. The adherence to a Christian framework is also reflected in his view of the reward that the mourner receives by grieving as the reward is formulated as a blessing and a greater understanding of life:

“Remember the deceased and you will receive the blessing that is inseparable from this act of love and in addition you also have the best guide to understanding life correctly” (Kierkegaard, 2013, p. 351).

**Sigmund Freud**

Freud’s ideas were situated in a time (1856-1939) marked by World War 1, industrialisation, and urbanisation. The world was becoming a market with Europe as its centre. European technology and way of thinking came to shape the world against the background of explosive population growth and a technical-scientific revolution. The rapid industrialisation led to a richer Europe, but also to the growing social inequalities. It was a time of struggles between classes and gender. Europe and its intellectual life became seriously modern and Friedrich Nietzsche declares the death of God (Abrahamsen et al., 2006a; Smitt & Vollmond, 2015a, 2015b).

Freud describes grief as a process that should end with the mourner detaching himself completely from the deceased emotionally which creates a focus on the grieving individual. This focus on individuality appears as an overriding value at Freud's time and may have been triggered by World War I, leaving the world shocked. The war came so unexpectedly and represented the transition to a differently chaotic 20th century. In wartime, trust between people is put to the test from which a focus on individuality can be born. Urbanisation may also have contributed as a driving force
towards increased individualisation as life in larger cities does not enable the community that exists in small rural towns. Finally, there is no longer a God who can act as a unifying force which may also have contributed to an increased focus on individuality.

Freud, who lived approximately 50 years after Kierkegaard, represents a rupture with the articulation of grief as an eternal act of love. Freud does not delimit grief to losses caused by death:

“Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal, and so on” (Freud, 1917a, p. 243).

Overall, Freud describes grief as an emotion and compares it to melancholy, which in his time was considered a mental disorder. Today, we would describe it as a depression. But even though grief has several features in common with melancholy, Freud emphasises that grief is a normal emotion and in this connection, he describes a number of differences between melancholy and grief. The biggest difference is that grief can easily be explained, because an external event exists in the form of a death, which is at the root of the grief. Based on this fact, he rejects the notion that grief requires medical attention, even if the grief involves strong deviations from normal behaviour. According to Freud, grief can both inhibit and limit the grieving person to such an extent that there is nothing left for other purposes and interests in the bereaved person’s life. But he also emphasises that this behaviour is easy to explain as not being an unhealthy behaviour. He expresses this in the following way:

“When this behaviour does not really seem to us to be pathological, it is only because we can explain it so well” (Freud, 1917b, p. 224).

Although Freud emphasises that grief is not pathological, he nevertheless has some initial thoughts that grief because of a disease disposition can develop into melancholy. Freud expresses how a failure to grief can produce mental illness as follows:

“Under the same influences, many people develop melancholy instead of grief, and we therefore suspect these to have a disease disposition. Furthermore, it is very characteristic that it never occurs to us to consider grief as an unhealthy condition and to leave it for medical treatment, even if it
causes significant deviations from normal behaviour. We have confidence that the grief will be overcame after a certain period of time, and we consider a disturbance of it to be inappropriate, even harmful” (Freud, 1917b, p. 223).

We can see here that Freud believes grief can be overcome with time, but he does not describe a specific period that grief lasts. The perception that it is possible to overcome grief is in line with the period’s general way of perceiving grief. In Freud’s time, it was common to describe grief as an emotional process that starts in one place and ends in another.

Since Freud assumes that grief will pass after a while, he differs markedly from Kierkegaard’s conception of grief as an eternal act of love. Other modern theories also highlight the continuing bond between the mourner and the deceased which is also recognised in the theory of Stroebe & Schut.

Kierkegaard and Freud do not have many common features in their way of expressing grief, but there is one element they describe with the same word. They both describe the effort that grief requires as ‘work’. However, Freud differs significantly from Kierkegaard in relation to the purpose of the work, since he emphasises that the emotional attachment must be removed from the deceased to end the grieving process. Freud acknowledges that such work takes a long time, but he believes that the person grieving will eventually realise that the deceased is not coming back and that it is necessary to end the emotional attachment with the deceased to move forward with life. Freud says:

“The reality test has shown that the beloved object no longer exists, and it demands that all libido is moved away from attachment to the object. Against this, there is an understandable resistance ... the normal thing is that the respect for reality goes away with victory” (Freud, 1917b, p. 224).

If the person grieving is able to complete the grief work by radically tearing themselves away from the deceased, then they, in turn, achieve a form of reward that Freud describes as follows:

“It is however a fact that the ego, after completing the grief work, again becomes free and uninhibited” (Freud, 1917b, p. 225).

Freud thus highlights the ego and its possibility to put grief behind it. Here, he differs from Kierkegaard, who emphasises that grief weighs on someone their whole life. Freud’s focus on the
individual is also seen when he describes who is involved in a grief process. He does not count on any God and a successful grief process is characterized by leaving the mourner without any emotional attachment to the diseased. Kierkegaard describes both the mourner, the deceased, and God as those involved.

Margaret Stroebe and Henk Schut

Stroebe & Schut’s model “The dual process model of coping with bereavement” is situated in a time (1999) where health appears as an approved meta-value as presented by, the English professor, Monica Greco in 2004. She describes how the validation of health over the years has become an increasingly prominent value in secularised societies. In Western democracies, health is born as an ideology that all people in the society should strive for. Health has become an inalienable matter and is not just a right but has become a duty (Greco, 2004).

Another characteristic of the societal context of this time is the transition to a society based on globalised market forces associated with neoliberalism. Nations compete for skills, development, knowledge, and efficiency. In Denmark, the concept of a competitive state is introduced by Ove Kaj Pedersen. He describes that a key element of the competitive state is a relentless effort to reform, streamline and convert institutions to create goods and services that are better and cheaper than the others (Pedersen, 2011).

In addition, it is described how happiness has become a central value since the introduction of positive psychology mainly prompted by Martin Seligman which Ashley Frawley describes as “the happiness turn” (Frawley 2015).

This interest in happiness has been explored by Greco and Stenner. They argue that a defining characteristic of the contemporary happiness dispositive is the feature of splitting the subject from their world, treating feelings and desires as purely internal, individual, and subjective affairs. There is an increased awareness of individuality, which makes the individual becoming largely responsible for the degree to which happiness is experienced (Greco & Stenner, 2013).

Finally, the societal context is described as a tendency to medicalise and pathologies existential human emotions. The Danish professor and psychologist Svend Brinkmann describes medicalisation as when a phenomenon such as grief is placed in a medical framework and how people in modern society have internalised medical and diagnostic perspectives in their self-understanding. Pathologisation refers to the process by which some agonising mental conditions turn into a disorder and deviations from an increasingly narrow normal range are determined.
through a diagnosis and require medical or psychotherapeutic treatment (Brinkmann, 2018a, 2018b).

Stroebe & Schut’s thoughts of grief are developed in a societal context that reflects a duty to stay healthy, an expansion of neoliberal values that tribute the strong and competitive human being, a happiness industry that distinguishes the subject from surrounding contextual conditions leading to a great responsibility placed inside the individual minds and finally a tendency to medicalise and pathologies agonising human emotions.

In relation to Freud, who thought of grief as a process that starts in one place and ends in another, Stroebe & Schut represent a rupture with this way of thinking. They have devised ‘The dual process model’, which is described as a new way of understanding grief. They break with the linear understanding of several previous theories including the work of William Worden (Worden, 1996) claiming that grief occur in defined tasks. This well-established notion that grief happens in clear and neat phases was a significant challenge for Stroebe and Schut as their theory emphasise that grief is a dynamic process that moves back and forth between two tracks (Stroebe & Schut, 1999). They say:

“This model identifies two types of stressors, loss- and restoration-oriented, and a dynamic, regulatory coping process of oscillation, whereby the grieving individual at times confronts, at other times avoids, the different tasks of grieving” (Stroebe & Schut, 1999, p. 197).

Stroebe & Schut thus describe grief as a fundamental dynamic coping process in which the grieving person alternates between being on a loss-oriented track, where the deceased is remembered, and a restoration-oriented track, which is an orientation towards life without the deceased. They emphasise that the model is not just a linear phase model but that the state oscillates between two opposite poles. They put it this way:

“It will already be evident that this model is not a phasal model, we do not propose a sequence of stages, but rather a waxing and waning, an ongoing flexibility, over time. Early on in bereavement, loss orientation dominates, later on, attention turns more and more to other sources of upheaval and distress” (Stroebe & Schut, 1999, p. 213).
Freud describes the purpose of the grief work as an emotional detachment from the deceased, Stroebe & Schut – like Kierkegaard – emphasise that there will be periods where the mourner orientates towards the deceased and longs for them and periods when grief is relieved by another state of mind such as joy.

If the mourner orientates too much towards the deceased or too much away from the deceased, it may be an expression of a pathological condition, and therefore it is precisely the moving between the tracks that is important for Stroebe and Schut:

“It needs to be done, the cognitive business needs to be undertaken, but not relentlessly, and not at the expense of attending to other tasks that are concomitant with loss. It needs dosage” (Stroebe & Schut, 1999, p. 220).

For Stroebe & Schut, the reward of an appropriate grief process is aimed at health and the negative health consequences that can be avoided. As they say:

“There is supportive evidence that it may be impossible to avoid grieving unremittingly without severe costs to mental and physical well-being, from which it would follow that oscillation is necessary” (Stroebe & Schut, 1999, p. 216).

**Diagnostic description in ICD-11**

Grief is included as an independent mental disorder in the acclaimed international diagnostic manual ICD-11 in 2018. At this time, it has been decades in the making where researchers with different backgrounds have put forward several diverse nuances, controversies, and views on the subject. The fact that prolonged grief now appears as a mental disorder called “Prolonged Grief Disorder” represents a radical rupture in the articulation of grief.

The diagnosis is described as a disorder that is characterised by a longing for the deceased or a sustained preoccupation with the deceased along with intense emotional pain. In the diagnostic manual, the condition is described as follows:

“Prolonged grief disorder is a disturbance in which, following the death of a partner, parent, child, or other person close to the bereaved, there is persistent and pervasive grief response characterised by longing for the deceased or persistent preoccupation with the deceased accompanied by intense
emotional pain (e.g. sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one’s self, an inability to experience positive mood, emotional numbness, difficulty in engaging with social or other activities)” (WHO, 2018).

In the diagnostic manual, requirements are also outlined that the above characteristics must be persistent and have lasted at least six months. Furthermore, the disorder must cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning (WHO, 2018).

The traces of prominent thinkers in today’s discussion
By observing today’s discussion of whether grief can and should be categorised as a mental disorder, it becomes clear that it is characterised by two opposing positions. One position argues for the diagnosing of grief and the other argues against it, but both positions draw on elements of past discourses made by prominent thinkers in history.

Freud describes grief as a natural loss-oriented process that does not require medical attention, which suggests elements of an existential philosophical discourse in which grief is associated with an existential human condition, as we also saw with Kierkegaard. However, at the same time, Freud puts forward the view that grief can at best be overcome with time or, at worst, develop into melancholy if a disease disposition is present.

In today’s discussion a danger of over-diagnosing and over-treatment is presented and this danger is noticeable as it is pointed out that up to 10% of all mourners develop a prolonged kind of grief that, with the right treatment, can be treated or even prevented. Emphasis is also given to studies showing that prolonged grief, if left untreated, can result in several different negative health consequences. The perception of grief as a condition that can have health consequences is one that we have seen previously. Within the psychological debate, the cognitive part of human beings is given great importance in relation to dealing with grief in an optimal and successful way. Stroebe & Schut mention that an effective cognitive coping strategy can help the individual through a grief process and help to reduce the risk of negative health consequences.

Most theorists hold the belief that grief and suffering are fundamental parts of life for people dealing with attachment and love which shows clear traces leading back to Kierkegaard’s existential philosophical discourse, where grief and suffering are perceived as unavoidable parts of life. However, to those who oppose the diagnosis of grief, this fact is the very essential argument
why grief cannot be considered as a condition that can be treated and cured like a disorder.

Final reflections
This paper unfolds how the articulation of grief has transformed over time from the 1800s to the present and how values and ideologies in the given societal context have contributed to this transformation. This clarification has led to some final reflections centred on the contemporary societal context and what conditions it provides for grieving.

As stated earlier in this paper, the contemporary societal context is described by several theorists as a context paying homage to individuality, strong health, happiness, competitiveness, and a tendency to medicalise and pathologise ordinary human suffering. It triggers reflections on how these values and ideologies are helpful when grieving because they seem to represent the opposite of what is usually associated with people in grief.

According to the Norwegian nursing philosopher, Kari Martinsen, we are part of countless networks and relationships and do not exist freely and independently on each other. She claims that the dependency on others is clearly evident in situations characterised by illness and suffering (Martinsen, 2012). Grief is the epitome of suffering why it represents a state of dependence on others. Grief is not a condition that the individual can or should manage alone as it requires interaction and togetherness with other people. How does this dependence on fellow human beings relate to the societal emphasis on individuality? The polish sociologist Zygmunt Bauman claims that the ability to interact relationally with other people is likely diminished in a society with a focus on individuality. Bauman shows how society as a result of this process of individualisation consists of isolated individuals and relationships with other people are short-lived, cynical, competitive, and superficial (Bauman, 2000).

This may increase the risk of the bereaved being left in a feeling of loneliness which is probably not conducive to a healthy grief process. It is unfortunate if the emphasis of individuality together with the mental disorder “Prolonged Grief Disorder” leaves a mourner between two options – either being left solely to oneself or in a professional relation.

Brinkmann outlines that today’s culture of diagnosing is based on a notion of individualism. Mental disorders are markedly located within the individual and the importance of the social context is downplayed (Brinkmann, 2010).

Ester Holte Kofod is a Danish researcher and part of a research project called ”The Culture of Grief”. She argues that grief should never be considered an internal individual reaction because the
individual always reacts in a context with his or her surroundings. A complicated kind of grief can not only be the inner reaction of the individual because the mourner's environment can be complicated to mourn in as Kofod states (Kofod, 2015b). If grief is characterised by being a condition that cannot be managed alone it raises reflections on what conditions, it leaves for mourners who have few or none relatives or if their social network is deficient. The societal ideology of happiness causes reflections regarding how it feels to be sorrowfully in a society that tribute happiness. Kofod outlines that we live in a time where society is characterised by the difficulty to tolerate suffering in general and in particular suffering that cannot be fixed or at least has a potential of development (Kofod, 2015b).

Anne Marie Jutel is a professor and has a background as a nurse. She has researched diagnoses for many years and argues that diagnoses, among other things, can help to legitimise a reaction (Jutel, 2009; Jutel, 2015). This is also reflected in a study where 20 parents who have lost a child have been interviewed. There is a tendency for the abandoned parents to see the grief diagnosis as a legitimation of their suffering. They describe that a diagnosis will probably make it easier for their friends and family to understand and relate to their problems (Kofod, 2015a). This indicates that we today do not automatically carry the grief with family and friends and that there is a need of legitimising how you react when you mourn.

A diagnosis is able to legitimate a reaction but it is also functioning as a normative ideal which is problematised by Kofod because it opens up the possibility that some would feel an obligation to live up to the criteria of a grief diagnosis to prove to themselves and others that they loved the deceased sufficiently (Kofod, 2015a).

Although grief is an extremely suffering phenomenon, it is described that some mourners have no desire to leave the grief completely, as the grief represents the only place where it is possible to still have the feeling of being with the deceased (Kofod, 2015a). It seems that grief can be a sacred place that the mourner cherishes because when a bereaved is forced to continue living without an indispensable loved one, grief may be the only place left where it is still possible to feel a kind of connection with the deceased even though it may be a painful place to be. This speaks for the perception of grief as a complex condition where the aim should not be curing or making the condition disappear.

Today's societal context is characterized by values of economic rationality associated with the competitive state (Pedersen, 2011). A diagnosis can trigger a specific treatment representing the possibility of re-entering in social obligations and contribute to the national competitiveness as fast
as possible. In the competition state, strong, resilient, and adaptive citizens are praised, which is not consistent with the characteristics most often associated with people in grief, and the question is whether the societal context that is built on the competition state’s values allows enough room for normal, human grief processes?

Brinkmann argues that the dynamics and changeability that characterise the competitive society mean that it is frowned upon to stand still, which is why the individual must constantly change and develop. The individual must be able to keep up with a changing culture where efficiency is one of the keywords. Deviation from this can therefore quickly be perceived as wrong or pathological (Brinkmann, 2014).

In summary, it raises reflections of whether values and ideologies represented in contemporary society cause a complicated context of which grieving is difficult or if the need for a diagnosis is more an expression of a society that is not compatible with the needs of grieving people? Grief is probably one of the most landmark experiences for a human being which causes a reflection of whether a single perspective such as a medical diagnostic or a psychological is too narrow in terms of what they can offer a grieving person. An existential and religious perspective might be able to contribute with a meaningful supplement in the form of a language, rituals, community, and relations between humans. Perhaps we need to unite several kinds of perspectives in future approaches to grief.

References


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