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CHAPTER 8 Sociocultural Influences

Figure

Every culture has rituals to mark the deaths of its members and to assist survivors. These outward expressions of mourning may be solemn or joyous, depending on the group's beliefs about death. Pictured here is the Young Tuxedo Brass Band of New Orleans (more...)

Bereavement is less akin to the acute experimental stress created in a laboratory (such as a film that makes viewers uncomfortable) than it is to the stress of immigrants' uprooting and acculturation. It ushers in altered social roles, a new set of interactions with individuals and social institutions, and a search for meaning.

Moreover, bereavement can be a source of distress not solely for one individual, or even a social network, but also for an entire community. Death poses a challenge or threat (at least symbolically) to the moral order and systems of ultimate meaning (religion) in society, one responded to by the institutions that maintain and authorize social reality. Hence, bereavement is a social and cultural as well as a psychobiologic phenomenon.

THE SOCIETAL CONTEXT

The social organization of bereavement practices, as well as the social reaction to death and dying, has changed in response to epidemiologic and demographic transitions. The shifts in age-specific mortality patterns and cause of death that accompanied industrialization, urbanization, and economic development altered the relationship between death and the social structures that surround it.

In preindustrial societies mortality rates were high, concentrated in the early years of life, and subject to great fluctuations due to epidemics and famines. Life expectancy ranged between 20 and 30 years. Preindus trial societies were also organized differently, with great emphasis on kinship, joint households, and religion. Communities were small and close-knit, with each individual and kinship unit tightly integrated into a community's economic and political sphere. The death of an individual in such a social structure affected not only the surviving kin but often the entire community. [4]

Because death in such a society represented a serious loss to the community's identity and continuity, bereavement and mourning practices were highly ritualized. Funeral ceremonies lasted months—sometimes years—and the entire community participated in these ceremonial occasions. Mourning rituals in a preindustrial society reinforced and reaffirmed the group sentiments, common bonds, and social solidarity threatened by death. [9]

The contrast between that picture and modem societies is striking. Mortality rates in Western countries are now low and controlled, and degenerative diseases dominate as the major cause of

death. Infant and child mortality has declined significantly while proportional mortality over age 50 has risen as life expectancy has increased.

The rise and rule of rational bureaucratic efficiency in modern society are clearly evident in what Blauner [4] calls the "bureaucratization of modern death control." Until recently, care of the dying, as well as death itself, took place in the home. Today modern bureaucratic institutions have, for the most part, not only removed death from the home, but have also effectively concealed many aspects of death and dying from patients and their families. One consequence is that survivors are less well equipped to deal with the aftermath of death.

Despite this standardization of the event of death, mourning practices in Western countries, especially in the United States, remain highly individualistic and variable. The norms and institutionalized conventions that govern these practices are less readily apparent when people live in large heterogeneous communities, in relative isolation from extended families, than in more homogeneous communities of persons who share the same ethnic and religious beliefs. A bereaved person may be unsure about how long and how much to grieve because grief is no longer shared and ritualized by the community. The mourning process in America today is supposed to be brief and private. According to Blauner, [4] "the individualization and deritualization of bereavement" lead to difficulties in adjustment because of ambiguity about the phases of, and behavior appropriate to, grieving and mourning. The lack of social prescriptions concerning mourning and bereavement may result in serious adjustment and recovery problems for the recently bereaved.

Over the years, there have been great changes in the social phasing of mourning in America. Until fairly recently, people in mourning were expected to wear dark clothes, often black, and to sequester themselves; to attend a movie a month or two after a spouse's death would be shocking. Now many feel that the opposite is true and that displaying grief in a public fashion is in bad taste. Private life is now more and more separated from public view.

All these salient characteristics of contemporary Western society, and others—such as the decline of kinship and religion, the nuclearization and high mobility of the family, a diminished sense of community, and the disengagement of the elderly—have important implications for recovery from bereavement and grief.

Although there are a variety of different cultural and religious prescriptions for mourning in the United States, social institutions today tend to be more uniform in the views they embody. These macroinstitutions—the law, the work place, funeral homes, and the medical care system—place explicit constraints on individuals' bereavement behaviors. And the attitudes underlying these institutional requirements may place implicit constraints on behavior.

Laws governing the disposal of dead bodies are designed to ensure the health of the community, yet public health legislation may be at odds with particular religious beliefs about when and how bodies should be disposed of. Because of such laws, for example, funeral homes, rather than the homes of the bereaved, have become the site of wakes.

This body of legislation has resulted in the development of specialists whose function it is to carry out the law. As recently as 100 years ago, undertakers were usually furniture makers and carpenters who built and sold coffins. [17] In the past few decades, the role of funeral directors has changed dramatically. Not only do they provide coffins, but they are trained in the technical skills of mortuary science and, most recently, as funeral "counselors." Students entering this profession must be interested in working with living people and receive some training in the

psychology of grief and grief management. [31] This evolution from carpentry to mortuary science to human service profession reflects not only changes in public health laws, but also an increasing reliance on external supports as extended family and community networks have diminished in importance.

Another major change that has resulted in increased involvement of macrosocial institutions in death and bereavement relates to where people die. Most deaths now occur in hospitals or nursing homes. Thus, what happens prior to and immediately following death is likely to be governed by institutional requirements and norms of the health professions, an issue discussed in detail in Chapter 9.

Employers, through leave policies, explicitly define a legitimate period of acute mourning when people are relieved of their work obligations without penalty. Such policies, which are uniformly restrictive, may inadvertently do a disservice to the bereaved who expect themselves to be able to perform adequately after only a few days but who find they are unable to concentrate and function well.

The federal government's policy, for example, is simply that a person may use annual leave in the event of a death in the family. However, government employees may take up to three days' bereavement leave to attend the funeral of a family member who was in the military. It appears from this policy that the government believes military personnel are likely to be away from home when they die, but that others will be at home. And yet a person's elderly parents or grown children are just as likely to live far away.

Other employers, such as the National Academy of Sciences, permit a three-day leave with pay in the event of the death of an immediate family member. Additional time, if needed, may be taken as annual leave or leave without pay. As discussed at length in Chapters 2 and 3, the bereaved are unlikely to be able to function after only a few days. Thus, these leave policies are unrealistic in terms of human nature.

In contrast, at least one Japanese automaker, Toyota, has no set leave allowance and treats a death in the family as an illness that has befallen the worker. Bereavement leave is left up to the work group, with tasks being covered by the survivor's co-workers and with the understanding that the bereaved person will take as much time as needed. Similarly, public utilities in Tokyo allow two weeks' leave for a death in the immediate family.

A number of publications in recent years have criticized the so-called American way of death. [2,32,42] At this point, however, there is strikingly little information on the impact of funeral and leave practices on the bereavement process. For example, does cremation versus burial make any difference? What about the attitudes inherent in the allocation of leave time? It would seem appropriate to consider the effects of these practices on recovery.

Social Support

The concept of social support has a rich and varied set of meanings. Insofar as it suggests a stable and reliable interpersonal scaffolding that sustains an individual's morale, well-being, or functioning, the term "social support" is misleading. In reality the social ties individuals maintain not only serve to sustain their functioning but are themselves affected by that functioning. Kaplan states: "A large number of environmental and individual characteristics interact to produce a person's social support system at any one point in time [and] the nature of all these

determinants changes with sequential role changes and other life events as an individual proceeds through the life cycle." [20]

In its broadest sense, social support refers to optimum personal and social integration [10] and may include the following elements:

- supportive religious and other social rituals
- supportive values and beliefs by which individuals and families are comforted
- supportive shared norms that provide "meaning"
- social networks that supply supportive needs
- the fit between the role(s) of the bereaved and the meeting of acute dependency needs at death and recovery time
- the availability and supply of nurturant others
- the availability of support that "protects" the self
- the function of self-supports in terms of the ability to seek and get support
- the availability of supportive others who "permit" or elicit emotional release
- structural supports such as community, work, and the like. [21]

Four aspects of social support—enhancing self-esteem and a feeling of being loved, problem-solving, networking, and providing relationship resources for meeting life cycle transitions—are thought to modify the effects of traumatic loss and to facilitate recovery from bereavement. [7,18,21] As discussed in Chapter 3, social relationships are an important determinant of self-esteem. They may enhance individual wellbeing by providing "information leading the subject to believe that he is cared for and loved ... esteemed and valued ... [and] that he belongs to a network of communication and mutual obligations." [7] Social support also is viewed as an important factor in the coping process, because relationships provide information and problem-solving skills an individual can draw on to solve basic tasks and devise strategies for meeting life cycle transitions. [3,16,18]

In addition, as a person's life situation changes, different constellations of support may be better able to meet his needs than others; a support network that may be optimally helpful at one point in time may be dysfunctional at another time. For example, during the early phase of grief, a small, dense network is most helpful. Later on, however, such a network "may entrap the individual within a limited set of normative expectations, information, and social contacts, rather than fulfill his need to make a transition to new social roles." [44]

Thus, it is believed that social support may exert a number of important modifier effects predicting who will and who will not do well following bereavement. [6,8] As discussed in several earlier chapters, perceived social support seems to be important in deciding the course of grief and the likelihood that the individual will return to effective functioning. [35,36,43] The hypothesized link between social support and outcome has not yet been adequately tested. The perception of support has usually been measured in gross terms by a few questions about the availability of others to be with and talk to but what these supports actually are like has not been specified in detail. Nor have particular groups of people who are likely to be lacking in social support been singled out for study. For example, certain types of professionals, immigrants, and

migrant workers are all geographically mobile by the nature of their jobs. When a family member dies, the only "community" that might be available for support is that of new friends and co-workers. It is not known whether this kind of social isolation automatically places such individuals at risk following bereavement.

THE CULTURAL BACKDROP

Culture exerts a significant influence on the way loss is perceived and experienced. Culture authorizes categories and norms for labeling the consequences of loss, priorities for ranking loss among other stressful life events, expectations about social support and coping styles, sarictioned idioms for articulating personal and family distress, and shared ways of regarding and responding to a death. The meaning of bereavement or other stressful life events may vary across groups with respect to who died and who is grieving. [13,26]

Cultural influences on bereavement interact with economic and other social influences that may amplify or dampen cultural effects. As intracultural diversity among members of a culture is often as great as intercultural differences, individual persons respond to loss differently, sometimes even differently from ways specified by group norms. Quite obviously, social class, economic and even sociopolitical factors will contribute (to greater and lesser extents) to negotiations of group norms guiding how bereavement ideally should be experienced and handled in particular local contexts. And there are only a limited number of ways that bereavement experiences can be socially organized. [40] Hence, there is both substantial continuity and significant variation in the bereavement experience across cultures, ethnic groups, and social classes.

The distress that death produces in a person (and group) will be articulated in more or less distinctive idioms—in one group, a particular pattern of somatization (the manifestation of emotional distress in physical symptoms); in another, through particular religious concerns; in still another, in particular social, moral, kinship, and other symbolic terms. [33] Responses to the distress will vary according to whom the group or individual regards as the locus of responsibility for coping (the individual, nuclear family, extended family, friends, co-workers, etc.); what coping styles are applied; which institutional resources are viewed as most relevant as appropriate sources of help; and how those resources are tapped and their responses assessed. [24] It is not just that different sources of support may be brought to bear but that there are distinctive cultural notions of what constitutes authorized support, how it is to be elicited, who can elicit it, and how it is to be evaluated.

With respect to cross-cultural variations in specific health consequences of bereavement, there is so little systematic research on this topic that it is only possible to speculate on what contingencies health care providers and prevention experts ought to consider. The consequences of the stress of bereavement may vary because of the genetic predisposition of particular groups, relative vulnerability of members of the culture owing to cultural and psychological processes in development, relative stressfulness of particular kinds of loss in particular cultures, differential efficacy of cultural resources, and varying categories for assessing outcome. Where there are no postbereavement expectations or categories of illness, none will be labeled as illness, even if the survivor has a poor outcome following bereavement. [38,41] Another label, such as religious or moral, will be applied.

Therefore, pathologic consequences of grieving, not surprisingly, are differentially evaluated and labeled. The contemporary Western practice of systematically looking for the health

consequences of bereavement is so unusual in cross-cultural perspective (in spite of the fact that most ethnopsychological systems are aware of the more untoward outcomes) that it can be regarded as a result of Westernization.

The development of bodily complaints following bereavement (somatization), while common in the general population, appears to be even more common among ethnic minorities, especially those whose members belong predominantly to the working class and who possess relatively lower levels of education. [22] Culturally approved somatization of bereavement among ethnic group members may be particularly diffi cult for health providers to identify and respond to effectively. [39] It may lead to misdiagnosis; costly, potentially dangerous, and unnecessary tests; delay in appropriate referral; or multiple prescriptions of potentially toxic pharmaceutical agents —all of which are likely to be inappropriate and potentially harmful. [25]

In America's widely pluralistic society, within the same ethnic group can be found extremes of secular and sacred, traditional and modem orientation that in part reflect levels of education and Westernization. The tendency of ethnic minorities undergoing acculturation and social mobility to alter beliefs and behaviors, coupled with the wide range of intra-ethnic diversity, should caution against stereotyping behaviors in an attempt to be culturally sensitive. In addition, because it is very difficult to predict in advance whether members of a given ethnic group have maintained traditional values, modified them, or replaced them entirely with those of the dominant culture, elicitation of bereavement beliefs and norms is essential if health care providers are to determine whether such practices are relevant in a particular episode of bereavement.

Uprooting, migration, and acculturation may leave first generation members of an American minority group few traditional resources for carrying out culturally expected bereavement practices and yet not make it appropriate for them to use mainstream bereavement practices. [1,12,19] For Southeast Asian refugees, for example, funeral homes are not an expected means of dealing with death, and bereavement counseling by health professionals is unprecedented. For certain more traditional ethnic groups, kinship networks play a bigger role in all aspects of the bereavement experience than professional agencies, which may be seen as alien and intrusive.

Thus, marginality in relation to mainstream culture may result in keeping traditional practices of an adaptive kind intact or may result in barriers (economic, linguistic, cultural) to access, knowledge, and the necessary skills for dealing with the secular bureaucracies that loom larger and larger on the American bereavement scene. The most marginal people are impoverished refugee and ethnic members who are moving away from traditional resources and support systems and who have not yet arrived at assimilation of, or even access to, the mainstream cultural orientations and institutions. Impressionistic observations of the Southeast Asian refugees suggest potentially negative health consequences of the loss of indigenous cultural support systems. The effects of marginality on the bereavement process should be systematically investigated.

Somatization is not the only culturally authorized idiom of distress through which grief is articulated. Religious and moral idioms among traditionally oriented ethnic group members are at least as prevalent, and probably more so. [19,25,33] It is not known, however, whether these public manifestations of distress differ with respect to the personal health consequences of the stress of bereavement. Are some more protective of the bereaved and others less so? This is a subject worth investigating among ethnic group members and also in the mainstream population.

Idioms of distress are at least as significant for the help-seeking pathways they authorize as for the psychophysiologic processes they activate or inhibit. [30] Somatic idioms lead mourners to clinics and patienthood, while religious and moral idioms lead to quite different sources of help. [24,38,41] It is intriguing to recognize that the chief contemporary professional sources of help—funeral home directors and staff—have not been systematically assessed to determine effect on outcome. Do satisfaction, compliance, and health consequences vary not only with individual traits of the bereaved, but also with the traits, functions, and competence of "bereavement professionals"? Do bereaved members of ethnic groups have better outcomes when helped by bereavement professionals of the same ethnicity, or by professionals of different ethnicity who have been systematically trained to deal with cross-cultural problems? These are questions for which there are as yet no answers.

A list of other potential problems could be cited based on the ethnographic and clinical literatures, but in the absence of empirical research data it is best merely to point up the likelihood that cultural and ethnic aspects of bereavement, abetted by the economic and social class problems that frequently accompany ethnicity, are likely to place minority ethnic group members, especially refugees and recent immigrants, at greater risk for negative health consequences. Because both poverty and migration are associated with higher mortality and morbidity rates, [1,12] it will be difficult to detect the actual cultural contribution of ethnicity, but it is worth considering recent migration or refugee status, along with low socioeconomic status or unemployment, as placing ethnic group members at greater risk for negative health consequences of bereavement.

With respect to the mainstream middle class population, historians, social critics, and behavioral scientists have maintained that the culture of individualism, the social arrangement of close nuclear families and loose social networks, and the weakening of traditional sacred and secular rituals for responding to bereavement have all placed the bereaved under greater strain with less traditional support. [28,29] Yet no research demonstrates an increase in the scope or severity of negative health consequences from bereavement in the West at present. Comparisons of bereavement outcomes across social class and cultural lines are important precisely for this reason: as natural experiments on the impact of different social circumstances on the bereavement process and its effects.

Finally, a cultural approach to bereavement should make researchers and clinicians sensitive to their own potential bias and barriers. The mental health and medical fields tend to discount the normative and the social dimensions of experience and to provide too superficial an understanding of a profoundly existential experience. Bereavement cannot be understood without taking these aspects into account. Hence, from the cultural perspective it is important to understand the distinctive ways families and networks shape bereavement, and to search for potential cultural conflicts with professional models that are also the product of a culture: the professional subculture.

Mourning Rituals

Although the cultural forms of mourning rituals and practices vary greatly, their structure is similar. Ethnography discloses in all societies an obdurate human grain that runs through the bewildering variety of cultural forms: grieving everywhere must be *experienced.* Mourning rituals involve changes in self-concept and transition to a new stage of personal identity. Viewed in a cultural perspective, they provide for the sanctioned public articulation of private distress; the reordering of disrupted social relationships; the reassertion of threatened core cultural codes

of meaning that address existential human questions; the remoralization of those demoralized and made desperate by loss; and both the reincorporation of the bereaved into the social fabric and reaffirmation of their solidarity with the group. [37,40]

Bereavement rituals order the disruptions of normal social roles so that the transitions are celebrated and thereby legitimized. The bereaved, whose transitional position in the society poses a threat to the social and moral order as much as to their own inner world, are symbolically and pragmatically escorted through these threatening stages. [15] In the vivid mythology of one Native American group, the widow, who must wear sack cloth during the bereavement period, throws off her rags at the end of mourning to display a dress in the colors of the rainbow. She is enacting her people's creation myth, which centers on the birth of the butterfly, and in the authorized symbolism of that myth her society announces she is once more available as a marriage partner and is expected to return to a normal social role.

Anthropologic findings suggest that the personal experience of grief, like the public articulation of mourning, may be quite distinctive in different social settings. [11] Puerto Rican bereaved women are expected to express their sorrow dramatically through displays of seizure-like attacks and uncontrollable emotions. Various Southeast Asian-American groups participate in public displays of wailing and open expression of sad emotion, but in private are expected to be contained and stoical, demonstrating their endurance and forebearance in the face of life's tragedies. Traditionally oriented Greek and Portuguese widows are expected to enact a lifetime role of grieving in which they demonstrate loyalty to the memory of the dead. In contrast, grief among middle class, college-educated Americans is increasingly regarded as an acute transitory stage, to be gotten through as quickly as possible with successful outcome measured in terms of developing new relations and giving up ties to the dead. Compare this with the no longer practiced but still deeply respected Hindu and Balinese traditions of ritual suicide of the wife on the funeral pyre of her dead husband as a sign of loyalty to the lasting commitments of marriage. [14]

The dominant institution in earlier times, and still one of great significance in the management of death and the rituals surrounding it, is formal religion. Among Western religions, key ritual activities for dealing with the dead have included washing the body, anointing, watching over the body, the recitation or singing of prayers, and wakes. Traditionally, these rituals assure survivors that life has gone out of the body, show respect and love for a person dear to their lives, and turn over to a transcendent reality the lives of the dead through meditation and prayer. [5,27] One of the few religious rituals that has survived in Western society in the twentieth century is the funeral. Some assert that the decline of other long-established rituals has contributed to the lack of socially acceptable guidelines to deal with dying, death, bereavement, and grief. This predicament may be worsened by mobility, as described earlier, and the resultant breakdown of neighborhoods as religious or ethnically distinct communities.

The social institutions available to recent refugees and immigrants, for example, may not be the same as those traditionally made available for bereavement. Puerto Ricans and other Hispanics in many American cities may find that churches lack Spanish-speaking clergy who can be effective in organizing expected religious rituals, like the long wake of many traditional Hispanic populations, and also that funeral homes and health care facilities neither understand nor tolerate traditional Hispanic dramatic enactments of grief. The absence or weakening of institutional resources such as traditional healers and religious experts may lead to increased negative consequences of bereavement.

Anthropologists of religion have observed that rituals are frequently very adaptive both for affected individuals and for their groups. Unlike contemporary Western culture, where rationalization, secularization, and demystification undercut this traditional work of culture, in more traditional societies and ethnic groups spiritual suffering is regarded as central to grieving and is seen not as an individual but as a group problem. Rather than being viewed as an illness, it is an occasion to assume a religious perspective on the world. The suffering is then worked through in a process involving religious rites which create an image of the deceased as an immortal and recast social relations of the living so they are no longer dependent on the deceased. [23,34]

CONCLUSIONS AND RECOMMENDATIONS

Considering the heterogeneity of American society, health and mental health professionals should use great caution in interpreting the bereavement experience of refugees, immigrants, and traditionally oriented ethnic group members as deviant because of the possibility that the norms for these groups may differ from their own and from those of the mainstream culture. Bereavement specialists should make an effort to be aware of and accommodating to alternative cultural practices for handling bereavement, and should be instructed in cultural differences in the bereavement process in an attempt to reduce the potential for cross-cultural miscommunication and iatrogenic effects.

The pluralistic cultural context of bereavement, its secularization, and the concern with therapeutic means among the relevant professions, make it understandable that individuals and families in the United States often feel uncertain about how to proceed in the bereavement process. This is an issue that should be addressed by the relevant religions and mortuary, mental health, health, and governmental agencies with respect to public education about existing knowledge and choices.

Research is needed on the various grieving experiences of ethnic group members to determine cultural norms of grieving and to lay the groundwork for determining pathology. High priority should also be given to research on the potentially greater risk for negative health consequences of bereavement among refugees, recent immigrants, and ethnic group members who experience social marginality and economic deprivation. In planning and conducting research in such communities, group members should be involved in the research process to determine risks and to plan culturally appropriate preventive and therapeutic interventions.

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Footnotes

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