The Social Basis of Loss and Grief
Age, Disability and Sexuality

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Abstract
• **Summary:** A review of the neglected area of the relationship between loss and grief and the less well-documented areas of discrimination in relation to age, disability and sexuality.
• **Findings:** There is an extensive and long-standing literature base relating to loss and grief. However, the major focus of such work is predominantly psychological and individualistic in its focus. Only recently a solid body of work relating to the sociological dimensions of loss and grief has begun to build up. This new literature has largely followed the pattern of the development of anti-discriminatory practice in social work, with a major emphasis on class, race and gender, and little attention paid to the less well-established forms of discrimination such as ageism, disablism and heterosexism.
• **Applications:** This article explores the relationship between these three forms of discrimination and loss and grief, with a view to establishing the importance of developing a broad-based anti-discriminatory practice in this important area of social work.

Keywords: ageism, disablism, grief, heterosexism, loss

The sociological basis of loss and grief has tended to be neglected (Field et al., 1997a). Indeed, a strong argument can be made to the effect that the professional literature has focused primarily on the psychological aspects. The need to take account of the broader social aspects can therefore be seen as a basic starting point for developing a more sophisticated theoretical understanding of loss experiences and the associated grief reactions. As Field et al. (1997a: xi) argue: ‘While death and dying have been a focus for research among theorists and practitioners from many fields, it is timely and indeed appropriate that social scientists for whom social differences are stock-in-trade should
be questioning a tendency to treat death as if its universality somehow transcended rather than revealed such differences.’

This can also be applied more widely to apply to loss experiences in general and not simply those that are death-related. Social differences and the associated problems of inequality can be seen to be relevant to loss in all its forms.

The sociological literature relating to loss and grief has begun to develop in recent years, with a number of significant contributions of note (Clark, 1993; Field et al., 1997b). However, as one might expect, a major focus in this growing body of work is the major social divisions of class, race and gender. While we welcome this focus after such a long period of neglect, we also recognize its limitations, in so far as it reflects the tendency in sociology more broadly and the theory base of the human services in particular to prioritize these aspects at the expense of less well-documented areas such as age, disability and sexual identity.

It is important to emphasize that this article cannot even begin to do justice to the complexities of these areas as they relate to loss and grief. Our much more realistic aim is to raise awareness of these rather underexplored areas and to draw attention to the need for a much stronger emphasis on these important aspects of theory and professional practice.

Age

Here we explore the nature of age discrimination and how ageist ideology affects the experience of loss for children and older people. We include an examination of how, because of the assumptions and stereotypes underpinning ageism, children and older people are excluded from the cultural expressions of grief afforded to others in the dominant Western ‘death system’ (Morgan, 1995). Central to these arguments is the notion of disenfranchised grief (Doka, 1989) as a significant theme to explain how children and older people are marginalized through the construction of the social division of age. Grief is said to be disenfranchised when it is not socially acknowledged, codified or sanctioned.

Ageist Assumptions

While contemporary Western societies do not generally acknowledge the enormity or the consequences of death, there is a prevailing ethos that we must protect those we perceive as most vulnerable from the hurt of loss. Dominica (1987: 108) comments on this sparing of feelings:

Our society does not handle death well. How often are the relatives asked to leave the hospital bedside when the patient takes a turn for the worse and the end seems perilously near and are only called back when it is all over? Perhaps it is because ‘heroic’ measures are to be taken to forestall the end and the intention is to spare the relatives unnecessary distress, but it may be worth considering whether some relatives would rather be there even so; I do wonder who it is who is afraid and whose feelings we are trying to protect.
Dominica’s view can be seen as particularly relevant when we consider the significance of age. Ageist assumptions portray older people and children as vulnerable groups in need of protection, more dependent, less able to make choices and decisions. In this respect we can see that ageism and the tendency to spare feelings about death and dying can combine to reinforce an ideology of exclusion from cultural expressions of loss for those who, on the grounds of age, are singled out for differential treatment.

The concept of citizenship features strongly in understanding how an individual’s rights are constructed, and equally the expectations of people in terms of their roles and duties to society. In turn, the result of ascribing certain values and attributing certain qualities in return for the rights of full citizenship is that persons deemed not to have full citizenship occupy a rather powerless position, with their contributions and needs marginalized (Thompson, 2003). The denial of citizenship can be linked with ageism, and so social workers should be wary of infantilization, the tendency to treat older people as if they were children (Hockey and James, 1993). Working in partnership with people in order to promote self-determination should challenge such paternalistic and oppressive approaches to intervention.

Older People and Loss

Older people are particularly prone to disenfranchisement in relation to death, dying and bereavement. Moss and Moss (1989) argue that bereavement for older people is multifaceted. The bereaved person may not have the opportunity to express the loss, and the impact of the loss may not be socially recognized. They argue that sociocultural attitudes to older people devalue their lives and therefore the effect of their deaths:

Older persons have lived in a world in which their social-cultural value tends to diminish with advancing years. Ageism systematically stereotypes and stigmatizes the elderly because they are old, seeing them as senile, rigid, disengaged, and sexless. Older people themselves tend to take on the stereotypes; thus ageism becomes a self-fulfilling prophecy. (p. 215)

This argument indicates that ageist assumptions portray older people as a homogeneous group and can still be found to be influencing practice. One author explains how the impact of a diagnosis of cancer may affect older people:

Old people have to accept their age and get used to the idea of death . . . To be old also means a modification of one’s image of oneself and one’s body, which is not always easy to accept. For patients who refuse to see themselves growing old . . . the diagnosis of cancer has every chance of brutally pushing them into it . . . those who have accepted that they have come to the end of their time, will not take the discovery at all badly, since they will easily understand that it will not greatly affect their chances of survival. (Geux, 1994: 25)

Assumptions such as these are particularly ageist and narrow, in that they take no account of the individual as a unique being, nor do they consider other
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factors as an influence, such as the social divisions of gender, race, culture and so on. These elements should be considered as factors influencing the experience of loss. For example, Bevan (2002) argues that poverty compounds the experience of loss. This is a significant practice issue to be acknowledged, as there is a higher incidence of poverty among older people (Thompson, 1995), who are more likely to live in poverty and are more likely to live and die alone.

For terminally ill older people ageism is significant with reference to access to specialist palliative care. Addlington-Hall et al. (1998) found that those aged over 85 are less likely to be admitted to hospice care. Harris (1990: 29) argues that older people are ‘an underclass of dying people . . . the disadvantaged dying’, and Cowley (1990) points out that ageist assumptions which attribute symptoms of poor health to old age, rather than to any underlying illness, result in the neglect of palliative care needs.

A significant feature of being an older person, yet not fully acknowledged, is the effect of multiple deaths. The deaths of friends, peers and significant others may create a bereavement overload for older people. Corr et al. (1997) suggest that older people may not have enough time or the support needed to grieve adequately before another death occurs, and thus suffer from the effects of cumulative loss. This aspect of loss is a key feature of bereavement support groups that we have been involved in, where older members value the opportunity of reviewing not only their own closest bereavements, but also of those recent deaths in their communities, sharing memories and stories and pondering on their changing communities.

Social work as a profession is most likely to come into contact with those with less power and economic or social resources to deal with grief. Social workers are well placed to offer practical help and assist with contacts such as support groups. This support would aim to acknowledge the duality of bereavement responses in facilitating the emotional and restorative expressions of grief (Stroebe and Schut, 1999).

Children and Loss

It is also important to recognize that age-based discrimination relates to children as well as older people (Thompson, 1997). An ageist culture does not foster the individual’s own sense of worth and value; this is particularly detrimental to those experiencing loss, as their concept of self and self-esteem may be threatened. Intervention needs to take account of the propensity for older and younger people’s grief to be disenfranchised.

The needs of children dealing with loss should be understood from a perspective which acknowledges both diversity and homogeneity. Insight into exploring the meaning of death to the child, what this loss means to their present and future, how the loss is understood and their coping strategies can only be gained by first actively listening. Assumptions that children will not understand death and dying can be tragically misleading and damaging, in that their needs will not be recognized, acknowledged or met.
Fortunately, the consensus of professional opinion now acknowledges that children of all ages grieve (Wass, 1995). From our own practice, we have observed that parents and others will go to great lengths to insulate their children from the truth of death. Generally, families are helped by talking through how each person is coping with the loss, and by some preparation, such as role play, before telling children sad news.

Although children’s understanding of death may develop with maturity, we advocate that it is necessary to explore the individual’s reality. This is for two reasons. First, grief is such a personal experience and it depends on variables such as gender, social support, and past experiences of loss and age. For example, for adolescents bereavement may represent a double crisis, because the developmental tasks of adolescence such as emotional separation and developing intimacy mirror so closely the tasks of bereavement. Second, we must also bear in mind that much of the current research has focused on white, middle-class children’s experience of death (Wass, 1995).

Issues such as the impact of socioeconomic status, race, sociocultural factors and experiences of violence can be seen to influence a child’s perception and understanding of death, but have not been adequately analysed in much of the research that has informed practice. Excluding these variables from studies therefore limits the value of the research, and emphasizes the need to assess with the individual the situation and most appropriate form of intervention. Lee (1995) expands on this point, arguing that an inner-city African-American child’s view of death may be very different from that of children who have not experienced the violence that permeates living conditions in some inner cities.

Wass (1995: 275) comments that children will learn about the fear of death while growing up; they will learn and absorb its ‘wisdom, myths, and practices, its ambivalence and anxieties’. Because Western cultural practices shield children from events related to death, they may be excluded from taking part in the rituals of mourning, attending funerals and so on. In this way their grief may be disenfranchised, in that their loss may not be recognized, and therefore their need to grieve and mourn may not be acknowledged or allowed for. Riches and Dawson (2000) highlight the plight of children as forgotten mourners; they advocate including children in the norms of societal rituals and family processes of dealing with bereavement.

Disability

The experiences of loss for those who have a disability can be exacerbated because of painful alienating and stigmatizing social responses to disability. These social responses are often the biggest factor in contributing to the disabling effects a person with physical and mental impairments has to deal with.

For example, consider the disenfranchised grief of people with learning disabilities, whose social and emotional needs are not always acknowledged or
appropriately met. Despite many positive changes in attitudes to people with learning disabilities, issues of loss and bereavement have largely been neglected. Oswin (1991) highlights the ignorance that influences views such as that they do not have the same feelings as the rest of us. She argues that the two subjects of death and learning disability are not openly spoken of and that, a situation which combines the two creates a double taboo considered too fraught to deal with.

The Social Construction of Disability

In order to understand the experience of disability in relation to loss, the wider social forces that structure this experience need to be considered. The dominant approach to disability can be seen to be derived from the medical model. This model of disability understands and explains disability in terms of deficiency and incapacity. In many respects, disability is seen as dysfunctional.

Dominant forms of language use convey disability as a category in which disabled people are cast as a homogeneous group. Jones (1994: 334) comments that this language of dependency, such as ‘impairment, burden, multiple needs – depicts dependants as less than complete individuals’. In this way, disability is socially constructed and conceptualized as individual disadvantage and pathology. It is through this powerful ideology that people with disabilities have been socialized and encouraged to perceive themselves as passive victims, with their situation presented as a personal tragedy (Oliver and Sapey, 1999).

The social construction of disability needs to be understood in a historical, political and cultural context. The medical model of understanding disability has been influential in social work, often producing a narrow service-led assessment, rather than a needs-led holistic approach. This prescriptive and individualistic approach tends to reinforce the oppressive, paternalistic nature of health and social care provision and thus fails to address the citizenship rights of disabled people. Oliver and Sapey (1999) advocate a model of disability that takes account of broader social and political issues. They argue that traditional perspectives on meeting the needs of those with disabilities which do not recognize the social model are likely to be discriminatory and oppressive in practice.

As Thompson (2001: 112) comments: ‘Disablism refers to the combination of social forces, cultural values and personal prejudices which marginalises disabled people, portrays them in a negative light and thus oppresses them.’

Disability, Identity and Social Death

Disablism reflects the dominant cultural images of people with disabilities. These inherently oppressive images will influence the process of forming identity. People with disabilities have the difficult task of challenging the personal, cultural and structural discrimination which conspires against forming any positive concept of self or autonomy. For some, these cultural images may be internalized to produce negative perceptions of our personal identities and the social roles defined and ascribed to us. Billington et al. (1998: 59) comment
on the difficult transitions faced by those who, because of illness or accident, become disabled in some way. They cite the example of Jenny Morris, who was no longer able to walk, having broken her spine in an accident: ‘Changes in her body and changes in her social identity did not mesh smoothly with one another. While medical professionals readily categorised her as disabled, the identity through which she and her family knew her was less easily transformed. Former social self and present were in tension with one another.’

This tension applies to those facing life-threatening illnesses; the concept of self struggles with the loss of identity and one’s own mortality, and social and cultural assumptions and prejudices compound this crisis. The social label of ‘disabled’ complicated Jenny Morris’s experiences of loss and the changes in her life, because others were stipulating that she should adopt this identity. Losing one’s sense of identity and self-worth is one component of death, dying and bereavement, challenging one’s sense of ontological security.

A useful concept to explain the decline in a sense of self is the idea of social death, a concept presented by Glaser and Strauss (1965) to explain the withdrawal of involvement in relationships with others and life. Sudnow (1967: 74) suggests that social death is when ‘a person is treated essentially as a corpse, though perhaps still “clinically” and “biologically” alive’. Mulkay and Ernst (1991: 178, 180) expand on the idea of how declining social activity and involvement lead to social death: ‘The declining feature of social death is the cessation of the individual person as an active agent in others’ lives . . . it is set in motion either by participants’ collective preparation for, or by their collective reaction to, the advent of biological death’. Clark and Seymour (1999) support this view when they warn of the inherent dangers of loss of citizenship as social death occurs.

In a society which idealizes youth, productivity and success, people who experience chronic illness and disability are presented as unfortunates who should be ‘pitied and helped’. These external and internal pressures can undermine the sense of being a valued citizen with rights to self-determination, and can foster a sense of hopelessness and helplessness. Social workers can explore with the individual their own sense of what this loss means, enabling the person to identify the wider issues associated with the loss. Putting their experience of loss into a wider context will bring to bear the structural and cultural factors. This approach helps the person deal with the situation in a less pathologizing way and therefore promotes positive mental health.

**Palliative Care and Social Justice**

Advocating the social inclusion of those dying or bereaved is a crucial area of social work involvement in palliative care. It is important that the power issues which debilitating those in this position are acknowledged and systems are developed to redress the inequity. McLeod and Bywaters (2000: 148) argue that the disability rights movement should include tackling social inequality for people living with a life-threatening illness, with the following aims:
• the identification of what is at stake as a question of rights;
• incremental changes in power relations concerning treatment and care, comprising:
  • equalizing access to information;
  • service user control over the organization of treatment and care;
  • service users having a central role in knowledge creation and research;
  • collective action to tackle social disadvantage within the experience of life-threatening disease;
  • collective representation of the interests of people with life-threatening disease.

McLeod and Bywaters point to social movements, such as the gay rights and women’s rights movements, arguing that they present a model for changes which could be taken right into the heart of any social justice movement in palliative care.

Identity is not purely a psychological issue, but should be recognized and acknowledged in a sociopolitical and cultural context. The dominant disablism ideology, as it is currently constructed, excludes and marginalizes those who are living with a life-threatening illness. This alienation has an adverse effect on the individual’s experiences of facing death.

Sexual Identity

The expression of sexuality is found in a broad range of feelings, thoughts and behaviours. Sexuality is an intrinsic component of being human; it is bound together in our identity and sense of well-being. The sexual dimension of being human is therefore inextricably related to our physical, emotional, psychological, spiritual and social selves as individual beings.

It is our view that negative aspects of loss are so often generated by the discriminatory attitudes and the oppressive actions of others. By this, we mean that prevailing attitudes have a divisive and alienating effect. Each of the social divisions constructed, such as class, race, age, gender, disability and sexuality have separate aspects of loss which are particular to them. These divisions also share the commonalities of the losses caused through disadvantage and discrimination in what is essentially an unequal society.

Two particular areas of concern are explored here: first, the way that people who are living with a life-threatening illness or terminal illness are precluded from expressing their sexuality; and second, the prevailing oppressive attitudes of culturally sanctioned accepted norms of expressions of sexuality. We shall consider attitudes towards sexual identity and the losses incurred by individuals and the larger community when the freedom to express sexuality is denied.

Sexuality, like other dimensions of what it is to be human, is often narrowly defined. This means that other issues arising from the same value structures,
such as sexism and ageism, will be closely related to how sexuality is defined and accepted. For example, attitudes and values towards women can be seen to be restrictive and paternalistic. Female sexuality historically is linked with serving others and reproduction (King, 1993). As de Beauvoir (1997: 20) comments on the somewhat illusionary emancipation of women: 'Even when her rights are legally recognized in the abstract, long-standing custom prevents their full expression in the mores.' Similarly, oppressive mistaken ageist assumptions are that our need to continue to express sexuality dissipates with age, issues relating to sex being judged to be irrelevant, with 'the assumption that older people are non-sexual beings' (Thompson, 1995: 36).

**Sexuality and Palliative Care**

Yaniv (1993) explores how sexuality can be integrated into the palliative care approach, arguing that this is a neglected area of caregiving. The assumption is that when people become ill they also become asexual. Commenting on the difficulty we have in addressing life issues such as sexuality, death and dying, Yaniv argues that it could be that when these issues are brought together, the two combined are just too difficult to deal with. Because of:

attitudes regarding sexuality [and cancer] . . . this might be the basis of our difficulty in uttering the terms 'sexuality' and 'cancer' in the same breath. Our interpretations of 'sexuality' are: beauty, physical fitness, high self-esteem and body image, optimism and a joy in life, whereas 'cancer' evokes images of suffering, altered body image, disability, low self-esteem, lack of hope, pessimism and death. (1993: 69)

From this we can see how, by avoiding sexuality while other palliative care needs are considered, we still fail to validate people holistically. Rando (1984) argues that the need for physical and emotional closeness heightens with the diagnosis of a terminal illness; these needs may be changeable, ranging from the need for sexual intimacy to demonstrations of affection such as holding and kissing. The human need to bond and connect with others physically, emotionally and spiritually and to touch and be touched throughout our lives do not lessen, and therefore they should not be underestimated or ignored. Leviton’s (1973) studies into the effects that loss of contact has on humans and animals illustrates that touching and sexual contact prolong life and improve health.

In social work practice it can be difficult to transcend the cultural norms of avoiding issues of sexuality. One colleague who works with people with life-threatening illnesses in a day hospice commented on the similarities of learning to cope with talking openly of death and dying and learning to instigate questions of sexuality with patients. We share this concern, but would also add the dimension of spirituality to this, because again this is also not easily spoken of. However, sexuality and spirituality are very closely attuned to one another. For example, the expression of a loving touch can be experienced as spiritually accepting and warming.
Heterosexism and Loss

Asen (1998) discusses the stressors that may lead to suicidal behaviour for teenagers who are managing change: socially, emotionally, biologically, cognitively and sexually, arguing that adolescence is a period when issues of sexuality are challenged and may include homo- and heterosexual experimentation. Managing sexuality, the pressure to achieve and intense experiences of loss are indicated as significant factors contributing to suicidal behaviour (Rubinstein et al., 1989). Similarly Davies (1996: 137) highlights the tragic circumstances of (para)suicide, with reference to gay people:

Several studies, including a British one (Trenchard and Warren, 1984). . . . have found at least 20 per cent of young lesbian, gay and bisexual people have made suicide attempts. Suicide is the second highest cause of death among young people . . . It is impossible to estimate how many young people each year do succeed in killing themselves because of the difficulties they experience and foresee in living their life as lesbian, gay or bisexual, but the figures are probably quite high.

Thompson (2003: 106) discusses the oppressive nature of heterosexism which, he argues, operates at three levels:

- **Personal** Direct prejudice against homosexuality is a commonplace occurrence and often goes unchallenged.
- **Cultural** Gay men, lesbians and bisexuals are commonly represented in derogatory terms and are frequently the butt of humour. Negative stereotypes are widespread.
- **Structural** Homosexuality is seen as a threat to family values and therefore inconsistent with capitalism and patriarchy.

Applying this to the concepts and experiences of loss, this oppressive ideology is seen to considerably affect the impact of loss. George (1997: 21) describes the situation of Peter Simons:

Simons first applied for community care services two and a half years ago, when he was left living alone after his partner had died. ‘During the assessment I didn’t feel that my needs as a gay disabled person were being addressed. I didn’t feel at all comfortable about having to justify my needs as a gay disabled man . . . he now has a partner who is also disabled and was reassessed recently. ‘I raised the issue of my unmet needs, and they offered me residential care without thinking of the implications . . . I also asked who would assess my partner’s needs if he spent the night with me in residential care.’ Not surprisingly, Simons has stayed in his own home.

Recognizing that sexuality, however expressed, is an important part of living and dying, whether the person is young, old, gay or disabled, is an important principle of both social work practice and the palliative care approach. The loss of sexual identity associated with illness which, because of social norms, cannot be openly discussed or grieved for, combines with a socially stigmatized sexuality to provide a doubly significant example of disenfranchised grief.

Consider, for example, the multiple losses incurred because of the death of
a partner in a gay or lesbian relationship. Because of discriminatory attitudes, the bereaved person’s grief may not be acknowledged or allowed to find its expression. The gay or lesbian disenfranchised griever may be refused the choice of being with their loved one at the time of death. Not recognized as a legitimate mourner, they may be excluded from death rituals, such as the funeral, and may possibly lose their home because the relationship is not recognized legally.

Social workers working with the concept that grief can be disenfranchised because of sexuality could draw on models of loss, to inform practice, such as meaning reconstruction theory (Neimeyer and Anderson, 2002) and Walter’s (1996) biographical model of bereavement. Grieving people who have little acknowledgement of their pain from their existing support system may benefit from support from social workers and other professional caregivers.

Heterosexist assumptions need to be challenged at personal, cultural and structural levels within death and dying. McLeod and Bywaters (2000) detail institutionalized, heterosexist discrimination in palliative care. They point to the absence of this issue from policy documents on palliative care development, such as the NCHSPCS (1998). Discriminatory issues associated with sexuality arise in many different areas of social work, so social workers should be prepared to actively promote the respect of a person’s sexuality, culture and lifestyle.

**Similarities and Differences**

In this article we have deliberately adopted a wide-ranging approach in order to draw attention to the vast areas of practice which have received very little attention in the professional literature, and to make the point that the intersection of loss and grief issues on the one hand and discrimination and oppression on the other needs to be studied more closely, particularly in those areas that traditionally receive less attention – namely ageism, disablism and heterosexism. We have covered a very broad terrain in relation to both theory and practice.

By identifying similarities we can emphasize common themes that need to be explored further across the range of forms of discrimination. By identifying differences between the areas we can emphasize the subtleties and complexities of addressing discrimination and oppression and warn against the dangers of reductionist approaches which have a tendency to oversimplify complex, multilevel phenomena.

**Similarities**

Of course, there are very many similarities or common themes. However, for present purposes, we shall restrict ourselves to three: disempowerment, denial of citizenship and biological legitimation.

In all the three areas of age, disability and sexuality, power can be identified
as an important theme. Those affected by discrimination are likely to experience a degree of powerlessness as a result of being identified as an ‘out group’ (Thompson, 2001), that is, a group of people who do not form part of the mainstream social order.

This is not to say that older people, disabled people, gay men, lesbians or bisexuals do not have power, but rather that their status as marked groups (in the symbolic interactionist sense of the term) is likely to contribute to a process of disempowerment by offering fewer life chances, restricted access to positions of power and greater obstacles to achieving personal objectives. In relation to loss and grief, such disempowerment can be seen to apply to all three groups, for example, in terms of the role of disenfranchised grief.

This notion of disempowerment is closely linked to that of the denial of citizenship, which implies, among other things, a set of rights. The right to mourn is not one that is generally given significant attention, but we would argue that it is one that merits closer study and greater emphasis. The tendency to downplay loss and grief in relation to childhood, old age, disability and sexuality can be seen as undermining citizenship, in so far as those who are adversely affected can be made to feel that they do not belong to their society. When this occurs at a time of major loss, and the important roles of social ritual and the cushioning effect of feeling rooted in a community are denied or undermined, the impact of the loss can be greater than it needs to be.

Thompson (2001) identifies the ideological legitimation of discrimination through biology as a common theme across many forms of discrimination. He argues that attempts to justify forms of discrimination are generally based on spurious biological arguments. This can indeed be seen to be the case in the three areas of discrimination discussed here. Discrimination against all three groups is conceptualized in biological terms: the frailty of old age; the emphasis on physical impairments rather than social handicaps in relation to disability; and the idea that same-sex relationships are unnatural.

Interestingly, the same argument can be applied to dominant conceptualizations of grieving as a natural process involving a number of stages. This approach to grief is increasingly being challenged as an oversimplification, and one which overemphasizes the biological dimension of grieving at the expense of a consideration of the wider cultural and structural aspects (Thompson, 2002).

Differences

In discussing discrimination, we are discussing people’s life experiences, and so it is inevitable that there will be differences in how discrimination operates, how it is perceived and the effect it has. However, we can also recognize broad differences across the three areas of discrimination.

The point was made earlier that older people tend to be infantilized, treated as if they were children. This applies in particular to loss and grief, in the sense that older people may be excluded from loss in much the same way as children...
are, albeit for different reasons (children to be protected from the emotions associated with loss, and older people because they are assumed to be used to loss). The process of infantilization also applies to disabled people, in so far as they are commonly patronized and looked after, rather than given their rights. However, for sexuality, the issue of infantilization is one that does not apply – or at least does not apply to the same extent.

Medicalization follows a parallel path, in so far as it applies quite strongly to both old age and disability, but far less so to sexuality. Both older people and people with disabilities are prone to being medicalized, that is, having their life experiences conceptualized primarily in medical terms. Old age and disability are often treated as if they were illnesses, rather than as complex, multilevel phenomena, with psychological, cultural and structural dimensions.

The situation with regard to sexuality is subtly different. Although it is only in fairly recent times that homosexuality has been removed from the official list of psychiatric disorders, the tendency to medicalize sexual identity is one that has also decreased markedly in recent years. While older people and people with disabilities may be patronized and seen to be in need of care and protection, gay men, lesbians and bisexuals are disapproved of because of the prevalence of heterosexist prejudices.

This takes us to the third of the differences, and again it is a difference between old age and disability on the one hand and sexuality on the other. The former two areas do not attract the same degree of social disapproval as the latter. This is largely because old age and disability are socially constructed as ‘unfortunate’ and the people concerned are thus portrayed as objects of pity, while homosexuality is constructed by dominant ideologies as deviant and ‘wrong’. In short, old age and disability are seen as pitiful, while homosexuality is seen as shameful. All three areas involve disenfranchised grief, but we can see that it occurs for different reasons.

Conclusion

In this article we have tried to raise awareness of and draw attention to the significance of forms of discrimination as they relate to the experiences of loss and grief. We have argued that, while the predominantly psychological focus of studies of loss and grief is steadily being counterbalanced by a more sociologically oriented literature base, understanding of the social context remains primarily geared towards the major areas of class, race and gender. We have therefore attempted to begin to counterbalance this by exploring a range of important issues which relate to loss and grief in the context of ageism, disabilism and heterosexism.

It is our view that matters of loss and grief are multidimensional, and that the sociological dimension is one that has been neglected in comparison with others. As part of the move towards giving greater attention to the sociological dimension, this article is a contribution towards broadening out the debate.
Indeed, what we would like to see is the debate extend to take in not only the three under-researched areas covered here, but also any other social division which plays a part in shaping the experiences of loss and grief and the actions and attitudes of caregivers and professionals at the time of a profound loss.

We have identified a number of areas that are in need of more detailed study and development. There are very many aspects of this subject area which are underdeveloped. In terms of professional practice, this leaves practitioners open to the influence of more traditional theoretical approaches to loss and grief which have a narrow psychological focus and are in part shaped by a medical model of grieving. If we are to take seriously the challenge of promoting emancipatory forms of practice, then it is clear that we need to address our attention more closely to the underdeveloped areas identified here.

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