

**DEFINING THE NEW ABNORMAL:  
SCIENTIFIC AND SOCIAL CONSTRUCTION  
OF COMPLICATED GRIEF**

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**ABSTRACT**

The current discussion about the status of “complicated grief” as a concept reflects not only a scientific process of validation and justification for a new diagnostic entity, but also a social process of reality construction. It is for this reason that the various professional, scholarly, religious and lay groups that advance competing discourses regarding “normal” and “abnormal” grief can be expected to continue to debate and challenge any given formulation, at least to the extent that pluralism is respected and dialogue is valued.

As the present series of articles makes clear, definitions of “abnormal” (and by extension “normal”) grief are undergoing significant renegotiation. In part, this reflects the burgeoning scientific literature on bereavement, which has indeed led to real advances in the understanding of grief in its biopsychosocial dimensions in recent decades. But this process of renegotiation also entails inevitable processes of social construction that arise whenever the formulation of new scientific concepts and criteria raise important moral and ethical questions, particularly those that bear on the “norming” or regulation of human conduct (Foucault, 1970). At issue here is not the *existence* of grief as a “real” phenomenon, but rather the social construction of its *meaning* by competing groups both within the professions (e.g., psychiatry, psychology) and beyond them, from various sociological, anthropological, humanistic, religious and indeed (a plenitude of) lay perspectives. In a pluralistic culture characterized by many alternative discourses contending with one another for legitimacy, reaching a

consensus on a specific definition of “complicated grief” (CG) can therefore be expected to be a difficult, or perhaps chimerical goal.

As a constructivist psychologist with social constructionist leanings (Neimeyer, 1998), but also a healthy respect for empirical research, I believe that it is meaningful to posit the existence of CG, in the same sense that one can cogently speak of anomie, quarks, democracy, power, or self-actualization. In each case, the phenomenon exists not as a concrete, “essentialized” thing, but instead as a social construct, reified in discourse, that is judged relevant and viable as a tool for interpreting, predicting or acting in relation to an aspect of the (human or natural) world. Similarly, all psychiatric diagnoses, CG included, represent social constructions (Raskin & Lewandowski, 2000) that should be judged in terms of both their *validity* and their *viability*, that is, in terms of their conceptual and empirical coherence on the one hand, and their ability to do useful work on the other.

This constructionist formulation, like Walter’s (this issue), does not so much undercut the scientific case for CG as it does place this formulation alongside other, sometimes broader cultural frames. This does not imply that one frame is correct and others incorrect, but instead that, for example, Mary’s complicated grief in response to John’s death can also be viewed as an existential crisis, a spiritual quest, a rite of passage, or even a process of disenfranchisement (Doka, 2002) or empathic failure on the part of her broader social system (Neimeyer & Jordan, 2002). Like any construct that is used in a propositional rather than preemptive fashion (Kelly, 1955/1991), each such “framing” will be relevant and useful in some discursive contexts, and less relevant in others. Moreover, because every particular discourse advantages some people or interests and disadvantages others, it is important to encourage “deconstructive” criticism of dominant frames, especially when these empower certain groups and disempower others. Thus, I believe that the spirited questions and challenges raised by the present series reflect a necessary process of social negotiation, rather than a regrettable sign of disunity in the field. As Machado argues eloquently in her analysis of contemporary debates concerning “discretionary death” in end-of-life contexts, “In the case of a profoundly important social matter . . . it is essential that members of a community have common understandings and grounds for judgment, interpretation, defining responsibility, likely sources of problems, etc. The outcome of the development of new normative concepts and classification schemes will likely be a stable, new master-frame characterized by key normative concepts. The success of the process depends in large part on . . . its perceived capacity to foster innovation, effective exchange of viewpoints, and broad consensus formation. The new frame with its particular normative concepts will ultimately have to be understood and accepted within a broad spectrum of social actors in medicine, law, politics, the mass media, the general public, and, of course, patients. . . . This is the foundation of a new normative order” (Machado, 2005).

To the extent that the definition of problematic grief has relevance to such a wide range of social actors and interests, it can be expected to generate continuing debate within, between, and beyond the mental health professions.

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