

Some Uses and Misuses of Thanatological Research

Einige Anwendungen und Missbräuche thanatologischer Forschung

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Thanatological research of various kinds can extend social theory. In this way, ethnographic research can shed light on professional practice and thus question it critically. Likewise, comparing how different groups die and grieve can contribute to social justice, and a sociological perspective reveals the community's potential to facilitate the experience of dying, grieving and caring. But thanatology can also be misused: theory can become a doctrine, empirical description of individual or social processes can become prescriptive, and some thanatologists become uncritically received gurus. Finally, the concept of modernity can be misused to romanticise pre-industrial ways of dying.

Thanato Sociology, comparison, theory, modernity, community

Die unterschiedlichen Formen thanatologischer Forschung erweitern Gesellschaftstheorien; ethnographische Forschung kann professionelle Praktiken beleuchten und dadurch hinterfragen; und der Vergleich, wie in verschiedenen Gruppen gestorben und getrauert wird, kann einen Beitrag zur sozialen Gerechtigkeit leisten. Der soziologische Blick offenbart Möglichkeiten, wie sich innerhalb von Gemeinschaften Erfahrungen mit Sterben, Trauer und Fürsorge abfedern lassen. Aber die Thanatologie kann auch missbraucht werden: Theorie kann zur Doktrin werden, empirische Beschreibungen individueller oder gesellschaftlicher Prozesse können eine präskriptive Wirkung entfalten, und manche Thanatologen wurden zu Gurus, denen kritiklos gefolgt wurde. Ferner kann das Konzept der Moderne dazu missbraucht werden, vorindustrielle Arten des Sterbens und des Todes zu romantisieren.

Thanatosozologie, Vergleich, Theorie, Moderne, Gemeinschaft

Though some seminal works date from the very early twentieth century (Hertz 1907; Genep 1909; Durkheim 1915; Freud 1917),¹ modern thanatology is often dated from the publication of American psychologist Herman Feifel's *The Meaning of Death* (1959). Thanatology, especially its American version, has been dominated by psychology, but there have also been a good number of

1 Hertz and Genep were not translated into English until 1960.

sociological contributions, along with various publications in psychoanalysis, social psychology, anthropology, history, religious studies, philosophy and other disciplines that clearly focus on social aspects of death and loss (Walter 2008). This article reflects on a few uses and misuses of socially-focussed thanatological research, though the article does not provide anything like a comprehensive survey.

Uses

Theory. Thanatological research has played a modest role in contributing to social science theory, essentially by reminding theorists that humans die and that social groups need to deal with this. I give two examples.

a) Death separates the living from the dead, destabilises social groups, and dissolves the identity of both the person who has died and sometimes also those left behind. Death therefore necessitates the re-affirmation of group solidarity, according to Durkheim through the performance of rituals. In his *Elementary Forms of the Religious Life* (1915), many of the Aboriginal Australian rites that he argued symbolised their society were in fact funeral rites. »When someone dies, the family group to which he belongs feels itself lessened and, to react against this loss, it assembles [...]. One never holds so closely to his family as when it has just suffered [...]. The group feels its strength gradually returning; it begins to hope and live again.« (Ibid.: 399, 402) Drawing on this insight, Marvin and Ingle (1996) argue that the ritual sacrifice of soldiers is the basis of nationalism; it is not just that funeral rites promote social solidarity, but that nations ›require‹ ritual sacrifice if they are to generate passionate loyalty. In this, modern nations are no different from ›primitive‹ societies. Death thus can be used not just to express but also to ›produce‹ social solidarity. Peter Berger (1969: 52) went so far as to claim, though he never really elaborated on this, that »Every human society is, in the last resort, men [sic!] banded together in the face of death.«

There are many examples, however, where society is not re-affirmed and stabilised after a death, but rather the death exacerbates existing conflict. Examples include families falling out over the inheritance, dissent over wartime deaths, regime change after the death of a leader, and the 2020 death of George Floyd at the hands of Minneapolis police. In *The Cue for Passion* (2000) Gail Holst-Warhaft draws on examples from 2,500 years or western history to show how the power of grief can destabilise society, leading to political change. Political authorities, fearing this, try to dampen grief – as subsequently theorised by Granek (2014).

We may conclude from this varied picture that death prompts social groups, from families to entire nations, to perform symbolic work. This can

lead variously to legitimating the social order, highlighting social conflict, or prompting social change.

b) The idea that humans, or modern humans, deny death and/or that death is taboo in contemporary society has generated a lot of claims, counter claims, hot air, theorising, and experimental psychological research. To survey theories, claims and uses of death denial would take an entire article, so here I will just mention ›Terror Management Theory‹ (TMT), a theory in social psychology which is the death-inspired social science theory that is probably best known outside of academia. TMT draws on Becker's book *The Denial of Death* (1973) which argues that humans ›have to‹ deny death. If repressed sexual energy is the driving force in Freud's psychology, for Becker it is repressed awareness of death that drives both individual and society.

TMT proponents argue that »we are horrified by the realisation that we are corporeal creatures« (Pyszczynski/Solomon/Greenberg 2003: 16) that bleed, defecate, urinate, perspire, menstruate, and eventually die and may be of no more ultimate significance than cockroaches or cucumbers. This creates an existential terror of meaninglessness, a terror that is solved by culture and its meaning systems. It is therefore crucial a) that faith in these meaning systems is sustained, and b) that the individual feels s/he is contributing to this meaningful reality.

Hundreds of experiments have been conducted in a range of countries purporting to validate TMT. For example, correlations have been demonstrated between mortality awareness, prejudice against outsiders and self-esteem: the more highly defended individuals are, the more prejudiced they are, clinging to their own culture over others. Clearly the theory has political as well as sociological implications. It has affinities to claims by sociological theorists such as Berger (1969), Berger/Luckmann (1967) and Bauman (1992) that culture provides a defence against the terror of death.

TMT relies on existential philosophy's assumption that humans are terrified of their own demise and ignores a wide range of historical and contemporary evidence that most contemporary westerners are more disturbed by the death of those they love than by their own personal mortality (Ariès 1981). Further, TMT's evidence relies on artificial psychological experiments with individuals (often students) rather than researching real-world groups. Its empirical sociological potential has yet to be realised and few sociologists are aware of TMT, while TMT researchers make no mention of cognate sociological perspectives. Earlier versions of the denial thesis have been modified and criticised by sociologists (Zimmerman/Rodin 2004).

Practice. A very different use of thanatology is when empirical thanatological studies have, on occasion, proved remarkably effective in reflecting back to

practitioners what they actually do, prompting them to reflect on, and in some instances change, their practice. Most examples come from ethnographic studies, not least in institutional settings.

Though Goffman did not write about physical death, his classic work *Asylums* (1961) did address the death of identity that occurs when people become inmates in a total institution such as a mental hospital, but also some other settings such as prison or a monastery. The cropping of hair, provision of a standard uniform, and various degradation rituals induce what Goffman termed »the mortification of self« (ibid.: passim) or erosion of personal identity. Goffman's book challenged administrators not only of mental hospitals but also of other institutions, such as other kinds of hospitals and old people's homes, and chimed with an increasing public mood in the 1960s that people's own home and community, rather than an institution, is the best place of care – whether the person needing care be mentally ill, a vulnerable child, or a terminally ill person. The 1960s was when English doctor Cicely Saunders founded the first modern hospice – a kind of non-institutional institution for the dying – and of course the hospice movement has subsequently promoted home as generally the best place for terminal care.

Two classic ethnographic studies of hospital dying in the USA in the 1960s prompted doctors and nurses to reflect on their practice. The more influential is Glaser and Strauss' (1965) study of communication with hospitalised cancer patients which identified various modes of awareness of the patient's condition. One is mutual pretence, where patient, family, doctors and nurses all know the patient is dying but pretend otherwise, thinking the others do not know, in order to keep up hope. This finding prompted considerable reflection, as a result of which in the 1970s the standard practice of doctors not fully informing cancer patients of the seriousness of their condition shifted to a standard practice of offering this information, first in the USA, then the UK. Other Western European countries took longer, but nevertheless a number of countries embracing individualism and individual rights shifted toward open awareness, though in many »family centred« Mediterranean and East Asian countries doctors continued to inform the family but not the patient.

The other classic 1960s hospital ethnography is Sudnow's *Passing On* (1967), which looked at death itself rather than the weeks and months of dying. Sudnow's major contribution was to use the concept of social death to demonstrate how imminently dying patients were treated as non-persons (a concept similar to Goffman's), a concept later used in studies of dementia and institutional care of the elderly. The subsequent history of the concept of social death, which actually has other roots as well as Sudnow (for example in studies of slavery and genocide), has been traced by Králová (2015).

More recent thanatological ethnographies have likewise shed light on professional practice. Lawton's (2000) ethnography of a British hospice revealed

that leaky, smelly cancers posed problems for hospice staff that were managed in ways that did not fit the curated image of hospice as cosy and homely. Her study caused quite a bit of defensive reaction in the hospice movement. In a different vein, Norwood's (2009) research in which she accompanied Dutch GPs on their home visits to the terminally ill concluded that euthanasia is a process of multiple conversations with patient and family that only rarely eventuates in the act of euthanasia. These conversations are deeply rooted in a Dutch culture that embraces low power differentials between actors such as professionals and clients, a system of single-handed GP practices in which doctors get to know their families over decades, and a centuries' old experience of the dangers of nature (the sea) being controlled by technology (dykes and windmills) – a communal cultural experience not replicable in other countries. Her study prompted me to think about euthanasia in an entirely different way, not least that what works in one country may well not work in another. Euthanasia is a cultural, as well as a legal and ethical issue.

Statistical studies can also reveal that practice is not always as claimed. Hospices often echo the claim of Cicely Saunders that hospice patients rarely ask for euthanasia; hospices attribute this to the excellent person-centred care their patients receive and claim this as evidence that society needs good palliative care for everyone near the end of life, not the legalisation of euthanasia. This argument is central to the hospice movement's anti-euthanasia stance. How to test this claim? Clive Seale (1998) analysed the results of a representative survey of 3'696 people dying in 1990 in 21 areas of England; structured interviews were conducted nine months after the death with the person who knew the deceased best in their last year of life; the response rate was 69%. Among the many questions asked were: »Do you think it would have been better if s/he had died earlier or later?«, »Did s/he ever say s/he wanted to die sooner?« and (if yes) »Did s/he ever say s/he wanted euthanasia?« Surprisingly, more respondents answered ›yes‹ to these questions when the person had received hospice care, even when levels of dependency and symptoms were controlled for. How this finding might be explained is a matter of debate. One possible explanation is that hospice patients are fully informed and are encouraged to choose how to live, so this might well prompt them to consider euthanasia. It is also possible that some patients, knowing that hospices reject euthanasia, choose not to voice their desires to hospice staff.

Comparison. The fact that all humans die impacts societies, both for the reasons Durkheim (1915) set out and also because it necessitates mechanisms that will carry culture and knowledge from one generation to the next. But comparison is at the core of sociology, so what possibly has greater impact on sociology is the differences in who dies, when, and how. How do culture, income and social class (Moller 2004), social connections, education, ethnicity (Kalish

1981), gender (Doka/Martin 2002), religion (Garces-Foley 2006), nationality (Walter 2020), history (Ariès 1981) and geography (Maddrell 2016) influence longevity, the dying process, funeral practices, grief and mourning? Who gets remembered, who forgotten? Are some deaths not deemed worth mourning (Butler 2009), some griefs disenfranchised (Doka 1989)? How do social and economic disadvantage in life extend to a person's last days? Are certain forms of dying stigmatised (Kellehear 2007)? Who gets the best end of life care, who gets excluded from good care? The social sciences in general, and sociology in particular, are well placed to answer such questions.

Reform driven by social science. The social model of disability argues that disability is caused not just by physical or mental impairment but by how society responds to disability, whether that be via attitudes to people with disabilities or via a physical environment designed for able-bodied people. Allan Kellehear (1999; id. 2005), drawing on his lifetime research into dying, has likewise argued that the experience of dying (and grieving) is profoundly shaped by social attitudes, by legislation, by institutional practices, etc. This perspective is now influencing palliative care away from a simple doctor-patient (or even doctor-patient-family) approach to a much more social understanding of the position of the dying person which highlights the need to mobilise the person's existing social networks and other resources available in the community. If, as the African saying goes, ›It takes a village to raise a child‹, so this social model of dying argues that it takes a community to make dying and mourning the best they can be. Community is central, not an add-on as is the case with a medicalised approach to end-of-life care. Though most westerners draw their last breath in a hospital or other institution, most of the time they spend dying is spent not in institutions or with professionals but with family and community, with relatives, friends and neighbours. As with pregnancy and birth, doctors and nurses have important roles to play, but both dying and birthing lose meaning if they are ›defined‹ as medical events.

Misuses

If thanatological research has important uses, it can also be misused, usually with the best of intentions. I conclude by sketching some classic misuses.

Theory. Thanatological theories, such as Durkheim's (1915) and van Genep's (1960) understandings of *rites de passage*, or the various theories of grief, can profoundly help our understanding and shape practice. But they can also undermine understanding, as when young trainee nurses or other practitioners, anxious about meeting their first dying patient, witnessing their first death, or

managing grieving relatives, latch onto theories for comfort and reassurance, making the unknown and unpredictable less scary. Thus, almost all trainee nurses can list Elisabeth Kübler-Ross's (1969) five stages of grief. Her stage theory, notably ›the anger stage‹, can also be used to deflect patients' and families' justifiable anger against poor medical care – their anger at the doctor or hospital is explained away as simply a projection of their anger that the person is dying or has died.

From description to prescription. Good theory arises out of empirical evidence. Kübler-Ross (1969) based her stage theory of grief on almost 300 interviews she conducted with dying patients. Hertz' and Gennep's theories of *rites de passage* were based on their secondary analysis of reports of funeral and mourning rites in several countries. From these extensive descriptions, scholars develop theoretical models which attempt to illuminate patterns found in the data. These can be very helpful in understanding, for example, grief or ritual, and in assisting practitioners in their work. The danger is that models become prescriptive, so that practitioners come to think that all dying people ›have to‹ go through Kübler-Ross' five stages, or that all rites of passage ›have to‹ have a three-part structure.

Gurus. Linked to this previous point, two researchers – Elisabeth Kübler-Ross (1969) and Ernest Becker (1973) – have attained guru status. In each case a psychoanalytically informed book, Kübler-Ross' *On Death and Dying* and Becker's *The Denial of Death*, prompted entirely new ways of thinking, but were too often read rather uncritically, possibly because their plethora of insights in such an existentially difficult field seduced some readers into switching off their critical faculties. These books – especially by popularising the concept of death denial – are brilliant, thought-provoking, seminal, and potentially quite dangerous. Kübler-Ross intended to give the dying a voice, but asserting that someone is in ›denial‹ has too often been used to silence the voices of those who are dying or grieving. In Becker's case, an entire society is presumed to be ›in denial‹.

The noble savage. A number of scholars, including myself (Walter 1994), have distinguished modern from traditional ways of death. This somewhat simple distinction has value but can play into the hands of those who like to damn modern industrial and post-industrial society and romanticise indigenous peoples – a twenty first century version of the myth of the noble savage (Walter 1995). I have argued that the way to develop better contemporary deathways is not to hark back to some mythical past or a romanticised ›other‹, but to use the very best of what contemporary societies are developing.

To sum up: Sociologically informed thanatology has several uses, and in this short article I have suggested a few: a) to conduct careful empirical research and develop empirically based theory that challenge popular but unfounded ideas concerning death, dying and bereavement; b) to suggest how contemporary societies might better deal with death, dying and bereavement; c) to be a critical friend to cognate disciplines, not least medicine, psychology, and philosophy.

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