Grief *is* good

Why the burden of mourning is lighter when shared.

By Hilary Hart

In a 2005 radio interview, Joan Didion—author of *A Year of Magical Thinking*, a memoir about her husband's fatal heart attack and her daughter's ultimately fatal septic shock—was asked what advice was most helpful to her during this painful time in her life. Her somewhat surprising answer: "Emily Post." »»

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Post's 1922 bestselling book, *Etiquette in Society, in Business, in Politics, and at Home*, offered guidance because, Didion explained, "Death was still up close, still in everybody's house. Everybody was still expected to know how to deal with it ... But at some point after that, we medicalized death. We put it in the hospital. And around the same time, we stopped being able to look it in the eye. We stopped knowing what to do or say."

Grief comes to us all. We lose the people and the things we love. In the painful abyss of grief, we're neither better nor worse than anyone else. We feel the vulnerability of our essential humanness—our need for comfort and our terror of being alone—and recognize in others a shared humanity. We need to know that grieving can take many forms, and might not follow prescribed patterns. We need to know that pushing away the emotional reality of grief isn't helpful. The medicalization of death that Didion talked about is just one form of denial. Others include keeping our grief private or trying to "move on."

In the West, at least, we're used to thinking of grief as a personal experience that comes with a largely individual process for healing. Yet new insights into the psychology of grief show it can link us together, in families, in communities, even within and between ethnic groups. Since grieving can be a shared experience, it makes sense that working through it with others can be a first step on the road toward healing.

But to let grief help us, we need to acknowledge what happens—to us and to others—when we avoid or deny it. That means looking mourning in the eye to understand how unresolved personal grief can have a wider interpersonal impact. Then, perhaps, we can begin to undo the patterns that perpetuate collective grief and step into a compassionate recognition that one person's suffering affects us all.

GRIEF IS A COMPLEX CONSTELLATION of emotional, cognitive, behavioral and physical symptoms that occurs in response to loss. Grief comes to us in many ways, through definitive deaths and in the wake of hidden and ambiguous sorrows, such as the loss of health or the denial of opportunity. It comes through our personal tragedies and through witnessing the tears of others.

Most of us are familiar with the feelings, thoughts and behaviors that come with grief—sadness, anger, guilt, depression, withdrawal, sleep disturbances, lack of motivation and self-destructiveness. Physical experiences can range from chills, diarrhea and fatigue to tremors, nausea and tightness of the chest. Scientists at Johns Hopkins University in Baltimore, Maryland, have even identified a"broken heart syndrome," a surge of adrenaline and other stress hormones caused by shocking and unexpected loss, which in some cases can mimic the symptoms of a heart attack.

Psychiatrist Sigmund Freud was an early student of grief. His 1917 paper *Mourning and Melancholy* described the necessary task of accepting the loss of someone or something to which you were attached. According to Freud, it was only through facing the reality that this attachment is irrevocably gone that an individual can reattach to another object of love and learn to relate to life again.

Psychiatrist Elizabeth Kübler-Ross wrote about the five stages of grief in the classic *On Death and Dying*, published in 1969. Kübler-Ross originally intended the five stages—denial, anger, bargaining, depression and acceptance—to apply to the process of dying itself, but some researchers observed that the bereaved also experienced these stages. Though most grief experts no longer believe a single pattern of mourning exists, Kübler-Ross' insights have become an integral part of our modern understanding of what we experience in response to loss.

Most therapists who work with those in grief recognize that accepting the reality of loss and working through the disturbing emotional maelstrom that ensues are prerequisites for regaining the willingness to live and to love. And they emphasize the role of community reflection and support, whether that means sharing grief with a therapist, a family member, a friend or an entire nation. They also agree on something else—that our resistance to grief makes things more complicated than if we face grief head on.

According to Gary Laderman, author of *Rest in Peace: A Cultural History of Death and the Funeral Home in Twentieth-Century America*, the medicalization of death was the product of a number of scientific and cultural changes in the early 20th century, including the proliferation of hospitals. From 1873 to 1923, the number of hospitals in the U.S. rose 3,800 percent, and medical facilities displaced the home as the place where most people became sick and died. In hospitals, death was increasingly regarded as a failure to solve the problem of illness.

As a result, how we mourned has changed as well. We no longer mourn in the privacy and protection of a familiar environment—the parlor of our own house—but in an impersonal setting under the watchful eyes of professionals. Today, there is a small but growing trend to bring death home again by organizing much more personal alternative funerals. (See "The laying on of hands" on page 40.) "It's amazing how we can block out the truth of death," says Frank Ostaseski, who founded the Zen Hospice Project and the Metta Institute, both based in northern California, to offer educational programs about death, dying and mourning. "If you are surrounded by a family or a culture that says, 'Don't talk or think about it,' it can hinder our capacity to acknowledge the loss."

Viewing the body of the deceased can be a powerful way to face the truth of loss. If we miss this step, we might be more likely to remain in denial. One study of data collected between 2003 and 2007 by the Department of Forensic Medicine at the University of New South Wales, Australia, found that participants who didn't view the bodies of their deceased loved ones had significantly higher trauma symptoms than those who did. At the Zen Hospice Project, Ostaseski found innovative ways to help people face death. "I would invite the family in to help bathe the body of someone who died," he says. "Sometimes they were very frightened. But inevitably they would come in, bathe, come in contact with the body and with the reality of the death. If we hide death, we hinder grief."

ANOTHER WAY WE CAN HINDER GRIEF, according to Pauline Boss, professor emeritus at the University of Minnesota and author of several books on stress and loss, is through our cultural insistence on closure and mastery—the assumption that if we work hard enough we can accomplish anything. To allow grief to proceed,

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she says, we often have to learn to live with ambiguity and our own powerlessness.

For more than 30 years, Boss has studied and aided individuals and families facing types of loss that make closure impossible—a parent with Alzheimer's who's physically present and emotionally absent, a family member who goes missing and is never located, a kidnapped child who's never found, a loved one who's the victim of a natural disaster or terrorist attack in which the body is never recovered. Boss calls such instances "ambiguous loss." Her research began in 1971 with the families of U.S. soldiers missing in action in Vietnam and Laos. She has also worked with the families of the victims of 9/11.

To facilitate the grieving process, Boss encourages people to change how they think and feel about uncertainty rather than to focus on finding the truth, which is often impossible in cases of ambiguous loss. "I encourage people to use paradoxical thinking and speaking," she explains. "For example, use 'both/and' language. If you are married to a man who has Alzheimer's disease, you might say, 'I am both married and a widow.' This loosens the bonds of certainty, and relieves the stress of needing things to be one way or another."

Boss explains that mastery-oriented individuals—those who are used to successful effort-based achievement—have an especially hard time with the feelings of powerlessness that come with grief. She cites her experience advising Microsoft employees whose colleague was lost at sea in 2007. Despite a relentless search, they never found the body. "These were the brightest and most intelligent individuals," Boss says. "They were used to solving problems. But no matter how hard they tried, they could not solve this problem. Many told me they found the 'both/and' language helpful. They learned to say, 'We both did our best to find him and yet we couldn't find him.' This reduced guilt, allowing them to move forward without having an answer."

"If we hide death, we hinder grief"

—Frank Ostaseski, founder Zen Hospice Project

OSTASESKI FOUNDED THE ZEN HOSPICE PROJECT TO OFFER EDUCATIONAL PROGRAMS ABOUT DEATH, DYING AND MOURNING.

WHEN GRIEF REMAINS UNPROCESSED— because of denial, avoidance or inability to work through emotions—some people can fall into a state of perpetual mourning called "complicated grief." Complicated grief can last for years, undermine renewed engagement with life and contribute to a wide range of health complications.

Estimates of how many people suffer from complicated grief vary between 15 and 20 percent of those surviving a loss, according to Katherine Shear, professor of psychiatry at Columbia University School of Social Work in New York City. Risk factors include violent or untimely deaths, multiple losses and a history of mood or anxiety disorders or difficult relationships with early caregivers, according to Shear. "There are circumstances of loss that are egregious that are certainly more difficult to process," she says. Signs of complicated grief can include disbelief about a loss, anger and bitterness and a continual focus on—and an intense longing for—the deceased. The condition can lead to major depression and anxiety. It can also increase the risk of heart disease, cancer and high blood pressure, as well as produce symptoms similar to those of post-traumatic stress disorder (PTSD).

Studies carried out by a team of neurologists and psychiatrists at the University of California-Los Angeles (UCLA) show that complicated grief can take on the characteristics of an almost addictive yearning. The UCLA researchers found

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that complicated grief turns on the nucleus accumbens, a part of the brain associated with feelings of reward and longing that's also active in people with addictions. The study involved 23 women, 11 with complicated grief and 12 with conventional grief. When the women looked at pictures of their deceased loved ones, their brains all showed activity in regions associated with feelings of physical and emotional pain. But the nucleus accumbens was only active in the women with complicated grief.

Researchers agree that complicated grief calls for different treatment and support methods than normal grief. Because it's often linked to trauma, treatments that help with PTSD can be effective, such as retelling the story of the loss in a safe setting. In one study carried out by Shear and colleagues, complicated grief was effectively treated in part through "revisiting" exercises, in which sufferers recorded their stories and listened to them later, a process Shear says is "helpful in facilitating full acknowledgement of the finality of loss that is important in successful mourning."

"If you are married to a man who has Alzheimer's disease, you might say, 'I am both married and a widow.' This loosens the bonds of certainty, and relieves the stress of needing things to be one way or another"—Pauline Boss, author of *Ambiguous Loss*

COMPLICATED GRIEF CAN AFFECT NOT just individuals but entire cultures when it's passed from generation to generation. *The Encyclopedia of Multicultural Psychology* defines "historical grief" as "unresolved, dysfunctional grieving of historical losses that interferes with an individual's well-being," and links historical grief to historical trauma—"an intergenerationally transmitted cluster of trauma symptoms experienced by members of an ethnic group or community whose history includes severe and cataclysmic trauma, such as genocide."

Psychoanalytic thinkers first developed theories about intergenerational grief during case studies involving the children of Holocaust survivors. The children showed symptoms similar to those of their parents, even though the children hadn't lived through the events themselves. Similar patterns of inherited grief have been found among the children of African-Americans suffering the aftermath of slavery, and Japanese-Americans interred at the beginning of World War II.

Maria Yellow Horse Brave Heart, an Oglala Lakota and associate professor of social work at Columbia University in New York City, has identified intergenerational grief and its effects among Native Americans. She cites the 1890 Wounded Knee massacre, in which hundreds of Lakota people were killed and thrown into mass graves; the forced displacements; and the government-run boarding schools in which physical and sexual abuse were common as major factors in Native American historical trauma. According to Brave Heart, the trauma suffered by Native Americans contributes to symptoms including grief, depression, anxiety, anger, low self-esteem, substance abuse and other self-harming behaviors. The prevalence of PTSD among Native Americans and Alaska Natives, for example, is 22 percent; in the general population, it's 8 percent.

The U.S. government established boarding schools for Native Americans in 1878 as part of a widespread policy of extinguishing indigenous culture. The imperative of the schools, as set forth by Captain Richard H. Pratt in an 1892 speech, was to "kill the Indian, save the man." Tiokasin Ghosthorse experienced the schools first-hand. From 1963 to 1969, Ghosthorse—a Lakota from the Cheyenne River reservation who produces and hosts the New York-based First Voices Indigenous Radio station—was forced to attend three missionary boarding schools, where he describes regular physical and sexual abuse. The effects of the abuse were made even worse, according to Ghosthorse, because his mother had been a student at a boarding school but refused to discuss it. "Those experiences are passed on without us even knowing it," he says. "It is still with all of us, even the young ones now, 130 years later, reverberating."

For Ghosthorse, healing began in the late 1980s after a failed suicide attempt. He wandered into a river in Washington state in the middle of winter, trying to drown himself in the freezing water. He walked out to a marker showing a 22-foot depth (some seven meters), but was confused when he arrived at the marker and was only in water up to his knees. Dazed, he climbed the riverbank and saw a sweat lodge, a traditional sacred space used in ceremony, in which he wrapped himself in cardboard and slept for four days. When he awoke, he felt a renewed commitment to healing, which has included re-connecting with his Lakota roots, language and traditions.

Eckhart Tolle, a spiritual teacher from Germany and bestselling author of *The Power of Now*, offers an esoteric description of how we're all connected through unresolved suffering: "The remnants of pain left behind by every strong negative emotion that is not fully faced, accepted and then let go of join together to form an energy field that lives in the very cells of your body," he writes in *The New Earth*. This "pain body," as he calls it, is largely unconscious, living through individual and collective violence and, according to Tolle, is stronger in some groups, like Jews, African Americans and Native Americans. Since the pain body is largely unconscious, the key to undoing these patterns is to become more conscious and present.

Sandra Ingerman, a shamanic practitioner for 25 years and author of books on shamanism and healing, suggests acknowledgment is an important first step. "When

we start becoming aware of a problem and begin to say, 'We are part of this; this needs healing by all of us,' we will be given ways to heal," she says. "But it won't appear until there is a conscious acknowledgement that we have not treated each other or the Earth well."

IF ACKNOWLEDGMENT IS THE FIRST step toward healing, the next step could well include bringing people together in ways that reflect our shared humanity. Ingerman tells a simple story of traveling to Germany to give a workshop. "I'm Jewish, and I was always terrified of going to Germany. During one trip, I was part of a ceremony with a descendent of a gestapo guard. Suddenly, I had the epiphany that we are all just people. The barrier between this woman and me was gone. I was never afraid of going to Germany after that."

Uniting with others—even with former "enemies"—can help heal the grief of historical trauma. The non-profit To Reflect and Trust (TRT) organization was founded in 1992 by Dan Bar-On, a psychologist at Ben Gurion University in Israel, to bring together descendents of Nazi perpetrators and descendents of Holocaust survivors to share stories and develop understanding. Today, TRT has groups for South Africans, Northern Ireland's Catholics and Protestants, and Israelis and Palestinians. Group meetings are built around the power of storytelling to help individuals work through their emotions and begin to heal.

Healing personal grief, much less the historical grief of whole cultures, can seem like a daunting task. But denial only feeds grief's fury and prolongs our pain. Grief can be good, if we give it its proper place. "I was teaching in the rural northwest," Frank Ostaseski recalls, "and a man said, 'Grief is like telephone poles!' I asked him to explain, and he said, 'I used to install telephone poles, and they can shake and fall. I told my partner that I would run if the pole started to fall. But he said, 'No, if it starts to fall, the safest thing to do is to head toward it and stand right up against it.' With grief, the healing is always found in the middle of the suffering; the only safe place to be is with both hands right on it."

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JENNIFER STEINMAN, CENTER, AND A GROUP OF GRIEVING MOTHERS DURING THEIR JOURNEY TO SOUTH AFRICA, AS DOCUMENTED IN *MOTHERLAND*.

Lost *and* found

How grieving mothers find solace by helping others.

BACK IN 2006, WHEN A FRIEND WAS grieving the death of her son, filmmaker Jennifer Steinman wanted to help. She offered to take her friend on a trip to AIDS-stricken South Africa, thinking that volunteering to help others would help her friend heal. Five mothers who had also lost children joined, and Steinman made a documentary film of their journey, *Motherland*. The women's encounter with the South Africans "inspired all of them to move forward, and to keep growing," Steinman says. Serving children in poverty and grieving in community with each other was transformative: "It gave them perspective," she says.

The inspiration for the trip to Africa came, Steinman says, while reading Stephen Lewis's *Race Against Time*, in which he describes the AIDS epidemic and the constant presence of death and grief throughout Africa. "I was struck by the image of a continent in mourning," says Steinman. "In America, people tend to feel very isolated in their grief. When something really bad happens to us, we go into our big houses and close the door and cry all by ourselves. In Africa, in the townships, they grieve together."

Anne Magill, one of the mother's on the trip, says this solidarity—with Africans as well as the other mothers—was powerful. When her 15-year-old daughter Grace committed suicide, Magill's friends and the local community were supportive. But she still felt few could understand what she was going through. At the time of the trip, two years after her daughter's death, Magill says people around her expected her to move on with her life. "In our culture, people are so focused on getting over it," she says. "They want you to get better. In Africa, everyone has lost somebody. While it's still painful, it's something they share."

Motherland has also inspired Project Grace, a grief therapy program named after Magill's daughter. Launched by Cor-Stone, a therapy center in California, Project Grace coordinates trips to needy communities in Mexico for grieving parents. "For us, it felt really important to give these parents a chance to get out of their environment," says co-founder Catherine Stern. "It's also a chance to be in a community with other people in grief and share that experience, without having to pretend you're ok."

The women who went to South Africa don't claim the trip healed them. Several mothers, including Magill, say "getting over" the death of a child is not really conceivable, or even desirable, because getting over it feels too much like forgetting. Still, the trip was a step forward into life. "When you lose a child, it's the most horrible thing, but it's also a gift," Magill says. "It's a question of how you're going to use it."—CARMEL WROTH

David Servan-Schreiber

THE TIME IS NOW

How long should we live with grief before asking for help?

LYNNE IS IN GREAT DISTRESS AND IS SEEKING HELP. HER STORY IS HEARTBREAKing. At 6 o'clock in the evening, her 10-month-old baby had a fever and seemed really sick. Over the telephone, after a few quick, specific questions, the pediatrician reassured her, "It doesn't sound very serious. A little Tylenol tonight and we'll see you tomorrow morning."

At 11 p.m., the baby was no better and Lynne was having trouble getting him to open his eyes. Despite the late hour, she decided to call the pediatrician at home. Clearly irritated at this intrusion, he answered that nothing major had changed. He told her to give the child a little more Tylenol and bring him into the office the next morning.

Lynne was still worried. She decided not to go to bed and settled down in an armchair in the living room to keep an eye on her son. Holding him to her breast while she rubbed his back, she felt his breath—too warm—against her neck. At 5 in the morning, she woke with a start, furious with herself for dozing off. The child she held in her arms was dead.

Since then, Lynne had gone virtually sleepless. What little sleep she got was troubled by nightmares. During the day, scenes of that last night with her son flashed through her mind. Her throat and stomach tightened. She blamed herself for being a bad mother. Why hadn't she disregarded the pediatrician's advice and taken the baby to the hospital? She didn't think she could go on living with her pain. Sometimes, she could feel her son's hand in hers or his breath on her cheek. She wondered if she was going mad. Finally, Lynne went to see a therapist.

The diagnosis was easy: traumatic bereavement. If Lynne had suffered that way for two years, nobody would hesitate to offer treatment to help her work through her grief. If it had lasted six months, some people would ask, "Has she mourned long enough?" And if it had lasted three months? In Lynne's case, only three weeks had gone by. Should she be sent home with her suffering? "Sorry, your pain is a reaction to the loss of a loved one and it must follow its normal course. You haven't suffered long enough to get help right now. Come back and see me when your grief has lasted at least six months."

Who's to decide how long someone else's suffering should go on? We know that fewer than eight sessions of grief-focused therapy are needed to relieve the symptoms of traumatic bereavement in more than 80 percent of cases. What benefit is there in depriving a grieving person of potential relief? Does a therapist have the moral right to refuse treatment to someone who asks for help?

Patients who have lost a loved one often feel their grief is a way of honoring the memory of the departed. But after several weeks, what would Lynne's son have wished for his mother? By the end of the therapy sessions, Lynne had found the answer to this question. "I no longer feel blocked by the horrible scenes of that last night with him. I can see again now the sweet and tender moments we shared. I'm grateful for everything he meant to me." Then she put her hand on her chest. "He's at peace now, and I feel him in my heart. I'll never forget him and he'll always be with me. My life can go on." Should she have waited six months?

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