Chapter 12
The Last of Human Desire: Grief, Death, and Mindfulness

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The last of human desire: he grasps at the air.
Jin' yoku no saigo koku tsukamu nari

—Senryu poet

Introduction

Death has, for millennia, intrigued and terrified, preoccupied, and mesmerized human beings around the world. Even more mysterious and frightening is what faces those who survive the death of a loved one: grief. Some resist and avoid, some deny and repress, and yet others turn toward grief. Artists sculpt grief. Authors lament grief. Spiritual leaders preach about grief. Ethicists argue about grief. Counselors seek to provide solace to the grieving. Cultures ritualize grief. Physicians treat grief. As the post-industrialization era has taken death and grief out of personal tragedy and into the private sector, they remain largely unexplored territory in contemporary Western culture.

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Death and Grief and Suffering

There are more than 2000 published studies on death anxiety, perhaps ignited by the work of Ernest Becker (1973) in his landmark book *The Denial of Death*. Strack and Feifel (2003) found that the majority in the Western world report some fear of death and that most people are more concerned about potential pain, helplessness, dependency, and the well-being of loved ones after their death. This latter fear is reported as more significant than their own deaths, that is, the fear of grief and how their loved ones will survive their deaths.

Western culture tends to deny death, push away thoughts of mortality (Becker, 1973), and run away from grief. There are a great premium placed on youth, happiness, and hedonism and a pervasive avoidance of aging, grief, and discomfort. Thus, suffering and mourning are treated as something to avoid altogether or from which we "move on" rather expeditiously. We have witnessed, personally and professionally, a pervasive pattern: many people are disturbed and frightened by grief and approach it with clichés and pat slogans—"it's meant to be," "everything happens for a reason," "don't dwell on the past," "God has a plan for you," and "just let go and choose happiness." These empty platitudes leave the grief-stricken person feeling worse than before they shared their grief—often full of shame about their inability to "let go" of their agony.

For several thousand years, Eastern philosophy has recognized that suffering is a central part of the human condition. In the Buddhist parable about the mustard seed, for example, the Buddha tried to help a grieving mother see that no one was immune to loss and suffering, revealing the qualitative oneness of grief. And yet, despite the explicit recognition in Buddhism that suffering pervades human existence, Buddhist-inspired theories and practices, especially when taken out of context, may not be enough to help those struggling with grief. Furthermore, we have seen the way spiritual theories and practices all-too-often lead to spiritual bypassing, attempting to do an end-run around unavoidable human and existential challenges. As Wallace Stevens (1982) noted, "The way through the world/Is more difficult to find than the way beyond it" (p. 446). Authentic living is harder than creating illusory solutions. In spiritual bypassing, individuals adopt a "spiritual" perspective, either as a means to temporarily comfort self or others—such as "God has a plan," "the self is an illusion," "just trust in God," and "all things happen for a reason"—or pursues a spiritual practice (e.g., meditation, yoga, prayer) so as to, often unconsciously, avoid, rather than turn toward, confront, and explore, what afflicts them so profoundly. This transitory solution is brittle and rarely enduring, and, of course, the grief remains unexplored and unprocessed. Often, it then returns with a vengeance in the form of symptoms, physiological, emotional, and social, adding unnecessary suffering to necessary grieving.

Mindfulness Comes to the Contemporary West

In 1979, mindfulness-based stress reduction (MBSR) was developed by Jon Kabat-Zinn at the University of Massachusetts Medical Center. The program, a secular group-based curriculum, was designed primarily to treat patients with chronic pain (Ospina et al., 2007), typically administered over 8 weeks and including a daily home meditation practice. Then, in the 1990s, Teasdale, Segal, and Williams developed mindfulness-based cognitive therapy (MBCT) specifically to prevent and treat major depressive disorder (MDD) relapse, combining aspects of MBSR with aspects of cognitive therapy plus the introduction of the 3-min breathing space (Ospina et al., 2007). Their program emphasizes awareness and tolerance of thoughts, similar to the way in which exposure therapy might function (Shigaki, Glass, & Schopp, 2006).

Now, mindfulness-based interventions have demonstrated significant efficacy in reducing symptoms for a broad range of medical and psychological ailments including fibromyalgia, heart disease, chronic pain, obesity, eating disorders (Grossman, Niemann, Schmidt, & Walach, 2004), asthma, type II diabetes mellitus, hypertension, substance abuse (Ospina et al., 2007), epilepsy, psoriasis, HIV (Carlson et al., 2004), and multiple sclerosis (Shigaki et al., 2006). And yet, despite the extensive applicability of mindfulness, deeper understanding demands that we also examine areas that have been neglected.

Death, Grief, and Mindfulness

Several scholars have begun to explore the relationship between mortality salience, or "impermanence awareness," and posttraumatic growth (Kumar, 2005; Wada & Park, 2009). The cultivation of this state of mind is believed to ease the overwhelming burden of grief by understanding its normalcy and necessity while not avoiding, pathologizing, or medicalizing grief. Wada and Park (2009) suggest that the mindful approach to grief recognizes suffering and emotional vulnerability as essential forces to propel one forward into growth, when he or she is ready, rather than the view of grief as pathology which requires medical attention. The middle path through grief wherein one neither avoids, represses, nor numbs affects nor does one grasp, cling, or unnecessarily punish oneself in grief. Both extreme states, that is, "severing the bond with the deceased or rigidly holding on to the loss…will not lead one to cope with the loss in a wholesome way" (p. 665).

Very few scholars, and even fewer empirical studies, however, have focused on death, grief, and mindfulness practice, for client, provider, *and* the relationship. Cacciatore (2011) proposed the first mindfulness-based paradigm, its utility focused on the tripartite relationship. The model's utility and success have been demonstrated in several studies since its inception (Cacciatore & Flint, 2012; Cacciatore, Thieleman, Osborn, & Orlowski, 2014; Thieleman & Cacciatore, 2014; Thieleman,

Cacciatore, & Wonch, 2014). For example, using this model, Thieleman et al. (2014) found a reduction in trauma, depressive, and anxious symptoms in a population of the traumatically bereaved after an average of just 14 h in counseling. Still, the model does not tout a particular goal or objective, nor does it seek to reduce symptoms within a specific time period. Rather, this paradigm merely seeks to facilitate and bear witness to a process of being with, surrendering to, then, when ready, doing, or taking compassionate action, with grief (Cacciatore, 2014).

The model, known as ATTEND (**a**ttunement, **t**rust, **t**ouch, **e**galitarianism, **n**uance, and **d**eath education), built upon a foundation of self-care practices, encourages mindfulness practice for the provider, modeling for the client, and bringing such practice into the therapeutic relationship (attunement). Providers, themselves, are strongly encouraged to cultivate a meditation practice and grief/death education as part of the client's treatment. Particularly with traumatic grief, it is crucial that providers have high affect tolerance and radical acceptance of the client's painful memories and accompanying emotions. In so doing, this psychological environment fosters a sense of safety and nurturance for the bereaved client (trust). In the context of this model, once trust has been established, haptic feedback in the form of non-perfunctory touch, when appropriate and therapeutic, is encouraged rather than anathema (touch). Relational power is shared, provider humility is paramount, and the counselor or therapist recognizes the client as his or her own expert, acting more as a guide. The emphasis is not on pathologizing the client's experiences; rather, the provider meets the client wherever he or she is in the grief experience and allows what is, in that moment, to be (egalitarianism). Because of the inherent fluidity of this model, there isn't a standardized protocol. Rather, the provider recognizes the individuality of each family, every circumstance, and every presentation as unique, acting with sensitivity for his or her cultural identification (nuance). The model also encourages providers to contemplate and study mortality and grief (death education), shown to significantly increase both mindfulness and empathy in second-year graduate students (Cacciatore, Thieleman, Killian, & Tavasolli, 2014). This yields benefits to both the practitioner and to the client, and this, ultimately then, supports the therapeutic relationship.

Finally, this model is built upon a foundation of self-care and compassion. Practitioners using this model are strongly encouraged to engage in various strategies for self-care, empirically demonstrated to diminish compassion fatigue and vicarious trauma, not just for their own benefit but, also, to help the client. Compassion fatigue is defined in the literature as a reduction in a provider's capacity for empathy toward clients as a result of repeated trauma exposure (Adams, Boscarino, & Figley, 2006). Obviously, both compassion fatigue and vicarious trauma have profoundly negative effects on both providers and the clients they serve. Yet, there is some evidence to suggest that a mindfulness-model of practice may protect providers from compassion fatigue and vicarious trauma.

Thieleman and Cacciatore (2014) found that providers using the ATTEND model, despite working in one of the highest risk populations (the traumatically

bereaved), were protected from vicarious trauma, provider burnout, and reported higher life satisfaction. No doubt, these protective variables yield a more helpful and compassionate environment for clients and thus they benefit from such a milieu (Thieleman & Cacciatore, 2014). Grepmair et al. (2007) conducted a double-blind randomized controlled trial wherein, indeed, the clients of "providers who meditated" had better therapeutic outcomes than clients of therapists who did not meditate. This is potent ethical motivation for provider mindfulness practices.

What Mindful Care Looks Like

Mindful care, vis-à-vis the ATTEND model, cannot be quantified, manualized, or put into a neat formula. Nevertheless, it has certain common ingredients including empathy and compassion, patience and humility, understanding, and flexibility. Deep self-awareness and attunement foster the development of all these states. Empathy, striving to understand someone from within their unique frame of reference (Kohut, 1977), is the foundation upon which the relationship is built because without it there is no safety or understanding. And compassion, ancillary to empathy, has been described as "empathic action" (Parr, 2002). Patience is crucial because the grieving person must have the time and space to experience the full range of their loss and agony. They cannot be rushed; nor can they follow someone else's timetable. Humility recognizes and respects the inherent wisdom of the client's pain, presenting "symptoms," and personal process. A humble provider fosters an environment of culturally appropriate care that is individualized for this particular person in his or her painful situation. Flexibility is crucial because each person is unique; and every therapeutic dyad must discover the best way to approach healing and transformation (Rubin, 1998).

We have found that there is always an emotional logic to the client's situation, even when we, as providers, don't necessarily understand initially. However, we strive to create an environment in which the client's feelings and experiences are not only fundamental but also revered—even if they clash with or are foreign to our own experiences. For example, we both believe in the transformative power of speaking about and witnessing what feels overwhelming and unbearable. But when a particular client needs to avoid talking about what afflicts them in order to protect against anticipated re-traumatization, their needs are more important than our models of helping.

We use the therapeutic relationship as an arena to gently explore, illuminate, and hopefully transform the client's struggles in coping with grief and trauma. Crucial to this process is our willingness to accompany them on their journey of mourning, witnessing, and validating their experience. They are our guide as together we struggle to understand and make meaning or sense of that which most haunts them.

Beyond Mindfulness: The Marriage of Mindful Care and Meaning

It's one thing to talk about mindfulness in treating traumatic grief. It's another thing to practice this unique type of caregiving. One of the greatest challenges facing clinicians who work in this field is how we, ourselves, process our own emotional reactions to traumatic loss, including feelings of vulnerability for ourselves and for our loved ones. Meditation and psychotherapy can be immensely helpful in doing this. And, also, each tradition has its blind spots and weaknesses, and the strength of each corrects for the limitations of the other (Rubin, 1996).

Meditation is a remarkable tool for cultivating heightened attention and presence, a wonderful asset to therapists and clients. But meditation tends to neglect meaning (Rubin, 2013). It features, for example, being aware of what arises, but that doesn't always lead to understanding its emotional significance. For example, noting anger while meditating is different than experiencing the disappointment and hurt that sometimes underlies it. The emphasis in certain meditative practices on investigating the causes and significance of experienced phenomena doesn't mean that meditators are illuminating the unconscious underpinnings of its meaning. Indeed, meditators, potentially, have greater access to their emotions; yet they often do not do enough with it. Western psychotherapy does a wonderful job of understanding meaning. Combining the meditative ability to develop refined concentration, equanimity, and self-compassion with the therapeutic capacity to illuminate human experience is an extraordinarily potent and often neglected means of helping people in pain. For example, when we are truly attentive and present, and then examine the emotional significance of what we are feeling—from anger and sadness to jealousy and grief—we are more likely to understand ourselves and be able to skillfully cope with our own feelings in the moment (Rubin, 2009).

[1]*Glenn, Client of JC*

Glenn is a first-time father in his early 30s of mixed ethnic descent. His son, Sean, died 2 years earlier during birth. Sean was 2 weeks over his due date when he died. Glenn and his partner discussed inducing labor but ultimately he discouraged the procedure, wanting to wait until Sean was "ready for birth." He blamed himself for Sean's death. So did his partner, Ann. Shortly after Sean's birth and death, Ann left Glenn. He began using alcohol, along with prescription drugs, to help him "cope with the grief of losing both his son and his partner." He began showing up late at work, personal hygiene declined, and his family expressed significant concern over his well-being. Glenn sought counseling at the urging of loved ones after being

[1]Clients' names have been changed to protect their anonymity and they have given permission to use their stories for this manuscript.

arrested while driving under the influence. He was reluctant to seek help because he "contributed to Sean's death" and felt "unworthy to live." I noticed, in my first few meetings with Glenn, that his affect was flat, inconsistent with what he reported verbally. His range of emotional expression felt stunted, frozen perhaps. While he could recount details of his experiences, much of the narrative was told in a rather detached manner. Once I felt Glenn trusted me, I asked him about the story he was telling. I inquired as to his degree of "deeply felt emotion" and asked if he felt he could share from a more authentic place. He said he'd felt this disconnect since he began using substances, and he reported a strong desire to stop the abuse. With the aid of his primary care physician, Glenn titrated off a low-dose anxiolytic and SSRI. Our weekly 2-h meetings continued. He shared more openly over time and eventually his emotional expression became increasingly more potent, congruent with the narrative of his story. It felt like a deeply trusting relationship, and I practiced being aware of my own sense of grief with and for Glenn, particularly when he would weep. My own meditation practice helped immensely in this regard. Within 9 months, Glenn was off his psychiatric medications and had restricted his alcohol consumption to two glasses of wine a week. Glenn still felt he was not ready to implement a mindfulness practice. He felt like there was a "truck sitting on [his] chest" and "breathing was hard." He also felt his discursive mind would interfere with his ability to be still. I invited him to a practice of mindful movement, which he embraced. He began walking every morning, in silence, paying careful attention to the placement of his feet, the cool air on his face, and the swing of his arms. Eventually, when he felt ready, we incorporated breath awareness to his mindful morning walk. He began to feel and express deeper sadness than ever, yet he had cultivated a practice wherein he trusted his ability to be with the pain—and the painful memories—without feeling overwhelmed, threatened, or paralyzed by it. Six months later, Glenn attended a meditation retreat for the first time. That was 5 years ago, and he continues his practice even today. He feels that his mindfulness practices help him to "both remember and cope with the inevitable suffering" and "lifelong grief" he will experience as a bereaved father.

Annie, Traumatic Grief Client of JC

Annie is a 38-year-old mother of three who lost her youngest child, Maggie, 8 years old, after a routine surgical procedure. She was given psychiatric medication 2 days after her daughter's death, both a benzodiazepine and an antidepressant which she had been taking, without adjunctive psychotherapy, for 2 years prior to seeking counseling. During Annie's first session, she lamented the loss of her primary social support system, friends who had children Maggie's age who she felt "now avoided" her because they were "too terrified to confront" her pain and grief. Annie was also experiencing marital discordance as she reported "no interest in sex or intimacy at all" and felt her "skin crawled" every time her husband tried to initiate intimate contact. When I asked her if she could share details of Maggie's death, she declined saying it felt "too hard to tell the story" and that "she hadn't told the story in years."

Of course, I did not push her; rather, I reengaged in exploring her experiences in the dyadic and social relationships which were so painful for her. When she spoke of her marital disharmony, she also said that she'd gained weight since Maggie's death and "felt unsexy and undesirable" noting a significant decline in sexual interest and arousal. She seemed to have some insight of this feeling "unfair" to her partner but was "uncertain how to change anything." Additionally, in recounting her feelings of isolation within her former social group, she noted that she "self-isolates," and despite being invited by her friends, she often "declines because of a lack of motivation" and "desire to be alone." We spent much of our first session building trust in the relationship and I listened deeply to not only the rare glimpses into her grief over Maggie's death but also her expression of isolation and loneliness. During our third session, Annie began to open up more fully, shared more detail about Maggie's death, and asked if I would be willing to look at photos of her, to which, of course, I replied an unequivocal assent. At one point while looking at photos, she began to divulge her sense of guilt: "I killed Maggie," she said with tears in her eyes. "Annie, tell me more, please?" I said softly and gently. She continued to explain that when they'd left the hospital, she had a "very specific feeling" that something wasn't "right with Maggie… that something bad, terrible, was going to happen." She began sobbing, uncontrollably, saying repeatedly how Maggie's death was her fault and how ashamed she felt for having "let her die." I noticed my own feelings of pain for and with Annie in this moment of abysmal suffering. I leaned into her pain and just sat closely with my head bowed: "I'm so sorry, Annie. I'm just so sorry." She continued to weep, audibly, for the next 10–15 min without pause. I remained silent but very present, holding space for her feelings of guilt and shame. I did not try to change her heart. I did not try to convince her otherwise. I just bore witness to the dark emotions that surfaced. By the end of that session, I could sense that something, inexplicable, had shifted. She hugged me before she left, thanked me profusely, and even sent a follow-up e-mail about how she'd never been able to share so honestly with anyone. It wasn't for a lack of trying. She'd tried to express her feelings of guilt and shame with others. But they couldn't bear to hear it and quickly dismissed her feelings as invalid, "ridiculous," and "outrageous." She stopped sharing her story, her feelings, and her thoughts shortly thereafter. By the tenth session, Annie began titrating off her psychiatric medications and we began to introduce brief breath meditation to her daily journaling practice. By the 15th session, she was off her psychiatric medication and "feeling much more depth and pain," but she also noted a renewed interest in sexual intimacy and social interaction. She attended a four-day meditation retreat, began a yoga practice, and lost 25 pounds. It's been 4 years since Annie walked through my door. The shift in her ability to cope has been extraordinary.

Beverly, Trauma Client of JR

Several years into treatment, Beverly, a middle-aged woman with a severe trauma history, began to unthaw from a horrendous history of abuse that left her feeling grief-stricken, demoralized, and self-doubting. While she was making significant

progress understanding the causes and the impact of her uncle's sexual abuse, she still struggled with a difficulty tolerating feelings and a tendency to either retreat into protective isolation or pathologically accommodate the wishes of those people she interacted with. She informed me that Buddhist meditation was very helpful in trying to cope with distressing feelings that seemingly came out of nowhere and made her feel as if she was drowning. But she sheepishly admitted that she was resistant to meditating. As we explored what happened when she tried to meditate at home on her own, I asked her if meditating at home left her alone with extremely painful feelings and if she stayed away from meditating so that she was not alone with these feelings. Tears rolled down her face as she shook her head up and down in assent.

We meditated together in that session and some subsequent ones and then processed the feelings that arose. Her capacity to sit with and accept a fuller range of feelings—especially sadness and grief—slowly developed. Meditation helped her become more self-accepting and less self-judging.

In our own personal and clinical experience, mindful care entails the marriage of mindfulness and meaning (Rubin, 2013). Mindfulness practices, like psychotherapy, increase awareness of our experience in the present. It also lessens judgment and increases our—and our client's—tolerance of painful emotions. In other words, both participants in therapy can sit with and through a wider range of feelings without prematurely and reactively denying them, drowning in them, or attributing them to someone else. And this makes it possible to explore their meaning and cultivate experiential understanding of their significance. And this is crucial for the therapeutic process. Without that mindfulness of feelings by itself—knowing that we feel sad without understanding its full meaning and significance (that we, e.g., might blame ourselves or imagine we are bad for feeling what we are feeling)—may not lead to coming to terms with that which, consciously or unconsciously, haunts us so.

Conclusion

Grief is inevitable for us all. Yet, a culture which does not foster a compassionate response in the face of inevitable and universal grief simply adds to the suffering of its members. And we live in a world in which individuals—and even various therapeutic and spiritual systems—tend to minimize, if not outright neglect and ignore, afflictive emotions such as grief, anger, and shame. Instead, both implicit and explicit messages coercively focus only on positive feelings, which can create an increasingly painful social milieu for those who experience traumatic grief (Cacciatore & Devine, 2015; Welwood, 2002).

Mindfulness practices allow us to deepen the genuineness of our relationships with self and other, bringing us closer, even amidst tragedy, and can enhance the feeling of safety as we all seek solace for our experiences of unfathomable pain. As providers, our hearts can remain open to the other, without needing to self-protect or to erect unnecessary boundaries of fear and death anxiety. But mindfulness

practices, while necessary, are often insufficient, for the grief-stricken mourner. They need to judiciously integrate mindfulness with developing and deepening meaning and understanding. And that provides something rare and vital in our fraught world—namely, an emotional home for the grief and trauma and death that permeate our lives.

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