Disciplinary Wounds: Has Grief Become the Identified Patient for a Field Gone Awry?

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Abstract

In the last few decades, grief and loss research in the psychological domain has focused almost exclusively on its dysfunctional nature. I examine what is underneath these questions about pathology and suggest that our discipline is suffering from an attachment wound where we have dissociated from our historical roots when it comes to the study of grief and loss. I argue that we need to ask new questions about grief and loss and present two examples of my collaborative work to illustrate innovative ways of thinking about and researching grief.

Keywords

grief; grief research; history of psychology; loss; psychoanalysis

I wasn't always interested in studying grief. Like many psychologists I came to my topic of interest through my own personal experiences. I was still in graduate school when my mother, who I was very close to, died of breast cancer after living with the disease for nearly 20 years. To say that my heart broke would be a cliché and an understatement. It's more accurate to say that I broke. *All of me* broke.

Fortunately, I happened to be pursuing a doctoral degree at York University in the History and Theory of Psychology program at the time that allowed me to reflexively examine my own personal experiences of grief using both an affective and intellectual lens. It is here where I started to collect my many shattered fragments—grieving daughter, intellectual scholar, curious psychologist—and weave them back together again through the writing of my dissertation.

The study I undertook traced the development of the construct of grief as a psychological object of study within the field. I looked at how and why we understand grief the way we do, and how this scholarship has infiltrated public understandings of mourning (Granek, 2008, 2010). Part of my focus was on the pathologization of grief, and I outlined the many debates emerging in the discipline on whether grief should be considered a mental health diagnosis (Granek, 2008, 2010, in press; Granek & O'Rourke, 2012).

Fast-forward several years and my dissertation has come to life. The debates about how and if grief is a pathology that should be included in the *Diagnostic and Statistical Manual of Mental Disorders* are raging (for recent reviews, see Lobb et al., 2010; Mancini, Griffin & Bonanno, 2012; Wittouck, Autreve, De Jaegere, Portzky, & van Heeringen, 2011; for debates about complicated grief, see American Psychiatric Association, 2010; Forstmeier & Maercker, 2007; Goodkin et al., 2005–2006; Horowitz, Siegel, Holen, & Bonanno, 1997; Prigerson et al., 1995; Prigerson, Shear, Bierhals, et al., 1997; Prigerson, Shear, Frank, & Beery, 1997; Shear et al., 2011). I have joined the chorus of voices on this issue and have written about the topic in both mainstream and academic journals (Granek, 2010, in press; Granek & O'Rourke, 2012).

In this commentary, I peel back a layer of this debate and examine what is underneath these questions about pathology, and furthermore, what our disciplinary history might have to tell us about this issue. When I speak about the singular “discipline” throughout this essay, I am referring broadly to what Rose (1989) called the psy-disciplines, which include psychology, psychiatry, social work, and other mental health professions. I suggest that our discipline is suffering from an attachment wound and that we have dissociated from our historical roots when it comes to the study of grief and loss. Grief, in this day and age, has unwittingly become the “identified patient” for some of our epistemological dysfunctions in the profession. In studying grief, I believe that Psychology, in its quest to be solely scientific in approach and methodologies, has caused a deep disciplinary wound in the field that is akin to the unconscious pain suffered by individual adults (Granek, in press). On individuals, attachment theorist Karen (1998) noted: “It is our earliest wounds that are most deeply unconscious, that are almost unknowable, unattached as they often are to memory or language, and therefore, the hardest to question, to symbolize, to verbalize, or to change” (p. 257).

Just like individual adults can have unconscious early wounds that are hard to identify and hard to articulate, so too can academic disciplines en masse. By disciplinary wounds, I mean that scholarship, knowledge production, and dissemination about grief today have largely been framed within a medical, scholarly, scientific model and have, in the process, cut out many questions and approaches to understanding grief and loss in its complexity and its depth. This erasure of how we used to think about grief as a holistic, necessary, human, relational experience is a disciplinary wound that goes so far back, and is so unspoken, that we have no language or memory of it as a discipline (Granek, 2012). As a result, what has become “normal” in the research domain when studying and talking about grief is a dissociated mode of procuring knowledge about grief that has led us to focus entirely on symptoms, dysfunctions, and treatments.

WHAT HAVE WE DISSOCIATED FROM? PSYCHOLOGY ON THE COUCH

In my article on the history of grief research in the field, I show how grief has evolved as a psychoanalytical, psychiatric, and psychological phenomenon over the last hundred years and how these transitions and understandings of grief happened in tandem with the changing cultural and historical transitions in the mental health field (Granek, 2010). I further outline how it is that we have come to understand grief today as something that can be predicted,

treated, and managed, and why we are now having these specific debates about grief (e.g., whether grief is a diagnosable mental illness, the best way to measure grief, etc.) as opposed to other types of conversations on mourning. For example, when psychoanalysis dominated the disciplinary zeitgeist, theorists such as Freud (1917) and Klein (1940) wrote about grief as a developmental, *normal* part of life. Freud, in particular, was clear that grief over the loss of a loved one fell outside of the domain of psychiatry and that tampering with mourners' grief process could potentially be harmful to them (Freud, 1917). In *Mourning and Melancholia* (1917), he stated:

Although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition and to refer it to medical treatment. We rely on it being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (p. 252)

Moreover, in a letter he wrote to his friend, Ludwig Binswanger, who was a newly bereaved parent, Freud noted:

Although we know that after such loss the acute state of mourning will subside, we also know that we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. And actually this is how it should be. It is the only way of perpetuating that love which we do not want to relinquish.

(Freud, cited in Bowlby, 1980, p. 23)

Several decades later, however, the field had gone through dramatic changes due to the two world wars, with grief becoming a completely new scientific construct so that the majority of psychologists studying and researching grief and loss today are almost entirely quantitative in their orientation. Moreover, the focus is almost entirely on grief's dysfunctional nature and how it can be measured, predicted, and treated (see Graneek, 2010, for elaboration of the disciplinary history and the evolution of the psychological construct of grief).

Two theorists I do not discuss in this article are John Bowlby, the British pediatrician who was best known as "the father of attachment theory" and had a tremendous impact on the development of psychology as a discipline, and another lesser known psychoanalyst, Paul Russell, who developed some of the most innovative theories of loss I have come across. Both had quite a bit to say about grief, but neither are mentioned very often, if at all, in any contemporary studies of grief and loss research. Here I briefly outline some their ideas on grief and offer suggestions as to why we may have unwittingly split these, among other alternative thinkers, out of our consciousnesses when it comes to grief and loss research.

Bowlby (1980) suggested, in his famous book titled *Attachment and Loss*, that for children (and for adults) "healthy mourning" involved:

[giving the child] prompt and accurate information about what has happened;
[allowing the child] to ask all sorts of questions and have them answered as honestly as possible; [allowing the child to] be a participant in family grieving, including whatever funeral rites are decided on; and [ensuring that the child] has

the comforting presence of his surviving parent, or if that is not possible of a known and trusted substitute, and an assurance that that relationship will continue. (p. 276)

In other words, Bowlby tells us, the conditions for resilience and *healthy mourning* are quite simple: The child (like the adult) needs time, space, ritual, validation, acknowledgment, responsiveness, and a holding container—a loving trusted person—in which to fully feel and experience her or his loss without dissociating from it and without being rushed through it. For Bowlby, pathological mourning happens when *none of these conditions are met*—when people's need for information, for time, for compassion, and most importantly for a secure attachment with a steady other who responds to and acknowledges the loss and validates the grief is not there. *This* to him is the root of psychopathology: not too much or too little mourning, or grief being expressed too intensely or not intensely enough. In stark contrast to our current debates about pathological mourning that focus on symptoms and duration, in Bowlby's view, it is the *sealing off* of grief that is the real pathology; sealing off mourning is sealing off love, and love and relationships are where all growth happens.

Paul Russell had a similar view. He was a little known psychoanalyst from Boston who wrote a series of papers that remained unpublished for the majority of his life (Teicholz & Kriegman, 1998). Indeed, although I have extensively combed the literature on grief and loss research, I first came across Russell's work through a conversation with someone who knew him personally and not through a published manuscript. In one paper titled "The Role of Loss in the Repetition Compulsion" published posthumously in 1998 in a book, and then in 2006 in a journal, Russell proposed:

Psychotherapy, to the extent that it works, necessarily involves grief. The treatment process itself thus becomes a necessary loss, or, more accurately, it helps the person to *feel* a loss that has heretofore, for whatever reason, not been grieved. Psychotherapy consists of the facing down of one's necessary losses. This has directly to do with the basic assumption of my paper; namely that the most important price one pays for the failure to grieve is repetition, compulsive repetition.

(Russell, 2006, pp. 86–87)

Russell makes several important, innovative and, to my knowledge, completely original claims in this article. The first, as described in the quote above, is his view that the role of psychotherapy and the profession of psychology is to very simply help people grieve their losses. As with Bowlby (1980), he suggests that the failure to grieve, the *curbing of grief*, is the pathology. He wisely remarks:

There are ways of avoiding or postponing loss. We refer to grief as pathological when, for any reason, there is an absence or failure of genuine grieving. Loss, almost by definition, is a situation where we see grief as being necessary. This helps us to be a little more clear about the nature of our underlying assumption. We assume that the avoidance of loss, the failure of grief, will take a toll which is far more costly to the individual than loss which has been grieved Strictly speaking, then, no loss is necessary; that is, no *grieved* loss is necessary. There are

ways enough to avoid our griefs, if not our losses. But loss is necessary if one is to grow. (p. 86)

Russell's ideas, like Bowlby's, run counter to our current disciplinary understandings of grief. Whereas our contemporary debates about pathological grief charge psychologists with diagnosing griever with a complicated grief or major depression diagnosis 2 months post-loss (or 2 weeks if the bereavement exclusion is removed; see Carey, 2012, for media debates and Wakefield & First, 2012, for academic debates), both Bowlby and Russell had fundamentally different ideas about loss and the role of the mental health professional in dealing with mourners. How do we understand these deep disjunctures? And why has our current medicalized model of grief taken precedence over these alternative understandings of loss?

There were many turning points in this process, and I discuss them in detail elsewhere (Grane, 2010), but the most significant one happened in the early 1930s and 1940s, post-Freud and pre-Bowlby, when we, as mental health professionals, were eager to model ourselves after the "hard" sciences. The way to do this was to turn all human phenomena into researchable science, using scientific tools like questionnaires, statistics, and labs. The history of psychology wherein it used the methods of natural science as a model is too well known to bear repeating here (see Danziger, 1997; Espeland, 2002; Teo, 2005; Ward, 2002). However, what is worth noting is that while there is certainly room for empirical research on the grief process, I believe that when we took on these methods and epistemologies—or put more simply, when we tried to turn grief into a science, or *only a science*—we also lost some of the deep engagement we had with the sheer humaneness of mourning and the transformative power of grief in our lives. The dramatic move from Bowlby advocating information, time, compassion, ritual, acknowledgment, validation, and love in coping with grief in a healthy way and the rejection of Russell's claims that the job of the psychologist is to help people mourn their losses to our current emphasis on what symptoms, and for how long, and what drugs, and which cures are two small examples.

Today, this disciplinary history and this context have largely been forgotten. And this "forgetting," or this dissociating from what we once knew, has caused the disciplinary wound I alluded to earlier. We rarely hear about any alternative understandings of grief within the discipline or outside of it in our newspapers and in our communities. I suggest again that it is like Karen's early wound for which we have little memory and little language, making it especially hard to question, hard to symbolize, hard to verbalize, and hard to change.

GRIEF AS THE IDENTIFIED PATIENT

But what if we could question it? What if we engaged in a process of integration and started to examine the splits caused by our disciplinary wounds? As a grief scholar, this desire for integration and recognition of these splits means asking questions about what it is that we know and don't know about grief—and more importantly, why we focus on some aspects of grieving and not others.

If Bowlby and Russell are right about grief, which I believe they are, then denying the normalcy, intensity, and duration of grief *is the pathology* rather than the other way around. This means, unfortunately for us as a discipline, that the dysfunction is *ours*—it's in our epistemologies, methods, and approaches—in our very limited scientific lenses in which we are attempting to understand grief. As with the identified patient (IP) who is saddled with the affective load of a whole family, we are pointing the finger at the grief diagnosis so that we don't have to look at our own pathologies, wounds, and splits within our family/discipline. Thinking of grief as the IP allows us to see clearly that as a discipline, we are spending our time, energy, and focus on breaking down the components of this particular affect so that we can control, manage, predict, and “treat” it, which also gives us the freedom to avoid looking at ourselves and why we are thinking about grief in this particular way.

SO, WHAT IS GRIEF REALLY ABOUT?

What is grief really about at the end of the day? Are there other questions we can be asking about mourning that are not about measurement, dysfunction, or treatment? If so, what kinds of new questions could we be asking in our field to start to integrate the split and heal our disciplinary wounds? These are questions that I have been consumed with since I began working in this field, and I have set out to try to understand and answer them in a number of different ways. In the following sections, I outline two examples of collaborative projects that have engaged a different set of inquires about grief and loss. The first is an online survey intended for a mainstream audience, and the second is a set of cross-national and cross-disciplinary meetings on grief and loss.

Slate Magazine

In an online informal survey I conducted with writer Meghan O'Rourke for *Slate Magazine* (Graneke & O'Rourke, 2011; O'Rourke & Graneke, 2011), we were interested broadly in people's phenomenological experiences of grief and were shocked by what we found. We had no specific agenda in designing this survey other than our own curiosity as women who had lost their mothers young and who had experienced intense grief over these losses. We wanted to know how others experienced their own losses, and very simply, what other people's grief felt like to them.

Within 1 week, nearly 8,000 people responded to our quantitative survey that had an optional qualitative component. We found that there was tremendous variation in people's embodied, lived, phenomenological experiences of mourning that significantly challenged contemporary psychological definitions of what grief should look and feel like, and more importantly how long it should last. For example, 60% of our respondents (out of a sample of 7,715) had dreams of the dead, and one-fifth reported imagining they had seen the deceased alive—symptoms that some health care professionals consider an indicator of complicated grief (Shear et al., 2011). (The sample size of 7,715 refers to the total number of people who answered the specific question I am reporting the data on. In total, we had nearly 8,000 responses to the entire survey. Some participants skipped some of the questions. For each of the findings I report on, I provide the total number of participants who answered the question.)

Even more compelling, we received nearly 2,000 qualitative *additional* answers to the question of whether respondents had experienced any other symptoms of grief that were not listed in the survey options (we included 34 common grief symptoms such as sadness, yearning, etc.). A smattering of these answers included feelings of “empowerment,” “being on a rollercoaster,” “easily irritated,” “lack of patience,” “questioning beliefs,” “searching for signs,” “dead inside,” and “alienation,” among many others.

In terms of duration, more than one-quarter (27%) of our respondents ($n = 7,081$) reported that they *never* went back to feeling like themselves after their loss, and another quarter (27%) said they felt normal only “1 to 2 years” after the loss. While complicated, pathological, or prolonged grief can be diagnosed 6 months after a loss, our respondents ($n = 7,081$) reported that “recovering” from a death of a loved one can take a year or several years, and for others “recovery” may never happen at all (27%). Indeed, a mere 11% ($n = 7,081$) of our sample reported feeling “normal” or symptom free again 6 months post-loss.

While the numbers of respondents and the variations in the answers were impressive, O’Rourke and I were most surprised by the time and energy put into the optional qualitative responses. Our respondents spoke at length about how grief had changed them forever, about how they had been expanded by their grief, and about how they both gained and lost parts of themselves from it. They had suffered terribly *and* had learned valuable life lessons. They were still in the grips of their pain even 10 years later *and* had become better people through the experiences of their mourning. They wanted their suffering to end *and* they wouldn’t change a single thing about their grieving process. It was the range, depth, and complexity of their phenomenological experiences and their existential understanding of the *necessity* of their pain that modern psychology misses most of the time in the context of grief and loss scholarship because the questions and the tools we use are often limited in their epistemological scope.

While this was an informal, non-validated survey, the number of respondents and the quality of their engagement with the questions, and their yearning and desire to help us understand what their experiences of loss were like for them, were astonishing. Moreover, our openness to what they had to tell us and the sheer curiosity and innovation of the way we asked these questions uncovered a wealth of new information about grief and loss that we could not have predicted in advance (Granek & O’Rourke, 2011; O’Rourke & Granek, 2011).

The Grief and Loss Project

Similarly, in another project intended to swirl up alternative conversations on grief and, in the process, reintegrate that which has been split off, I invited colleagues Michelle Fine, Karen Fergus, Judith Kuppersmith, and Robin Stern in the United States and Canada to put together a series of cross-disciplinary, cross-national meetings on grief and loss. The Grief and Loss Project, funded by the Canadian Institutes of Health Research, was seeded in the recognition of the untenable insularity of the academy and the need to bring together a kaleidoscope of knowledges about grief and loss from research, community, and health care communities in addition to input from mourners on the ground. The meetings integrated scholarship, politics, affect, and culture and involved cross-generational intersection of senior and junior scholars. Each meeting brought together distinguished professors, health

care professionals, students, and community partnership representatives including clinical professionals, but also participants who accessed community resources (e.g., participants who accessed homeless shelters or bereaved parents who accessed clinical grief groups at local community centers).

Our goal was to move grief and loss out of the shackles of the medical model so that it might be understood as an affective thread that moves across societies, institutions, communities, and relationships. In other words, we wanted to explore some new questions about grief, and invited a broad range of communities together in order to do so. When putting together the program, the only restriction I had was that none of the talks focused on the already much-discussed issue of pathologizing grief (including talks critiquing the pathologization of grief). The intent was to generate new ideas and new questions about grief and loss.

What we ended up with was a series of compelling talks, films, theatre performances, workshops, and discussion groups. Among the dozens of speakers across four meetings over 3 years, we had a wide variety of topics and lectures including one by George Bonanno talking about grief and resilience, Tina Chery speaking on grief as a motivator for community mobilizing, Lynn Lavallee speaking about aboriginal ways of coping with loss, Bruce McEwen speaking on the neurobiology of grief, and Kate Kenny and Star Mitford speaking on the grief of mothers who have lost their children to custody. More compelling was the conversations *between* speakers from various backgrounds who normally would not come into contact with each other. For example, on a 9/11 panel, we had firefighters, first aid workers, national policymakers in charge of allocating millions of dollars for 9/11 victims, educators, therapists, clergy, and people “off the street” talking to each other for the first time about a multitude of losses caused by the tragedy.

The most interesting parts of these meetings were the questions that were raised through the *interaction* of all of these people together. Whereas in the past, each of these communities dealing with grief and loss were working in silos, these meetings brought them together, and the alchemy produced from these interactions was golden. For example, Tina Chery, a community activist, bereaved mother, and speaker who started an organization called The Louis D. Brown Peace Institute (Chery, 2012) for families of homicide victims (and as an educational hub for curricula on peace and nonviolence), was paired up with world-renowned, award-winning neuroscientist Bruce McEwen, who invented the concept of “allostatic load,” or the idea that chronic psychological and physical stresses can lead to a host of physical and mental health problems over one’s lifetime (McEwen & Lasley, 2003). Their panel and conversation inspired a series of completely innovative questions around the different affective and neurosocial trajectories of grief and loss among people experiencing trauma alone and those experiencing it in community.

Other combinations of speakers inspired other inquiries. Participants spoke about the possibilities of designing longitudinal studies of different cultural groups dealing with grief and loss combining a North American evidence-based approach to treating trauma with people’s personal experiences from diverse cultures and countries to test the efficacy of interventions. Others wanted to know about the health consequences and social isolation of “hidden” losses such as miscarriages, abortions, reproductive losses, geographic

displacement, and chronic diseases. Some raised questions about how to incorporate grief and loss education into the school board curriculum so that grief is normalized as day-to-day affect rather than an individual and shaming burden for individual mourners. Because each perspective offered at the meetings was radically different, and because none of these people ever had contact with one another before, we were able to stir up new questions, thoughts, and knowledges about the topics of grief and loss. It was the *integration*, or the bringing together of the disparate and variegated talks and people, that produced the new ideas. This integrated, holistic approach to grief was embodied in the meeting design with both the topics studied and the people invited. As a result, each meeting braided together affect, politics, and research in such a way that allowed for the free flow of tears, dissent, and production of new ideas and thoughts about grief and loss.

Indeed, grief *should* be eliciting in us as mental health professionals varied questions about loss, about love, about politics, and about attachment. These used to be the core tenants of what we did as psychologists. Instead, to our own detriment and because of our own disciplinary pathologies, we focus almost exclusively now on questions of diagnosis, treatment, and categories of disease.

CONCLUSION: PAIN IS NOT PATHOLOGY

Psychoanalyst and philosopher Robert Stolorow wrote in the context of trauma and child development: “Pain is not pathology. It is the absence of adequate attunement to the child’s painful emotional reactions that renders them unendurable and, thus, a source of traumatic states and psychopathology” (Stolorow, 2011, p. 7). As with Bowlby and Russell, Stolorow’s argument is simple: *Pain, or one might argue, grief, is not a pathology. It’s our inability to respond to and acknowledge it that makes us sick.* In order to heal our disciplinary wounds, we need to release grief, at least of the psychological variety—grief as the object to be studied, manipulated, predicted, diagnosed, and treated—from its prison as the identified patient, and ask ourselves instead how might we look at this affect differently? How might we respond to and acknowledge grief and loss in our scholarship in a way that does not continue to make us sick as a discipline? Instead of focusing on the one question of whether or not grief is a pathology that has dominated the field for the last 10 years, and most certainly dominated the media lately, we can ask a whole new set of questions that will serve to integrate all that has been split off.

These questions include: What don’t we know about grief? Why don’t we know it? Why are we looking at grief in these particular ways? What are different ways we can study and think about grief? How do our limited scientific tools curb what we can know about grief? And most importantly, how might we go about finding new ways of generating research, collaboration, and partnerships to gain a more complex picture of what this necessary and powerful human experience of grief is all about?

I mentioned Bowlby and Russell, two theorists who come from the psychological disciplines, but there are others outside of the field who have addressed these questions as well. Viorst (1986), for example, writing for a mainstream audience, notes in her bestselling book *Necessary Losses* that grief and loss are a normal part of the human condition. She

wrote, “We live by losing and leaving and letting go. And sooner or later, with more or less pain, we all must come to know that loss is indeed a ‘lifelong human condition’” (Viorst, 1986, p. 237). In the same vein, Kellehear (2007), a sociologist, noted that “we have been told so frequently in the academic and professional literature that grief is sad and bad for your health that we steadfastly refuse to create, much less recognize its census of positive features” (p. 75). In addition to turning our gaze inward, we would do well as a discipline to also turn our attention outward and see how others have been talking, researching, and writing about grief and loss. We may find, as in these two cases, additional questions we have failed to explore such as how do we learn to accept and live with grief as a “lifelong condition,” and is it possible that there are any “positive features” to be found in this pain?

In this commentary, I have begun to outline my own first steps as an early career scholar in engaging these questions. I’ve gone online and found thousands there who have joined me. I created spaces for people to meet and talk and engage and ask new questions about grief, and passionate engaged people came by the proverbial busloads. There is a deep yearning in academia and in our culture for a more integrated, more whole, more compassionate, more complex approach to grief and loss research. It is time to heed the call. I hope you will join me.

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Biography

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