Mindfulness practices for loss and grief

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Broader Horizons is an occasional series of articles focussing on related fields of relevance to bereavement or to those who care for bereaved people. In this article Margot Hasha looks at the potential of mindfulness practices in therapy, including its uses in palliative care and in dealing with loss and grief

As a Western psychotherapist practicing with individuals, couples and families for nearly 30 years, I have learned that virtually all clients arrive for treatment with unresolved grief over life's losses. Such losses include, but are not limited to, deaths (traumatic or expected), divorce, termination of employment, illness and disability, and childhood abuse and neglect. Some are bereaved and exhibit symptoms associated with acute grief, such as strong emotions, cognitive changes, physical and behavioral reactions, alterations in social relationships and activities, and difficulties with spirituality or religious beliefs (Corr, Nabe & Corr 2008; Kastenbaum, 2008). Many quickly experience relief through sharing their stories and finding attention and support in the safety of a brief therapeutic alliance. Meta-analytic evidence suggests that grief is naturally self-limiting, and while individuals experience it differently, nearly half fall into a *resilient* pattern, with the ability to have positive feelings about the loss and future life with little or no 'grief work' (Bonanno *et al,* 2002). Other people display symptoms consistent with complicated grief, or what Prigerson and colleagues refer to as *prolonged grief disorder* (PGD) (Prigerson *et al*, 2009). As many as 15% of bereaved persons experience intense, intrusive and painful longings for the deceased, severe interruption in daily activities, avoidance of social activities which are reminders, difficulty trusting others, role confusion, and inability to integrate the loss (Prigerson *et al*, 2009; Shear & Shair, 2005). For some, severity of symptoms threatens both physical and emotional health.

My clinical experience has taught me that a pathological focus on the past constitutes one aspect of clients' suffering. For example, clients can feel terrified about constructing new roles, setting even the simplest goals, and resuming friendships and social activities. Torn between past regrets and fears of the future, many clients experience the *present moment* as terrifying and debilitating. So often, I have heard in their anguished cries, 'But how am I to live *right now*?'

I strongly believe that mindfulness practices, with their emphasis on presence, acceptance, and the ever-changing impermanence of life, can have beneficial effects for mitigating symptoms of complicated grief. This article defines mindfulness and provides evidence for its beneficial effects in medical and psychotherapeutic settings with an emphasis on core mindfulness programs, its application in hospice and palliative care, and concludes with a case study from my own practice, in which mindfulness meditation was included as a therapeutic intervention for a client suffering from the loss of a relationship.

What is mindfulness?

Mindfulness meditation, rooted in Buddhist contemplative psychology and spiritual practice, generates deep insight into thoughts, behaviors, and motivations while expanding compassion for self and others (Hanh, 1987). It may also be described as non-judgmental observation or the ability of the mind to see and examine without criticism or partiality (Gunaratana, 1991). Western molecular biologist, Zen practitioner, and developer of the Mindfulness-Based Stress Reduction program, Jon Kabat-Zinn, defines mindfulness as, 'moment-to-moment awareness….cultivated by purposefully paying attention to things we ordinarily never give a moment's thought to….a

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systematic approach to developing new kinds of control and wisdom in our lives, based on our inner capacities for relaxation, paying attention, awareness, and insight' (1990, p2). Zen Master Thich Nhat Hanh has said of mindfulness, 'It is the miracle by which we master and restore ourselves' (1987, p14).

In our common everyday sensory perceptions, objects are briefly held in focal attention. Being mindful involves developing a conscious receptivity during which one's mind registers phenomena *without reaction* while remaining fully present. In this way emotion, cognitions, physical sensations and impulses are observed as ongoing and changing – *impermanent* (Olendzki, 2013). With practice, mindfulness fosters a deep understanding and acceptance of one's ever-changing experiences in the social and physical environment. Insight into the impermanence of life opens us to what Goldstein calls 'the seed of freedom' (1993, p166). The state of mindfulness and the understanding of impermanence is the opposite of feeling trapped in our emotions, cognitions, human interactions, fears, and physical and psychological pain.

Use of mindfulness in clinical and therapeutic interventions

For several decades mindfulness practices have proved effective for mitigating symptoms associated with varied psychological and medical conditions. Mindfulness-Based Stress Reduction (MBSR), which combines cognitive-behavioural techniques with yoga and mindfulness meditation, was developed in 1979 to teach patients skills for coping with suffering associated with illness, stress and pain (Kabat-Zinn, 1990). Emphasis was on learning new ways of *being with* these conditions through the discovery and development of patients' *interior* resources. A positive byproduct of MBSR was the amelioration of patients' symptoms, leading to subsequent research by Kabat-Zinn and others, who examined its effects on anxiety disorders (Davidson, Kabat-Zinn, Schumacher *et al*, 2003), skin disorders such as psoriasis (Kabat-Zinn, Massion & Kristeller *et al*, 1992), alterations in brain and immune function (Miller, Fletcher & Kabat-Zinn, 1997), and relapse prevention for major depression (Kabat-Zinn, Wheeler & Light *et al*, 1998; Teasdale, Segal & Williams *et al*, 2000; Williams, Teasdale, Segal, & Soulsby, 2000).

Development of other mindfulness-based *acceptance strategies* quickly followed, including Acceptance and Commitment Therapy (Hayes *et al*, 2001), Dialectical Behavior Therapy (DBT) (Linehan 1993a, 1993b), and Mindfulness-Based Cognitive Therapy (Williams *et al* 2007). Acceptance strategies emphasise development of attention to one's relationship with thoughts, feelings, and bodily sensations, increasing clients' moment-to-moment awareness of internal experiences while they learn to acknowledge and tolerate emotional distress (Segal *et al*, 2004). Utilisation of mindfulness skills helps clients to develop a position of curiosity and non judgment rather than one of avoidance and control.

Linehan's development of DBT was influenced by her own studies of Zen Buddhism and mindfulness meditation. Integrating mindfulness and cognitive-behavioral techniques, DBT is effective for treating suicidal and para-suicidal behaviors in individuals diagnosed with borderline personality disorder (Linehan 1993a, 1993b). DBT techniques stress *experiencing* difficult emotions rather than avoiding them and teaches clients to incorporate positive and effective action toward developing meaningful life experiences (Follette, Palm & Rasmussen Hall 2004).

Stephen C Hayes' Acceptance and Commitment Therapy (ACT), based upon mindfulness meditation and Relational Frame Theory, enables clients to focus on present-moment experience as a way to learn commitment and values-based living and to dismantle the cognitive traps that contribute to anxiety and depression (Hayes *et al,* 2001; Hayes & Lillis, 2012; Hayes, 2005). ACT interventions increase emotional flexibility by pointing out the high costs of psychological rigidity. Skills include acceptance, present-moment awareness, recognising the difference between choice and action, modifying cognitions, and incorporating behavioural changes linked to values and meaning (Hayes, 2004).

Mindfulness practices are effective in medical settings as well. Shennan and colleagues (2011), in a study of 13 research papers composed of randomised control trials, pre- and post-test designs, and qualitative studies, found significant improvements in anxiety, depression, stress, physiological arousal and immune function among cancer patients. Tsang and colleagues (2012) investigated the beneficial effects of MBSR on general health of patients with terminal cancer. Findings demonstrated that MBSR promoted physical and mental health of patients in a cost-effective manner that they could continue to practice by themselves. A meta-analysis reviewing 209 mindfulness-based studies implemented in the treatment of a variety of medical and psychological disorders over three decades found robust results obtained and maintained at follow-up (Khoury *et al*, 2013).

Mindfulness in hospice and palliative care

One of my own teachers, Thich Nhat Hanh (2002), states that humans are afraid of three things: death, separation, and nothingness. Individuals trapped in these fears become depressed, hopeless, and unable to live in today's society. Western culture encourages faulty beliefs that form the illusory foundation of a happy life built upon what we hope will be permanent. Such illusions are not sustained when normal life reveals the frailty of our identities, possessions, and loved ones. We cling, even when all evidence indicates that we should let go, thus creating more suffering or what Buddhism refers to as *samsara* (Sogyal Rinpoche, 1993). Coping with death or any loss requires re-evaluating or releasing what has existed before *while learning to accept what is now,* which can be a terrifying prospect for the individual facing death or bereavement

From the Buddhist view of death and bereavement, facing our fears *enriches* us, making life more meaningful *because* it is so short. Appreciating life and accepting its impermanence leads to an intensification of our human experiences: the sky is bluer, food tastes better, love is deeper, even death is clearer,

less fraught with fear and confusion. Approaching life and grief mindfully, we embrace opportunities to heal as well as to offer and receive forgiveness. Practicing mindfulness through suffering and bereavement, individuals notice changes *between* moments, leading to openness and the ability to let go. For example, one may experience pain/release or dependence/independence, reinforcing ever-changing states of being. Bruce and Davies (2005) explored mindfulness experiences among caregivers at a Zen hospice. Findings indicated that caregivers cultivated both internal and external environments in which direct experiences with patients were increasingly held without judgment.

Models incorporating mindfulness to address grief in counseling settings and to mitigate patients' suffering in hospice and palliative care have met with success. In 2009, Wada and Park called for the integration of Buddhist psychology with grief counseling. Cacciatore and Flint (2012) proposed a mindfulness-based bereavement care model, ATTEND, for use in mitigating effects of traumatic bereavement and improving psychological outcomes for health-care providers experiencing burn-out or secondary trauma. *Techniques of grief therapy* (Neimeyer, 2012) includes a chapter on the potential benefits of mindfulness training for clients experiencing complicated or traumatic grief, as well as a chapter on the use of ACT for the same purposes (Thompson, 2012; Romanoff, 2012). Rushton and colleagues (2009), noted benefits of the mindfulness-based *Being With Dying* program developed by Roshi Joan Halifax on moral distress, grief, and burnout of health care professionals. In 2009, Back and colleagues described the benefits of compassionate silence derived from contemplative practice with hospice patients (Back *et al*, 2009).

The Project on *Being with Dying* was developed in 1994 by Roshi Joan Halifax, a Western trained medical anthropologist who began Zen studies during the 1960s then worked with cancer patients during the 1970s. Offering annual training to physicians, nurses, psychologists, social workers and clergy, BWD teaches contemplative and compassionate care of the dying (2008). Halifax believes that clinicians who provide compassionate end-of-life and bereavement care must first '(1) become self-aware and recognise their own suffering, (2) make a commitment to addressing their own suffering, and (3) develop receptivity, compassion, and resilience through nurturing physical, emotional, mental, spiritual, and social dimensions in their own lives and in relationships with others' (2008, p215).

I had the opportunity to participate in Roshi Halifax's BWD training in May 2014. The seven-day training included meditation three hours daily, Yoga and other embodiment practices, experiential explorations into our own dying and death, exercises to develop compassionate care-giving skills, and up-to-date cognitive neuro-science research on effectiveness of mindfulness practices. For me personally, an integral component was the Buddhist practice of the Boundless Abodes, consisting of deep meditation and phrases that can 'help us swim the waters of grief until grieving is transmuted into compassion and equanimity' (Halifax, 2008 p195). Park and Halifax (2011) describe the effects of this practice as 'cultivating a tender heart' (p362). Examples from the Boundless Abodes include such phrases as 'May I fully face life and death, loss and sorrow' and 'May I accept my sadness, knowing that I am not my sadness.' This practice, along with the overall training, helped tremendously with grief over my mother's death in August of 2013. By week's end, I experienced a deeper ability to reside in the awareness of the impermanence of life, while also embracing the ways in which my mother still exists in my memories, ongoing relationships with family and friends and in what she taught me.

Cacciatore and Flint (2012) and Niemayer (2012) have proposed the use of mindfulness practices for treatment of traumatic and complicated bereavement. Based upon my own clinical experience with those suffering from grief and loss, I strongly believe that mindfulness practices can provide long-term benefits to sufferers. I offer the following as an example.

The case of Anna

Anna (not her real name), a 42-year old, college-educated, single female arrived for outpatient psychotherapy requesting treatment for 'anxiety, depression, and social phobia.' Initial intake revealed that Anna was an only-child who had been born one year after her parents' first child (a boy) died in infancy. While early childhood memories were scant, Anna was aware through an aunt that her mother was hospitalised for several weeks at least twice after her birth and before she was four years old. Anna's aunt described the need for hospitalisation as 'nervous breakdown.' Relatives cared for Anna because her father worked the night shift at a local oil refinery. At school-age, she feared leaving home, often becoming so emotionally distressed and physically ill that her mother would be called to pick Anna up. Anna's history indicated insecure attachment and childhood separation anxiety. Adolescent and adult dating was almost non-existent, with one significant exception.

At age 17 Anna began an emotional and sexual relationship with a married woman twice her age (whom I shall call B). While the psychodynamics of this relationship are beyond the scope of this paper, what is relevant to this discussion is that the relationship continued for three years then ended abruptly when the woman became pregnant with her first child and moved out of state with her husband. Efforts at communication by the now 21-year old were fruitless.

Essentially, Anna had been stuck in a state of grief for 21 years. She yearned for B, often crying inconsolably as she ruminated over the circumstances of their break-up. She felt angry and resentful and avoided all attempts at discussion of B's husband and child. Anna could not imagine ever being in another relationship, was unwilling to engage in social activities or make friends, and described her life as 'empty.' Anna was employed but often changed jobs when she either performed poorly or refused to collaborate with co-workers.

Medication helped very little with Anna's anxiety and depression; however, over time we were able to establish a therapeutic alliance that included small, consistent steps toward trust. Therapy was primarily cognitive-behavioral, and I began to introduce basic mindfulness practices to Anna each time we met. Initially, she learned to focus on her breath in order to develop awareness of the present moment. Soon, Anna was able to recognise that while breathing and paying attention to her breath she could differentiate her intrusive thoughts and emotions from what was actually occurring in the therapy room. She learned to recognise the space between the *now* and the moment when her ruminations would carry her away. Eventually, Anna could make a choice to let go of the intensity of the emotions and intrusive thoughts while also tolerating them. She learned to relax into her breathing, experiencing incremental periods of relief from anxiety. Anna began to feel she had some control over her thoughts and emotions, and this led her to practice mindfulness at home, daily. She kept a journal of her meditation sessions, recording shifts in mood, cognitions, and emotions. In this way, along with cognitive-behavioral techniques used in therapy, Anna began to heal. Little by little, she was able to recognise the gradual 'letting go' of her lost love while simultaneously creating a more fulfilling life for herself in the present. She slowly developed supportive friendships with two co-workers and sometimes went out to dinner or a movie. About a year into her meditation practice, Anna began dating someone regularly. Occasionally, she is reminded of her relationship with B, and she still struggles with intimacy and commitment, but she now recognises her fears and pushes through them. She has committed to the therapeutic process and to meditation, what I consider real successes. Her levels of anxiety and depression are significantly reduced, she has friends, her work performance is improved, and she speaks of hope for the future. Anna's partner is supportive and patient and together they are working to slowly build a satisfying relationship.

Conclusion

Today, there are many methods for integrating mindfulness practices into therapeutic work (Germer *et al*, 2005). Therapists may:

(1) personally practice mindfulness meditation in order to cultivate more therapeutic presence in the consulting room;
(2) implement a theoretical frame informed by mindfulness practices, such as MBSR, MBCT, ACT, or DBT; or
(3) teach clients how to practice mindfulness in sessions and at home (Germer *et al*, 2005).

As a meditating therapist I have used all three methods successfully with myriad client complaints, including bereavement.

Pema Chodron (1997) asserts that fear is a natural reaction to moving closer to the truth that all things change, and that life invites us to meet each and every experience, no matter how painful or terrifying. Mindfulness practices teach us to face life, suffering and grief *through* each moment without avoiding or stopping the process. Through meditation we can face our fears of change, illness, suffering, and even bereavement while also living more fully and in the present.

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