

UNRESOLVED GRIEF AND MOURNING IN NAVAJO WOMEN

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ABSTRACT. Grief and mourning are normal psychological processes in response to loss. They are the means whereby individuals psychologically let go and free themselves from the bonds of attachment to others. Although characteristic stages and phases of this process can be discerned, there is considerable cultural patterning and shaping of this experience. Case examples are given of Navajo women who experience spontaneous dreams and hallucinations of lost loved ones as an expression of their unresolved grief and mourning.

Introduction

In the history and tradition of Western medicine and psychiatry, grief and mourning have been used to describe the psychological process normally experienced by individuals who suffer an emotionally significant loss. It is understood that typically these processes are most completely manifested under circumstances where an individual has experienced the loss by death of an emotionally important person such as a close friend or relative.

Freud (1915/1955) in his paper entitled "Mourning and Melancholia" wrote:

Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one such as one's country, liberty, an ideal, and so on. In some people the same influences produce melancholia instead of mourning and we consequently suspect them of a pathological disposition. It is also well worth notice that 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 its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (pp. 243-244)

Later in that paper Freud describes the work of grief and mourning as consisting of the emotionally powerful and painful processes of withdrawing attachments from a "loved object" which "reality-testing has shown ... no longer exists."

At the same time loss, grief, and mourning are an essential and universal human experience. Every culture's religious and healing tradition must deal in some way with these processes. To some extent each culturally distinct group of people identifies itself through how it copes with the fact of death in its eschatological practices and how it provides pathways of support for the living survivors. Cultural patterning and shaping of the grief and mourning experience appear to have as their

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objective the normal, healthy adaptation and liberation of the mourner. Yet in any culture these processes can go awry and one might expect there to be a cultural prescription for diagnosing and treating pathological outcomes.

So it is not surprising to discover in the rich history and tradition of Navajo culture and medicine a complex system of rites, rituals, and ceremonial practices dealing with the experience of loss, grief and mourning. Beauty Way, Hand-Trembling Way and Blessing Way chants encourage and facilitate normal grief and protect against pathological outcomes (Sandners, 1979, pp. 41-78). Begay (1988) describes how *Nidah* or Enemy Way (Squaw Dance) chant and Evil Way (Ghost Way) treat disturbed and/or unresolved mourning.

Grief and Mourning as Processes

In every culture the psychological processes of grief and mourning provide the means whereby the living survivors work through the loss of a "loved object." Across cultures these processes appear to follow a regular sequence.

Many writers have described the processes of grief and mourning. Psychiatrist, George Engel (1961), in a paper entitled "Is Grief a Disease?", defined grief as:

the characteristic response to the loss of a valued object, be it a loved person, a cherished possession, a job, status, home, country, an ideal, a part of the body, etc. Uncomplicated grief runs a consistent course, modified mainly by the abruptness of the loss, the nature of the preparation for the event, and the significance for the survivor of the lost object. Generally, it includes an initial phase of shock and disbelief, in which the sufferer attempts to deny the loss and insulate himself against the shock of the reality. This is followed by a stage of developing awareness of the loss, marked by the painful affects of sadness, guilt, shame, helplessness, or hopelessness; by crying, by a sense of loss and emptiness; by anorexia, sleep disturbance, sometimes somatic symptoms of pain or other discomfort, loss of interest in one's usual activities and associates, impairment of work performance, etc. Finally, there is a prolonged phase of restitution and recovery during which the work of mourning is carried on, the trauma of the loss is overcome and a state of health and well-being re-established. (pp. 18-19)

Many psychiatrists have made efforts to define the sequence and patterning of grief in order to better understand it. Bowlby (1961) defines grief as "the sequence of subjective states immediately following an irretrievable loss," and he distinguishes mourning as "the psychological process set in motion by an irretrievable loss leading to the relinquishment of the object." Hence, "shock and disbelief" as well as "disorganization and painful affects" are more the propriety of grief; while the whole process including restitution and reorganization is essential to satisfactory mourning.

Pollock (1961) gives emphases to the "adaptive" and "liberating" aspects of the grief and mourning experience. He agrees that the process regularly occurs in successive phases and stages. The initial stage of shock, the grief reaction and the work of mourning lead to a necessary liberation of the "energies of cathexis" for new

attachments. Pollock gives emphasis to the notion of growth through loss and adversity. Bereavement comes to an end when the loss is assimilated and the meaningful aspects of that attachment are entrusted to memory.

Dreams and hallucinations of the dead in association with grief and mourning experience have been reported by other writers. Matchett (1972) noted repeated hallucinatory experiences as a part of the mourning process in Hopi women. He described Hopi women as inviting images of their lost loved ones on themselves through a kind of spontaneous self induced trance state in the twilight of the evening. Shen (1986) reported similar phenomena and suggested that perhaps this was a normal characteristic for Hopi grief and mourning. Apparently, Hopi hallucinations do not seem to have the same ominous pathological connotations that they have for Navajos. Finally, Rees (1971) drawing from a large sample of widows, reports hallucinations of images of their dead husbands as part of their normal mourning experience.

Disturbed grief and unresolved mourning occur when the bereaved person is unable to complete this process. Many ways of failing the completion of this process and getting stuck are imaginable. A full account of the aberrations and pathologies associated with these processes is beyond the scope of this paper; however, the case examples presented should be illustrative.

Navajo Cultural Context

The *Dineh*, as Navajo people call themselves, inhabit the arid lands of northeastern Arizona, southeastern Utah, and northwestern New Mexico living on a reservation of about 25,000 square miles. They number about 135,000 people making them the largest tribal group of American Indians. The traditional economy of the culture was based on raising sheep and this continues to be the main stay of wealth. Although known for their silversmithing and rug weaving these traditions do not apply in every family so remain a supplemental source of income for some. Families live in close-knit matrilineal, matrilocal group encampments referred to as "camps" usually at some distance from one another and often at considerable distance from any town.

Contemporary Navajo families do not live the "leisurely and relaxed" life described by Vogt and Kluckhohn (1951) for the 1940s. Evidence of poor housing with lack of running water and electricity persist; yet, it is not uncommon to see hogan, housetrailer and television satellite antenna juxtaposed. Family life styles follow suit blending past and present in uncertain harmony. Even Navajo language in common use is pidgined and punctuated with English words and references.

Formally leadership is centralized in the Navajo tribal offices at Window Rock, Arizona but rurally in remote camps leadership remains situational. Tribal elders and traditional medicine men continue to receive the respect and esteem of the people as they are sought out for counsel and healing.

Traditional Navajo religious and medical practices are complex and seem to resist Anglo efforts to understand them. Even so, the extensive work by Kluckhohn and Leighton (1946), Haile (1943), Reichard (1950), and Sandner (1979) give us a basis

for understanding the “Beauty Way” principle of the individual living in harmony and balance with nature. Illnesses arise out of disruption of these patterns of harmonic balance. Natural and supernatural forces can cause disharmony and thereby cause illness. Natural phenomena like lightning and ill winds; as well as skinwalkers, witch people and ghosts are believed pathogenic.

Traditionally, the loss by death of a close relative was perceived as a dangerous time. As Kluckhohn and Leighton (1946, p. 185) pointed out “the intense and morbid avoidance of the dead and everything connected with them rest upon fears of ghosts”. Traditionally, it was believed that most of the dead may return as ghosts, to the burial place or former dwelling especially if the deceased was not buried properly. Leighton and Kluckhohn (1948, p. 91) add the fact that ghosts were believed to be “especially malevolent toward their own relatives.”

Miller and Schoenfeld (1973) in their paper “Grief in the Navajo: Psychodynamics and Culture” describe the Navajo patterning of grief and mourning as follows:

The accepted pattern of mourning limits grieving to a period of four days. During the time of discussion of the lost members is allowed and expression of feeling condoned. However, even during this time excessive show of emotion is not looked upon favorably by the community. Following the four-day period the mourner is expected to resume his usual routine with no further expression of emotion concerning the loss. Involved in this restriction is the fear of the power of the dead person. (p. 188)

Case Examples

Case No. 1

Mrs. RC was a 28-year-old married Navajo mother of two children who was brought to the hospital emergency room by her family because of acutely agitated, wildly out of control behavior, threatening suicide. The family gave the history that she and the family had been on vacation in the mountains near Ouray, Colorado and had stopped at one of the scenic overlooks. RC’s 10-year-old daughter had been playing and climbing out on the rock overhang there when she accidentally slipped and fell 200 feet to her death. RC reacted immediately with outcries of protestation and calling out to her daughter. Family had to restrain her as she made efforts to throw herself over the precipice struggling to join with her daughter in death.

Initially in the hospital she responded to mild sedation and slept for an extended period seemingly exhausted. For the first several days in the hospital she remained withdrawn, awakening at intervals only to stare off as if in a trance. As she was invited to talk about her background she described having spent the summer with her family in the mountains in her mother’s “sheep camp.” This outing had been her first time off the reservation in several months. As she became more comfortable talking, she was able to talk about the accident and her daughter’s death. She expressed her grief in convulsions of tears and expressions of longing and sadness.

In several interviews she talked about vivid dreams in which her daughter would appear lonely and in need of comfort. Less disturbing to her were apparitional visitations, i.e., visual hallucinations, in which her daughter would appear at her bedside reaching out for her hand. RC felt ambivalent about her dreams and hallucinations both wishing for them but fearing them at the same time.

Family showed less ambivalence about RC's reports of these experiences and when the idea of traditional Navajo treatment was explored, her husband offered that he had already consulted a "hand-trembler" known to his family and an Enemy Way singer of Squaw Dance had been recommended. As he said that this would be expensive and take some time to arrange he was told to take her to another "singer" for a Blessing Way to protect her until the other could be done. She was sent out of the hospital on pass for the Blessing Way which left her feeling quite relieved. She was discharged from the hospital and seen on an outpatient basis for four follow-up psychotherapy visits past the time of her Enemy Way "Nidah" ceremony which she talked about as having brought her great relief and comfort.

Case No. 2

Mrs. BB was a 50-year-old widowed Navajo woman who came to the office because of disturbing dreams about her deceased husband who had been drinking in Gallup, New Mexico when he was hit and killed "run over" by a train. Although she had a high school education and a good job with the Bureau of Indian Affairs (BIA), she was disturbed by what she claimed were her mother's and grandmother's ideas that she was being bothered by her husband's ghost. She acknowledged that she had trouble sleeping and sometimes felt a vague sense of his presence. Initially she decided to see a psychiatrist as she had felt reluctant and a little frightened to go "Navajo Way" as her rural traditional family was insisting. By her second and third sessions of psychotherapy she had started antidepressant medication and she was opening up to further invitation to think about what she was experiencing the way her mother and grandmother would.

BB talked about how she had begun to experience ghostly apparitional visits sitting in her home in the evening but that the medicine had helped her sleep so that hallucinations went away during the night. In psychotherapy she reviewed in detail her understanding of the gruesome accident and the care that the family had taken to make sure that his body was prepared "Navajo Way" including clothes rented, rings placed on index finger, turquoise and four sacred plants in the casket. In spite of all of this precaution she was still troubled. After the third session she consulted a "star-gazer" who diagnosed the problem saying that a piece of her husband's skull bone with hair and blood would be found at the scene of the accident and needed to be buried properly with him. Also she needed an Enemy Way ceremony which was provided for her by her family. She was continued in psychotherapy supportively and on medication until four sessions after her Squaw Dance.

Case No. 3

Miss NB was a 24-year-old single Navajo woman who came into an alcohol and drug treatment center stating that she was thinking of killing herself since she had been drinking to considerable excess since the death of her mother five months before. She had a near fatal accident while driving under the influence just the week before her first clinic visit.

NB was invited to talk about her background which she described as rural and traditional. She had been raised the next to the youngest girl of eight children. As she had been born with a congenital hip disorder, she and her mother had been especially close throughout her growing up years. In the BIA boarding school she had done especially well compensating for her obvious physical difficulty. She had gotten a good secretarial job in the BIA offices and her family had been proud of her success. She would drive many miles to visit them nearly every weekend. She had not abused alcohol to any extent before mother's death.

In about May some five months previously she described having driven up to her mother's sheep camp in the mountains. As she was out herding sheep with her mother and sisters, lightning had struck and killed her mother instantly. NB described herself as having been left stunned and horribly frightened. She remained with her family for the usual weekend period only and then returned to her job as usual leaving the funeral arrangements and the traditional arrangements for treatment of the sheep herd and family members in a "Male Shooting Way Chant" ceremony. Although she attended the funeral she reported having experienced sadness but no tears. She stubbornly refused to attend any traditional "Navajo Way" ceremonies and returned to her job.

At home alone she began experiencing insomnia with disturbing dreams vividly imaging mother. She started drinking in an effort to sleep better; then her life lost meaningful pattern. She started messing up on the job, quit eating and cared less about her appearance. She had been suicidal at the time of her roll over accident.

NB was anxious to talk and very responsive to psychotherapy. She quit drinking and accepted appropriate vitamins and antidepressant medication. She got back on track with her job and she was encouraged to reapproach her family. The family insisted that she have the appropriate ceremonies in order; Male Shooting Way, Blessing Way and finally Evil Way (Ghost Way). She continued in psychotherapy throughout and she was maintained on medications. Interestingly, toward the end of therapy after her ceremonies she reported healthy pleasurable dreams again including one involving her mother in the afterlife taking care of and raising a child whom she had imagined to be the female fetus she had aborted some years before.

Discussion

Each of the three women in these case examples experienced profound loss in the death of someone to whom they were deeply, meaningfully attached. Each of them lost loved ones suddenly in freak accidents over which they had no control.

In retrospect, RC's reaction was the most natural, normal and unconflicted. She had no hesitation or embarrassment about availing herself of both medical systems—White Anglo doctor/hospital and traditional Navajo medicine man/chantway. BB struggled in conflict over who to see and what to do seemingly caught between the two cultures. With some respectful nudging and coaxing, she too made use of both systems. Finally, NB was most conflicted about allowing herself any expression of her grief at all, not wanting to deal with the fact of her mother's death. Not until her own near death experience in a roll over accident in a car did she become willing to get any help from either system. In the end, NB was able to bridge successfully back and forth between the two cultures and the two healing traditions getting something of what she needed from each one.

Although the kind of "bridging" or "coupling" across cultural context and medical traditions can be very useful, it also can be touchy and temperamental. Respect for the patient's ego defenses, as well as the therapist's empathy, interest, patience, and concern for the well being of the patient in his/her family context are essential threads in the weave of any transcultural theory effect. Conscious, deliberate listening and pacing with the patient's process, and attention to his/her interdependent, interpersonal world are equally important.

Finally, in discussion of these cases, taking them in reverse order, one is reminded of what Pollock (1961) has suggested. That is, NB in losing her mother lost her past; BB in losing her husband lost her present; and RC in losing her daughter lost a part of her future. All three women were traumatized and all had manifestations of pathological mourning.

Summary

Few experiences in the human life cycle approach the richness, intensity, depth and complexity of grief and mourning. Mind, body (heart), and spirit (soul) react and respond voluntarily and involuntarily in simultaneous interplay. Culture shapes and patterns this weave of the fabric of grief and mourning.

Navajo culture allows for the bereaved's experience of significant dreams and hallucinations of the deceased person. Even though these experiences in cultural context may harbingers "ghost attacks" or "ghost illness" they may announce to hallucinophobic culture's such as our own another dimension of the full range of grief and mourning experience. Perhaps all clinicians would serve their bereaved patients better in asking them about such experience. Dreams of the dead and all varieties of hallucinatory experience may be more in the realm of variation than deviation when it comes to grief and mourning experience.

In the cultural wisdom of traditional Navajo medicine, a Navajo medicine man has been quoted as saying:

In the old days
 Everything spoke to the Dineh (the people)
 The rocks, the grass, the trees—
 They all taught us
 But nowadays
 The Dineh have gotten so busy
 That the rocks, the grass and
 the trees don't speak anymore
 Or maybe the people
 have just forgotten how
 to listen

When it comes to grief and mourning, therapists need to learn how to listen with open minds and open hearts to the full range of human experience which constitute the grief and mourning processes.

Clinical experience teaches that significant dreams and all kinds of hallucinations are ubiquitous in the normal grief/mourning spectrum. Culture shapes and patterns these processes and interprets and judges significant aspects of the individual's experience. The intensity, frequency and affective response to dreams and hallucinations seems to lead to a determination as to whether these experiences are deemed "normal" or "pathological" in a given cultural context.

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