MI-03 Grief, mourning and ritual across cultures: how the bereaved are carried

HEALING after the FALL, research library, MI-03

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Findings by section

1. How to read this report

Grief is not an illness. Most bereaved people, in every society that has been measured, carry a death and go on living, and they do it with the help of their kin, their neighbours and the rites their culture gives them. A minority do not. Their grief stays at its first intensity for a year and more, and they stop working, eating or caring for others. A further group dies sooner than they would have done: the widowed, the parents of a dead child, and the old whose partner has gone. This report is about all three groups, and about the village's job, which is to carry the many, notice the few, and keep the frail alive.

The report does not cover the care of the body after death or the public health of burial, which belong to NU-07. Suicide after bereavement and the care of those bereaved by suicide belong to MI-08, and the long loneliness of the old widowed belongs to MI-13. None of the three has been written yet, so this report says where it touches their ground and leaves the detail to them. The dying person and the good death are in NU-06, and trauma with its narrative therapy is in MI-01. Ritual and community as healing in general are in TR-16, and depression is in MI-04. Where grief has become depression, MI-04's screening and treatment apply.

Three kinds of claim are kept apart throughout: what each tradition says its rites do, what the record shows happened to mourners, and what modern science infers. Restricted knowledge, such as gendered or initiated mourning lore, is named as existing and not described, following the library rule (THRIVING library, SY-04).

2. The traditions on their own terms

The Ngaju of Borneo and the double burial. Robert Hertz published his essay on the collective representation of death in 1907, and Rodney and Claudia Needham translated it in 1960. His material was largely from the Ngaju Dayak of south Borneo. In his reading of their practice, the body, the soul and the mourners pass through the same intermediate period together. The corpse is kept or buried provisionally while the flesh decays. During that time the soul wanders, unsettled and dangerous, and the close kin live under restrictions. Only when the bones are dry does the great final feast come, the *tiwah*, which in the secondary accounts lasts about 30 days and ends with the bones placed in a *sandung* ossuary. With it the soul reaches the village of the dead and the mourners are released back into ordinary life (Hertz 1907, secondary summaries only). Hertz's point was that death is a social process that takes time, not a moment, and that mourning ends when the community declares it ended.

Van Gennep's three phases. Arnold van Gennep's *Rites of Passage* (1909) gave the frame that most later writing borrows: separation, a liminal or threshold period, and incorporation (van Gennep 1909, via Britannica). Funerals,

he noted, are rich in rites of transition, and the mourners themselves pass through a liminal stage in which they are set apart. The modern inference is plain: almost every culture gives the bereaved a bounded time out of ordinary life and a marked return to it.

The calendars of the living religions. Many traditions set the bounded time with dates. - *Judaism.* Burial is swift. The first seven days are *shiva*, when mourners stay at home and the community comes to them with food and prayer. *Shloshim* runs to the thirtieth day. A child mourning a parent says *kaddish* for eleven months, and the anniversary, *yahrzeit*, is kept every year (My Jewish Learning, timeline of mourning). - *Islam.* Burial is swift. Mourning is three days for most of the bereaved. A widow mourns four months and ten days, a period set in the hadith (Sahih Muslim 1486b). The schools of law differ on what the widow may do in that time, and the village should ask its own scholars rather than take one reading from this report. - *Japan.* Buddhist memorial rites fall on the seventh day and the forty-ninth day after death, when the soul is held to have passed through the intermediate state. Further memorials are held at one year, three, seven and thirteen years, and continue to the thirty-third or fiftieth year (Japan Living Life, memorial customs, a popular source).

What these calendars say they do differs by faith: honour the dead, discharge a duty to God, guide the soul. What they share is a structure. Company is densest in the first week, there is a turning point at about a month, a release at about a year, and a yearly return after that.

Ancestors and continuing bonds. Dennis Klass studied Japanese ancestor worship and argued that its household altar, daily offerings and spoken reports to the dead give the bereaved a socially approved way of keeping a bond with the dead, rather than breaking it (Klass 1996, abstract only). This was one root of the *continuing bonds* idea, which overturned the older Western view that health means letting go. Tony Walter's biographical model makes the same move for secular Britain: the bereaved build a durable story of the dead person, chiefly by talking with others who knew them (Walter 1996, secondary summaries). The inference for the village is that a mourner who still talks to the dead, keeps their things, or feels their presence is not stuck. In Rees's mid-Wales study of 293 widowed people in 1971, almost half had felt, seen or heard their dead spouse, and most found it helpful and kept it to themselves (Rees 1971). A later interdisciplinary review found these experiences common and mostly benign (Kamp 2020).

Sorry Business in Aboriginal Australia. In Aboriginal and Torres Strait Islander communities the period of mourning after a death is called Sorry Business. A 2023 guideline from Cemeteries and Crematoria NSW, written with Aboriginal communities, sets out its public shape (Cemeteries and Crematoria NSW 2023): - The family sets the time frame, not the institution. - Many communities do not speak the name of the dead or show their image for a period, and some use a substitute word. - In some communities Sorry Business ends when the first rain washes away the dead person's footprints. - Ceremonies cannot begin until the people who must be present have arrived, and more than 450 people may come. - Smoking ceremonies, wailing and vocal mourning, burial in perpetuity and soil from Country all have a place.

The same guideline notes that there are cultural protocols specific to men and to women. These are restricted knowledge. This report records that they exist and does not describe them (THRIVING library, SY-04).

The rule against speaking the name collides with a line in the library. MI-01's grief rite says "say the names aloud" (THRIVING library, MI-01). For many mourners and many traditions that is right. For an Aboriginal family in Sorry Business, and for any community with a similar rule, it is a breach. This report therefore disagrees with MI-01 on one point: the village must not impose naming. Each family decides whether its dead are named at a communal rite [OWNER].

The Ilongot and the rage in grief. Renato Rosaldo worked among the Ilongot of northern Luzon in the Philippines. Older men told him that the rage born of grief drove them to take a head, and he did not understand them. He did understand after his wife, the anthropologist Michelle Zimbalist Rosaldo, died in a fall in the field on 11 October 1981. His essay "Grief and a headhunter's rage" (1984) argues that anthropology had described funeral rites as orderly routines and missed the force of the emotion inside them. After martial law in 1972 ended headhunting, many

Ilongot converted to Christianity, which the men described as a new way to carry grief (Rosaldo 1984, secondary summaries). The modern inference is that anger is part of grief in many cultures. A rite that gives it a safe channel matters, and a society that removes the old channel needs a new one.

The Alto do Cruzeiro and the dispute about "death without weeping". Nancy Scheper-Hughes studied mothers in a shantytown of Bom Jesus in north-east Brazil, where infant mortality was 152 per 1,000 in 1987. Dead infants were *anjinhos*, little angels, whose small coffins were carried by older children. Mothers spoke of babies who had or lacked a "knack for living" and seemed to withdraw care from the weakest, and they wept little (Scheper-Hughes 1992, as reviewed by Flowers 1992). Marilyn Nations and Linda-Anne Rebhun, working in the same region, read the same flat affect differently. In their account it came from folk Catholic belief that tears wet the angel's wings, not from absent attachment. They found that failure to seek care was explained by poverty and barriers to access (Nations and Rebhun 1988). Both readings warn the village. Where children die often, mothers' grief may not look like grief, and the healer must not read restraint as either indifference or health.

What the cross-cultural record shows. Paul Rosenblatt, Patricia Walsh and Douglas Jackson coded grief and mourning across societies in the Human Relations Area Files (HRAF) for their 1976 book. Their supported findings include these (Rosenblatt 1976, via the HRAF summaries): - Where there was a final ceremony that closed mourning, prolonged grief was less often reported (Pearson correlation, one-tailed p below 0.05). - Where ritual specialists played a larger part, there was less anger and aggression. - Women cried more and men showed more anger. - Societies with levirate or sororate remarriage also had customs that broke the tie to the dead spouse.

The HRAF pages conflict on whether attending a final ceremony itself reduced later grief, and the sample size could not be confirmed [VERIFY]. This is ethnographic correlation, not trial evidence (Grade B to C), but it is the nearest thing to a test of Hertz across many cultures.

3. Grief that heals itself

Most people recover without help. George Bonanno and colleagues followed 205 older Americans from before their spouse died to 18 months after (Bonanno 2002). The largest group, 45.9 per cent, were resilient, with low distress throughout. Common grief, with distress that rose and then fell, was 10.7 per cent, and chronic grief 15.6 per cent. The depressed-improved group, 10.2 per cent, were people whose depression lifted after the death, often of a long-ill partner. Chronic depression, present before and after, was 7.8 per cent. Delayed grief was rare at 3.9 per cent. Chronic grief was predicted by dependency on the spouse before the loss, not by the absence of early tears. A later pooled analysis of trajectories after loss and trauma gave about two thirds resilient, a fifth recovering and a tenth chronic (THRIVING library, MI-01, citing Galatzer-Levy 2018). Bonanno concluded that resilience is the norm, not the exception (Bonanno 2004).

Grief has no fixed stages. Paul Maciejewski and colleagues measured disbelief, yearning, anger, depression and acceptance in 233 bereaved people in the Yale Bereavement Study (Maciejewski 2007). Acceptance was the most endorsed item from the start, and yearning was the commonest negative one. Yearning peaked at about 4 months, anger at 5 and depression at 6, and all negative indicators had peaked within about 6 months. The authors used this to say that distress still high after 6 months deserves attention. Margaret Stroebe, Henk Schut and Kathrin Boerner later argued that stage theory has no sound evidence and that health workers should stop teaching it, because it makes the bereaved feel they are grieving wrongly (Stroebe 2017). The village should not tell mourners what stage they are in.

Talking about it is not the medicine. Two prospective studies by Stroebe and colleagues found that disclosing emotions, including the Pennebaker writing task, did not speed recovery from bereavement (Stroebe 2002). Bonanno and Dacher Keltner found that the bereaved who showed anger on their faces when talking about the dead at 6 months had more grief at 14 months, and that those who laughed or smiled had less (Bonanno and Keltner 1997). Social support also disappoints in the narrow sense. In older widows, support had a main effect on depression, but there

was no evidence that it buffered the effect of the loss or sped recovery (Stroebe 2005, secondary summaries). This does not mean company is useless. It means the evidence for company in grief is weaker than the romance suggests, and that its main proven work is against depression and isolation, which belong partly to MI-04 and MI-13.

4. Prolonged grief disorder

The criteria. Since 2018 the WHO's ICD-11 and since 2022 the American Psychiatric Association's DSM-5-TR recognise prolonged grief disorder (Eisma 2023):

	ICD-11 (6B42)	DSM-5-TR
Time since death	At least 6 months	At least 12 months (6 for children)
Core	Longing for or preoccupation with the dead, with intense emotional pain	Yearning or preoccupation nearly every day for at least the last month
Further symptoms	Examples given: sadness, guilt, anger, denial, blame, difficulty accepting, loss of part of oneself, numbness, inability to enjoy	At least 3 of 8: identity disruption, disbelief, avoidance of reminders, intense pain, difficulty re-engaging, numbness, life meaningless, intense loneliness
Impairment	Significant	Significant
Culture	Clearly exceeds social, cultural and religious norms	Exceeds norms of the person's culture and context

The cultural clause matters after the Fall. A widow in four months and ten days of Islamic mourning, or a family in Sorry Business, is not disordered for keeping the rite. The clock starts, in effect, when the culture's own mourning ends. The criteria were validated in a US sample by Holly Prigerson and colleagues in 2009 (Prigerson 2009, abstract only).

How common it is, by kind of death.

Kind of death	Prolonged grief	Source
Natural death, adults, pooled	9.8% (6.8 to 14.0), 14 studies	Lundorff 2017
Unnatural death (accident, suicide, killing, disaster), pooled	49% (33.6 to 65.4), 25 studies	Djelantik 2020
COVID-19 deaths, pooled	24% (13 to 36), 13 studies, 5,766 people	Li 2026
Norwegians bereaved by the 2004 tsunami, 2 years	47.7% screened positive, 130 people	Kristensen 2010
The same, 6 years	12% prolonged grief, 94 people	Kristensen 2015
South Indian coastal villages, 9 months after the tsunami	25.9% of 351 bereaved	Rajkumar 2015
Widows of the Rwandan genocide	12.5% (5 of 40), with 40% major depression	Schaal 2009
Parents bereaved by a child's cancer	About 1 in 3 probable	Pohlkamp 2019, cited by Eisma 2023

In Djelantik's meta-regression, prevalence was higher after the death of an only child, after violent killing and in non-Western studies, and lower with more time since the loss and after natural disasters (Djelantik 2020). MI-01 gives the

49 per cent figure as Lundorff 2020 (THRIVING library, MI-01). The pooled figure for unnatural losses is Djelantik and colleagues 2020, and this report corrects the attribution. A latent class study of 433 bereaved Germans found no symptoms in 47 per cent, moderate prolonged grief in 32 per cent and high prolonged grief with post-traumatic stress and depression in 21 per cent (Heeke 2022). Separation distress formed its own factor in Rwandan survivors, distinct from depression and post-traumatic stress (Schaal 2012).

The three tiers. The public health model of bereavement support, set out in the NICE guidance on supportive care for adults with cancer (2004), sorts the bereaved into three groups. All need information and the ordinary support of family and friends. Some need a chance to reflect with a volunteer or community group. A few need specialist help (NICE 2004, secondary summaries only). In an Australian population survey of 678 bereaved people, the risk groups were 58.4 per cent low, 35.2 per cent moderate and 6.4 per cent high, against the model's predicted 60, 30 and 10 (Aoun 2015). The ratios match the trajectories. About six in ten need only their people, three in ten need a little more, and one in ten needs real help.

5. The bereaved body

The widowhood effect. Grief kills the frail. Jinkook Moon and colleagues pooled 15 cohorts and 2,263,888 people and found a relative risk of death of 1.41 in the first 6 months of widowhood and 1.14 after that. Men's risk was raised by 1.23. Women's was 1.04 and not significant (Moon 2011). Eran Shor and colleagues, pooling 123 publications, gave a hazard ratio of 1.23 overall, 1.27 for men and 1.15 for women (Shor 2012). Felix Elwert and Nicholas Christakis followed 373,189 elderly American couples from 1993 to 2002 (Elwert and Christakis 2008). The hazard ratio was 1.18 for men and 1.16 for women. Their introduction cites earlier work finding 30 to 90 per cent excess mortality in the first 3 months, falling to about 15 per cent later. Two details matter for the village: - There was no significant widowhood effect when the wife died of Alzheimer's or Parkinson's disease. The authors read this as anticipatory grief and time to prepare. - Men's risk rose by more than 20 per cent when the wife died of lung cancer, infection or sepsis, chronic lung disease, other heart disease or diabetes, deaths that were often sudden or short.

The heart in the first days. In the Determinants of Myocardial Infarction Onset Study, Elizabeth Mostofsky and colleagues found that the risk of a heart attack was 21 times higher (13.1 to 34.1) in the 24 hours after the death of someone significant, about 6 times higher by the end of the first week, and falling across the first month. The study had 1,985 patients, of whom 19 had lost someone in the previous day (Mostofsky 2012, secondary sources only).

Parents. Jiong Li and colleagues followed 21,062 Danish parents whose child had died, against 293,745 controls (Li 2003). Bereaved mothers had a mortality rate ratio of 1.43. Their risk of unnatural death, including suicide and accidents, was 3.84 times higher in the first 3 years. Fathers had a raised risk of unnatural death of 1.57 only in the early years. Suicide after bereavement is MI-08's ground.

The modern inference is that the first week and the first six months are when the village should watch the bodies of the bereaved, especially old men whose wives died suddenly and mothers whose children died.

6. When the rites could not be held

Philadelphia, 1918. On 3 October 1918 the Pennsylvania health commissioner, B. Franklin Royer, ordered public gatherings closed. Funerals of influenza victims were to be private. By mid-October the city reported 1,299 deaths in a single day's count (15 October). Undertakers and gravediggers ran out, bodies waited in homes, trucks carried them to a potter's field, and the requirement for death certificates before burial was suspended. The closure was lifted on 30 October. Philadelphia's excess death rate for the epidemic was 748 per 100,000 (Influenza Encyclopedia, Philadelphia). No grief outcome data were collected, so the effect of the missing rites is unknown. The lesson the record does support is practical: when the dead outnumber the hands, the rites collapse first.

Rwanda. After the genocide of 1994, widows and orphans lived with mass graves, unknown fates and killers as neighbours. Prolonged grief and depression were heavily comorbid in survivors and hard to tell apart (Schaal 2009, Schaal

2012). Each April Rwanda holds Kwibuka, the national commemoration. In a Rwanda Biomedical Centre survey of 611 people during Kwibuka 24 in 2018, 92 per cent of them women, 65 per cent reported trauma symptoms after the commemoration and 59.1 per cent named poverty as a cause (Rwanda Biomedical Centre 2018). The national rite is valued and also acts as a trigger. The village should plan for its yearly rite to bring some mourners to crisis, and staff it accordingly. MI-01 records guided mourning with narrative work for Rwandan orphans (THRIVING library, MI-01).

Aceh and the 2004 tsunami. In Aceh perhaps 160,000 or more died, many never found [VERIFY: figure not read in a primary source]. In a survey of 262 people in tsunami-affected communities, 83.6 per cent had severe emotional distress and 77.1 per cent depressive symptoms, and distress rose with the number of household deaths (Souza 2007). The STAR study of more than 16,000 adults found that destruction of the community itself worsened post-traumatic stress, independent of personal loss (Frankenberg 2012). The village of the dead mattered as well as the person. More than 14,000 unidentified dead lie in the Ulee Lheue mass grave, and families who never found their dead visit the Ulee Lheue and Siron graves each year (Associated Press 2024, via ABC News). Annemarie Samuels described how rumours that missing children had been trafficked left parents in an uncertain future, unable to close their mourning (Samuels 2015, abstract only [VERIFY]). No study of prolonged grief prevalence in Aceh was found.

The tsunami also gave the best data on bereaved tourists. Among Swedish survivors, 41 per cent were resilient, 48 per cent recovering and 11 per cent chronic, and the strongest predictor of chronic grief was a child's death (Sveen 2018). Losing a child raised prolonged grief scores more than any other factor (Johannesson 2011). Among the Norwegian bereaved, being female, losing a child or spouse and a long wait for confirmation of death predicted prolonged grief, and social support protected (Kristensen 2010).

The restricted funerals of 2020. In the COVID-19 pandemic, funerals were limited and many could not visit the dying. In the Netherlands, grief after COVID-19 deaths was higher than after natural deaths, explained by unexpectedness and the inability to say goodbye (Eisma and Tamminga 2022). A recent loss during the pandemic raised grief only a little, d 0.17, in 1,600 people (Eisma and Tamminga 2020). In the UK, 34.6 per cent had high grief at about 13 months and 28.6 per cent at 25 months. Isolation and lack of support raised scores, and feeling supported by health staff around the death lowered them (Harrop 2023). Helene Mitima-Verloop and colleagues compared Dutch mourners before and during the pandemic. How mourners attended and judged the funeral was linked to prolonged grief symptoms. Other grief rituals were not, and half had used alternative rituals (Mitima-Verloop 2022). The village's epidemic rule follows TR-16 and HY-07: keep the rite and change its form, because unsupervised funerals spread Ebola at about 2.58 further cases each (THRIVING library, TR-16, citing HY-07). The handling of the infectious body is NU-07's ground.

The missing. Where there is no body, mourning is held open. Pauline Boss's term for this is ambiguous loss [VERIFY: Boss not read directly]. An Italian qualitative study of 8 relatives of missing persons described an endless grief in waiting (Testoni 2020). A Dutch pilot of cognitive behavioural therapy with mindfulness for 17 relatives of missing persons lost 47.1 per cent to drop-out (Lenferink 2019). The evidence base is thin. The Aceh families' yearly visit to a mass grave, and the Aboriginal requirement of soil from Country, both suggest that a place and a date can stand in for a body.

7. Which parts of the rite matter

The funeral itself. Alexander Burrell and Lucy Selman reviewed 17 studies of funeral practice and bereavement outcome. Five found benefit and six did not. Benefit depended on the bereaved being able to shape the funeral and say goodbye in a way that mattered to them, not on the funeral as such (Burrell and Selman 2022). This sits uneasily with the HRAF finding on final ceremonies. The reconciliation may be that a rite chosen and shaped by the family helps, and a rite imposed does not [VERIFY: own inference].

A performed ritual, even a small one. Michael Norton and Francesca Gino found in experiments that people who

performed a ritual after a loss, whether of a loved one, a lover or a lottery prize, reported less grief, and that the effect ran through a restored sense of control (Norton and Gino 2014, Grade A, small effect, abstract only). TR-16 draws the practical rule: give the bereaved something to do with their hands (THRIVING library, TR-16).

Seeing the body. In a Swedish population survey of 666 parents whose child died by suicide, 460 viewed the body and 96 per cent did not regret it. Viewing was linked to more nightmares (RR 1.61) and intrusive memories (RR 1.20), but not to more depression or anxiety (Omerov 2014). In an interview study of 80 bereaved by traumatic death in the UK, few who viewed regretted it, and those who did not view sometimes did. Relatives needed to be told what they would see (Chapple and Ziebland 2010). Jane Mowll and colleagues found that viewing or not viewing after sudden death could be transformative either way, and the choice mattered more than the act (Mowll 2016, abstract only). The rule is to offer, prepare, and accept a refusal. In an epidemic the offer may have to be refused for everyone [OWNER].

Timing. The brief asked for the time window in which rites matter most. No study was found that tests a window. The physiological record (the heart in the first day and week, mortality in the first 6 months) and the traditional calendars (the first week, the month, the year) agree on where company should be densest, but this is convergence, not proof [VERIFY: own inference].

8. Treatment for the few

Help offered to everyone does little. Joseph Currier, Robert Neimeyer and Jeffrey Berman pooled 61 controlled studies of bereavement interventions. The effect was small after treatment and absent at follow-up. Interventions aimed at people already in marked difficulty did as well as other psychotherapies, and untreated controls improved naturally (Currier 2008). A secondary account gives d 0.13 overall and 0.39 for those at risk [VERIFY]. For children the pooled effect was about 0.14 (Currier 2007). Bonanno and Scott Lilienfeld set out the earlier estimates: 0.43 in Allumbaugh and Hoyt's meta-analysis of 1999, 0.11 in Kato and Mann's of 1999, and minus 0.35 for social activity interventions in Kato and Mann (Bonanno and Lilienfeld 2008). They also noted that a much quoted claim of harm from grief counselling rested on an unpublished statistic that was never peer reviewed. Cindy Wittouck and colleagues pooled 14 trials and found that treatment of complicated grief works and its effect grows at follow-up, while prevention offered to all the bereaved does not (Wittouck 2011). Mia Johannsen and colleagues pooled 31 trials of psychological interventions for grief: g 0.41 after treatment and 0.45 at follow-up, 0.31 after adjustment for publication bias, with the larger effects in people selected for distress (Johannsen 2019).

Who gets help	Effect	Source
Everyone bereaved	Small, gone at follow-up	Currier 2008, Wittouck 2011
Children, all comers	About 0.14	Currier 2007
Social activity programmes	Minus 0.35	Kato and Mann 1999, via Bonanno and Lilienfeld 2008
Selected for distress	g 0.41 to 0.45, adjusted 0.31	Johannsen 2019
Complicated grief, CGT	Response 51% to 83%, NNT 3.6 to 4.3	Shear 2005, 2016

Complicated grief treatment. Katherine Shear's complicated grief treatment (CGT) is the best-tested treatment. In 2005, 95 adults received 16 sessions over about 19 weeks. Response was 51 per cent with CGT against 28 per cent with interpersonal therapy, number needed to treat 4.3 (Shear 2005). In 151 adults over 50 the figures were 70.5 against 32.0 per cent (Shear 2014). In 2016, 395 adults were randomised to CGT or not, with citalopram or placebo. CGT with placebo gave 82.5 per cent response against 54.8 per cent for placebo alone, number needed to treat 3.6. Citalopram added nothing for grief, though it eased depression, and on its own it was not better than placebo. CGT reduced suicidal thinking (Shear 2016). The treatment combines work on accepting the loss with work on restoring

a life. From the manual's preview, as summarised, it includes imaginal revisiting of the death from about session 4, recorded and listened to daily, situational revisiting of avoided places from about session 5, memory work from about session 6, and the setting of personal goals (Columbia CGT manual preview, search summary only [VERIFY]).

What a village can deliver. No trial was found of lay-delivered grief treatment in a low-income setting with grief as the main outcome. MI-01's narrative exposure course, delivered by lay counsellors, is the nearest tested tool, and MI-01 records it with guided mourning for Rwandan orphans (THRIVING library, MI-01). Protocol 7 below adapts the CGT outline for a trained lay healer. It is untested in that form [VERIFY] [OWNER].

9. A child's death, the many dead and the bereaved healer

A child's death is the heaviest common loss in the record. It was the strongest predictor of chronic grief after the tsunami (Sveen 2018, Johannesson 2011), the mothers' risk of unnatural death rose almost fourfold (Li 2003), and about one in three parents of a child dead of cancer met probable criteria (Eisma 2023). Siblings are bereaved too and are often forgotten [VERIFY: no sibling data read]. The Alto do Cruzeiro shows that where infant death is common, the rites change shape, and the healer must not mistake restraint for indifference (Nations and Rebhun 1988).

The many dead. Mass death destroys the carriers: the kin, the neighbours and the rites. The Aceh data show that the loss of the community adds its own harm (Frankenberg 2012), and Philadelphia shows the rites failing first. Interventions for everyone after mass death have not been shown to work, but the community's own continuity, its yearly date and its place of the dead, are what the survivors return to.

The bereaved healer. The healer in a small village will have treated most of the dead, and often loved them. Healers and helpers are rarely given mourning leave and are expected to carry everyone else's grief. The burnout and moral injury that follow are MI-12's ground. This report adds one rule: the healer is also one of the bereaved, and the village names a deputy so that the healer can mourn [OWNER].

Evidence grades

Practice	Grade	Tradition says	Record shows	Inference
Bounded mourning period with final ceremony	B to C	Releases soul and mourners	Less prolonged grief across HRAF societies	Plausible, correlational
Funeral attended and shaped by family	B	Duty to the dead	5 of 17 studies benefit, 6 none	Helps when chosen
Small performed ritual	A	The dead must be sent	Less grief, small	Restores control
Company in the first week (shiva, wake)	C	Duty of the living	Support eases depression, not grief itself	Keep, for the body and mood
Continuing bonds, presence of the dead	B	The dead remain	Common, mostly benign	Normal, not pathology
Viewing the body	B	Varies	Rarely regretted, some nightmares	Offer, prepare, accept refusal
Stage model	X	Not a tradition	No evidence	Do not teach
Forced emotional disclosure	X	Telling heals	No benefit	Never compel

Practice	Grade	Tradition says	Record shows	Inference
Grief counselling for everyone	X	Clinical	No lasting effect, social programmes negative	Do not mass-deploy
Treatment for those selected by distress	A	Clinical	g 0.41 to 0.45	Offer at 6 to 12 months
CGT	A	Clinical	NNT 3.6 to 4.3	Best treatment, untested lay
Citalopram for grief	X	Clinical	No better than placebo	Depression only (MI-04)
Forced widow cleansing or inheritance	X	Removes the death's pollution	Experienced as rape, HIV risk	Ban [OWNER]
Divination naming a culprit	X	Finds the cause	Violence against widows and children	Stop (TR-16)

Means ledger

Practice	Hands and knowledge	Hearth	Garden and still	Village dispensary (300)	District infirmary (3,000)	Hospital before the Fall
First-week company	Neighbours sit, listen, do chores	Food carried, fire kept	The same	Visiting rota, register	The same	Bereavement services
Watching the bereaved body	Know who is at risk	Warmth, food, sleep	The same	Check the widowed and parents at 1 week and monthly to 6 months	Heart and suicide referral	Cardiology, crisis team
Rites at month and year	The family's form	Meal, fire	Candles, oil	Yearly village day	District commemoration	Memorial services
Six-month notice	Neighbours notice	The same	The same	Healer asks the screening questions	Supervisor reviews	Clinical assessment
Treatment for prolonged grief	None	None	None	Lay healer with 7 sessions, supervised [VERIFY]	Trained counsellor, 16 sessions	CGT by therapist

What each rung changes. Hands and the hearth deliver most of what helps most people: company, food, chores and the rite. The dispensary adds the register, the six-month notice, and some treatment for the one in ten. The infirmary adds supervision and a place for the suicidal. The hospital adds a trained therapist, whose benefit over a well-supervised lay healer is unknown [VERIFY: own inference].

Harm test

Practice	How it harms	Never for	Signs	Action
Fasting, vigils, prolonged mourning restrictions	Dehydration, falls, heart strain	The old, pregnant, sick, children	Dizziness, confusion, no urine	Water, food, rest. MI-01 and TR-16 rules
Forced expression or debriefing	Distress, worse grief	Anyone who declines	Withdrawal, anger	Stop asking. Offer later
Exposure work on the death	Re-traumatisation	The suicidal, psychotic, intoxicated, unsafe	Dissociation, panic not settling	MI-01 Protocol 4
Viewing a damaged body unprepared	Intrusive memories	Those who refuse	Nightmares	Prepare, describe, allow refusal
Widow cleansing and inheritance	Sexual violence, HIV	All widows	Fear, coercion	Ban [OWNER]
Accusation and divination	Exile, killing	Widows, children, the old	Talk of a culprit	Stop, protect
Pathologising grief	Shame, stigma	Normal mourners	Mourners hiding grief	Use the 6 and 12 month rule and the cultural clause
Epidemic funerals	Further infection	Everyone in an epidemic	Cases after funerals	Change the form (TR-16, NU-07)

Widow sexual cleansing deserves a direct word. Among the Luo of Kenya, the rite of having a widow sleep with a man to remove the death's pollution was described in interviews with 27 widows as forced and often as rape (Munala 2022, Munala 2023). In Mozambique, 359 people were surveyed on the acceptability of the related *pita-kufa* rite, with HIV prevention the concern (Vera Cruz 2018). The tradition says the rite protects the family. The record shows coercion and infection risk. The village should ban any rite that requires a widow to have sex [OWNER].

Red flags

1. **Chest pain, breathlessness or collapse in the first days after a death,** especially in the old. Treat as a heart attack (THRIVING library, NU-06 for comfort if nothing more can be done).
2. **Talk of joining the dead, a plan, or giving away possessions.** Do not leave alone, remove means, follow MI-04 Protocol 1 and MI-08 when written.
3. **Not eating, drinking or sleeping for more than a few days,** or a carer who stops caring for children (THRIVING library, TR-16).
4. **An old man widowed suddenly, living alone.** The highest mortality risk. Visit daily in the first week.
5. **Heavy daily drinking after a death.**
6. **Hearing or seeing the dead with fear, commands or confusion,** rather than comfort. Unlike common presence experiences, this may be psychosis or delirium (Kamp 2020).
7. **Yearning, numbness and inability to function unchanged at 6 months** after the culture's mourning period ends.
8. **A mother after a child's death,** especially in the first 3 years (Li 2003).

What to do anyway, if the district cannot help: keep someone with the person day and night, keep food and water going, and do not argue with the grief. Say what is true: "This is the worst thing. I will not leave you alone with it."

The case against

The strongest case against the medical view of grief comes from inside psychiatry and from anthropology. Jerome Wakefield, Joanne Cacciatore with Allen Frances, and Chiara Bandini have each argued that prolonged grief disorder turns a normal response to love and loss into a diagnosis, that the time limits are arbitrary, that the cultural clause cannot be applied by a clinician from another culture, and that the diagnosis will be used to sell drugs (as summarised by Eisma 2023). The citalopram result supports the last point. Derek Summerfield's critique of trauma psychiatry in war zones makes the same argument about imported categories (THRIVING library, MI-01). In Ismay's 1939 planning, the psychiatric casualties expected from bombing never came in the predicted numbers (THRIVING library, MI-01).

The case against the romance of rites is also strong. Funeral studies split 5 against 6 (Burrell and Selman 2022). Social support does not buffer grief (Stroebe 2005). Rites can be cruel: widow cleansing, accusation, and fasting that kills the frail. A rite that is mandatory and fixed can trap the mourner as easily as a diagnosis. And the cross-cultural correlation between final ceremonies and less prolonged grief is decades old and coded from ethnographies written by outsiders.

Against this report's own protocols: the six-month screening may produce exactly the pathologising its critics fear, and the lay treatment in Protocol 7 is untested. The evidence that the first week matters is from mortality in the frail, not from any trial of visiting.

What survives: most people do not need treatment. The few who do can be found at about 6 months and helped. The frail can be kept alive by being watched. Rites should be the family's own.

10-line summary

1. Most bereaved people recover without treatment: about half are resilient and a fifth more recover (Bonanno 2002).
2. Prolonged grief follows about 1 in 10 natural deaths and about half of violent or sudden ones (Lundorff 2017, Djelantik 2020).
3. A child's death is the heaviest common loss.
4. The widowed die sooner, RR 1.41 in the first 6 months, mostly men (Moon 2011).
5. Heart attack risk is 21 times higher in the first day after a death (Mostofsky 2012).
6. Grief has no fixed stages, and disclosure is not the cure (Maciejewski 2007, Stroebe 2002).
7. Help offered to everyone does little. Help for the distressed works (Currier 2008, Johannsen 2019).
8. CGT treats prolonged grief with an NNT of about 4. Citalopram does not (Shear 2016).
9. Rites help when the family shapes them. Imposed or cruel rites harm.
10. The 6-month point after the culture's mourning ends is when to notice the few.

Open questions

- Does a final ceremony reduce prolonged grief, or do societies with less grief keep such ceremonies?
- Can a lay healer deliver a short CGT safely and with effect in a village?
- Is there a time window in which company or a rite protects health?
- How should prolonged grief be judged where mourning lasts years by custom?
- What helps the families of the missing?
- How large is the widowhood effect for women where women depend economically on their husbands, and does the village's support change it?
- What happened to grief after 1918, when the rites failed?

Sources to read in full

1. Hertz R. 1907, Death and the Right Hand (Needham translation, 1960).
2. Rosenblatt, Walsh and Jackson 1976, Grief and Mourning in Cross-Cultural Perspective.
3. Rosaldo R. 1984, "Grief and a headhunter's rage".
4. Bonanno 2002, Resilience to loss and chronic grief.
5. Shear 2016, Optimizing treatment of complicated grief, and the CGT manual.
6. Djelantik 2020 and Lundorff 2017, prevalence of prolonged grief.
7. Eisma 2023, PGD in ICD-11 and DSM-5-TR.
8. Elwert and Christakis 2008, widowhood by cause of death.
9. Cemeteries and Crematoria NSW 2023, Aboriginal requirements for burial.
10. Burrell and Selman 2022, funerals and grief.

At the bedside after the Fall

The household. Sit with the bereaved. Do the chores, cook the food, keep the fire. Keep the old widowed warm and fed, and stay the first nights. Hold the family's own rite. Let children take part if the family wishes, and tell them the truth in plain words. Needs: neighbours, food, time. First failure: everyone comes in the first week and nobody comes in the second month.

The village of 300. In an ordinary year the village may see perhaps 3 to 6 deaths, each leaving several close mourners, and so 1 to 3 new cases of prolonged grief a year, many more after a disaster [VERIFY: own estimate from crude death rates not read here]. Keep a bereavement register with the date of each death, the close bereaved, and the dates of the 1-week, 1-month, 3-month, 6-month and 1-year visits [OWNER: who keeps it]. Train one or two lay healers to ask the 6-month questions and deliver Protocol 7 under supervision. Hold a yearly day for all the dead. Needs: a notebook, a calendar, a quiet room, two trained people. First failure: the six-month visit is forgotten.

The district of 3,000. Supervise the village healers, take referrals for the suicidal and those not improving, and coordinate rites and burial in epidemics and mass death. Needs: a trained counsellor, a safe room, links to NU-07 burial teams. First failure: the district is overwhelmed by a disaster and the villages wait for it instead of acting.

Protocols

Protocol 1. The first week

- ☐ Day 0 to 1: someone stays with each close bereaved person through the first night. Old men widowed suddenly are never left alone in the first 24 hours.
- ☐ Ask the family what their rite requires, who must be present, whether the dead are named, and how long mourning lasts. Do not impose any form.
- ☐ Days 1 to 7: food carried in twice a day, chores done, children cared for. The bereaved need not cook, work or host.
- ☐ Check every day: eating, drinking, sleeping, chest pain, breathlessness, talk of joining the dead. Any red flag, act at once.
- ☐ Let the family see the body if they wish. Describe it first in plain words. Accept a refusal. In an epidemic follow the burial rules (NU-07, TR-16).
- ☐ No fasts or night vigils for the old, the pregnant, the sick or children.
- ☐ Enter the death in the register with dates for the next visits.

Protocol 2. The first month

- ☐ Visit at least twice a week for 4 weeks (THRIVING library, TR-16).
- ☐ Do not ask the bereaved to talk about feelings. Let them talk if they want to. Do practical things together.

- ☐ Let them talk to the dead, keep the dead person's things, and feel their presence. This is normal.
- ☐ Mark the month (day 30) with the family's rite, or a meal if they have none.
- ☐ Release from work: the family's tradition, or at least 7 days of full release and a month of light duties [OWNER].

Protocol 3. The six-month notice

- ☐ At 6 months after the death, or 6 months after the culture's own mourning ends if that is longer, a trained person visits.
- ☐ Ask, in fixed words: Do you long for them most days? Is the pain as strong as in the first weeks? Do you feel part of you died? Do you avoid places or things? Do you feel numb? Has life lost its meaning? Do you feel alone? Can you work, eat and care for others?
- ☐ Count: daily longing plus 3 or more of the others, plus inability to function, means probable prolonged grief. Offer Protocol 7 (Eisma 2023).
- ☐ Ask the PHQ-9 and the suicide question (THRIVING library, MI-04). Depression is treated by MI-04's protocols.
- ☐ Any suicidal plan, follow MI-04 Protocol 1 and MI-08.
- ☐ Repeat at 12 months for anyone with daily longing but not meeting the count.

Protocol 4. The year and the anniversaries

- ☐ Visit on the anniversary of the death.
- ☐ Hold the family's year rite. Close the formal mourning if the tradition does.
- ☐ Hold a yearly village day for all the dead, on a fixed date. Naming the dead at it is the family's choice [OWNER].
- ☐ Expect some to be worse after the yearly rite. Have two people ready to visit anyone in distress in the following week (Rwanda Biomedical Centre 2018).

Protocol 5. A child's death

- ☐ Both parents are watched. Mothers especially in the first 3 years (Li 2003).
- ☐ Siblings are told the truth in plain words, kept in their routine, and allowed at the rites if the family agrees.
- ☐ The six-month notice is certain for both parents.
- ☐ No one blames the mother. No divination for a culprit.
- ☐ Where infant deaths are frequent, do not read calm as indifference or as health. Ask.

Protocol 6. The many dead and the missing

- ☐ Record every death and every missing person with a name or description, date and family.
- ☐ Bury quickly and safely where needed (NU-07), but record the place for the families.
- ☐ Hold a rite even without the body. Use something belonging to the dead or a symbolic item.
- ☐ Set a place and a yearly date for the dead and the missing.
- ☐ Rebuild the village's ordinary life early: markets, worship, work. The loss of the community harms on its own (Frankenberg 2012).
- ☐ Give priority at 6 months to parents, the widowed and the families of the missing.

Protocol 7. Grief sessions for the few [VERIFY] [OWNER]

Adapted from CGT for a trained lay healer, untested in this form.

- ☐ Only for those meeting Protocol 3 at 6 months or more. Not for the suicidal, psychotic, intoxicated or unsafe (THRIVING library, MI-01).

- ☐ 7 sessions, weekly, 60 minutes each.
- ☐ Session 1: listen to the story of the death and the relationship. Explain that grief is love continuing and that the work is to carry it.
- ☐ Session 2: talk about the person's life, good and bad. Set one small goal for the coming week.
- ☐ Sessions 3 to 4: tell the story of the death in detail, slowly, in the present tense if possible. Stop if distress does not settle within 10 minutes (MI-01 Protocol 4).
- ☐ Session 5: visit one avoided place or thing together.
- ☐ Session 6: a conversation with the dead, spoken aloud or written.
- ☐ Session 7: review goals, plan the next year.
- ☐ Supervision weekly.
- ☐ Refer to the district if no improvement after 7 sessions, or if worse.

Protocol 8. The bereaved healer

- ☐ When the healer loses someone, name a deputy for at least 7 days [OWNER].
- ☐ The healer follows Protocols 1 to 4 like any other mourner.
- ☐ After each death the healer attended, a short talk with the deputy or supervisor (MI-12 for the full care).
- ☐ After mass deaths, the healer gets the same yearly day as everyone else.

Numbers to carry

1. **1 in 10:** prolonged grief after a natural death (Lundorff 2017).
2. **1 in 2:** prolonged grief after a violent, sudden or disaster death (Djelantik 2020).
3. **6 and 12 months:** when prolonged grief can be diagnosed (ICD-11 and DSM-5-TR).
4. **60, 30, 10:** the per cent of bereaved needing only their people, a little more, or real help (Aoun 2015).
5. **1.41:** the widowed's risk of death in the first 6 months (Moon 2011).
6. **21:** the multiplication of heart attack risk in the first day after a death (Mostofsky 2012).
7. **About 4:** the number needed to treat with CGT for one more recovery (Shear 2005, 2016).
8. **3.84:** bereaved mothers' raised risk of unnatural death in the first 3 years (Li 2003).

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