

Personal History

What Science Knows About Grief

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By Amanda Petrusich

June 22, 2026

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"We talk about trauma recovery," a psychologist said. "We do not talk about grief recovery. Grief is an adaptation process." Illustration by Jillian Tamaki

In 1967, Leonard Cohen released “So Long, Marianne,” a requiem for a love affair that was unravelling, or at least transforming in some critical way. The song is romantic—the Marianne of its title was Cohen’s girlfriend and muse in the nineteen-sixties—but its fourth verse contains what I’ve always thought was a profound articulation of grief:

Your letters, they all say that you’re beside me now
Then why do I feel so alone?
I’m standing on a ledge and your fine spiderweb
Is fastening my ankle to a stone.

I listened to “So Long, Marianne” dozens, possibly hundreds, of times after my husband experienced two catastrophic seizures and died, in the summer of 2022. The spiderweb—the object of my grief—became both a tether to and a protection from danger. The night of his death, I left the emergency room in the gauzy predawn hours, carrying our thirteen-month-old daughter. I was alone, stupefied with shock, mentally replaying a scene in Joan Didion’s “The Year of Magical Thinking” in which a hospital social worker gestures toward Didion and asks, “Is this the wife?” I had not been assigned a social worker. Maybe that meant my husband wasn’t dead. I felt hot and weightless, as if my feet weren’t making full contact with the ground. A nurse had offered my daughter a little package of crayons, but she was too young to use them, and now I was clutching them in one hand. I woke up my sister, who was living in New England. Her voice was tight but steady on the phone. I must have sounded insane. I let her assume the controls: Buckle the baby into the car seat. Is she safe? Are you sure? Get in. Put on your seat belt. Start the ignition. Are the headlights on? Can you drive? Are you sure? It felt as though I were a dazed passenger attempting to land a nose-diving airplane. I tried not to think about the clatter and thud of his body being slid into a refrigerated compartment. My parents lived fifteen minutes from the hospital; they were standing in the driveway when I pulled in. Had I phoned them? The horizon was a soft and murky pink. Did I open the car door and fall out? Did my mother get the baby? I don’t know. My husband and I met as teen-agers, and married in our late twenties.

Later that morning, I called his family. I called his boss. I called our friends. Most of them answered the phone cheerfully.

My daughter and I stayed with my parents for a couple of months. When I went back home for the first time, to collect some toys and clothes, I cleaned streaks of my husband's dried blood off the floorboards and threw up in the kitchen sink. Then I cleaned that up, too. I put his eyeglasses, still cloudy with fingerprints, into a drawer. It seemed impossible that he didn't need them anymore. When I was presented with a rendering of my husband's headstone, after pawing through a binder of unhinged-seeming designs (did he want an etching of the Buffalo Bills logo?), it felt like a gag gift, something that friends might have mocked up for his birthday. It suddenly seemed so easy to disappear. "*Media vita in morte sumus*," someone said at the funeral. In the midst of life we are in death.

My situation was, on some level, achingly ordinary. People die all the time. Or worse things happen. My father lost his father when he was a toddler. My mother lost her sister when she was a teen-ager. My husband lost both his parents. After a while, a sort of austere survival instinct kicked in for me. My existential panic was subsumed by more pragmatic concerns. When a death is quick, and the practical ramifications are both vast and immediate, any platitudes associated with "good" grieving feel like luxurious fantasies. There was no time for grace. I was astounded—fixated, on some level—by the irresolvable mathematics of my scenario. My household income had been halved, and my domestic responsibilities had doubled. I was now a single mother, with a slate of grisly and endlessly regenerating administrative chores, most of which concluded with the faxing of a death certificate to an institution, accompanied by a deranged note saying "Thanks!" I returned a car that we had bought a few days prior to his death, sitting in the exact same stiff, faux-leather chair at the dealership, trying to explain to the very smiley salesperson that my husband, whom he'd recently shaken hands with, was not alive anymore and I didn't need two cars. He was flummoxed, then horrified. My parents had to finish the paperwork.

Between grief-induced insomnia and waking in the night to care for my baby daughter, I was feral with exhaustion. The tiniest decisions were paralyzing. Was the trash full enough to take out? Was her fever high enough to call the pediatrician? What was for dinner?

Grief mangles cognition and memory in ways that can make even banal tasks feel surreal, if not impossible. When a bank clerk asked me for my daughter's birth date—I was attempting to add her name to our savings account—it felt as though I'd been charged with solving a math equation. I did my best. I boxed up and donated my husband's jeans and sweaters. I took his toothbrush out of the holder and threw it in the garbage. I ordered a new sofa. I thought that if the room looked different I could begin to resolve some of the dissonance of sudden loss. I indulged in my share of magical thinking. The question that hounded me the most that fall was: Where did he go? Perhaps that's why the word "lost" is so synonymous with death—it can feel as if your person is simply misplaced.

I went back to work. People marvelled at this, as though it were a choice, but I needed money, and I needed to engage some cooler, steadier portion of my brain. Unfortunately, I found music largely unlistenable—an inconvenient development for a professional pop critic. The emotional circuit that my favorite songs lit up inside me was too vivid; music felt overwhelming, if not revolting. There were a few things I could stand: Nick Cave and the Bad Seeds' "Ghosteen," P. J. Harvey's "Stories from the City, Stories from the Sea," Paul Simon's "Graceland," anything by Leonard Cohen. Some Nina Simone, some Miles Davis. Listening to most records felt shaky, ominous, like reintroducing food after a stomach bug. What could I receive without retching? Somewhat serendipitously, I was already in the midst of reporting a Profile of Metallica, a band famously preoccupied by death. (Metallica's bassist Cliff Burton died in a ghastly bus accident in 1986, when he was twenty-four, an event that haunts even the current iteration of the group.) I now found the singer and guitarist James Hetfield's clenched-fist articulations of despair wildly comforting. Death was

interesting to him. These songs both normalized pain and made it beautiful. Understanding that this was even possible—that grief could shape-shift into something less ugly, less weak—kept me going.

Appearing steady around my subjects was hard. (One afternoon, while watching the indie-rock band the National rehearse at its airy, sunlit studio space in Hudson, New York, I had a fairly sizable breakdown in the bathroom, stifling my sobs with a mitten.) But I was grateful for the sense of control I felt when writing. The real work of nonfiction, and of profile writing especially, is in making a series of arbitrary and disconnected events legible. The best profiles force a coherent arc from a string of mostly random occurrences: of course it all happened just like that. Writing was a corrective to my reality, which felt incoherent.

The rawness and terror of that first year was so visceral and embodied. “And grief still feels like fear,” C. S. Lewis wrote, in 1961. His wife, Joy, had recently passed away, of cancer, at age forty-five. “Perhaps, more strictly, like suspense. Or like waiting; just hanging about waiting for something to happen.” I was locked in a kind of defensive crouch. My daughter surely sensed the hum of my heartbreak, though I tried to be soft, even joyful, in her presence. I was toggling maniacally between otherworldly love for her and anguish that her father was dead and she would have no memory of him. During nap time, I’d tiptoe out to the driveway, sit in my parked car, place the baby monitor in my lap, and weep into the hood of my sweatshirt. Part of me wanted her to know that grief is a reasonable reaction to a devastating occurrence, but mostly I just wanted her to remain connected, in the way children are, to the ecstasy and wonder of existence, without any premature knowledge of its concomitant pain.

I got very good at sensing when the heft and finality of the loss was making someone uncomfortable. I found this both relatable (I surely wouldn’t have known what to say, either) and alienating. Grief can’t be “fixed”—death is famously irreversible—so conversations about it require both parties to abandon problem-solving and accept a kind of

unpleasant stasis. When well-intentioned friends or colleagues asked me how I was doing, I felt dread. What I wanted to say was *This feels exactly as bad as you think it feels*. What I usually said was *Yeah, I'm O.K.*

I was having a hard time connecting with anyone who hadn't locked eyes with a particular sort of darkness. I sought out people who felt complicated and fucked up—who were able to reckon in some way with the lunacy of human life. In 1986, a trio of social psychologists introduced an idea called terror-management theory, based on the cultural anthropologist Ernest Becker's claim that fear of death is “the mainspring of human activity.” (Becker's book “The Denial of Death” won the Pulitzer Prize for general nonfiction in 1974.) T.M.T. posits that civilization itself is largely a response to mortality—an elaborate system of distraction and repudiation. Because humans have a sophisticated and symbolic awareness of death, we invest aggressively in shared cultural beliefs, which “provide the universe with order, meaning, value, and the possibility of either literal or symbolic immortality.” Simply sitting with the idea that death is compulsory and irreversible is too hard. Most of us will do almost anything to forget it.

Yet becoming a young widow was easily the most fascinating thing that has ever happened to me. In fact, it often felt like the only thing that had ever happened to me. In a 2019 conversation between Stephen Colbert and Anderson Cooper, Colbert spoke about the isolation of grief, even decades later: “Why is nobody asking me about this? My brothers died forty-five years ago, and sometimes I'll go, ‘How come nobody is asking me about Paul?’ ” I knew what he meant. Talking about anything else felt nuts. It was hard not to think of “moving on” as a kind of annulment, a final act of severance. In this context, the whole idea of recovery seemed vaguely dehumanizing—too results-oriented, too transactional, too American. Who was I to believe that I could vanquish the ache of death?

I liked speaking with people who could acknowledge the enigma at the core of existence without feeling embarrassed. One afternoon, the Episcopal minister who'd performed my husband's funeral service said to me, only half jokingly, "I guess he has all the answers now." I found the idea that he'd suddenly been made privy to cosmic information both funny and comforting. Rare air; good for him. In 2023, Paul Simon released a thirty-three-minute album of acoustic hymns titled "Seven Psalms." Simon spends most of the record musing about a higher power and what happens, or doesn't happen, when we die. On "The Sacred Harp," a gentle and circuitous song, he sings, "The Lord is my personal joke / My reflection in the window." I repeated the phrase like a mantra.

Encountering new motherhood and acute loss in quick succession was harrowing, though I eventually came to see them as deeply consonant experiences. Both required enormous amounts of selflessness, stamina, plasticity, courage, and improvisation. I reminded myself to take it day by day, or, sometimes, minute by minute. I sent a lot of weird texts to friends. I posted very personal things on Instagram. I fumbled a few relationships. I wanted to be around people all the time, but I also couldn't bear anyone needing anything from me, including my polite participation in a social interaction. At Christmas, my daughter and I caught the flu. We stayed home by ourselves. I had a panic attack at the pediatrician's office, triggered by the sound of a blood-pressure machine in another room, or the starchy crinkle of parchment paper on the exam table, or maybe just the ambient smell of rubbing alcohol—it was all too close. I yanked off my mask and tried to suck in just enough air not to pass out. The situation was so grim that it was almost funny; I was so sick I couldn't stand. On Christmas Eve, I had to crawl up the stairs, one arm dragging my body, the other cradling my baby, who was ruddy with fever. At that moment, I could not imagine ever feeling good again.

In 1999, *The New Yorker* ran a cartoon of two beleaguered cowboys looking out over a cliff with the caption "Hard to tell from here. Could be buzzards. Could be grief counsellors." It's difficult to say when grief tips from normal to pathological. It's even more difficult to say when it

might require intervention. “I don’t think that any grief is pathological, actually,” Katherine Shear, the founder and director of the Center for Prolonged Grief, at Columbia University’s School of Social Work, told me recently. “It’s a little bit analogous to pregnancy, in the sense that it’s a normal state, but it’s a high-risk state.” She continued, “The problem people have is not in the experience of grief itself. The problem is how to learn to accept the unthinkable.”

The Center for Prolonged Grief, which was founded in 2013, is an academic institution focussed on education and research. (It is not a brick-and-mortar clinic open to the public, though in the months immediately following my husband’s death I often yearned for a place like that: something in between an urgent-care center and an A.A. meeting, where the mental and physical symptoms of bereavement are recognized, and the ebb and flow of sorrow doesn’t require explanation or apology.) The center’s work is largely supported by outside grants, though it also generates income through its clinical-training programs and workshops. Shear first studied internal medicine but then decided that she wanted to be a psychiatrist. She completed her residency at Cornell in the late nineteen-seventies, when, she said, grief was not very well understood by clinicians. “A group of colleagues who were doing depression research had started seeing people who were bereaved and thought they were depressed,” Shear said of her time as a professor at the University of Pittsburgh, in the early nineties. “The depression treatment wasn’t working, basically. Those colleagues, like almost all mental-health professionals, including myself, knew almost nothing about grief. Everybody knew that loss is important, but grief wasn’t in the curriculum.” In 2005, Shear published a paper in the *Journal of the American Medical Association* that demonstrated the efficacy of a treatment plan for “traumatic grief.”

In March, 2022, a revision of the *Diagnostic and Statistical Manual of Mental Disorders* included something called prolonged-grief disorder, which for adults is defined as debilitating, life-altering grief that is still ongoing a year after loss. Shear led a committee that lobbied for its

addition. (The World Health Organization's *ICD-11*, a global analogue to the *DSM*, gives a timeline of six months for the same condition.) According to some estimates, P.G.D. could affect about seven to ten per cent of all bereaved people. The diagnostic criteria include "intense yearning/longing for the deceased person" and "preoccupation with thoughts or memories of the deceased person." A P.G.D. diagnosis hinges chiefly on time; clinically, at least, the difference between functional and nonfunctional grief is duration.

The inclusion in the *DSM* was controversial for obvious reasons—grief is not a mental disorder. The decision was preceded by several decades of fervent debate and disagreement among practitioners; detractors argued that adding the disorder was reckless, if not mercenary. A formal diagnosis means that a patient can be categorized, and that doctors can be more easily reimbursed by insurance companies for treatment. In an editorial published in *The Lancet Psychiatry* in 2022, the psychologists and researchers Joanne Cacciatore and Allen Frances described the decision as "a huge mistake that solves no existing problem and creates many new ones," including the careless prescription of antidepressants or other drugs, without consideration of the immediate cause of a patient's distress. They added, "Pathologising grief is an insult to the dignity of loving relationships—it proclaims grievers as mentally ill." They concluded, "Grief warrants strong social support and compassionate connection, not medicalisation."

In the book "The Other Side of Sadness," the psychologist George Bonanno points out that the most common response among bereaved people is resilience. Grief "is something we are wired for, and it is certainly not meant to overwhelm us," he writes. When I met with Bonanno in New York, in February—he is a professor of clinical psychology at Columbia, though he is not affiliated with the Center for Prolonged Grief—he told me, "We evolved these emotions because they're functional. They do something very efficient from an evolutionary perspective." He continued, "If they go on for a long time, then they become problematic. Stress is adaptive, but after about a

month it goes into the realm of being maladaptive.” In our conversation, Bonanno was careful to distinguish grief from clinical depression. “Depression is objectless, and grief has an object,” he said.

Ultimately, the *DSM* is a diagnostic tool; it doesn’t include guidelines for treatment. Though I understood the misgivings about the medicalization of grief, I also found the naming and codifying of it sort of validating—it acknowledged that the situation had gravity. Seeking out “social support and compassionate connection” is generally excellent advice, but those things aren’t always so easy to come by. Spending time with a grieving person is exhausting. It requires enormous amounts of patience and generosity. After a while, people get tired of your bottomless melancholy.

The Center for Prolonged Grief used to be known as the Center for Complicated Grief. (The name was changed to align with the diagnosis in the *DSM*.) I told Shear that I liked the earlier name better—it felt gentler, less contingent on a schedule of recovery. “I agree,” she said. “I now think it really should be called post-loss stress disorder or post-traumatic-loss disorder.” She went on, “When I started this work, grief was defined as deep sorrow. That’s how people think of it, even today. My latest thought is that it’s a trans-diagnostic psychological state, because grief contains many emotions, not just one. You experience sadness, anxiety, anger, guilt, the whole range. Even positive emotions come up—they’re a part of grief. It’s a complex state of being.” She also felt that the diagnostic criteria could be more flexible. “Our therapists see people as early as two or three months sometimes. If you are really, really struggling, even for two months, that’s a long time to feel underwater,” she said, then paused. “I guess I don’t have to tell you. You know what it feels like. It’s very reasonable to want a little help.”

The center has its own recovery program, a six-part plan supported by studies from the National Institute of Mental Health. It contains elements of exposure therapy (the gradual, repeated introduction of a triggering thought or object, ideally leading to habituation), as well as a variety of

established psychotherapeutic methods that encourage patients to recount and reframe their trauma. It was the first treatment for the condition to be found efficacious in a randomized controlled trial, and, in 2024, Shear received the Award for Research in Psychiatry from the American Psychiatric Association.

Now there are numerous emerging treatments for P.G.D. One involves the use of naltrexone, a drug previously approved to manage alcohol and opioid addiction. Some studies indicate a connection between symptoms of P.G.D. and the reward pathways responsible for addiction, suggesting that, in some way, grief requires a kind of detox. Transcranial magnetic stimulation, which uses magnetic fields to stimulate nerve cells in the brain, has also been trialled for efficacy. (T.M.S., as both an isolated and a repeated treatment, is currently approved by the Food and Drug Administration as a therapy for major depression, obsessive-compulsive disorder, smoking addiction, and migraines.) One of the more compelling developments for P.G.D. involves the monitored use of various psychedelic drugs, usually administered in conjunction with traditional therapy. Psilocybin, in particular, appears to be highly effective for helping people with terminal illnesses feel less terrified of dying. A Johns Hopkins study of fifty-one patients with cancer who had exhibited “clinically significant” signs of anxiety or depression found that a monitored dose of psilocybin resulted in “increases in ratings of death acceptance.” I was too timid to take psychedelics, though the thought of increasing my death acceptance was appealing. What is grief, after all, if not a reaction to the overwhelming perpetuity of mortality? Certain drugs seem to make the membrane between Here and There feel more permeable—maybe, by that logic, the person you lost might begin to feel a little less unreachable. A little less gone.

My husband had been dead for six weeks when I asked my primary-care doctor about a form of psychotherapy called E.M.D.R. I’d read that it was useful for coping with trauma and post-traumatic stress disorder. She was encouraging, though she also reminded me that I wasn’t post-anything yet. I was grieving—active verb. A month earlier, I’d reached

out to the photographer Tabitha Soren; in 2021, she and her husband, the writer Michael Lewis, lost their nineteen-year-old daughter, Dixie, who was a passenger in a car that crashed in Northern California. Soren suggested that it might be helpful to think about my grief as a brain injury—to be awake, at least, to the ways in which it might manifest physically. There was a reason that the phrase “grief-stricken” had entered the lexicon. The experience was not entirely dissimilar to getting whacked in the skull.

When I asked Shear about the biological aftermath of grief, she brought up two-person neuroscience, an emerging discipline that studies how our brains affect other brains. “Our closest relationships, especially when we’re living together—in particular, when we’re living together—have an impact on our immune system, our cardiovascular system, our sleep, our eating, probably the whole body,” she said. “I think we have to understand what happens, neurologically, when we’re with someone to really understand what happens when we lose them.” (In the three months immediately following the death of a spouse, particularly in older couples, the surviving partner’s risk of death can increase by as much as an extraordinary sixty-six per cent, a phenomenon known colloquially as the widowhood effect.)

E.M.D.R., an acronym for eye-movement desensitization and reprocessing, combines elements of talk therapy, exposure therapy, and bilateral stimulation, or alternating activation of the right and left hemispheres of the brain. This is most often achieved via guided eye movements, though it can also occur through a number of benign physical sensations: a patient might tap her own shoulders, or hold a buzzer in each palm, or listen to a series of alternating tones on headphones. In the past decade, E.M.D.R. has moved from the fringes to the mainstream, both within the culture and among clinicians. In 2021, Prince Harry, who suffers from anxiety, underwent E.M.D.R. on camera for an episode of the Oprah Winfrey-produced docuseries “The Me You Can’t See”; in 2025, Miley Cyrus told the *Times* that the treatment had saved her life by helping her to process unresolved childhood trauma.

I was already seeing a therapist, who'd helped me navigate a series of routine yet formidable transitions: moving out of the city, changing jobs, becoming a parent. I found our sessions useful and edifying, but she didn't practice E.M.D.R. (Practitioners are not legally mandated to be certified beyond their country's basic therapy-license requirement, though the E.M.D.R. International Association requires at least forty hours of training, and ten hours of direct consultation, before offering its approval.) I eventually Googled my way to a local therapist who was certified in E.M.D.R. In my introductory e-mail, I described myself as "hopeless."

He was intelligent and compassionate. Sessions were held in a little wood cabin on his property. Sometimes a small dog nosed in the door and curled up by the space heater. I was still in the roughest and least comprehensible stage of my grief. Most of the time, driving to his office felt like an insurmountable task, but I went anyway—twice a week at first. I held a little buzzing paddle in each palm. I narrated my memories of the event. There are eight formal stages to E.M.D.R., which typically unfold over eight to twelve weeks, though it's the fourth and the fifth stages, desensitization and installation, that feel the strangest and most crucial. In desensitization, patients repeatedly recount a traumatic event while receiving bilateral stimulation (squeezing the buzzing paddles, in my case), ideally until they are close to unperturbed by the memory. Discomfort is measured via something called the Subjective Units of Distress Scale, or SUDS. In installation, the bilateral stimulation continues, and a positive belief is added to the narration—usually some version of "But I survived." I cried a lot during both parts. I'm not sure how to describe the experience beyond some vague sense that my pain was coalescing. For me, it happened quickly, after three or four sessions. Grief started to seem less predatory—it was no longer lurking around a dark corner, eager to pounce. It was here. I could see its contours. That felt good.

The therapy was first formalized in the late eighties, when a psychologist named Francine Shapiro took a walk and found that the anguish she associated with traumatic memories was alleviated when she was also experiencing rapid and simultaneous eye movement. According to Shapiro, E.M.D.R. is designed to target specific “unprocessed” or “pathogenic” memories—which contain negative emotions, sensations, or beliefs—allowing them to be integrated and therefore defanged. In “EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma,” first published in 1997, Shapiro suggests that E.M.D.R. works “on a physiological level.” Sometimes, she writes, “the system becomes ‘stuck’—as if it was choking on trauma—and often requires assistance in order to get moving smoothly again.”

Shapiro, who was born in Brooklyn in 1948, received a Ph.D. in clinical psychology from the Professional School of Psychological Studies, in San Diego. She had previously been enrolled in a Ph.D. program in English literature at New York University, and in the late seventies, while she was still living in New York, she was diagnosed with breast cancer. In 1985, Shapiro told the Los Angeles Times that she believed cancer was “a stress-related disease,” which led her to start researching alternative life styles. She eventually discovered neurolinguistic programming, a behavioral theory positing that people experience the world via a combination of three distinct perceptual systems (visual, auditory, and kinesthetic), with one becoming dominant. Being able to recognize which system a person is primarily engaging in can help strengthen relationships and communication, or, perhaps more nefariously, be used to influence decision-making. (The founders of N.L.P., Richard Bandler and John Grinder, eventually began marketing it as a business tool, selling courses in California.) N.L.P. isn’t directly associated with E.M.D.R., though Shapiro’s interest in what most consider a tawdry New Age scam—the L.A. *Times* once compared N.L.P. to Scientology—has been fuel for skeptics.

E.M.D.R. touts itself as evidence-based, and the treatment is recognized as effective for trauma by the American Psychiatric Association, the

W.H.O., and the Department of Veterans Affairs. But our understanding of why it might work is limited. It's possible that E.M.D.R. mimics aspects of REM sleep, a phase also marked by eye movement, and associated with the processing of memory. Another hypothesis, usually referred to as the working-memory theory, focusses on the way that bilateral stimulation encourages something called dual taxation, or, basically, what happens in the brain when we try to remember something while doing something else. A 2022 study asked patients with P.T.S.D. to draw a figure, solve a math problem, or play Tetris while simultaneously recalling a trauma. The study suggested that "the secondary task distracts attention away from the retrieval of memory" and has "a detrimental effect on storage." Because the memory was now imperfectly stored, it would also be imperfectly retrieved. "The partial retrieval of these memory traces would blur their content, resulting in the reduction of vividness or the level of emotion," the study concluded.

In a 2007 paper, Bessel van der Kolk, the author of "The Body Keeps the Score," which has spent almost six years on the *Times* best-seller list, conducted a study in which eighty-eight P.T.S.D. patients received either eight weeks of E.M.D.R., a course of fluoxetine (the generic form of Prozac), or a placebo pill; seventy-five per cent of the patients in the E.M.D.R. group who had experienced adult-onset P.T.S.D. "achieved asymptomatic end-state functioning compared with none in the fluoxetine group." In 2012, a team of Italian researchers, led by Marco Pagani, used electroencephalogram imaging to "fully monitor neuronal activation throughout EMDR sessions," and found that "traumatic events are processed at cognitive level following successful EMDR therapy, thus supporting the evidence of distinct neurobiological patterns of brain activations during bilateral stimulation associated with a significant relief from negative emotional experiences." Which is to say, E.M.D.R. can help the brain to process trauma in a more adaptive way, thereby lessening its capacity to completely capsize a person.

Roger Solomon, who has been practicing psychology since 1979, learned E.M.D.R. directly from Francine Shapiro, in 1990. "I think it

was the second class she taught in the United States,” he recalled. Today, he teaches E.M.D.R. workshops and seminars around the world. Solomon has found the treatment transformative in its ability to shift the way we remember trauma. “With your husband dying under those circumstances, those are risk factors—the unexpectedness, the violence of it,” he told me. “You have the loss, but it’s a traumatic loss. Hopefully, what E.M.D.R. does is to reduce the trauma so that you can go through the mourning process, which is still continuing.” He went on, “It will always continue. It doesn’t stop. It evolves. We talk about trauma recovery. We do not talk about grief recovery. Grief is an adaptation process.”

Therapeutic modalities are famously complicated to substantiate, and there are plenty of clinicians who think that E.M.D.R. is mostly theatre—exposure therapy bolstered by dual taxation and repackaged as something else entirely. “For trauma, the best treatment, statistically, is exposure therapy,” Bonanno told me. “It’s also the most painful and difficult for both therapist and patient. It involves reliving every moment in a traumatic event, verbally describing it to the therapist, audiotaping it, and then listening to the audiotape repeatedly.” He added, “Understanding what you went through works a lot better if you tell the story. People can’t get over a loss, convince themselves of this distorted view of what happened, that it’s somehow their fault, they did something wrong, they could’ve done more. Then, when they play the whole event through, it’s, like, Oh, it’s not my fault.”

Gerald M. Rosen, a retired clinical psychologist and professor at the University of Washington, and the author of the 2023 paper “Revisiting the Origins of EMDR,” expressed distaste for the way the therapy has been sold. “My central concern about E.M.D.R. is that it’s what we call a ‘Purple Hat Therapy,’ ” he wrote to me. “Let’s take a driving phobia that develops after a car accident. We know that imagining the event while relaxing and finding new ways to think about current threats versus recalled fears helps 99% of driving phobics. Now, we have a person practice all that while they wear a purple hat. When the person

gets better, we attribute the benefits to the Purple Hat even though it didn't do anything. We also charge an extra \$250 for the hat. E.M.D.R. uses exposure plus a distracting and novel task like eye movements. We notice that the distraction helps the person stay with the imagery, so it increases exposure. See what's happening? E.M.D.R. is a falsely packaged and trademarked therapy that isn't helping individuals think clearly about the meaning of their loss and the ways to find restorative meaning in what remains."

I wasn't sure whether the path out of grief was, as Rosen said, to "find restorative meaning" in my new life or to stop thinking so one-dimensionally about meaning itself. Mostly, it reminded me of the Fiona Apple song "Paper Bag," in which she sings, "He said, It's all in your head / And I said, So's everything."

Grief forces a kind of radical transformation, for better or for worse. I found it to be a shockingly generative state: I'd never been more pliable, tender, open, or raw. Miracles, catastrophe—it all felt so *possible* in those early months. In that way, grief itself is a psychedelic journey. Shortly before the one-year mark, when I theoretically would have been qualified to seek out a P.G.D. diagnosis, the shape of my grief changed again. It began to feel less like a slowly unfolding apocalypse and more like I'd been handed an invisible shield—as if my intimacy with pain had led to a kind of immunity from it. Some days were still hard, but most days were O.K.; eventually, the hard days were aberrations. Music was listenable again, even the really sad songs, though a few still got me. (The first time I heard Zach Bryan sing "Your funeral was beautiful / I bet God heard you comin'," I had to pull my car off the road.) I developed a new and funny admiration for the ways in which music distilled and centered emotion. I liked that songs, for the most part, took living seriously. I did, too. I found a rhythm to life as a solo parent. I got better at asking for and receiving help. I was more forgiving. The future felt sort of interesting again. Then, incredibly, the future felt almost exciting. What a bold and miraculous thing—to be alive at all.

I was still meeting regularly with my original therapist. Our sessions became less about triage and more about integration. I told and retold the story; she repeated it back to me when I needed to hear it. Eventually, I learned to cultivate an odd kind of gratitude for my grief, and for the very modest miracle of my own survival. It's possible that E.M.D.R., or some aspect of it, helped me claw my way back from what had seemed, at the time, like the end of my life. Ultimately, I didn't really care about the therapy's scientific bona fides. All I had wanted was to stop feeling as though the world was unsafe and everyone I loved was about to die. Besides, what did science really know about death, or what happens afterward?

The primary thing I recall from E.M.D.R. is unrelated to the therapy itself. Often, at the beginning or the end of our session, my therapist would remind me, firmly and repeatedly, to grieve—to suffer. I can't remember how he phrased it; possibly, it was as simple as him saying, "Let's make sure you're really grieving." It felt bizarre, even sort of grating: all I was doing was grieving! Yet, in retrospect, I understand it as a remarkable kindness. Humans are instinctively averse to pain, conditioned instead to solve and strengthen and maximize, to inure ourselves to hurt. The idea of willingly spending some indeterminate amount of time feeling bad is unthinkable. But that was how I understood his counsel: feel bad. A bad thing happened, and it is reasonable to feel bad. Thrashing against it was both exhausting and fruitless. The experience reminded me of the woven bamboo finger traps I played with as a kid—the harder you tried to free your hands, the tighter and more frightening the whole thing got. To feel better, I had to find a way to value and nurture my grief. To understand it as some invisible but essential system inside me. ♦

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