The Soul of Sorrow Work
Grief and Therapeutic Interventions With Families

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The courage and willingness to walk alongside families in grief calls forth particular beliefs and practices in nurses and other health care professionals. In this second phase of a study on grief and grief interventions, the researchers examine experiences of bereaved family members who received care in a grief support program and explore program clinicians' explanations of the work that they do with the bereaved. Findings of this interpretive study suggest that it is not so much models of grief intervention but maps that most guide the clinicians maps that are drawn out of experience and with awareness of their limitations. The family members and the clinicians bring us to an understanding that, often, it is the willingness to step off of the map that makes for the best traveling companion in the spiritual walk of grief.

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Experiences of grief are life-changing, deeply touching, and profoundly moving human experiences that occur in response to the death of a loved one. As family members move to incorporate loss into their lives, and to shift to new, changed, but continuing relationships with their deceased loved ones, they enter uncharted territories that involve questioning, meaning making, and life recalibration. The often-groundless terrains of these unknown expanses of experience arise in conversations between families and health care professionals. The nature of these conversations of suffering (Wright, 2005) in grief might be seen as spiritual conversations, and the willingness to enter them requires a degree of courage on the part of the practitioner, as well as a veneration of the sacredness, privilege, and healing possibilities of such conversations.

This study is the second phase of a research project on grief. In the first phase, grief was examined from the perspective of beliefs that are embedded in our personal and societal regard of the experience (Moules, Simonson, Prins, Angus, & Bell, 2004; Wright, Watson, & Bell, 1996). Examination of clinical work conducted in the Family Nursing Unit at the University of Calgary (Wright, Watson, & Bell, 1990, 1996) focused

less on the nine participant family members and rather on the beliefs that surfaced in the clinical work (see Moules et aI., 2004, for more detail).

In the first phase, the experience of grief showed as a lifelong event and a continued connection to the lost loved one. Traditionally, "grief work" has been conceptualized as a cognitive, behavioral, and emotional experience of assisting the bereaved to move through stages of bereavement to arrive at a place where grief is no longer experienced and the bereaved person has successfully resolved the loss. The findings in the first phase of the study supported a different premise that grief is a lifelong experience that has components of suffering but also aspects of celebration and continuing, evolving connection. The findings of the first phase invited further exploration into the ways in which these beliefs and suffering might be mitigated in clinical practice.

For the second phase, the practice context of the Calgary Health Region Grief Support Program was chosen for its community reputation of out standing work in being helpful to those bereaved. This phase examined clinical work and therapeutic interventions with bereaved families from the perspectives of clinicians and family members, reflecting their understandings and experiences of clinical intervention in the face of suffering and grief.

Brief Review of the Literature

Since the time of Freud, grief has been regarded as a human experience of mystery (Attig, 1996; Klass, Silverman, & Nickman, 1996). This mystery, like all mysteries, has called forth the temptation to understand, define, and predict it. This is a call that has resulted in an evolution of thinking of grief as a process of energy withdrawal involved in the psychic process of releasing and transferring energy (Freud, 1917/1947); grief as a disease or pathology with predictable trajectories (Eliot, 1932; Engel, 1961); grief as a process involving stages and expectations (Bowlby, 1980; Fulconer, 1942; Parkes, 1985; Rando, 1984; Schneider, 1984; Worden, 1982); grief as requiring models of clinical practice that involve tasks and accomplishments in the work of letting go (Parkes, 1985; Rando, 1984; Schneider, 1984; Worden, 1982).

A more recent conceptualization of this "mystery that pervades our human condition" (Attig, 1996, p. 15) is a regard of grief as an unavoidable life experience that is not predictable, is not related to stages, is not resolvable or to be "gotten over," but is an event of loss that becomes a part of living in unique, mutable, lifelong, and life-changing ways (Attig, 1996; Klass et al., 1996; Moules, 1998; Moules & Amundson, 1997; Neimeyer, 2001a, 200lb; Worden, 2000). Ultimately, grief does not result in a "resolution," as seen as a return to the familiar, but in an incorporation of the loss into living forward and an ongoing connection with the deceased that allows one to continue to move ahead in life (Klass et aI., 1996; Moules et al., 2004; White, 1989).

Experiences of grief have been under study and, in evolving ways, are becoming more knowable, at least in the academic sense. What is little known or researched are the interventions that health care professionals offer in assisting individuals and families to navigate bereavement experiences. Therefore, this research has focused on the experiences, interpretation, and understandings of clinicians and bereaved family members.

Context and Setting for Research

The second phase of the study was situated at the Calgary Health Region Grief Support Program, Calgary, Alberta, Canada. The program, founded and coordinated by Rev. Bob Glasgow, began in 1989, with a vision to promote and support a view of grief as a natural healing response to loss, in contrast to a dominant societal discourse of grief as a pathological experience from which one must recover. The program's mission is to provide a safe, supportive, and healing environment for bereaved individuals to process their grief in meaningful ways. This process is facilitated by a combination of individual and group counseling, led by trained and credentialed therapists and counselors, as well as volunteer group facilitators who have been through the program as bereaved family members.

Method, Data Collection, and Process of Analysis

This research project is a hermeneutic study, based on the philosophy of Hans-Georg Gadamer (1989). Philosophical hermeneutics begins with the premise that the world is interpretable, we are always in the process of interpretation, interpretation is inseparable from understanding, and truth in hermeneutics is a meaningful account that corresponds to experience (Gadamer, 1989). Therefore, hermeneutics may be seen as the tradition, theory, and practice of interpretation and understanding in human contexts.

Hermeneutic inquiry involves the selection of participants or exemplars of practice that can best illuminate the topic and invite an extended understanding of it. In this study, three clinicians were selected from the Grief Support Program (GSP) on the basis of experience and willingness to be interviewed. Of three clinician participants, one was male and all were Caucasian; their years of clinical experience ranged from 5 to 26 years. One of the clinicians was prepared at a baccalaureate level in social work, one at a master's level in psychology, and one as a clergyman.

The clinicians each volunteered one family member with whom they had worked, who was also willing to be interviewed, and who they believed could best speak to their experiences of being in the program. No other selection criteria were employed. The six participants partook in individual interviews. Of the family members, all were female, Caucasian, aged 30 to 55 years, married, single, widowed, and had experienced losses that ranged from 2 to 8 years. The losses included loss of parent, spouse, and child. The limitations of gender in this sample are acknowledged and beg for further investigation that includes male participants.

The six interviews were transcribed verbatim and analyzed interpretively. The process of analysis in this study involved individual team members' thorough reading of the textual data and subsequent writing of interpretive memos. This research approach did not include a process of coding of data nor a fracturing into themes that bear legitimacy by repetition alone, but rather moved into a generative, interpretive analysis that was expanded and brought to a "fusion of horizons" (Gadamer, 1989) in the research team meetings. These meetings were organized around arriving at a collective hermeneutic understanding of the data. The meetings were audiotaped, transcribed to text, and became further data for analysis, recognizing that the research conversations

moved the analysis to another level of understanding as each interpretation buoyed, resonated, contradicted, but always called for more from the other. This research was granted ethical approval through the Conjoint Health Research Ethics Board of the Faculties of Medicine, Nursing and Kinesiology, University of Calgary, Canada.

Findings

The Inarticulate Nature of Grief

In our efforts to understand the work of clinicians with families experiencing grief, we found ourselves face-to-face with the inarticulate nature of grief. The ability of grief to evade description (Moules et al., 2004) seems to be mirrored in the difficulty for clinicians to articulate practices with the bereaved. Some of the clinicians commented on the very challenge of trying to find language to describe what they do that makes a difference.

> *I don't know what my approach is . . . sometimes you just do stuff and you don't even realize. (third clinician)*
> *How do you choose different interventions? (interviewer)*
> *(laughter) You're assuming that I choose different interventions. . . . This is actually really good because it helps make me think about things that I don't. . . normally think about. . . . Um Boy. . . It's funny. . . you can do the same stuff and never really realize it. (third clinician)*

The inarticulate nature of grief and clinical work with the bereaved showed itself repeatedly in our interviews, although for some of the clinicians, there was a clear ability to find language that fits with their work. The most articulate descriptions of the work seemed to come from attempts to conceptualize it in a spiritual domain-"the work of angels," as stated by one family member. To the more experienced clinicians in grief work, there appears to be a distinctive, poetic, healing language that evolves in the description of the work. For others, there was a struggle to articulate what it is they do that they believe makes a difference. Yet, despite this struggle to find language, as this clinician engaged in the research interview, she began to describe what she believes makes up the work of grief:

> *Well, retelling the story is just so important . . . creating a safe environment . . . validation of the experience. . . re-decision making. . . creating a relationship [with the deceased].*

In the course of this research, we had to resist the pull of wanting to assign language; yet, we recognized that it is the purpose of hermeneutics to bring to language what perhaps existed unsaid. Caputo (1987) suggested that hermeneutics succeeds

> *only if it brings to words what we have all along understood about ourselves but have thus far been more or less unable to say. . . . It comes down to its ability to provoke in us the ultimate hermeneutic response; That is what we are looking for. That puts into words what we have all along understood. (p. 81)*

Much of the language that surrounds grief is dichotomous and this, in part, might be because in an attempt to define and understand the mystery of this human condition, there is almost a tendency to categorize it in black and white terms. Yet, grief is something that lies in the in-between, reminding us that things-life in all its complexity-

are never clearly "quite this" or "quite that." Grief is universal and individual; benign and malignant; life-giving and life-requiring, active and passive; internal and external; a state and process, heart and head; inarticulate and poetic; celebration and bereavement. With this in mind, we strove, along with the participants, to adequately elucidate and articulate what is perhaps one of the most difficult human mysteries.

All Grief Is Complicated

Each of the clinicians spoke to the complexity of grief and a firm commitment to resist the practice and language of pathologizing grief. People struggling with integration of grief into their lives have often been pathologized by society and the health care system as having abnormal, pathological, unresolved, chronic, morbid, prolonged, dysfunctional, or exaggerated grief (Jacob, 1993; Moules, 1998). Rather than seeing grief and divergences from "normal" in grief reactions and experiences, the clinicians normalized a wide range of experience and acknowledged that grief is a complicated, complex, and tangled experience.

Within this complexity, however, there was an alertness to when experiences of grief can invite problems in people's lives (Moules & Amundson, 1997):

> *Grief can sponsor participation in a life that feels oppressive, limiting, and painful…Grief can entice people into experiences of self-blame, other blame, "self loss" (White, 1989), despair, guilt, withdrawal from life, and especially the belief in an inability to move on with life, otherwise known as inertia. (p. 380)*

The first clinician, although reticent to pathologize experiences of grief, does consider signals or markers that indicate that people are struggling in healing. One marker identified the transformation that occurs when "healthy short-term anger" is sustained over time and begins to take the shape of embitterment or resentment.

> *If you talk to them about their grief experiences, you wouldn't hear about the loved one who died, or reminiscing about that life and that shared life. What you would hear about is this deep bitterness towards some aspect either of the loss or another person in that loss. . . . Anger dominates other emotions and that's all you would hear, you wouldn't hear the sorrow, wouldn't hear the love, wouldn't hear the gratitude for knowing the person, sharing the years. (first clinician)*

Another signal of struggle, identified by the clinician, is guilt. Guilt, the omnipresent handmaiden to grief (Moules & Amundson, 1997), was some thing also mentioned by each clinician and each family member. One of the family members came to the program with the hope "that I would feel less guilty." The clinicians confirmed the research team's beliefs that grief rarely exists without guilt holding its hand. Guilt is a persistent, stubborn, even loyal handmaiden, and it is sometimes unshakable. Getting guilt to drop its hold on grief is a challenging task because guilt cannot be commanded or willed away. The first clinician knows its presence but also its marker when it has dominated the other emotions of grief.

> *Sometimes the guilt is so strong that it dominates the other emotions of grief…so they don't surface. . . if it's rational guilt, what are the atonement things we can do? Things we can do to move towards forgiveness and…reconciliation within ourselves. If it's irrational, how do we move it more from the emotional level to the cognitive?*

A third marker for this clinician can Occur when there has been a loss of the one person who defines the person's identity.

> *If the person who died was too important for their sense of identity and so they have no identity without this loved one. And it feels like they've not only lost their loved one but they've lost their own heart and soul.*

In spite of the recognition that all grief is complicated and there is a complexity to its many layers, there are recognizable signals that alert clinicians to the need for attention. The dictionary defines *complicated* as something "made up of parts intricately involved . . . hard to untangle, solve, understand, and analyze" (Agnes & Guralnik, 1999, p. 299). Although guilt, anger, and loss of identity are very common characteristics in experiences of grief, there are times when these cross over into areas that stand in the way of moving forward in life. When this occurs, the moving forward in grief may result in an inertia, such as described by Moules and Amundson (1997). Clinicians may recognize this inertia or complication at behavioral, emotional, cognitive, spiritual, or relational levels, but the skill in the clinical work seems to fall in knowing where and how, in these many domains, to intervene. The clinician makes a discernment about where to step in to offer the greatest leverage for shifts in the complication. The skill, then, of the experienced clinician falls in the ability to recognize complication, to identify where it lies, and to offer something that may be received as helpful. The first clinician suggests, for example, that the work around some aspects of complication, such as embitterment and long-standing anger, occurs best in individual rather than family or group work, as this level of anger is not always helpful to others in the group. The individual work, in this case, then would focus on conversations of forgiveness, atonement, and reconciliation. On the other hand, the complication of identity seems to call for a different intervention of grief groups as a means to help reclaim identity through the eyes and presence of others.

Connecting Rather Than Letting Go

In the first phase of this research, Moules et al. (2004) explored the idea of grief as an experience of connection rather than severance of relationship. This finding was supported in this second phase of the research and reinforced by the clinicians in this study.

> *We are not letting go of our loved one; we're letting go of their physical presence. . . but I see the healing process is all about connecting. . . to the memories, the heritage . . . the spirit of their loved one. (first clinician)*

> *I think it helps them to keep a connection. . . maintain that relationship. . . . It may not be the relationship that they would like, it's different, but nevertheless, it's still a relationship. (third clinician)*

The experience of grief is about changed understandings of relationships and connections. It seems that much of the third clinician's beliefs about the experience of grief relate to acknowledging and attending to the evolution of personal connections. This is significant because not only is a person obliged to understand the relationship with a lost one in a new and changed way, but grief obliges a person to understand, revise, revisit, and transform relationships with one's self, spouse, family, society, and

grief itself, in new and challenging ways. The connective structure of everything is changed in grief. A focus on re-ordering, re-meaning-making, re-creating, and re-linking relationships and connections is much a part of the work of grief. Engaging in relationships with clinicians and support groups, family members may begin or enliven the process of changing life and death connections.

"The Real Answer Is Never": The Lifelong Experience of Grief

Another finding from the first phase of this study that was supported by these clinicians and family members is the view of grief as an ongoing rather than temporally limited experience. Sometimes the "ache goes away" but not for all losses. The clinicians spoke to their recognition of this quality of grief:

Ongoing life has taken more shape. . . but there's still this ache in their heart. . . . I think in the loss of a child it never goes away. . . there will be a part of a parent's heart that never heals. (first clinician)

So many writers use the word recovery and it's not a word I particularly like. Because it's like saying then you're over it. You never get over it. So, how do you learn how to make it a part of your life? (third clinician)

[Grief is] not a problem to be solved. It's not something to be overcome. It's some thing to be lived and experienced. (second clinician)

The family members, as well, validated this quality of grief:

I wish that people understood that it wasn't a short-term process, and that it is a life long change. (first family member)

There was a person who kept asking how long. How long does it last? I don't want to answer that question. I hate that question. But if you really, really insist, I would say if after 2 years or 2 and a half years you're still where you are now, then you need to be concerned. But the real answer is never. . . . It's not going to be like this forever, but it's not going to go away either. (third family member)

The first family member reminded us of the continuing presence and appearance of grief in a poignant description of seeing a bassinet and the power of healing that can come in the knowledge that grief does remain as a lifetime companion in some form or another:

The best thing that I've ever heard anybody say. . . "Well, it sounds like the waves are up for you right now." . . . Things will come out of nowhere that really hit you from the side. You'll think you're fine. And situations where you think you're going to fall apart, like going to a baby shower, or something like that, you seem to handle. And then, you know, you'll just see. . .like in the Sears catalogue, you'll see a bassinet that you were thinking of getting and then the whole day is gone. (first family member)

This family member spoke of waves as, at times, an ebb tide and, other times, "just rolling and rolling and rolling." She has learned to ride them, to "just go with them." She is discovering a new world in which there will always be bassinets and endless other reminders that call in the waves.

One might question if this view of the lifelong presence of grief invites a sense of hopelessness, but this is not what shows in this research. Acknowledging that grief is

not confined within a temporal aspect seems to validate rather than pathologize its remaining presence. It opens possibilities for other aspects of grief to emerge: celebration, connection, and comfort (Moules, 1998; Moules et a!., 2004).

> *We don't have choices necessarily in our losses, but we have choices in our grief. And my hope is that people make choices that are life-giving, that fit with the resiliency of the human spirit. (second clinician)*

The Work of Grief

All the clinicians spoke of grief as a kind of work. The language of "grief work" has been used in theoretical literature for many years (e.g., Rando, 1984; Worden, 1982). In this language, grief arises as an active process, something in which the bereaved is engaged, that requires participation. This very nature of active participation of both the bereaved and the clinician in the *work* of grief is "what one does" (Agnes & Guralnik, 1999, p. 1649) in grief. Perhaps the conceptualization of grief as work offers a sense of purpose that can open space for an emotional satisfaction out of a job well done, bearing the risk that as work takes over lives, grief too might walk the razor's edge of balancing between participating in it and not letting it take over.

In this work of grief, some of the clinicians made a distinction between intellectual and emotional grieving: "When people are very intellectual grievers, they make sense by thinking" (second clinician). The emotional intensity that characterizes grief is irrefutable. In this work of grief, perhaps the work of clinicians is to negotiate the conversation between affect and cognitions. Do clinicians feel they have had a better session with someone when the person has emoted, or when they have started to make sense of their grief and to make some cognitive connections? That someone feels sad in grief is a given, but we suggest that the domain of influence lies in the sense that is made of the sadness, how it is understood, how it is accounted for, what kinds of self-talk it evokes, what questions it creates, and the beliefs embedded (Wright et a!., 1996). These clinicians believe that affect is important, that at the heart of grief is excruciating sorrow. They also know that it is not within their skills to take away excruciating pain, but they have the opportunity to challenge cognitions that feed into the pain. There is a delicate juggling of when to bring forth cognitions and when to call on affect. For example, if someone articulated thoughts well or articulated a sense of meaning making, but there was absence of affect, or incongruent affect, then clinicians might at this point inquire around affect. Perhaps, as clinicians, we invite affect and discussions of affect when there is *only* intellectualization. Perhaps a part of the work of grief that the clinician navigates is encouraging a dialogue between affect and cognition, allowing each to inquire about the other.

At the Core of Grief Work: Spiritual Comfort and Spiritual Healing

In all of the interviews with clinicians, aspects of spirituality were spoken about in such a way that we interpreted that the core of this program's work was spiritual in nature. Perhaps this might be because the program is founded on the work of a program coordinator who is a chaplain, however, we think it is more complex than this. We offer that the core of work with the bereaved is spiritual in nature because the core of grief is a spiritual experience. It is an experience of making meaning, doubting

meaning, or questioning the purpose of lives lived, living, and lost. The first clinician speaks of spirituality in grief as something people deeply carry:

> *It's a hope, a comfort that doesn't take away the pain but is a hope and a comfort that lives with the pain. And even though it's an area that can bring hope and comfort, it is also an area that is fraught with some kinds of difficulties. (first clinician)*

This clinician also spoke of the ways that grief can create a "woundedness" that leads to what can sometimes be regarded as "unhealthy spiritual practices" (first clinician), such as looking for reassurances that their loved ones are okay in the afterlife by seeking out those who claim they contact the dead, or healing from psychics who make extraordinary claims.

The second clinician also spoke to the nature of this work as spiritual:

> *It is a spiritual place because I think our spirits are involved in grief. I think often with people there's a point in where there's a connection between the client and the therapist in a soul-to-soul way. And you can feel it in the room. It is almost a sacred space.*

Tending to Wounds

The woundedness to which the first clinician referred invites the discussion of the ways in which clinicians tend to wounds. Paradoxically, physical wounds heal with predictable timelines, processes, and structures; aiding and abetting factors are known and controllable. It might be natural in that we revert to societal discourses about grief wounds that venerate predictability, dependability, confidence, and certainty.

The first clinician talks about interconnected dimensions of grief: devastation, alienation, all-encompassing, sorrow, paranoia, distrust, anger, resentment, guilt, lack of identity, traumatic, spiritual. These notions brought forth a characterization of grief in terms of *rawness.* Grief is raw. The first clinician says, "You get to meet the real person" when you form a therapeutic relationship in the context of grief. You get to meet the real person because veils and facades are shed and broken down to expose wounds in all their rawness. To create safe, comforting environments that value courage and honesty is proficient practice, but it means to walk beside exposed rawness.

The first clinician offered some ideas about how woundedness might show itself: tears, crisis, observable signs and symptoms. As nurses, we have a preference to heal physical wounds by debriding, cauterizing, and suturing the wound as cleanly, neatly, and quickly as possible. We know that for the wounds of the physical body, these actions may support healing and prevent infection and other complications. Woundedness of the spirit, however, is radically different in its nature and we must approach it in a different manner. The intent to heal in the GSP seems to be based on the will of the family members and their own inherent abilities and capacities to heal themselves. The wounds of the bereaved are open and ragged. These kinds of wounds are more difficult and painful and involve longer trajectories and more scarring. As health care professionals, we must honor our trust of the body and spirit to heal naturally, this trust overriding directives of technical wound care. Ultimately, we must be comfortable with scars, as scar tissue is a particularly tough form of connective tissue. This kind of healing asks us as clinicians to recognize the value of connection in healing

and compels us to resist quick fixes. It demands us to be willing to be present, patient, and open to connecting in new ways. Florence Nightingale (1969) wrote about the work of nurses as being the creation of environments where the "natural reparative" abilities of the body can work and be supported. The wounds of grief are raw and open, but there are natural reparative abilities of the body and soul that, given the right environment, hold the hopeful and powerful capacity to heal.

Mapping the Territory or Knowing the Maps

Maps were a significant depiction by these clinicians in accounts of their work with the bereaved. Maps provide support, reassurance, and elements of certainty or clarity. In listening to the words and hearts of the bereaved, clinicians learn over time of some common landmarks that provide some illumination of a very dark walk. Although the clinicians follow in behind after loss, they quickly learn to walk alongside in the sometimes mapped but, most often, mapless journey of grief.

The clinicians identified many beliefs held by society that are not helpful and support that, across settings, we encounter pervasive ways in which societal discourses shape our experiences of grief. In the taken-for-granted faith in cultural discourse, a particular map is drawn as a way to navigate grief, a chart where, very often, people get lost in this uncharted territory. The betrayal of this map, then, lies in experiences that, after having lost loved ones, the bereaved find themselves also lost. Being lost is an isolating experience where it becomes easy to lose touch with one's instincts and to second-guess one's direction of travel. It is here where the experienced clinician offers a different map of grief.

The second clinician speaks of a map of the territory as held by the GSP, admitting that it does not have all the street names on it but that, over time, with experience, the clinicians have been able to identify several main roadways and potential potholes. This is the map that takes up where the smooth pavement of life leaves off, for when the "tried and true" ways and beliefs have not worked. The second clinician speaks of ways to assist people to navigate: supporting, acknowledging, giving space, and asking questions. The clinician suggests markings on the map in these knowledges: family members who share the same loss have different experiences of grief; there is a spectrum of experience between thinking and feeling; there are gender differences in grief. The clinician uses these markers to create conversations about the individuality of experience, grief education, normalizing, and encouraging people to ask for what they need from others. The clinician seems to recognize that suffering increases when grief is accompanied by a concurrent loss of sustaining relationships and connections.

The third clinician speaks of these directional signposts in a map of grief work: creating a safe environment; having family members retell the story of loss; validating family members' experiences; re-decision making (such as wanting to see the body, videos, etc.); encouraging family members to create relationships with the lost other and maintaining the connection; and supporting the integration of grief and showing signs that they are moving on. As a research group, we were somewhat surprised at the simplicity of these directional instructions, and yet there is a subtle complexity to this simplicity. The third clinician stated,

> *I don't mean to trivialize . . . it's pretty simple, basic stuff.*

This clinician may be speaking to the face of the overwhelming, consuming, and complex nature of grief and how it may not help to develop a practice that is equally complex. Perhaps it is about understanding the complexity of grief alongside an appreciation for the simple things that can be comforting when all else is overwhelming. In this "simple" approach, it is as though the clinician develops a stance that shares expertise, knowing that family members are already navigating their own complex emotional and spiritual terrains. Simple approaches might be legitimizing while resisting the simplification of people and their experiences. The apparent simplicity of approaches might be the very entry to the complexity of the way that grief plays out in lives and conversations.

It was a safe environment to spill it all out. (second family member)

What contributed to this sense of safety was permission. . . . You can cry and you can feel awful here and nobody's gonna freak out or stop you. I could put myself in their hands without worrying that something bad was going to happen to me. And something really bad had happened. . . and there were lots of tissues around. (third family member)

In spite of signposts, markers, and best-laid plans, grief is an experience that is uncharted. The wisdom of these clinicians seems to lie in the awareness that clinicians are not cartographers; they have read maps, they read signposts, and they know that maps of intervention will offer only guides, but there are places on the road that no map can anticipate. Maps in grief work are only as helpful as the recognition that experiences of grief come with "curves that happen without warning" (Wallace, 1985, p. 20). The work of clinicians, then, lies in the willingness to bend into the curve.

Bending Into the Curve: Following in Behind

We don't lead people in grief. We follow in behind. (first clinician)

We follow along . . . letting people choose their own path . . . kind of following along behind. . . even though you know the roadmap and you know some of the theory, letting people make their choices in how they navigate it. (second clinician)

In meeting people at the point of their loss and grief, perhaps the clinician has no choice but to follow in behind. A part of doing a "loss history," as the first clinician suggests, is about trying to catch up to the person so that you can walk alongside the bereaved. This following in behind, according to these clinicians, involves listening, being present, being a witness, acknowledging the suffering, normalizing it, and giving space for the pain. The notion of systemic and relational experiences of loss has long been recognized in the nursing and family literature with respect to the place of multigenerational family losses, developmental life cycle stages, nature of death, relational and communication patterns, and social and ethnic context in this careful navigation of moving with the family (Herz-Brown, 1989; Jordan, Kraus, & Ware, 1993; Walsh & McGoldrick, 2004; Wright et al., 1996).

Group Work: The Power and Price of Groups

Out of deep woundedness, there has also been a deep compassion. (first clinician)

The GSP has a strong belief in and reliance on the use of group work. The three clinicians who work with grief every day unequivocally support this style of intervention. Yet, the idea of group work for the bereaved arose in this study as a conceptual and philosophical struggle for some members of the research team. These members found themselves believing in grief as profoundly personal, intimate, and private and wondering how solace and support through a group could effectively occur. The first family member expressed a similar initial belief and doubt:

> *I had no idea why we would go talk to a bunch of people about something that was so personal and private. . . didn't want to go just to listen to a bunch of sad people.*

This research, however, called the prejudice of the research team into question. The first family member, in trusting the clinician, joined the group. The family member believed that, as an extrovert, her personality would benefit from the group, but she worried for her husband, although she was open to the idea that he may be helped by the exposure to other perspectives and "different personalities having the same kind of experiences" (first family member).

Perhaps it is the aloneness and loneliness of grief that seems to make room for an openness to group experiences. Freedman and Combs (1996) described the self as an activity that occurs between people. Perhaps as people are rebuilding themselves, and once they increase the audience of this rebuilding from individual and couple sessions to groups, there are more opportunities for this activity to occur and for the self to reshape.

We live in a societal discourse of individualism that defies the idea of groups. Yet, the first family member spoke of the safety of the group: "It's definitely the safety of the group." The idea of safety reminds us of the history of safety in numbers. Groups originally formed as a means of protection from predators. To travel alone was to set oneself up for target, but groups gather, surround, and guard, using shared resources to provide security. Perhaps what the group offers, in part, is around the omnipresent hand maiden to grief-guilt. The group experience offers a chance to share the burden of guilt, to see others struggling with it in the same way.

> *I knew a group would help my husband because of different perspectives, and different personalities having the same kind of experiences. . . and, that actually did. . . that's what came through with him. . . one guy is an accountant, one guy is a business man. . . . People from different life experiences and personalities helped him see that it's okay to be grieving. (first family member)*

The connective tissue that occurs in wound healing is perhaps reconstructed in the connections that are made in the group. The second family member explained the power of the group to be in the found commonality, connection, and intimacy. The group creates a community where there can be a sense of communion. The dictionary traces community and communion to *communio,* which means sharing and participation (Agnes & Guralnik, 1999).

> *It just gave you kind of a kinship with that group of people and. . . took away that "oneness"-I'm not the only one that's experiencing this. (second family member)*
> *Not only were there other people who were feeling it, but it was like women in the caves felt this same emotion. This goes back generations, generations, generations. It was an odd connection. . . it's*

> *killed. It would be the same sadness. I don't know why that's important. Connection. . . feeling part of it. (third family member)*

The bereaved talk of their fears that they are "crazy, nuts, insane, losing it" (third family member). This inner discourse seems to scaffold their pain. After being a part of a group of others who are grieving, the third family member recognized a commonality, a mutual ground for gathering. Recognizing that she came to believe that she was not "nuts" but on "solid ground" located her isolated experience of grief within a group. Her loss remained the same, but her suffering was reduced.

This feeling of being on solid ground speaks to the third family member's theft of what had previously grounded her. When her husband died, she reported that as the physician told her of his demise, she felt as if her senses had been turned off; she felt nothing. Perhaps this awareness of the solid ground beneath her was a beginning of the return of her senses. This family member spoke to an awareness that this work of grief would be painful, but she strongly believed that if she did not do it, she would pay a higher price later; the longer her senses took to return, the more the ground would be unreliable. In this return of senses, she also knew that she would feel many things, including sadness and pain. This knowingness seemed to start with the individual work of her clinician in carving a portal to these feelings. Hermeneutics regards openings as altethia, the uncovering of something hidden or forgotten (Moules, 2002). The work of grief is so much around this notion of uncovering, of carving openings to something that was once closed.

Moules et al. (2004) wrote of the grief walk that seems to occur in a backward way. We know, however, that to walk at all requires a connection to something, to the ground. If we cannot feel the ground beneath us, we cannot walk. We need to trust that there is firm ground to walk on; we prefer it when others have gone before us, posted signs, and perhaps even left vague footprints that guide the way and tell us we are not alone on the journey. Perhaps it is not the ground that changes at all, but it is our location to the ground, our appreciation of it, and that it is sometimes the group that paves a grounding that allows new travelers to tentatively step down.

Yet some of the family members had concerns about the groups, such as not having a choice about whether names or phone numbers were given out to the rest of the group (although the clinicians reassured us this *is* a choice). There are also aspects of groups that can foster coercion. There is safety in numbers, but there is also the power of "group think" and adherence to group norms and expectation. There is also a paradox in sharing grief that speaks to the tension between the uniqueness of grief experiences and even a perhaps necessary possessiveness around them. To make room for grief, one must claim it as one's own. The second family member spoke to a sense of individual experience:

> *I do think every grief experience has to be very individual and unique because of the type of person you are, or how you perceive what's happened, or the timing.*

There was another issue of the separation into genders in groups. In a survey distributed at the GSP, family members are asked to rate the strength of their couple relationship. Subsequently, they are divided into gendered groups. In the research interview, when asked if the groups helped to strengthen their relationship in any way,

the first family member answered, not as a couple, but spoke to her group relationship. She described herself as being in love with the group. This comment invited the questioning of whether the intimacy shared in the group may be at the expense of the intimacy shared in the couple relationship, the important sense of sharing in a community at the need in the time of loss to strengthen the couple relationship. We did not know if the couple were reunited in later work, but the analysis invited consideration of the danger of the separation into gendered groups that may potentially fuel the gender difference experienced in grief. One could question that this couple who lost a baby together may be at their most challenged time in their relationship and that separation may have been the antithesis of what they needed. Yet, this family member offered her belief that if they had not attended the program, they would have separated.

Perhaps groups are developmental. When one considers a young person, a young adult at a developmental stage of differentiating from family, there is an openness to finding community. As we age, however, we often call in intimacy at very different levels, not needing groups in the same way. Boundaries often tighten, encircling those in the intimate sphere. Perhaps grief does have some developmental aspect to it, during which, at one age of it, there is a call to community, kinship, and joining. As grief ages, it becomes more intimate, even more boundaried. The idea of groups at times flies in the face of a particular logic that recognizes the individual nature of grief. Nevertheless, recent research (Hubble, Duncan, & Miller, 1999) suggests that it does not matter what kind of intervention or approach is used; it is that there is one at all. The first family member talks of the value of the group, but would she have had a richer experience if, instead of 10 group meetings, they had 10 individual or family sessions with a skilled clinician? Perhaps, the commonality and kinship found in a group by one person would feel violating to another, and this may be where the clinical judgment and discernment of the expert clinician comes in play.

For the family members in this study, however, a situation was created in the groups where people felt validated, not violated. To come to a place where there is room for grief, where grief is accepted and expected, is perhaps the greatest intervention of all.

> *When people go through suffering and alienation, they feel very alone, and in that state of aloneness it's hard to do healing work, and so with the loss of a loved one . . . people need other people moving towards them in healing ways. (first clinician)*

A Love of Grief

"I love talking about grief," the second clinician informed us. There is something noteworthy about the willingness and intention to enter into these conversations and relationships with those in deep suffering in loss. The first clinician says,

> *I want to hear what's happened, what they are going through, what's taken place. . . . I have a need to hear about how their loved one died, what they went through, how they experienced that. . . . I'm wanting to know those kinds of things. . . in my need to know.*

We think of this love of grief as making space for it and legitimizing it. It is a belief in the depth, power, and character of grief. "We give space to grief," the second clinician stated.

My belief [is] that the hardest experience we go through in life is the death of a loved one who's meant a lot to us and so I believe that people draw upon every strength, every support that they have in their life at the given time they have to face into that loss. (first clinician)

The third clinician spoke of the honor of working with people experiencing grief:

It's a privilege, it's an honor, you know. . . every day I get to work with heroes. . . people that are so courageous, who come in to face their pain. . . . I know this might sound really crazy and bizarre, but I actually find it more energizing than draining.

The family members interviewed in this study sensed the clinicians' comfort with grief. When asked if there was anything the clinician had done to make these kinds of conversations possible, the second family member responded,

Just his kind and caring attitude. But still that feeling that he was very knowledgeable…that I could feel comfortable to talk with him and feel that he had an expertise in this area. He made me feel very comfortable. And it was a safe environment to spill it all out. It felt good. I no sooner got in the door and I started to cry. . . . I was looking for some kind of sanctuary. . . and as soon as I walked in the door it was, okay, you're gonna be okay.

Perhaps there is something in the interest, curiosity, and love of this very unlovable thing that is an intervention in and of itself. Few people are willing to open up their hearts to working with sorrow. Most people are humbled by the enormity of it and are tempted to conspire with the bereaved to hide, camouflage, and ignore it. A love of grief, a willingness to enter this sacred territory with those who are suffering in grief, is work that has its own toll and its rewards.

I do this work because I love it . . . because I'm passionate about it, because I know it makes a difference. . . because I grow from it. And it's life-giving work for me and it is for the people that I work with. . . and so, it's not hard work. (second clinician)

I think any time you are emotionally present to someone who's wounded, you do open yourself up to change. It's part of what counselors need to do-be aware of how people's stories impact you. And the way I've changed is in the early years I could be quite devastated and take with me a lot of people's journey and feelings and stay kind of inbred in me. And the way I've changed is I've had to kind of disassociate myself from the suffering event and the tragedy and rather focus in on what is healing. And what is healing is very exciting, it's very encouraging. And so for me to be able to see others take healing steps, especially when you're involved with them for a period of time
that they don't think anything is yet possible in their life. . . and maybe you meet them in society a few years later. You see what's shaped and formed their lives and some people go on to a greater sense of well-being after a loss than they had before because they know they can transcend incredibly difficult experiences in life. . . . And so, for me, doing sorrow work has fed my own hopefulness for life. (first clinician)

Perhaps embarking on this kind of work requires a degree of commitment, as it requires love, to open space for something that paradoxically requires a lot of space and yet is often denied it. The second clinician called it "soul work." Grieving is soul-stirring, soul-changing, and soul-calling. This work begs for connection-a connection that takes on a soul quality. In clinical work, there is often a profound connection and it usually occurs most around very strong life experiences; therefore, it is not surprising that it shows up in grief. It is here where the experienced clinician makes room for it to

show up and demonstrates "courage to keep working. . . trust in the process. . . maybe faith in their ability to handle it" (second clinician). These clinicians, in a love of grief, have chosen to take up the life work of walking alongside families; they have the courage and compassion to step into the hollow of sorrow.

Final Discussion: Entering the Hollow of Sorrow

> *Sorrow wears itself a hollow, cleans me out with its crying. . . . At first I thought it was malevolent, something that wouldn't leave but now I know it is no different from the light that washes in and brings me my body back, an opening that finds the people I love, still here . . . this gentleness we learn from what we can't heal.*
> *Wallace (1985, pp. 76-77)*

In the research, we found a fit between our shared assumptions and beliefs about grief and the beliefs expressed by the clinicians and families in this study. For this reason, there were few unexpected findings in this study. The clinicians seem to define their role as being present to help family members give themselves to the process, to guide them to listen to their own way. There is a valuing of family members' strengths, resilience, and inner resources, and this valuing seems to work alongside their own trust in grief itself. They trust that grief will not betray or destroy. They trust that it will not lead the bereaved or the clinician astray. They trust that it knows where to go and acknowledge that there will be risks along the way such as pain, self-learning that is not always flattering, or looking at issues one would rather not revisit. Still, grief is something to be trusted and honored, despite its concealing and uncertain nature. Our research team was struck with the similarity of trust in the process of grief to that of faith, of believing in a higher power even if it cannot be seen. This faith in grief is about trusting to follow something that chooses its own direction. We follow along with families. Two of the clinicians said that we follow in behind, the second clinician stating, "In coming in behind, we listen, witness, and acknowledge suffering, normalize, give space for pain."

Our biases, as researchers, allow us to make an ardent argument of how the lack of models in practices with bereaved families serves us well. In our clinical experiences, we have come to see the ways that models can often constrain, modify, conscript, and conform experience. Models around experiences of grief and models around grief work abound, but what might be the more important quest is finding a way to suspend models and consider how we describe and teach the sacred and privileged work of helping those bereaved.

Rather than using models, the GSP uses maps of experiences that offer signposts and markers in the journey into the hollow of sorrow. They do employ a type of model of experiential learning wherein "veterans" of grief lead support groups. Similarly, they use some models of educational practices in offering information about grief. One might suggest that they subscribe to a model of individual/family counseling, segueing to group counseling. Apart from these models of practice, however, it seems as though these clinicians, too, leave models behind and, with the aid of maps of expertise and experience, enter into relationships with families and family members that are more sophisticated and difficult to articulate than the apparent heuristic simplicity of a model. Perhaps it is less about the abandonment of prescriptive models or maps but the openness to anything that allows attentiveness to the particularities of the sufferer to

best guide the navigation in grief. So much of what was articulated by clinicians and by family members in this study seemed to be a mutual goal of getting to a place-a physical, emotional, social, and spiritual place-a safe sanctuary where there was room created to experience. In this room of safety, there were tissues, expertise, compassion, experience, trust, faith, community, and timing, refracted through many lenses of beliefs and practices. Perhaps at the heart of it, this place of refuge and growth, is the cultivation by those who love grief-who are not afraid of it, who have faith in it, who are willing to suffer it. Compassion means to suffer with (Agnes & Guralnik, 1999). Through compassion, these clinicians recognize that sometimes what the bereaved are most running from is ironically the very thing that can give them comfort.

This research moves us from the entrapment of interpretations of grief as inarticulate, pathological, and predictable to the natural complication of grief. Grief calls us to a recollection of connections. It alerts us to the work of healing in grief as a character of connection to the living and the dead, a lifelong work that is borne by the bereaved who carry the inherent capacity to heal through love, and clinicians willing and skilled to join in behind.

The work of this program, individually, in couples, families, and groups, seems to be about creating a space and place where what the bereaved are running from is allowed to meet them. They are allowed to embrace, reverence, suffer, sorrow, and celebrate their grief. In the embodiment of grief, there is a communion of sorts. Ironically, communion is about uniting the body and spirit, about finding grounding, of knowing where the feet hit and the heart hurts, of recognizing the hollow that sorrow wears. The hollow of sorrow is very occupied yet strangely empty. It is a cavernous, vacuous, yet crowded place that feels ungrounded. It is into this hollow of sorrow that families and clinicians must dare to journey together, the person who bears the hollow courageously traveling ahead with the clinician willing to "follow in behind."

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