Legitimizing Grief: Challenging Beliefs That Constrain

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The author explores the commonly held belief that grief; in response to a significant loss, is a finite, time-limited, and predictable process. Examination of this idea suggests the possibility that this belief creates personal and societal expectations that contribute to increased suffering in the lives of grieving people and renders them subject to diagnostic labels fostering incompetence, failure, and pathology. Alternately, the author offers her assumptions and beliefs about the opportunity of developing a relationship with grief that is potentially l but livable, and as much filled with comfort and creativity as it is with sorrow. A clinical advanced nursing practice model, as developed and presented by Wright, Watson, and Bell (1996), is explored in relation to working with grieving families and to targeting beliefs about grief that constrain families, nurses, and our cultural ideas and expectations of this life experience. Clinical examples and a clinical exemplar are offered.

A family experiencing grief is seen by a clinical nurse specialist in an outpatient mental health facility The postsession discussion with the clinical team unearths one team member's belief, expressed in the statement: "1 think this grieving family is in the stage of denial." What does this statement mean? What does this statement reflect? How could this statement invite the team and the nurse into being with this family? What further meanings and experiences could this statement become complicit in creating? What implications does this statement have for families, for nurses, for society, and ultimately for ourselves as human beings who are not immune to suffering, death, loss, and grief?

GRIEF AS: A LIFE-CHANGING EXPERIENCE

The Chilean neurobiologist Humberto Maturana offered a post- modem belief that the world is a world brought forth with others through language (Maturana & Varela, 1992). Within this worldview, there is room to legitimize the experiences of others in recognition of their unique "bringing forth" of their own worlds. As we legitimize experiences of people who are grieving, we are gently guided away from normative, prescriptive, and pathologizing descriptions of others' experiences. In exploring the statement "This grieving family is in the stage of denial," I enter into a reflection of my own beliefs about grief, families, and advanced family systems nursing practice. I recognize that just as there is no one single human response to loss (Rosenblatt, 1988), this article is a glimpse of but one world which I invite you to invoke with me through language.

My worldview of grief originates from a personal core belief that grief resulting from the loss of a significant person becomes a lifelong and life-changing experience. Some people and some families are able to struggle through the suffering in grief and ignore the cultural voices that suggest that they must give up and "get over" their grief in a predictable, timely, and orderly fashion. They are able to find ways to privately make room for relationships with

grief that are not subject to public scrutiny and criticism. Other people seem to come to impasses in their experiences of loss where their grief continues to subsume them with suffering and recruits them into lifestyles that are characterized by continued efforts to end grief and subsequent experiences of failure to do so. The cultural discourse that describes grief in normative, predictive stages and that suggests that not only is grief "resolution" possible but expected and normal contributes to a sense of failure and incompetence. People struggling with individual integration of grief into their lives have been pathologized by society and the health care system as having abnormal, complicated, pathological, unresolved, chronic, morbid, prolonged, dysfunctional, or exaggerated grief (Jacob, 1993). Traditionally, therapy or clinical intervention has been focused on helping people continue to find a way to end their grief (Rando, 1986; Schneider, 1984; Worden, 1991).

The practice model explicated in this article allows for different assumptions of grief and, as a result, a very different approach to clinical work. I describe my responses to the description of a family in a "stage of denial," my assumptions about grief, and I explicate a practice informed by the Wright, Watson, and Bell (1996) model of advanced family systems nursing practice.

"THIS GRIEVING FAMILY IS IN THE STAGE OF DENIAL"

Grief is most commonly explained as a process involving a dynamic progression through phases that although nonsequential, contain within them inevitable commonalities of tasks required to resolve grief (Cowles & Rodgers, 1991; Rando, 1984; Schneider, 1984; Worden, 1991). Stage model theories of grief such as those based on Kubler Ross's (1969) work have been generally discarded for more fluid and nonlinear interpretations of the grief process (Cowles & Rogers, 1991). The language of stages, however, persists in cultural discourses rep resented in media and popular self-help literature. Stage models, although they may contain some heuristic value, obscure unique experiences and narrowly focus on psychological responses such as denial, anger, bargaining, depression, and acceptance while overlooking the social, spiritual, familial, and physical domains of the experience. Stages imply that grieving occurs passively in expected sequences that disregard individuality and fail to resonate with personal experiences (Attig, 1996). Most important, stage expectations shape and distort the understandings of observers of grief who may be clinicians, people who participate in the maintenance of the very same discourses that have influence. The language that surrounds grief, such as process, work, resolution, and recovery, serves to further constrain and mold our ideas of grief.

Denial is defined as "a refusal to believe or accept" (Neufeldt & Guralnik, 1988, p. 368). The names that we choose to label and describe experiences have obvious and inadvertent consequences. Names are invocations in their calling forth of particular meanings, assumptions, prejudices, traditions, and practices. Names contain within them their own power, and linguistic nuances influence our thoughts and actions (Muller & Dzurec, 1993). The language we use with others and the consensus of this language brings forth and sustains

realities (Maturana & Varela, 1992). Language can be evocative, generative, and engender relationship or it can oppress and create distance in understanding. "Words can hurt and words can heal" (Bell, Wright, & Watson, 1992, p. 37); "we kill or elate with words" (Maturana, 1988a, p. 48). Names locate experience in a sociopolitical space, with cultural, historical, and personal contexts and implications. When we agree on a name such as denial, we create a reality but at the same time we exclude other realities; therefore, the name we choose to label and communicate the experience of another becomes complicit in its own creation and perpetuation. In view of this, we must be vigilant in recognizing the complexity that goes with a word, all of its meanings and "not meanings." Madigan (1996) wrote:

> It is the discourse unnoticed, the words of everyday therapeutic description, that demands our vigilance. If our therapeutic discourse is allowed to go unchecked we might be in danger of promoting and recreating the very contexts which have assisted the problem stories we are attempting to eliminate. (p. 58)

The power of the word denial is evident. It suggests intentionality and pathology and it implies noncompliance or resistance. It is laden with implications of abnormality failure, and dysfunction. Wright and Levac (1992) suggested that based on Maturana's meta-theory of cognition and structural determinism, noncompliance is biologically impossible. Bell (1995) offered the idea that to distinguish pathology is to disregard strengths and competencies. Using alternative descriptions, such as "This family is suffering in making sense of their loss" or "This family has the wisdom to move slowly," or even "This family may have beliefs that are constraining them from making a relation ship with grief," has powerfully different implications than the descriptor originally offered.

Anderson, Goolishian, and Winderman (1986) suggested that problems are determined in a coherence and consensus of language. A problem is created and maintained within a language that privileges one reality while marginalizing other possibilities. Maturana and Varela (1992) further suggested that to accept one's subjective reality as truth is operating in a domain of objectivity as truth, an impositional domain that denies other realities. The professional distancing that comes with privileging an "expert" description over a family's description is counter to my belief that families contain within them immense wisdom, strengths, competencies, resources, and the abilities to solve their own problems.

The statement "This grieving family is in the stage of denial" raises questions that challenge "taken for granted" beliefs about grief. Questions that are generated include: When we define a family by its experience, when we call a family a "grieving family," do we ignore the complicated and delicate fabrics that constitute the family's uniqueness and the essence of its intangible entities that make the members who they are? Against which and whose standards do we measure denial? Is the absence of affect evidence of denial? Is an experience of numbness indicative of denial? Is "refusal" to discuss the loss a sign of denial? Is a family's return to normal routine without expected rituals of

mourning considered denial? Finally, I question: When we do not understand or recognize a response, are we lured into pathologizing it? Ultimately, I believe that all experience is legitimate and can be measured only against its own existence and within our personal criteria of explanation and acceptability (Maturana, 1988a). The question that seems central to this discussion is: Does thinking of a family's suffering as "denial" serve to foster a reality of judgment rather than a reality of compassion? In response to these questions, I offer my assumptions and beliefs about grief.

GRIEF: ASSUMPTIONS AND BELIEFS

Literature Review

The genesis in the evolution of our current understanding of grief is generally attributed to Freud's (1915) work on mourning and melancholia in which he described grief as the process of energy withdrawal from a person that is lost. Eliot (1932) began to study successful and unsuccessful recovery from grief. In his 1942 doctoral work, Fulconer (cited in Jacob, 1993) introduced the idea of stages of grief and the progression from shock and denial to resolution. The later work of Kubler-Ross (1969) on death and dying became land mark in viewing grief as a fluid, nonsequential process through stages originating in shock and denial and resulting in eventual resolution. Lindemann's (1944) classic work on grief and its symptomatology positioned grief as a crisis that follows loss, a crisis with physical symptoms and a recovery trajectory of 6 to 8 weeks. More current literature suggests that recovery needs to be measured in years rather than weeks; however, it still suggests that grief is a process of tasks through a temporal sequence, contained within time and ultimately ending in resolution (Bowlby, 1980; Engel, 1964; Parkes, 1972, 1975, 1985; Rando, 1984, 1986; Schneider, 1984; Worden, 1991). Engel (1961) first equated grief to a disease with symptoms and trajectories, and later (1977) argued for an expanded biopsychosocial medical model of grief. There is some description of grief as an emotion (Attig, 1991, 1996) and some as a socially constructed emotion (Averill & Nunley, 1988).

Defining Grief

Grief is an experience within the phenomenon of loss. Losses can take the form of loss of another through death, or losses can be circumstantial, such as losses of hope, relationship, job, health, youth, pets, safety status, self, and so forth (Cowles & Rodgers, 1991; Pine, 1990; Rosenblatt, 1988). The influence of the loss seems to be related to the type of loss, the timing, and the context of the loss (Herz Brown, 1989; Walsh & McGoldrick, 1991). The type of loss that generally results in intense grieving seems to be the loss of a significant person through death. It is suggested that the nature of this grief is affected by the degree of significance, the kind of attachment and relationship, the age of the lost person, the synchronicity of the loss with life stage and expectations, and the conditions around the loss (Cowles & Rodgers, 1991; Jacob, 1993; Rolland, 1991).

Although grief is defined as sorrow and the emotional suffering caused by loss (Neufeldt & Guralnik, 1988), I see grief as larger than sorrow. Sorrow is an overwhelming sadness, an emotion that is contained within grief, but grief is as much the celebration of the lost person as it is the relinquishing or sorrowing of the loss. Within grief there are aspects of intense sadness, but intense sadness over loss can, and sometimes does, end, yet I propose that grief remains. It remains because loss becomes a part of our biological structure (Maturana & Varela, 1992). The type of loss, and the significance and strength of relationship to the lost other, determine the degree of perturbation of the event and thus the degree of structural change. As a result, grief becomes a permanent, enduring, sometimes relenting, sometimes poignant, but always present part of the life of a person who has lost.

I define grief as the structural (Maturana & Varela, 1992), emotional, cognitive, social, and spiritual change that occurs as a direct result of the experience of significant loss and that creates a mutable, evolving, but lifelong, relationship with the loss. This definition evolved, in part, from my practice with families of children who have died. Family members suggest that they experience an ongoing relationship with their grief that changes in nature over time, vacillates in intensity is personal and particularized, but that perseveres and endures as a part of their lives. Grief has intensive and sometimes unrelenting elements of suffering and pain, but it also has attributes of comfort, connection, and celebration. The parents I have worked with who have lost their children suggest to me that although changing in nature, they will never be without a relationship with their grief. They describe that they feel like different people and that they will never be the same people that they were before their loss. I argue that because grief may create changes at a structural level, not only do they feel different, they truly are different people. Although they might want to abandon the painful part of their grief, the sorrowing part, or the emotionally numbing part (which could even be interpreted as "denial"), they do not want to forget their loved one, and their grief reminds them. Grief is the experience of keeping in relationship with the lost person, who although physically absent, is still profoundly a member of the family.

Because society does not tolerate the visibility of grief in an endless way (Averill & Nunley, 1988; Frank, 1991; Solari-Twadell, Schmidt Bunkers, Wang, & Snyder, 1995), people learn to establish a relation ship with grief that is private and not open to public scrutiny. Within this somewhat clandestine relationship, people may pathologize themselves as abnormal for continuing to feel grief, and this self- diagnosis may sponsor stories of incompetence, withdrawal, inertia (Moules & Amundson, 1997), depression, or isolation. People who think they are not experiencing grief to the extent they "should" can be recruited into a diagnosis of "denial." As pathologizing stories find ways into lives, people may become conscripted into cultural descriptions of dysfunction and may seek out clinical intervention.

ADVANCED NURSING PRACTICE

My advanced nursing practice is guided by philosophical underpinnings of postmodernism. Legitimizing the other is a philosophical stance consistent with postmodern beliefs. The essence of postmodernism suggests that there is no one absolute and fixed reality but that there are infinite ways to view and interpret the world (Mills & Sprenkle, 1995). A postmodern lens situates relationships in sociopolitical, historical, and moral contexts. Postmodernism does not suggest that "anything goes" (Efran, Lukens, & Lukens, 1988, p. 33) because people are connected and committed to each other in ethical, political, and social ways. A clinician can (and usually does) have preferred outcomes and can recognize when beliefs constrain people from living their lives with integrity There are preferred realities or ways people would rather be living their lives; therefore, realities may have equal legitimacy but not desirability (Freedman & Combs, 1996; Maturana, 1988a; White & Epston, 1990).

The journey of finding a way to incorporate grief into one's life and family has a reciprocal relationship with beliefs, family context and relationships, cultural discourses, gender, and gender discourses. Incorporation is ongoing, with the experience being recursive and folding back on itself. Although the belief in a desirable outcome of grief "resolution" continues to pervade the literature, the notion of incorporation of grief into one's life is beginning to emerge. White (1989) wrote of incorporating "the lost relationship in the resolution of grief" (p. 29), suggesting that resolution can occur but it evolves through a process of incorporation. Attig (1996) described grief as a process of "relearning the world" and accepting the mystery or enigma of grief as a persistent challenge that people have no choice but to confront repeatedly in discovering an acceptable way to continue to live with loss. The statement offered by the member of the clinical team, "This family is in the stage of denial," extends an invitation to the nurse clinician to defy the call to cultural critique and to, instead, join in an exploration with the family in uncovering beliefs about their experiences of grief and in finding a way to begin the incorporation of loss in their lives.

The Wright, Watson, and Bell Model of Advanced Family Systems Nursing Practice

The practice model I offer to families experiencing grief is the Wright, Watson, and Bell model of advanced family systems nursing practice (Wright et al., 1996). Out of many domains of family functioning, this approach to advanced family systems clinical practice has pulled to the foreground an emphasis on beliefs. Because "beliefs, stories, and illness are intricately intertwined" (Wright et al., 1996, p. 22), and beliefs influence biology spirituality, psychology, and relationships, clinical work is therefore targeted at beliefs. People and families have beliefs that are facilitating and beliefs that are constraining in the ways that they affect and influence their lives, and it is the belief about the problem that is at the core of the problem itself and at the heart of healing in clinical work with families (Wright et al., 1996).

This clinical approach offers interventions and clinical work in the language of "moves," preferring to emphasize the nonhierarchal, shifting, coevolving, and relational nature of moving, rather than privilege the suggestion of "intervention" as "doing to" another. The invitations to reflections offered to families through these moves respect Maturana's (Maturana & Varela, 1992) idea that what will be a "fit" for a family, and what will be taken up as a perturbation or "call to change" by an individual, cannot be strategized; it can only be offered in the spirit of curiosity wondering, and creativity and with the belief that what will be a fit is determined not by the nurse but by the structure of the person.

Four macromoves are identified within the clinical work described by this model (Wright et al., 1996). These are the moves of creating a context for changing beliefs; uncovering and distinguishing illness beliefs; challenging, altering, and modifying constraining beliefs; and distinguishing change through identifying, affirming, and solidifying facilitative beliefs. Macromoves are operationalized by many micro- moves that facilitate purposeful and intentional clinical moves offered as invitations to reflection.

Implications for Practice

Guided by different assumptions about grief, I believe that a clinical practice with the bereaved must be open to the legitimacy of others. I feel obligated to work with the "denying" family within a context of offering a nonpathologizing voice to their experience, and within a context of actively challenging the cultural and medical discourses that foster labeling and pathologizing. Within this therapeutic relationship, I would advocate for the use of descriptors that are empowering and resourceful, rather than ones that suggest failure and incompetence. People experiencing grief deserve to privilege their stories of suffering but they also have a right to experience and tell their stories of survival and strength. Therapeutic conversation within the practice model described in this article allows for the outcome of clinical work not to be "getting over," resolving, or ending grief, but finding a way through suffering to make room for a relationship with grief that is livable, acceptable, creative, and for a life that may even be richer for its presence.

In the process of integrating grief into one's life, people can struggle with the influences that cultural discourses play in their relation ship with grief. Cultural discourses are described by Freedman and Combs (1996) as dominant cultural beliefs, practices, and structures that "share common values" (p. 42). The discourse that there is a normal experience and expression of grief and a pathological one is the discourse that creates labels such as denial. The discourse about grief that seems to have the greatest influence on suffering is the proselytizing of the message that grief is a finite, time-limited process that starts with loss and ends with resolution. As people continue to be in relationship with their grief and as they continue to want to be in relationship with their grief because of the connection it offers them to their lost other, they may begin to experience a sense of failure, alienation, and incompetence. Their sense of

alienation is fueled by the cultural messages that a visible grief is unhealthy and intolerable.

Macromove: Creating a Context for Changing Beliefs

The macromove of creating a context for therapeutic conversation and for change is described by Wright et al. (1996) as the "central and enduring foundation of the therapeutic process" (p. 129). The relationship that takes root in initial conversations with families is not only an antecedent of change, it is change (Wright et al., 1996). It is the softening of structures of the nurses and family members to become less different from each other and to begin the process of structural coupling (Maturana & Varela, 1992). Creating a context involves engagement (Wright & Leahey, 1994) or joining (Minuchin, 1974; White, 1995), distinguishing the problem, and removing obstacles for change (Wright et al., 1996). The relational stance that the nurse assumes is fundamental to the creation of this relationship. Robinson (1996) wrote that although the relationship between nurse and client has been recognized as influential, it is generally considered to be only background to change. She suggested that rather than background, relationships are pivotal to change.

"To enter the world of one who is grieving, we must choose to listen to the pain behind the words" (Gibbons, 1993, p. 599). Families within my practice have welcomed the opportunity to tell their story, to talk of their loss and their lost other, and to speak and honor their grief. Families need the opportunity to "story" their experience. Privileging of the story is a part of creating a context for change. Grieving people generally have more access to their stories of suffering and because these stories are often oppressed by society, they do need to be voiced and acknowledged. It is generally through the process of telling these stories, and the careful sifting and challenging by the clinician, that other stories of competency success, and change, that are marginalized by suffering, can be discovered (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990; Wright et at., 1996).

Macromove: Uncovering and Distinguishing Illness Beliefs

Beliefs about grief. Embedded within stories are the beliefs of the family members about their grief. They may have guilt around the circumstances of the death and how they believe they may have directly or inadvertently contributed to the death. Many families have enduring guilt about things said or left unsaid and ways that they believe they could have somehow eased the suffering of their loved ones (Epston, 1991).

People may have beliefs regarding how grief "should" be experienced and may believe they have been incompetent in how they have experienced it. Some people believe they are not grieving enough, and some believe they are grieving too much. People may believe that in the spirit of protectiveness, grief should not be shared with other family members. Family members may resent the openness of other members in their expressions of grief, and it may result in feelings of inadequacy in their own experiences and expressions of grief. Some people believe it is appropriate to seek support in developing a relationship with their

grief, whereas others view it as a sign of pathology, weakness, or ineptitude. People may struggle in their desire to "control" grief and are shaken when they are subject to the fluctuating, unpredictable nature of grief. They may feel helpless when they unexpectedly encounter the consuming moments that grief can demand. If a person subscribes to the description of grief as a time-limited event, he or she might experience a disparity when grief continues to persist beyond the expected time boundary The type and significance of the loss, the events surrounding the loss, religious and spiritual beliefs about death and afterlife, and experiences with past losses have tremendous effects on how a person makes sense and meaning of the current loss (Herz Brown, 1989; Schwartzberg & Halgin, 1991).

Gender beliefs and influences. There is a suggestion that gender has influence on expectations, expressions, and experiences of grief (At fig, 1996; DeFrain, 1991; Hughes & Page-Lieberman, 1989; Moore, Gilliss, & Martinson, 1988; Parkes, 1988; Rosen, 1990; Shapiro, 1994). Hare-Mustin and Marecek (1988) suggested that exclusive attention to gender differences can serve to mask inequality social inequity, and power differences and may ultimately defend the status quo and eliminate possibilities for change. A focus on gender differences minimizes the differences within gender groups themselves (Hare Mustin, 1987; Hare-Mustin & Marecek, 1988) and negates the highly individual nature of grief. Conversely, a focus on minimizing differences ignores the social context of gender and the notion that we are never "meta" to our cultural experiences (Goldner, 1992).

The literature offers the debate of attributing differences in gender experiences of grief to biology or to socialization, but preference seems to be on the side of socialization of gender roles rather than pure sex-linked differences (Cook, 1984; Pine & Brauer, 1986; Rando, 1986; Schatz, 1986; Schiff, 1977). Although the debate between biology and social learning persists (Goldner, 1988; Goldner, Penn, Sheinberg, & Walker, 1990; Hare-Mustin, 1988, 1991; Hare-Mustin & Marecek, 1988), Maturana and Varela (1992) suggested that because we are in constant structural change in response to both internal and external environments, there is a mutual influence between biology and socialization. This reciprocal interaction makes space for the explanation of differences both in people and in relationships (Robin son, 1994). Rather than arguing etiology, it may be more useful to understand the implications of gender differences in grief and how the differences are lived out individually and in relationships.

In the context of a gender-difference discussion, typically, women care for others before themselves and often at the expense of them selves (Bepko & Krestan, 1990; Boss & Thorne, 1989). As women grieve their own losses, they are often simultaneously enduring their responsibilities to fulfill family obligations. Socialized or biologically disposed, women feel deeply and are in many ways more emotionally connected to their roles of caring for others (Hare-Mustin, 1992). In particular a mother who has lost her child struggles to define herself in the ambiguous and impotent position of being a mother without a child to care

for, a mother without a receptacle for the vast amount of endless love that she continues to feel for her child.

Men, on the other hand, are conditioned to "marginalize their own humanity" (Parry 1991, p. 50) by believing that feelings of vulnerability, caring, and emotional pain or suffering are the domain and privilege of women (Jenkins, 1990; Parry, 1991; Zilbergeld, 1992). The socialization that instructs men to continue with their active, often emotionally detached, roles even during times of sorrow may entice men to return to work and routine prematurely and out of synchronicity with female partners (Schatz, 1986; Schwab, 1990,1992). My own practice suggests that men experience oppression in their drive to move on with life without giving themselves the gift of their own pain. Men can see women as submerged and subverted by grief, and women can experience oppression in this judgment. Schwab's (1992) research on the effects of a child's death on the marital relationship uncovered that men viewed women's expressions with concern and frustration and that women experienced anger over men's lack of emotional sharing. A couple can experience difficulty in moving beyond the gender discourses that conscript them into very different relationships with, and expressions of, their own grief.

Family relationships. Because grief brings about individual structural changes, and because its nature is inconsistent and vacillating, family members often experience relationships with their grief that are out of sync with each other. As a result, and as a function of the personal and particularized nature of grief, families can experience difficulty with internal family relationships (Attig, 1996; Herz Brown, 1989; Schwab, 1992; Shapiro, 1994; Walsh & McGoldrick, 1991). The incidence of marital separation following the death of a child is disputed, with some authors suggesting a higher divorce rate (Herz Brown, 1989; Lehman, Wortman, & Williams, 1987) and some equal to or even lower than average (Rando, 1986; Schwab, 1992). There does seem to be, however, some agreement that family relationships are challenged during times of grief. Whether the family functioning and context prior to the loss has impact on the experience of grief is not completely known, and there are conflicting opinions within the literature (Gilbert, 1989; Herz Brown, 1989; Martinson, McClowry Davies, & Kuhlenkamp, 1994; Rosen, 1990; Schwab, 1992; Walsh & McGoldrick, 1991; Worden, 1991). Walsh and McGoldrick (1991) maintained that the most crucial mediating variables on the adaptation to loss are family patterns of organization, communication pat terns, and family beliefs. Although experiences of grief are individual, people are in relationship to each other, their experiences are relational and reciprocal, and they "are best understood in their relational contexts" (Wright et a!., 1996, p. 53).

Uncovering beliefs. The macromove focuses on uncovering the beliefs around the etiology prognosis, healing, and treatment of grief; the role of family members and health care professionals; and the beliefs about mastery control, and influence in relationship with grief (Wright et al., 1996). How a family makes meaning for loss is often closely related to its beliefs about religion and spirituality. I believe that the beliefs that people hold about the place of grief in

one's life are close to the heart of the clinical work with people suffering in their grief. The exploration of this area often reveals the constraining belief that people need to "get over" and "deal with" their grief, and this may coach the presentation of a facade of denial. Once this belief is distinguished, the clinical work can be directed toward modifying it into a belief that is not only more useful but is probably closer to experience than to the voice of cultural expectations. The altered belief would be that grief must be accepted into one's life, rather than "dealt with" or ended.

Macromove: Challenging, Altering, and Modifying Constraining Beliefs

The macromove of challenging, altering, and modifying constraining beliefs has particular relevance with the population of people experiencing grief. One micromove within this macromove that has usefulness with grieving families is the offering of commendations (Wright et al., 1996). Families need to hear that the continuing presence of grief in their lives is not an indication of failure or that the absence of expected emotions is not pathological. The strengths and creativity of families in suffering loss and making room for grief need to be acknowledged and commended. Normalizing (Wright et al., 1996) can occur with the use of research findings and the offering of stories of other families' experiences with loss and grief. The practices of reflecting teams (Andersen, 1987) and therapeutic letters (Epston, 1994) open opportunities to offer commendations and to challenge constraining beliefs. "Speaking the unspeakable" (Wright et al., 1996, p. 177) gives the family the opportunity to speak of the death and to explicate their beliefs around the cause of the death, their guilt, and the meanings they may need to make room for finding.

Challenging a constraining belief is exemplified in the story of a woman who was maintaining a vigil at her dying child's bed whispering, "Keep fighting; hold on." The nurses approached me with concerns that the mother was "in denial" and that her words were causing anguish to the child and the family. In looking back at this situation, it is now evident to me that this mother had a constraining belief that "good mothers do not give up on their children." Our conversation together somehow opened space for the alternative belief that "good mothers are able to let go in love." Within an hour of this conversation, the mother was able to give her child permission to die. Her child died peacefully in her arms, with the mother believing that she had done what only a good and loving mother could do.

Macromove: Distinguishing Change by Identifying, Affirming, and Solidifying Facilitative Beliefs

The macromove of distinguishing change by identifying, affirming, and solidifying facilitative beliefs is based on the belief that for change to be a reality it needs to be observed and distinguished (Wright et al., 1996). Change needs to be noticed, explored, explained, and celebrated. Change, within this model, does not have to be an entirely "new story" because it is understood that changes in beliefs will lead to new beliefs, new stories, and new ways of being in and understanding the world.

One change that may be distinguished is the redefinition of grief that occurs as the nature of grief changes. A mother whose son died 7 years ago offered her current definition of grief as a "quiet, warm reminder deep in my soul that I have loved." This definition was profoundly different from her definition 7 years ago of grief as "in sufferable agony."

CLINICAL EXEMPLAR: MAKING ROOM FOR GRIEF

Julie was a 50-year-old professional woman seen in crisis therapy on referral from her family physician. The referral was initiated due to concerns about Julie's reaction to the recent death of her 25-year-old eldest son, Andrew, from an overdose of alcohol after a lengthy battle with alcohol addiction. Julie's presenting concerns were that she felt emotionally disassociated from the death of her son and that she was not fully experiencing the influence of her loss. She believed and was being told by others, including her physician, that unless she stopped "denying" her grief and started to "deal with her loss," her emotions would be disabling in the future.

Family History

Julie had three sons from her first marriage to Tom. She described a turbulent relationship with Tom that was characterized by Tom's chronic and incapacitating alcoholism and by his physical and emotional violence. Julie left the relationship with the children 12 years ago. At 15 years of age, Andrew began a lifestyle of alcohol abuse. His second sibling, David, also drank heavily. David was admitted to a rehabilitation program and had been "clean and sober" for 4 years. Andrew, on the other hand, entered into an intense relationship with alcohol, which eventually eroded his relationships, career, and health. Julie and her other two sons became very engaged in rescuing Andrew, but despite their vigilant attempts, he continued to escalate in his drinking. Andrew did make brief forays into sobriety the longest of which lasted 33 days. During these periods of time, Julie would feel a "return" of her son and of her hopefulness.

Julie described the experience of having "lost" her son, as she knew him, 2 years ago. She identified feeling "disgust" at the person he had become. Since his death 2 months prior, she had felt detached, relieved, and generally numb. She had been told by others that she was "repressing" and "denying" her feelings.

Beliefs and Clinical Work

The clinical work with Julie consisted of three sessions. The first session was the creation of a context for change (Wright et al., 1996). This session consisted of engagement (Wright & Leahey, 1994), exploration of a genogram and family history and the storying of Julie's experience of her battle with Andrew's alcoholism and the events leading up to and including his death. This session uncovered Julie's beliefs about her complicity in the creation of Andrew's problem, her beliefs in her failure to "save" him, and her most constraining belief that she was not "doing this grieving thing right."

At the second session, Julie noted it was the first time she had ever told the entire story and that she experienced it as helpful and healing. Since the last session, she had come to believe that she was most troubled by her lack of good memories about her son. She felt angry at him and believed that her anger fueled her inability to recall positive memories of him and of their relationship. Her anger was further fueled by the belief that Andrew could have escaped alcohol ism (she witnessed one son do it) if only he had tried harder. She had conflicting beliefs that she should have tried harder to save him yet believing that he needed to save himself. The session incorporated White's (1989) notion of "saying hello" to the lost person, in addition to goodbye. In an effort to challenge the belief that memories about deceased should consist of only good memories, an alternate belief was offered that memories are the integration of the realities of complicated and sometimes troubled relationships in life. We discussed recreating a story of Andrew that was a blend of both kinds of memories. Julie was open to the idea of welcoming Andrew back into her life and, in doing so, finding a way to incorporate and make sense of her loss.

The third and final session involved the use of an "internalized other interview" (K. Tomm, personal communication, March 1997). Internalized other interviews operate on the notion that the self is constituted by art internalized community of relationships that have the continuing capacity to change. The exercise of interviewing Andrew as he was internalized in Julie opened space for Julie to explore memories of her son that existed prior to the recent struggles, and particularly memories of him in relationship to her.

Significant clinical work was the challenging, altering, and modifying of the constraining belief (Wright et al., 1996) that Julie was not appropriately experiencing her loss in the way legitimized by cultural discourses, popular literature, and advice from others. Her sense of numbness and sterility of emotion defied the societal and cultural discourses that are normative and predictive in their descriptions of suffering in grief. The influence of discourses led Julie to believe that her experience was "abnormal" and would eventually result in "dysfunction." This particular macromove constituted the heart of this clinical work and was the context that contributed to healing her greatest suffering. At the end of the third session, Julie stated that she believed that she did not need to return.

Beliefs: The Heart of Healing (Wright et al., 1996)

Julie's suffering in her loss of her son was being inadvertently and insidiously fueled by her constraining beliefs. The exploration of these beliefs and the invitations to consider alternative beliefs served to offer some healing. The clinical work involved challenging beliefs that were contributing to her pain and creating room for beliefs that might result in less suffering in her life.

The belief that "all people can escape alcoholism." Julie was asked the question: "If you were to believe that some people, despite their best intentions and efforts, cannot escape alcoholic lifestyles, would it free you up to be more forgiving of Andrew and of yourself?" It appeared that the nature of this question

had an enduring effect on Julie, because she continued to return to the question, to think about it, and to challenge herself around this belief.

The belief that *"remembering someone who has died should consist of only good memories."* challenging this belief led to some important realizations for Julie that she did have some validly painful and unpleasant memories of Andrew. Paradoxically, accepting the presence of "bad" memories, without feeling guilty, seemed to open space for her to access other memories of him. The intervention of "interviewing the internalized other" served as a vehicle for Julie to access memories that were embedded in herself and in her experience of herself as a mother in relation to her son.

The belief that *grief resolution involves forgetting rather than remembering.* Grieving is concurrently saying goodbye and hello to the lost person and to a new and changed relationship that does endure after death (White, 1989). Julie's belief, fed by prevailing societal discourse, that grief resolution occurs when one can disengage from memories was in painful juxtaposition with her desire to rediscover her memories and her relationship with her son. The process of challenging this belief and offering the alternative belief that grief can be integrated into one's life and that successful resolution is not measured by forgetting seemed to be a freeing experience for Julie. Another paradox was faced as Julie discovered comfort in the belief that her grief in losing her son, although it may bear many different and changing faces over time, will continue to be a part of her life. She stated that in many ways this belief convinced her that in her experience of grief, her son remains with her. Julie was encouraged to make room in her life for her grief by making her own relationship with her grief and ultimately with her son.

The belief that *"grief is predictable and follows a predictable course for all people."* Julie's suffering at many levels seemed related to her sense of failure about "not grieving right." Therapy focused on offering alter native explanations for her experience of grieving, and she was encouraged to accept her experience without subjecting herself to evaluation by comparison. It was suggested to Julie that perhaps her sense of numbness and relief was a natural reaction to having experienced a very painful, intense, and tumultuous 2 years of watching her son in a process of self-destruction. The notion that perhaps Julie really experienced losing Andrew a few years ago seemed to be of particular fit for her.

Summary of Clinical Work

A telephone call with Julie several weeks after her last session elicited the report that she had a sense of peacefulness in allowing her feelings and experience to develop in her own individual way. She did not see herself as suffering at this time, and she found she was able to spend more time thinking about her son in ways that she found comforting and healing.

It is my observation that Julie needed to review her loss experience and to tell the story of her loss. In doing so, we cocreated a context of opening space for new ideas. In the uncovering and challenging of the beliefs that seemed to be contributing to her suffering, Julie was able to embrace some relief, particularly in

the concern that she was "abnormal" in her experience of grief. It is my belief that Julie will continue to experience the loss of her son in different ways at different times throughout the remainder of her life but that she is learning to make room for a relationship with her grief that does not contain only suffering, but other voices of comfort and peace.

RETURN TO REFLECTION: "THIS GRIEVING FAMILY IS IN THE STAGE OF DENIAL"

Invoking through language the reality of "denial" obscures all other experience and serves to recruit both observers and family members into a discourse of pathology. This statement challenges my practice by serving as a powerful reminder that we participate actively, resolutely, or sometimes innocently and unknowingly in the creation of the discourses that define our understandings. Discourses around grief have inadvertent consequences that reach into the do mains of families, nurses, education, literature, research, and society. They reach into our biological structures: our cells, our minds, and our hearts.

At the very least, this statement is naive and assumptive. At most, it negates the legitimacy of the other and could even be considered violent within Maturana's (1988b) description of violence as holding one idea to be true and demanding another to change.

In my advanced nursing practice, this statement strengthens my commitment to remain open to others' experiences and to explore others' beliefs rather than to impose a reality of my own judgment. It reinforces my belief that as an advanced practice nurse, Jam obligated to remain vigilant to words that "hurt and heal" (Bell et al., 1992) and to challenge beliefs that constrain us at all levels of systems.

SUMMARY

"Grief is, for the most part, a blurred and muddy journey" (Gyulay, 1989, p. 2). Grief is somewhat of a journey, but it is a journey of relationship. It is a relationship that searches for meaning and searches for a place in the lives and relationships that it touches. It is a volatile, labile, unpredictable relationship that is as much filled with surprises as it is filled with sorrow and suffering. The journey can become "blurred and muddy" when it is clouded by the influences of beliefs, culture, gender, and histories that generate only the experience of suffering in the relationship. It can become muddled through judgmental and pathological interpretation of the legitimacy of experience. Through the clinical approach offered in the Wright et al. (19%) model of advanced nursing practice, people who are suffering in loss or in beliefs about grief can be guided into finding a fitting place in their lives for a relationship with grief.

Only people who avoid love can avoid grief. . .the point is to learn from it and remain vulnerable to love" (John Brantner, cited in Haig, 1990, p. 1). Maturana described love as the opening up of room for the existence of another (Maturana & Varela, 1992). When people make room for grief in their lives, when

they sorrow and celebrate the space that was made for another in love, it is the purest evidence that they have loved well. Finding a way to make room for the existence of grief in one's life is the celebration of love.

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