

## **Grief—An Invitation to Inertia: A Narrative Approach to Working With Grief**

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*Grief is a complex, compelling, and profound life experience that is a normal and healthy response to the death of a significant other. Personal experiences of grief, when juxtaposed against the cultural and health care discourses that see grief as a process that eventually results in a resolution characterized by the absence of grief feelings, can sponsor constraining and limiting experiences of life after loss. A narrative approach offers one way for nurses and other health care professionals to view grief and grief's possible "problem" states. Narrative invites the bereaved into seeing and storying their experiences in a more accepting and facilitative fashion. This article outlines a narrative approach to a particular problem state found in grief: a problem state of inertia. Implications for family nursing are discussed.*

The narrative tradition suggests that the stories we tell ourselves not only speak of the lives we live, but in fact "author" them. Stories are not mirrors of reality; they constitute, map, and shape our lives over time. Narratives that describe peoples' lives represent revelation of personal "truths" and expressions of personal experience. White (1989/1990) encourages us to envision personal experience as multileveled, rich beyond the apparent, and composed of alternative, even marginalized stories capable of equivalent value, if not equivalent preference. In this regard, Parry (1991) warns us that, although a story might be preferred, such preference is an act of censorship; the stories that hold us overshadow and even oppress alternatives.

In a therapeutic orientation, narrative focuses on the "re-authoring" of one's story deconstructing the "text" of a problem, and questioning the "taken for granted truths" (Freedman & Combs, 1996; Parry 1991; Parry & Doan, 1994; White 1989a, 1993). Successful clinical work seeks to pursue "unique outcomes" in the sense of searching for experience outside of the given, dominant narratives of a life. Narrative ideas are of significant importance for clinical work in general and work with loss, sadness, and grief, in particular. When families experience grief in response to a loss, the way family members story the experience is influenced by their individual histories and cultural discourses. Parry (1991) wrote, "A story is not a life, only a selection of events about a life as influenced by that person's beliefs about herself and others" (p.43). In this article, the theory, ideas, and practices of narrative are applied to experiences of grief. Included is explication of a narrative therapy process as well as of the beliefs held by the first author regarding this area of human concern. The creation of these beliefs was

significantly influenced by the author's experience as a family nurse in pediatric oncology.

## **GRIEF AS A THERAPEUTIC "PROBLEM"**

Grief has been described as the intense, sorrowful emotion experienced following a loss (Haig, 1990). Losses can be obvious or unrecognized, culturally sanctioned or unsanctioned (Pine, 1990; Rosen, 1990). Attig (1991) offered the distinction that where grief is an emotion, grieving is a process. The emotion of grief is expressed affectually, physically, socially, spiritually, cognitively, and behaviorally (Haig, 1990; Worden, 1991). Grieving, however, is an intensely personal, unique, and pervasive experience that touches, infiltrates, and changes much of a person's life (Pilkington, 1993).

Though grief is referred to as a "problem," it is important to state that grief is not a problem per se. Although the experience of grieving is personal and intense, it is a normal, healthy response to loss. Grief does, however, invite differing responses from different individuals. For example, within their grief, some individuals experience opportunity and growth, whereas others encounter more disabling experiences. It is generally these "other experiences" that find a way into clinical situations as people so disabled find themselves kept from living their preferred narratives.

Psychotherapeutic traditional language that assigns labels to grief, such as complicated, compromised, delayed, morbid, dysfunctional, unresolved, or atypical, invites a pathologizing of grief that may disregard the uniqueness of individuals and families. Brown and Burns (1987) suggested that grief is not a linear, orderly, and tidy process. A narrative approach in working with grief allows clinicians and nurses to respect the large variability in experiences of grief without compelling either the family or the nurse to subscribe to a belief that there is a normal experience of grief *and* a pathological one.

Grief is a powerful emotion. It is, however, an emotion and an experience that people often do not want to be separated from, nor can it be assumed that they should be. Narrative therapy does not suggest that people be separated from their emotions, nor that emotions always be specifically externalized (Freedman & Combs, 1996). Nonetheless, grief can sponsor participation in a life that feels oppressive, limiting, and painful. The presence of grief can entice people into experiences of self-blame, other-blame, "self-loss" (White, 1989b), despair, guilt, withdrawal from life, and especially the belief in an inability to move on with life, otherwise known as inertia. People may seek assistance after having succumbed to the influence of grief that has encouraged an experience of inertia by creating the belief that they are unable to continue with their lives. It is no longer the grief that is oppressive but the inertia it has introduced.

## **INERTIA AS CULTURALLY SPECIFIED**

Inertia initially depends on cultural discourses, or dominant cultural beliefs and practices, to pave the way for its presence. White (1993) referred to discourses as “taken for granted realities and practices... those familiar practices of self and of relationship that are subjugating of person’s lives” (p. 34).

The cultural discourses that feed inertia are the ones that suggest that grief is an act, an action, something to get over, to resolve, and to finish. The discourses ignore thinking of grief as an ongoing process. They contribute to a dangerous belief that if one continues to feel grief, “grief work” has not been successfully completed. The concept of grief work is informed by normative, prescriptive models that map the grieving process in stages (Cody, 1995; White, 1989b). The cultural and health care discourses that suggest that resolution consists of “getting over” feelings of grief lead people to believe that if they continue to feel grief, they have not moved ahead or they cannot move ahead until they no longer experience grief. Inertia, or “remaining in a fixed position without change” (Neufeldt & Guralnik, 1988, p. 690), then becomes of greater possibility. An individual may experience inertia in believing that the continuing presence of grief contradicts the dominant cultural discourse and prescribed practice of grief resolution.

Parry (1991) offered that “people’s stories are often constrained by finding themselves living out a story into which they have been recruited” (p. 45). This means that we are picked up and carried along by the customs, regularities, and authority of our culture. For example, recruitment into cultural stories about the social context of gender sets a stage for the presence of inertia. There are references in the literature to gender differences in experiences and expressions of grief (Attig, 1996; DeFrain, 1991; Hughes & Page-Lieberman, 1989; Moore, Gilliss, & Martinson, 1988; Rosen, 1990; Shapiro, 1994; Walsh & McGoldrick, 1991). The literature reflects the debate of attributing differences in gender experiences of grief to biology or to social learning, 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). Rather than arguing etiology, it may be more useful to understand the implications of gender differences in grief, how the differences are lived out individually and in relationships, and how the differences contribute strongly to the creation of powerful discourses.

Gender discourses create an expectation for women to care for others before themselves and often at the expense of themselves (Bepko & Krestan, 1990; Boss & Thome, 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).

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 invite men to return to work and routine prematurely and out of sync with women partners (Schatz, 1986; Schwab, 1992). The first author’s practice suggests that men experience oppression in their drive to move on with life without giving themselves the gift of their own pain.

Schwab’s (1992) research on the effects of a child’s death on the marital relationship suggested that gender differences invite men to view women’s expressions with concern and frustration and women to experience anger over men’s lack of emotional sharing. In some cases, couples experience inertia in their perceived inability to move beyond the gender discourses that conscript them into very different relationships with their feelings. As grief, inertia, and gender traditions conspire, marital couples diverge in their practices. Men can see women as submerged and subverted by grief, and as both partners experience differing relationships with their feelings, each then is taken from the other by emotions and the prescribed responses experienced.

Weingarten (1995) suggested that although we do not always hear the voices of cultural discourses and are not always conscious of their presence and influence, we are subjected to many of them on a daily basis. We are never “meta” to our cultural experiences (Goldner, 1992).

## **GUILT AS A HANDMAIDEN TO INERTIA**

When an individual’s experience of grieving invites inertia, the inertia itself can become the problem. It develops its own strategies to gain influence and further its own life. Inertia often evokes a sense of inadequacy, a belief in a lack of strength or fortitude to move on and to move beyond the feelings of grief. The sense of failure is self-perpetuating and pervasive; it is continually reinforced by the presence of grief. It infiltrates all of one’s life and is fueled by skewed media representations of how people survive in the face of terrible grief and loss and move on with their lives. Inertia receives further support from popular self-help literature that suggests that any individual, capable of hard work, can struggle through the stages of grief and emerge victoriously.

Inertia works cooperatively with self-doubt, despair, inferiority, and guilt. It is coached and supported by guilt related to the loss itself. This may then inspire further guilt, inherent in the perception of an inability to resolve the old guilt. Because of the universal nature of grief, cultural discourse around such is ubiquitous. Normalizing therapeutic prescription in our culture generally has to do with “getting over,” “working through,” or “resolving.” It then becomes an issue of

strength or personal capacity, measured by the extent to which sadness is controlled, if not banished, from a person's life. Failure in this specified task can lead to guilt and self-blame and sponsor further the feeling of constraint contained within inertia.

## **INERTIA AND ITS INFLUENCE**

The influence of inertia on one's life can become pervasive. Attitudes of self-doubt and failure can sponsor behaviors of social withdrawal and isolation. The behaviors can affect a person's participation in life. Individuals may stay away from school or work, remain emotionally or physically apart from friends and family, avoid social situations and recreation, and withdraw from generativity. A woman in the first author's practice suggested that for a long time after the death of her daughter, she felt guilty doing anything "fun" or even felt guilty when she just laughed. She would find herself momentarily forgetting her pain, and then would feel guilty as though, by betraying her commitment to her grief, she somehow was disloyal to her daughter. The influence inertia had over her was to convince her that grief commanded a certain kind of loyalty and that the inertia itself reflected her love for her daughter. Inertia invited her to ignore the changing, mutable, and vacillating nature of grief over time.

Relationships are seen as threats by inertia. A relationship invites involvement and an exchange of emotions. The expression, investment, and sharing of feelings that are implicit in relationships inevitably brings about change and *change defies inertia*. Inertia coaches people to avoid relationships and to withdraw from intimacy. The pain of grief may reinforce withdrawal from relationships by suggesting that "to love is to lose."

Inertia often attempts to include the clinician in its agenda. When people present with despondent views of themselves, as convinced by their experience that they cannot move past their grief, the problem can very easily recruit clinicians into believing that the nature of the pain is overwhelming. White (1989b) wrote of the invitation to answer this call of despondency by feeling overwhelmed himself. The antidote to this call finds roots in the belief that therapeutic relationships and conversations are an opportunity for *change*, an opportunity present in the co-creation of new meanings, understandings, and beliefs (Anderson & Goolishian, 1990; Wright, Watson, & Bell, 1996). *Change contradicts inertia*.

White (1989b) suggested that people experiencing profound grief often appear to have "lost their own 'selves' as well as the loved one" (p. 29). Because of particular cultural beliefs that encourage us to define ourselves (particularly women) by our relationships to others (wife, mother, daughter), our sense of who we are is challenged by the loss of significant others. This cultural lens may unduly support the idea that the self is only an activity that occurs between people. A mother who lost her son described this clearly and painfully to the principal writer by stating, "The greatest pleasure in my life was being a mother to

my son. When I lost him, I lost me. I am no one's mother. I am no one." Grief abuts such beliefs and experiences about the self and then inertia tempts people to believe that if they cannot move past the loss, they will never regain a sense of self.

## **RE-AUTHORING THE PROBLEM**

In relation to grief and inertia, mental health discourse perpetuates the names of "abnormal," "delayed," or "pathological mourning," which find roots in the medical model of bereavement, which depicts grief as a disease from which one recovers (Trunnell, Caserta, & White, 1992; White, 1989b). Parry (1991), however, has emphasized the need to make an "effort to escape the classifying tyranny of pathologizing" (p. 41). Often, diagnostic and pathologizing labels contribute directly or inadvertently to the perspective that the person is the problem and it is the person's failure and personal inadequacies that have resulted in a current inability to deal with the problem. When there is a belief that the person is the problem, it is difficult to invite a story of competency.

The concept of inertia, on the one hand, is "experience-near" or close to, and reflective of, the experience of an individual. Although the term inertia may or may not fit for individuals, the problem of inertia can be externalized. People do not have to relinquish their grief or escape it. In fact, it is both authors' belief that grief, once experienced, remains with people, though it assumes different influences and has different voices over time. This belief was exemplified by a mother whose son died 7 years ago, in the offering of her current definition of grief as a "quiet, warm reminder deep in my soul that I have loved." Her definition was profoundly different from her description 7 years ago of grief as "insufferable agony."

Accepting the ongoing presence of grief after a significant loss is one way to circumvent the cultural stories of resolution that sponsor an experience of inertia. Grief has a place in the life of one who has lost. It connects people to their loss and it links them in relationship with their lost other. One can have an evolving relationship with grief without succumbing to inertia. Grief, alone, is not debilitating, whereas inertia is.

Other possible names for the problem might be "failure," "selfdoubt," "career as a "passenger in life" (White, 1989a, p. 15), "incompetence," "standing still," or "guilt." Freedman and Combs (1996) discussed the need to define the problem with individuals and to find names that fit their experiences and privileges their language. The process of defining problems with clients rather than for them is encouraged by the clinician who assumes a "not knowing" position (Anderson & Goolishian, 1990, 1992; Freedman & Combs, 1996) or a stance of being a "respectful listener who does not understand too quickly" (Stewart, Valentine, & Amundson, 1991, p. 24).

Naming the “plot” can become an adjunct to externalizing the problem. If inertia is named as the problem, one might discover inertia’s plot to be “getting tricked into believing you are standing still.” White (1993) wrote of “exoticizing the domestic” (p. 35), which is to open up to examination of cultural authority or common practice. The “domestic” or norms of social practice objectify personal and cultural knowledge. Questioning or “exoticizing” norms allows people to choose to live by other stories. The challenge becomes the creation of a counterplot, which opens space for a new story, in juxtaposition to a less enabling, perhaps suffering-promoting dominant discourse.

Although people need to experience their grief and find room in their lives for a livable relationship with it, co-optation with inertia is not usually a preferred outcome for individuals. A therapeutic conversation is an opportunity to assist people in finding a way to develop a relationship with their grief that is cooperative and resourceful and that resists recruitment into inertia. Freedom from the actions and thoughts of the problem can be found in the deconstruction of the problem story, in identifying new outcomes, and in co-creating alternate and preferred stories.

## **STRATEGIES FOR DEVELOPMENT AND SURVIVAL OF A COUNTERPLOT**

A counterplot is a means to introduce alternative meaning. Within the story of inertia, a useful counterplot would involve movement: movement in the face of death or loss, life or generativity. The counterplot “crowds” the dominant plot that grief and inertia might become, and in doing so opens up space to relate to grief in more expansive and moving ways.

The survival of the counterplot depends on active participation by the person in creating strategies to protect and nurture it. One strategy is for the person to challenge and alter the constraining belief (Wright et al., 1996) that people cannot choose to live their own selected stories and to embrace a belief that stories do not need to live them (Parry 1991). This strategy finds roots in discovering and privileging one’s own voice and not accepting others’ descriptions of one’s life. It is encouraged by acknowledging news of differences and recognizing unique outcomes.

To escape the influence of inertia, one must acknowledge and accept a relationship with grief and loss and, in doing so, recognize the ongoing relationship with the lost other. White (1989b) wrote of the need for full recollection and reclaiming of the relationship with the lost person as a way to complement the dominant “saying goodbye” metaphor with a metaphor of “saying hello.” The new metaphor permits a “re-positioning of themselves in relation to the death of a loved one, a re-positioning that would bring relief” (p. 30). White recognized that there is much to say goodbye to and the process of grief is about

saying goodbye and then saying hello again to the relationship, although changed, and to life.

A mother whose 6-year-old daughter had died a month earlier disclosed to the first author that she had been unable to part with her daughter's ashes and urn, despite concerned and direct messages from family and friends that it was time for burial. She felt as though she was being forced to say goodbye before she was ready. Other strong messages from well-meaning people in her life suggested that it was not healthy for her to talk about her daughter and especially to "talk to" her daughter as she was doing. As a result, she kept the urn hidden and struggled with her pain, compounded by alienation, loneliness, and misunderstanding. She fought the inertia that beckoned to her and, privately, she said hello again to her daughter, voicing silently the things she believed she needed to say to her. After another month of this sequestered and hidden process, she felt she was ready to place the urn in the grave and say hello again to a new relationship with her daughter, with her grief, and with her life. She gave herself the privilege of this process in spite of disapproval and concern from others.

Returning to relationships, as an example of "saying hello," circumvents inertia. One cannot be in relationships without experiencing change: change in the relationships and change in oneself. The bereaved person *is* different as a result of the loss, and necessarily relationships will be different. It is within this difference that one experiences change, and one cannot experience change and remain inert.

Another strategy is the acknowledgment of personal agency or the "agentive self" in the emerging story (Freedman & Combs, 1996; White, 1993). A clinician can contribute by recognizing the heroics, competency, and strength of people in resisting inertia and making room for a relationship with grief, with change, and with life.

Other strategies to stand up to the problem include a "thickening of the plot" through a process of adding complexity, details, documentation of successes through therapeutic letter writing and audible note-taking, widening the audience, and increasing the circulation of the counterstory (Epston, 1994; Freedman & Combs, 1996; Parry & Doan, 1994; White, 1995; White & Epston, 1990). The documentation of successes in counterplot creation, particularly through letters, serves to textualize change through carefully composed language. Parry and Doan (1994) offered the idea that letters allow the clinician to enter the new story as a correspondent and to participate as an editor. Words put to text have an enduring quality that continues to perturb and invite changes over time as meaning and context differs over time.

## **UNIQUE OUTCOMES AS OBSTACLES TO INERTIA**



To examine behaviors, thoughts, and feelings that are a part of the alternate story one might plot preferred stories in landscapes of action and consciousness (Freedman & Combs, 1996; White, 1993). The landscape of action, or the plotting of events through time, can be explored by asking “how” questions that invite stories of personal agency or enact the agentive self (Freedman & Combs, 1996). Bereaved persons who have created counterplots of standing up to inertia, while claiming relationships with grief, might be asked questions around how they have managed to escape the grip of inertia, how they have observed themselves moving ahead in spite of inertia’s influence, or how they have managed to find relationships with grief that encourage a collaboration with life. With a focus on unique outcomes, people would be invited to explore the details of these events. Behaviors such as social emergence, resisting the call to withdraw, cooperating with grief when it asks for indulgence (crying, being alone, looking at pictures, etc.), returning to work, and re-entering into intimacy are examples of unique outcomes that can be plotted within the landscape of action. The young mother who allowed herself to grieve in the way she needed to before burying her daughter resisted the call of inertia by privileging her grief and moving with it at the pace she needed.

After detailing the behaviors that constitute unique outcomes, people are invited into the landscape of consciousness by examining the thoughts and feelings associated with the actions. They are invited into meaning-making. This is a re-authoring of “themselves” in the light of sadness and loss.

The mother who allowed herself her own time, actions, and agency defied the powerful call of social influence and expectations. When asked what her actions reflected about her, the mother stated that they told her that she was strong and that she knew best for herself. Six years have passed since her daughter died, and in a recent reflection, this mother offered the idea that, as strange and concerning as her actions appeared to others, to her they demonstrated her strength and proved her capacity to continue and to survive. Acknowledging her voice and her wisdom was the obstacle she created to obstruct inertia. She offered the idea that, at this time, she continues to privilege her pain and grief when they beckon her, and this very action is what she believes *is* what allows her to live her life in a way that is productive and progressive, and definitely not inert.

Thoughts and feelings that may be present in alternate stories and that can be pursued in therapeutic conversations might be ones of competency, control, personal agency, wisdom, a joining with feelings rather than a denial of them, a valuing of relationship and of life, and thoughts about the ongoing, yet changed, relationship with the lost person. People may experience a reclaiming of self or an emergence of a new self, defined by strengths and resources rather than failure and incompetence. One might experience defining self, not solely through

relationships with others, but by relationship with itself and its own experiences, one of which is grief.

## **IMPLICATIONS FOR FAMILY NURSING PRACTICE**

There is perhaps an almost paradoxical tension to the notion that the way to escape inertia in grief is not to escape grief but to embrace it. The first step for family nurses, in shifting their beliefs and thinking about grief, would be embedded in grappling with this seemingly paradoxical idea. Learning to develop a relationship with grief that allows for its fluctuating and changing nature would be the altered goal that nurses can work toward in a cooperative and collaborative way with families.

It would seem that a starting point for nurses would be developing an awareness of the discourses that invite restrictive thinking of a finite nature of grief. Nurses can develop awareness of cultural and health care discourses that coach them to measure the effectiveness of interventions by the degree to which they believe they have aided families in “resolving,” “dealing with,” or “escaping” their grief. The same discourses that invite normative and prescriptive expectations of grief also sponsor the temptation to pathologize differences. When nurses respond to these discourses and act within their confines, they become complicit in creating a culture that rejects the particularized nature of grief and that creates an audience for inertia to exert its influence on both the bereaved and the nurse.

To resist the call of inertia and to counteract its influence, a nurse might caution against resorting to the platitudes that are so often used when one is at a loss for words to comfort. Expressions of compassion that take the form of “it must have happened for a reason; you need to accept it,” “you’ll get over it,” “it takes time,” “you’ll forget with time,” “time heals all wounds,” “try not to think about it,” or “don’t try to talk about it” all contribute to the beginning messages that a visible grief is an unhealthy grief and that grief is time-limited. These messages deny the right of, and the need for, someone who has lost to fully experience and express his or her grief as a part of the initial process of acknowledging change and incorporating loss into his or her life.

A further significant contribution that a nurse can make to the counterstory of inertia is to persistently recognize unique outcomes in a bereaved person’s attempts to rebel against inertia. It is important to not only recognize obvious unique outcomes of a return to life, such as return to work, relationships, or recreation, but to observe and distinguish the subtle efforts that indicate that a person is allowing time and space for his or her grief. An example of this would be to celebrate and commend the time that a person allows himself or herself to think and mourn his or her lost other and to recognize that the relationship with the lost person exists and persists even though changed. Assisting people in labeling their commitment to this relationship, not as “being stuck in grief,” but as

taking an *active* role in moving ahead is the development and nurturing of a counterplot to the force of inertia.

Family nurse clinicians can adapt narrative practices in their clinical work with people and families experiencing grief. Viewing the experience of grief through a narrative lens allows the family *and* the clinician an opportunity to externalize the problem states or experiences that grief can invite without disrespecting the presence of grief.

## **SUMMARY**

Parry (1991) wrote, "a story remains only a story, ours to invent, ours to tell, and ours to live" (p. 53). Reality and knowledge are constituted through language (Freedman & Combs, 1996; Maturana & Varela, 1992) and nurtured through the telling of stories. The story of grief is profound, consuming, and inviting. It can invite wisdom and opportunity and it can invite inertia. When people decline the invitation to participate in a plot of "being tricked into standing still," they can begin a journey with their grief that speaks of change, growth, and life. Along this journey, new stories are created and lived. When the voices of the marginalized narratives are welcomed into one's life, a new plot begins, and with it a new audience is recruited and a new life may emerge.

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