Multiplying Death, Dying & Grief Narratives
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Abstract

This experiential workshop explored commonly held assumptions in counseling professions about death, dying and grieving. We examined influences and stories that dictate a "perfect death" and a "perfect bereavement". We looked at how these models evolved into dominance & what communities contributed to these conversations. How did diverse medical, cultural, religious and counseling voices contribute to conversations of death and grief? We also explored the impact of incorporating alternative voices of imperfection that narrate death and grief as non-ordered, unpredictable and expansive process. How did including these vantage points help us fully embrace death and life?

In my work as a clinical social worker and family therapist with Hospice, I want to understand death and dying in an attempt to ease people's suffering as they face life transitions. What is of particular interest for me is to work with expansive paradigms that shifts focus from pathologizing interpretations of grief towards postmodern narration that incorporates multiple stories, outcomes, and resiliencies while reestablishing a renewed relationship with the deceased. The workshop described above took place at the New Zealand Association of Counsellors conference in Hamilton, New Zealand, in June 1999 to discuss such ideas. As reflected in the workshop description, conversations explored the meanings and implications of seeing life transitions from a new perspective.

Models of Grief in Recent Psychology

Recent psychology that has focused on death and dying has evolved from a medical orientation. Disease and death have been labeled as enemies to overcome (Kearl 1995; Neimeyer, 1995). Positivist thinking shapes stories around

grief as a deviation from normalcy that requires corrective action (Silverman & Klass, 1996). These influences can be seen in Freud's work. Psychoanalytic theory describes grief as something to get over and move on from. In Mourning and Melancholia (1917), Freud elaborately points to the loss of the "love object" as the pain of mourning. As a way of restorating the individual's functional life, detachment from memories of the deceased and accepting reality of death is assumed to offer wholeness back to the mourning person(s) (Silverman & Klass, 1996; Rando 1995). According to Freud, mourning is completed when the "ego becomes free from and uninhibited by the lost object". (Rando 1996)

Other psychological models interpret grief in similar fashion. Viewed from these medically based perspectives, emotional symptomotolgies of death and grief are delineated. Object relations and attachment theory frameworks set forth a prescriptive order that make it necessary to die or grieve in the appropriate way. Only then, when the prescription is followed, does one become a healthy individual. Other authors, not necessarily associated with a particular theory, have made dramatic contributions to this evolution of understanding grief as a linear, positivist event. Erich Lindemann coined the term "grief work" in his 1944 article *Symptomology and Management of Acute Grief* (Rando 1996). Beverly Rapheal's *The Anatomy of Bereavement* outlines normal and pathologic grief (ibid). Although these names may not be common place, they were among the contributors to shape discourse in the field of grief and death. As evidence from these titles, the medicalization of death and grief has been prolific.

In all of these traditional models of grief, assumptions are made that we should be capable of standing alone, independently of others. Not unlike models of children's progressing through separation and individuation, grief has been treated as a developmental hierarchy. The stepping stones through grief are built upon the assumptions of Western rugged individualism. Collaborative

interdependence is shunned as weakness that is often used to describe periods of pathologically mourning as co-dependency or as "complicated" grief patterns (Rando, 1996). In this hierarchical system, individuals gain esteemed placement when they progress through the

stepping stones on their own accord and in a timely manner. Upon reaching this mythological riverbank, the grieving person is seen as whole, unfragmented and without unfinished business.

   However, the literature fails to offer examples of those who have successfully achieved this graduation and we are left to conclude that it may only be a mythical place. In the world of grief work, achieving individuation or self-actualization may only serve as a carrot on the path of losses. As each loss is to be felt, acknowledged and relived along the path to successful grieving, one hardly has time to move from the past before being re-triggered by yet another loss (Rosenblatt, 1996; Rando 1996). Sadly, in this world view, life becomes a series of losses that consumes our energy to heal and robs us of a more invigorating future. It is a liability of a positivist system that punctuates and reinforces deficits in our personalities, bodies and psyches (Kleinman, 1988; Gergen 1994).

   These interpretations of grief are further compounded by gender specific stepping stones. In spite of dominant discourse that constructs women as primarily concerned with maintaining and nourishing relationships (Gilligan, 1982; McGoldrick, Anderson & Walsh 1991), traditional theories of grief expect women to be capable of standing stoically on their own in times of loss, particularly if widowed. Women are also more likely to be seen as needing emotional support during periods of mourning and are diagnosed in disproportionate numbers with pathologic grief disorders and prescribed pyschotropic medications (Neimeyer & Van Brunt, 1995).

Traditional grief models can have gendered implications for men as well. In stereotypical Western male development, expressing sadness is discouraged. Getting quickly over a loved one's death has been valued as good and desirable while continuing a relationship with the deceased is negatively judged as weak or pinning, or even worse as pathologic grief. Men who are grieving the death of a loved one may find few outlets that acknowledge their experiences during periods of mourning. In a culture that tends to be less supportive of a man's need to emote, these ridged rules of how we should grieve can be especially challenging to men.

One Family's Journey

I was asked recently to consult with a family. They wanted me to speak with their mother who was grieving the loss of their father. They painted a picture of their mother crying daily, not being able to sleep or eat, and refusing their offers to sort through their father's clothing and possessions "to get the house back in order". When I did meet with her, I learned that all her daughters had told me was also her story about her recent life. Yes, in fact, she was crying frequently and not sleeping well. And, she really did not want to sort her husband's things. She told me how her husband had died from stomach cancer; a diagnosis he had only received two months before his death. His particular disease interrupted one of their usual ways of joining with each other. Prior to his illness he had been a man of good appetite and she loved to cook for him. She shared how hard this was that he lost interest in food and no longer ate.

She doubted whether she had done a good enough job in comforting him. She looked for other ways to nurse him. Staying with him around the clock, she recounted stories of rubbing his feet during the night when he was in pain. She slept in the chair next to him so she could stay alert to his needs for medication or attention. I began forming a new picture, different from that of her daughters.

What I was seeing was this woman was not only a grieving person but also a loving and devoted wife. She was mourning the loss of her life-long companion. As she told me of these events, I was astonished to hear that her husband, whom she had been married to for 53 years, had died three weeks prior to our appointment. This new information changed my ideas about how to be supportive for her and her daughters.

In attempts to help their mother, her daughters truly believed she should move on as quickly as possible from the memory of their dead father. These encouragements were accented by the fact that their parents' love had been a deep and consistent one that touched many. The daughters thought any memory of him would simply be too painful for their mother to bear. The beliefs about how grief should look -- that we should all return to "normal" as quickly as possible, put away our dead one's things and never speak of him/her again are prevalently accepted as ideology. These unquestioned beliefs guided the daughters effort in wanting to help to the extreme that they imagined something must be terribly wrong with their mother as she had been crying for three weeks.

The daughters well meaning interpretations had been shaped by discourses that infiltrate our daily lives. They had undoubtedly heard numerous conversations that would suggest moving on as the most efficient method in handling the loss of a husband. They probably saw titles on magazine covers at the grocery checkout, how to survive a loved one's death or well intentioned articles about widowhood and "getting on with it". In addition, they most likely saw many movies and television programs that would have supported and encouraged their actions. Long before "Love Story", grieving persons were encouraged to move on with life as an effective restoration after the death of a loved one. Traditional models of grief, woven into our fabric of being are

unquestionably influential. Without stopping to understand their etiology, we live as if these theories are fact. Like with this family we form layers of meanings and perform actions based on taken-for- granted assumptions of the correct way of doing death and grief.

Kübler-Ross

When Dr. Elisabeth Kübler- Ross's pioneering work appeared in 1969, it brought attention to the field of death and dying. Prior, emotional and spiritual components of death and dying this had largely been ignored by the medical professions (Klass, Silverman & Nickman, 1996; Hockey, 1990; Wass & Neimeyer, 1995). A new discourse, also based in a medical paradigm, sprung forth that today has become commonplace in conversations about any form of loss. Whether this loss is the death of a loved one, or the loss of an idea, or a perceived future loss (as in the case of anticipatory grief [Rando 1995]), her work has been used as a guidepost for traversing the field of grief. Kübler-Ross's five stages describe the ways in which a person would/should face death and come to terms with it. The five stages are denial, anger, bargaining, depression and finally acceptance (Kübler-Ross, 1969). Initially intended as descriptors of the dying person's process, assuming the dying person has time before their death, these stages have become scales against which to measure the correct way to die or grieve. What was intended in her work as a hopeful invitation to dialogue, has grown into a prescription. It gets used as a gauge of abnormality for all who unsuccessfully navigate the steps. The diagnosis of unsuccessful progression includes those who are seen as taking too long with a particular emotion or stage and not advancing to the next level. For example, in the story above, the wife might been accused of not doing grief in the "right way" if we apply the 5 stages of death and loss to her experiences.

Kübler-Ross's model has been unfortunately used to label people whose process is different. As with many forms of professional knowledge, it creates distance between professional and "patients". Professionals can start to act as gate keepers of knowledge about the right way to die or grieve, or about the timing in which a grieving person should move on. How often have I heard that a particular dying patient "is in denial" or a family "is needing to be in control" of their loved one's death. The implication of these expressions is that the professionals are claiming to know the correct time and protocol that a particular person should grieve by. If we believe grief and dying should proceed according to a formulaic equation then we undermine opportunities for the wisdom of the family to emerge (Anderson 1997; Gergen 1994).

A Comforting Hand

One woman I met was bravely facing the loss of her husband. They were Italian and spoke no English, so when I sat with them, I truly just sat in an attempt to offer reassurance. She would gesture me into his hospital room where I would sit beside her as she spoke Italian as he laid close to death. At times she would reach over and take my hand as she cried into her handkerchief. It was all I knew to offer her.

I had learned from their son that they had recently buried their 48 year old daughter after she died unexpectedly. The woman, as was her custom, still wore black and a veil in honor of her daughter's death. When her husband died, she was very upset and expressed herself loudly, wailing and crying. The hospital staff were uncomfortable with this and came to me to see if I could quiet her. They were concerned she might upset other patients and family members in the hospice unit. Had I done this, or even attempted to do this, I would have disrespected her knowledge of what was needed during this life change and potentially invited judgmental accounts of her and her process as not good

enough or not doing it the right way (Hockey, 1990). She needed to create her own formula of what would work in fitting with her multiples losses and her cultural voices (Noggle, 1995; Hockey 1990).

Because of the language differences between us it was perhaps easier to assume a position of not knowing what was best for her (Anderson, 1997). I intentionally wanted her to show me what was helpful for her at this time. I did not take her to a quieter place, away from others, where she could regain composure. I did not ask her son to act as interpreter to instruct her of the correct way to behave. Because I couldn't communicate with her in my usual ways, I was provided an opportunity to slow myself and follow her lead. I would have however, made similar choices had we spoke the same language.

What Constructs Death

At the NZAC workshop, we looked at the voices that construct death and dying narratives, including what histories and cultural aspects play into this formation.

- How do cultural heritage and religious beliefs add to this conversation?
- How do our beliefs in our professional communities help or hinder the inclusion of this knowledge?
- What rituals/stories/beliefs & practices do you most appreciate from your family/ culture/spiritual background that has helped you when facing death and dying?

Embedded in these questions is the assumption that local knowledge holds more importance and value than a prescribed correct way to navigate effective change. If we define local knowledge and community as the shared voices that shape our meanings and guide our actions, then these become our individual maps to challenges. Thus, stories gleaned from life experiences and personal knowing that we carry within override the five stages of death and dying. We

can look to our external communities - our families, friends, co-workers, neighbors - to reflect our choices of what is right for us. We all carry with us beliefs, stories and practices that have been helpful to make sense out of death and grief. In my work, I hope to create opportunity for people to access these ways of knowing. I want to connect people again to their communities to serve as healing audience in times of duress (Myerhoff, 1980; White, 1997).

A Dancing Death

The example of one woman's story holds special meaning for me when I think of facing life with phenomenal courage. Similar to the woman of Italian descent above, she had faced tremendous life changes in the previous year. In her struggles, I quickly gained a tremendous appreciation for her. She and her husband had lost both of their only children, only six months apart. In an attempt to get their lives back on track, they took a vacation. While out of state, her husband suffered a massive stroke and was left comatose. She flew him home and he was transferred to hospice for terminal care when no other medical options were feasible. When I met her, she was expectedly beside herself with grief. This was not how she had planned her life and was a drift in the midst of what was facing her now. As she and I talked, I invited her to reflect about her husband. "How would his friends have described him?", I asked. "What did they admire about him?" I inquired about this man through the eyes of his deceased children and asked her to share with me stories about how they were touched by his life. I wanted to know about how he saw her, "if your husband could speak with us now, what would he say he was proud of you for? What would he be telling us about his admiration of his wife's strength and ability to cope?"

My inquiries were quite intentional. In asking questions in this fashion, I wanted to deliberately invite hope that she could continue to access her husband's voice and version of her. I wanted to bring to life a sense of her

communities, stories and strengths. I wanted to "externalize" his presence (White 1989, 1995, 1997) in an attempt to keep his image alive. Since he had been a large part of her healing during the year, externalizing his presence could help anchor his voice as she faced his physical death.

My purpose in doing this was to make available to her a remembrance that stories and connections do not stop even after a person dies, as with her children (White, 1989). I wanted to plant seeds that might allow her to invest in a relationship with her husband, after his death, to continue to see her strength through his belief in her.

When I asked the type of questions I did, what I learned were many wonderful life-affirming stories about her husband that may have been missed had I only focused on the story of her loss. Had I believed that to be her exclusive account of life I would have missed out on knowing stories of tremendous joy that he carried around in his life. I heard about how he had been active in the Polish Club, a social gathering place where he was known for prolific story telling and polka dancing. The specific format of my questions allowed her to experience her husband as if through the eyes of numerous friends and family members as well as experience his stories about her. These were places of knowledge about their family and community that would make this death bearable to live through; feeling his presence all around her even as he was physically leaving.

A friend of the family's from the Polish Club had stopped by with audio tapes of polka music late that afternoon. As we had talked about the importance of continuing to talk to him and that he could still hear in spite of being in a coma, they thought that listening to his favorite music would be a comfort. The walkman with head phones was placed on this wonderful man as he lay in the hospital bed making way for his transition to death. An hour later this is how

the priest, who came at the families request, found him. While prayers were said the polka music could be heard.

This endearing moment actually became an important thread for the wife. She told me how she imagined her husband was laughing at the irreverence of the priest finding this large comatose man with polka music blasting out from under his walkman. He too would have loved the irony, she told me. I asked her if she thought he was dancing his way to God. "Yes" through tears she said. " He's dancing his way to the other side". I imagined that she would be able to rely on this meaning as an important one in the days, months and years ahead.

Reinventing "Death"

What if death and dying was not seen as a finality or an event that the grieving person needs to get over? When we are faced with the death of a person that we love, it is a horribly difficult thought for most people that they will never again have this person in their lives. If we understand people as living through stories this perspective changes. When we assist people to understand the strength of story as undying, people's anxiety can be alleviated. This is also true for the person facing death. It is a discomforting thought to think that after I die I would be forgotten as my loved ones resume life. I, like most people, want to know that even in death, my life matters.

I think about how my mother, who has been dead for over twenty years, has a strong relationship with my almost seven year old daughter. Addison doesn't hold to any theory that she should not have a continued relationship with her grandmother. Addison sings her grandmother's songs and tell stories about her grandmother's life. When making pancakes the other day, she asked if it was my mother who taught me to cook. When I told her it was, she proceeded to convincingly state that Grandma must have told me, "someday you will have to teach Addison how to make pancakes".

In Addison's community of voices, her grandmother plays a large role. She doesn't know that there is any separation between death and life as she learns how to make her grandmother's pancakes. By not seeing death as a finality, my mother is continuously re-membered as part of our family (Myerhoff 1980; White, 1997). There is no loss, no stories of grief to be worked through, only an extension in the meaning of family in this framework. It is my hope that because of this, my daughter will have additional places to draw from in challenging times of her own.

When clinicians seek opportunities for families to reinvent and reestablish relationship with their dying loved one, we offer ways of honoring their stories. In a providing new form of maintaining relationship with the deceased, and nurturing this, we are realistically honoring that person's presence in the family. We are profoundly acknowledging that this person has touched and shared and shaped the rhythm of the family. Tending to their stories once they are dead continues to respect this. This is not to suggest a cavalier attitude implying that death of a loved one can be free from discomfort or denying at times that it is excruciatingly painful. It is however intended to question the way in which professionals can offer help, especially when that help at times, can serve to exaggerate the pain and sense of loss.

I have heard criticism levied against a narrative approach that the emotional content is overlooked or that cognitive functioning is overvalued. I believe that neither of these points are consistent with my experiences of this approach. What I have found is that there is a blending and balance of emotional with thoughts and meanings. In traditional theories of dying and grief, emotions have tended to be privileged; that is, the experience of the feeling state takes precedence over other forms of communicating or living. I am inclined to doubt if the encouragements of people to indulge the emotional experience of loss can

actually assists people to move into a fuller existence in more effective ways. Moreover, models that elaborate loss can be neglectful of stories of strength and resiliencies.

I am often asked questions about my work, both by other clinicians as well as by people who are not associated with clinical work. People are curious to know if I find my work depressing. How is it that I can do what I do, they ask? I love these questions as opportunities to talk about the incredible life-affirming reality of death. When I work, I hear the most glorious love stories and witness people in the throws of discovering they are filled with phenomenal courage. I am privy to the most private moments and conversations that occur when death is present. Incredible moments when death swoops in and opens our heart to our amazing ability to be compassionate and love. It is a place of honor that I sit along side people as they discover this about themselves and that they have trusted me with their loved one's stories.

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