Bereavement Care and Counseling

> Blessed are those who mourn, for they shall be comforted.
>
> —MATTHEW 5: 4

> He comforts us in all our troubles, so that we in turn may be able to comfort others in any trouble of theirs.
>
> —II CORINTHIANS 1: 4 (NEB)

> In the midst of winter, I finally learned that there was in me an invincible summer.
>
> —ALBERT CAMUS[1]

Bereavement is the universal human crisis, striking everyone sooner or later. Clergy are the key professionals in helping people with this crisis. Wayne Oates observes:

> Through the centuries the pastor has been the primary person responsible for dealing with the bereaved... Whether or not the pastor has accepted these responsibilities, carried them out with skill and wisdom, or even appreciated the weight of the expectations placed upon him or her, nevertheless the pastor is the one to whom people still look for the care of the bereaved.[2]

Ministers are the only professional persons with training in counseling who have automatic entree to the world of most sorrowing people. This gives clergy an unparalleled opportunity and responsibility to be effective guides and companions of the bereaved as they walk through their shadowed valley of loss. Obviously it behooves pastors to develop a high degree of competence in bereavement care and counseling.

There is no dimension of the pastoral care ministry in which the stakes are higher in terms of human wholeness. Psychiatrist Erich Lindemann, a pioneer in grief research, reports:

> Studies show that many people become sick following the death of a loved person. A great many more hospital patients have had a recent bereavement than people in the general population. And in psychiatric hospitals, about six times as many are recently bereaved than in the general population.... Furthermore, in a great many conditions, both physical and psychological, the mechanics of grieving play a significant role.[3]

Grief is involved in all significant changes, losses, and life transitions, not just in the death of a loved person. Every life event on the Holmes-Rahe stress scale involves some loss and therefore grieving. There is evidence that many psychophysiological (psychosomatic) illnesses are related to unhealed grief. The same is true of much alcoholism and other addictive illnesses (including food addiction). Several years ago, the staff of the pastoral counseling and growth center of which I am a clinical director, decided to ask all persons who came for help if they had experienced major changes or losses within the preceding two years. More than a third of our clients could identify a painful loss or cluster or losses. In many cases, a major loss was correlated with the onset or dramatic worsening of the painful symptoms that brought them for help. Included were persons with a wide range of presenting problems—depression, marriage and family crises, sexual problems, job difficulties, substance abuse, psychophysiological illnesses, and religious problems. Also included were persons with general spiritual malaise—boredom, zestlessness, feelings of deadness, lack of creative energy and purpose in life.

Blocked, unfinished grief takes a heavy toll, sapping one's creative juices. The longer the healing is delayed, the more costly the protracted grief is to the person's wholeness. The death of my younger sister, Ruth, on her first birthday when I was four and a half, cast a dark shadow over our family. We all paid a high price for not knowing how to experience healing of our grief. More than thirty years of reduced aliveness, chronic drivenness, and periodic depression in my life followed Ruth's death before my infected but hidden grief wound was eventually lanced in my therapy so that healing could occur. If our pastor had known how to help our family express and work through our devastating feelings of loss and guilt, we all could have been spared years of unnecessary suffering and diminished wholeness.

There is a virtual epidemic of unhealed and largely unrecognized grief wounds in most congregations and communities, particularly those with a sizable group of older persons. Life is a continuing series of separations and losses, small and large. Handling bereavement is an indispensable part of human growth. Many losses are potential opportunities for personal and spiritual growth. The frequency of losses accelerate with the passing years. For this reason, learning to handle losses without being crippled by them is an essential skill of creative aging. The decline of community support and of corporate rites of passage and mourning in our society has made it more difficult to recover from grief. The uprootedness of the lonely crowd in megapolis has deprived millions of people of a community of caring. Personal crises and tragedies are exacerbated by the loneliness and social crises in our world.

In the last decade, I have asked many adult groups, both lay and professional, "How many of you have had painful changes or losses within the last few years?" In most groups, depending on their ages, from 35 to 50 percent raise their hands. Since most of us are adept at hiding our wounds (even from ourselves), my hunch is that the percentage of those with grief wounds may actually have been higher. A new strategy is needed to help those with unhealed grief experience healing. Congregations and their pastors must have a central role in devising and implementing such a strategy.

The loss of someone who has been a significant part of one's world of meanings and satisfactions is a psychological amputation. How traumatic it is depends on the nature and importance of the relationship in one's life. The responses people employ in coping with major bereavements are the same ones they have learned in coping with previous deprivations, frustrations, or losses—small or large. These are the coping skills they learned from their culture, as filtered through the responses to loss by their parents. If the individual has learned constructive, reality-oriented coping skills, his/her psyche will follow a somewhat predictable process of working through the mixture of powerful feelings resulting from the bereavement and making the adjustments required to live without what has been lost. Lindemann calls this process by which the grief wound heals, "grief work. " The work is by the grieving person's own psyche.[4]

Healing the Grief Wound

The following chart lists the five tasks of this process and the type of help that facilitates the completion of each task.[5]

Grief Work Task	Help Needed
1. Experiencing shock, numbness, denial and gradually accepting the reality of the loss.	A ministry of caring and presence, practical help, and spiritual comfort.
.2. Experiencing, expressing and working through painful feelings—e. g., guilt, remorse, apathy, anger, resentment, yearning, despair, anxiety, emptiness, depression, loneliness, panic, disorientation, loss of clear identity, physical symptoms, etc.	A ministry of caring, and responsive listening to encourage full cartharsis.
3. Gradual acceptance of the loss and putting one's life back together minus what was lost, making decisions and coping with the new reality; unlearning old ways of satisfying one's needs and learning new ways to satisfy these needs. Saying "goodbye" and reinvesting one's life energy in other relationships.	A ministry of crisis care and counseling, facilitating reality testing, and support in the difficult tasks of rebuilding one's life (the ABCD approach).
4. Putting one's loss in a wider context of meaning and faith; learning from the loss.	A ministry of facilitating spiritual growth.
5. Reaching out to others experiencing similar losses for mutual help.	A ministry of enabling outreach to others.

Except for the first two, these grief work tasks do not necessarily occur in lineal sequence. For example, coping with the new reality brought by the loss (task 3) begins almost immediately after the loss and continues throughout the other tasks. (These tasks will be discussed now in terms of the death of a loved

person; the tasks in other severe losses are similar.)

When death or any severe loss strikes, the usual response is feelings of psychological numbness and shock (nature's anesthesia) mixed with feelings of unreality—of being in a nightmare from which one expects to awaken. The mind cannot yet accept the overwhelming pain—the reality that the person is really gone. Accepting the full reality of the loss must eventually occur or the healing will be incomplete. This acceptance must occur gradually, usually over a period of months.

The minister's role in facilitating normal grief is to cooperate with the psyche's inner process of recovery. During this shock phase, effective caring includes using supportive care methods, including gratifying dependency needs. Severe losses activate the inner Child (in TA terms), often bringing painful feelings of anxiety, deprivation, and abandonment. The need to be comforted is intense. I remember nothing the minister said at my mother's funeral, but I recall with appreciation that he put his hand on my shoulder as he left the funeral parlor after the service. Acts of ministry, including familiar scripture, prayers, hymns, and rituals often bring quiet comfort to the bereaved. Both physical touch and gifts of food are symbolic nonverbal ways of communicating caring and nurture. A congregation's lay caring or grief recovery team should surround the grieving individual and family with the supportive caring they need. The meal after the funeral affirms the ongoingness of life in spite of the loss. Eating together becomes a kind of communion meal—a way of saying, "we can and must go on, together. "

In seeking to understand why some people's grief wounds healed relatively soon, some very slowly, and some not at all, after the 1942 Coconut Grove nightclub fire in the Boston area, Lindemann made a striking discovery *—experiencing and expressing the agonizing feelings fully is an indispensable part of the healing process!* Blocked feelings = delayed healing. Thus, the second grief work task is facilitated by responsive listening, which enables the full catharsis of whatever feelings the loss has triggered in the person. These can include any feeling from total despair to relief and joy. Often the feelings are ambivalent and conflicted. The catharsis task begins intermittently as the numbness and denial gradually diminish, and the stark reality of the loss is allowed to enter awareness. In major losses, the working through of feelings occurs on many different levels and usually takes at least a year. Several years are often required in severe loss such as the death of a spouse or child. My father has been dead for nearly seven years. Most of my feelings about his death have been worked through and released. Yet, recently I experienced a wave of sadness and nostalgia when I saw a corner full of fishing tackle in the room of an elderly man I was visiting. (My dad loved to fish.)

To help people do the healing catharsis of their grief work, one must go against the cultural tendency to avoid painful feelings. During the visit immediately after the death, as the funeral is being planned, the minister should encourage the bereaved family to talk together about their loved one—the circumstances of the death, and the memories and attributes they most cherish about that person. (These cherished memories can well be incorporated in the memorial message during the funeral.)

One purpose of the funeral is to facilitate the emotional releases of grief feelings. What is said during the service should be straight and clear about the painful reality of the loss, so far as this life is concerned, and the appropriateness of mourning. Nothing should be said implying that stoicism in the face of grief is a sign of real strength or Christian virtue, or that one whose faith is genuine will not experience agonizing grief. The funeral should include familiar hymns, prayers, and scripture that bring enspirited comfort and also help release dammed-up feelings. A grief-enabling meditation on a text such as "Jesus wept" (John 11: 35) or "Blessed are those who mourn" (Matt. 5: 4) can help to give permission to grieve to those who need this. (The Greek word for "mourn" in the latter text refers to the most open and demonstrative type of grieving and lamentation.) The funeral is also a service of thanksgiving for the deceased person, a service of mutual support of the bereaved by the Christian community, and an affirmation of the beliefs of this community that helps the bereaved put the loss in the larger context of a life-affirming faith. The pastor can help the family and friends mourn by expressing her or his own feeling of grief and loss, and by creating appropriate rituals of participation such as inviting everyone to put a flower on the casket as they leave the grave site.

It is crucial that caring support of the family continue during the weeks and months following the funeral. Many people are unaware that the bereaved continue to need special support during the extended process of working through the loss. Catharsis of feelings can be encouraged by asking questions such as these during post-funeral visits with the family: "What have you been feeling since the funeral?" "What sort of memories keep coming back?" "How often have you let yourself cry?" "Have you had trouble keeping going?" "Would you tell me more about the

way he/she died?"[6] The two feelings that most often infect the grief wound are unresolved *guilt* (remorse, shame) and *anger* (resentment, rage). It is important therefore to ask questions such as, "If you had your relationship to live over, what would you do differently?, " "Do you feel much anger or resentment?, " and "Have you been able to express these feelings?" These questions should only be asked when the pastor is willing to help the person express, talk through, and begin to release and resolve the intense feelings they may elicit.

The way people respond to losses varies greatly depending on their own resources, the quality and length of the relationship, the timeliness of the loss, whether the death was expected, and the nature of the death. The more dependent and ambivalent the relationship, the longer and more complicated the recovery process. Grieving following the untimely deaths of children or young people is usually exceedingly difficult. Sudden, unexpected or violent deaths usually are followed by more extended and difficult grief than slow, expected deaths. There are several reasons for this—there has been no anticipatory grief work before the death; there is greater shock and often greater anger; there are more unfinished aspects of the relationship, producing greater guilt; the vacant social roles of the deceased have not been gradually filled. Deaths where the body is lost or terribly mutilated (so that the casket is left closed) often result in protracted recovery because the bereaved persons are not able to accept the reality of the loss and deal with the dead person's body image. Since our own identity and that of others is integrally related to body images, having an opportunity to deal with feelings about the body is often essential for the grief wound to heal fully. The traditional wake or visitation time before the funeral, when the body is visible, can be a grief-enabling experience for many mourners.

The difficult grief task of rebuilding one's life without the lost person involves unlearning countless habitual responses, learning new behavior to meet needs formerly met by the deceased, and making countless decisions about how to cope with the new problems the loss brings. Church members in general and the lay caring team in particular should be guided in functioning as a substitute extended family for those who lack a support system, offering whatever practical help and emotional support is needed. Such support can take many forms—e. g., a widow who has never handled her finances or a widower who has never cooked for himself need help in learning these skills. Both emotional support and reality-testing are needed as bereaved persons make decisions and begin to venture out into new relationships and experiences— e. g., going to social gatherings without the lost person, dating, beginning a new job. Two signs that persons are moving toward the completion of the recovery process are "saying good-bye" (emotionally) to the lost person and reinvesting some of that energy in other relationships. The grief wound cannot heal fully until one has *accepted the reality* of the loss, *surrendered* one's emotional tie to the lost person, and begun to form other relationships to provide new sources of interpersonal satisfaction.

Religious resources have much more than a supportivecomforting function in bereavement. The death of another confronts us with our own mortality. Existential anxiety (about nonbeing) can be handled constructively only within the context of a vital faith. The symbols and affirmations of one's religious tradition can touch deep levels of the psyche, gradually renewing the feelings of basic trust that alone can enable persons to handle existential anxiety creatively. Therefore, the minister's teaching and priestly roles are important in helping the bereaved put their loss in the context of faith. A pastor's skills in facilitating spiritual growth may help grieving people enlarge their faith and revitalize their relationship with God.

In crisis and bereavement counseling, the original root of the word "religion"—*religio,* to bind together—has dynamic significance. When shattering loss fragments one's life, vital religion may help bind it together, restoring some sense of coherence and meaning. The crisis of death confronts some people with the poverty or obsolescence of their beliefs and values. This awareness can open them to the growth process of revising and renewing their spiritual lives. A renewed faith usually develops only after one has finished much of one's painful grief work and is able to reflect on and learn from the painful loss.

In working with the bereaved (as with the permanently handicapped), it is crucial to help the person learn to distinguish what can and what cannot be changed in the situation. AA's familiar "Serenity Prayer" (authored by Reinhold Niebuhr) may be useful in such counseling:

> Grant me the serenity to accept the things I cannot change,
> The courage to change the things I can,
> And the wisdom to know the difference.

In discussing crisis therapy Gerald Caplan states:

> Not all problems are capable of solution by removal of the threat to need satisfaction; but in these cases, too, a "healthy" type of activity, consisting of *an act of resignation* of this avenue of need satisfaction and *its replacement by alternatives,* can be differentiated from "unhealthy" problem avoidance in which no decision is made and no conflict resolved. Thus, in the crisis of bereavement . . . the sufferer must actively resign himself to the impossibility of ever again satisfying his needs through interaction with the deceased. He must psychologically "bury the dead"; only after this has been done will he be free to seek gratification of these needs from alternative persons. Those who cope maladaptively with bereavement may pretend that the loved one is not dead, or they may magically introject his image by taking his chracteristics into their own personality, and they will thus evade the painful act of resignation. This is likely to result in their energies remaining bound up with the deceased, so that they are not free to love others.[7]

The Grief Wound that Does Not Heal

In normal recovering from grief, persons gradually deal with those ambivalent feelings that are present in all close relationships. If, instead, persons continue to overidealize the deceased, they are utilizing the defenses of denial and repression. These defenses enable them to avoid the agony of the loss, but they also prevent the grief wound from healing. The wound is infected and cannot heal until the person deals with the repressed feelings.

Here are some danger signs that may indicate pathological grief if they persist over several months or longer: increased withdrawal from relationships and normal activities; the absence of mourning; undiminished mourning; severe depression that does not lift; severe psychosomatic problems; disorientation; personality changes; severe, undiminishing guilt, anger, phobias, or loss of interest in life; continuing escape by means of drugs or alcohol; feelings of inner deadness. Skillful bereavement counseling in the early phases of such maladaptive responses, may help heal some pathological grief. When ministers encounter what appears to be blocked grief work, they should encourage the person to talk about and express feelings about their relationship with the deceased, and to continue to do so until these feelings are faced and talked through. By responding acceptingly to tentative expressions of mixed or negative feelings, further catharsis is facilitated. Along with resentment and/or anger (toward the lost person, God, relatives, physicians, etc.) there is usually a load of guilt about these feelings that must also be worked through. The grief wound must heal from the inside. Healing cannot be forced, but the counseling relationship can help facilitate the process. If pathological grief symptoms persist after several months in spite of the minister's efforts, referral to a competent psychotherapist is imperative. The longer grief work is delayed, the more painful and costly to a person's mental and spiritual health the grief will be, and the more psychotherapeutic skills will be required for healing.

It is important to emphasize that grief *per se* is not an illness. It is a normal human healing process for which most people have adequate resources—resources that they can be helped to mobilize by pastoral caring. Only when a grief wound is infected does it become a pathological process requiring counseling or psychotherapy. In our death-denying culture, many grief wounds become infected. Most of these infections are relatively minor and will respond to the helping skills of a counseling pastor.

Setting Up and Leading a Grief Healing Group

The new strategy needed to enable a congregation to minister more effectively to the bereaved, has three parts. The first is to inform members of the congregation, through sermons and adult education programs, about the nature and importance of grief work, and how they can enable this healing in themselves, their families, and friends. The second part of a strategy is to train a carefully selected lay-caring team to carry much of the load of supportive caring of persons with normal grief in the congregation (see chapter 16). There are too many persons going through a variety of crises, losses and transitions in a typical congregation, and the process of full recovery is too extended (at least a year and often much more) for a pastor working alone to respond fully to these multiple pastoral care needs.

The pastor of a downtown church in Minneapolis discovered that ministering to the bereaved was requiring more of his time than anything else. As he became aware of the many widows and widowers in his congregation,

he realized that he had a rich pastoral care resource at his fingertips:

> He invited these widowed people to meet with him to plan a lay ministry to the bereaved... Each year there is a training period of six weeks for new recruits to this ministry. When someone dies, the pastor selects a grief minister from this group and introduces him or her to the bereaved. This grief minister commits him or herself to minister to the bereaved person or family for a year, making regular contacts that complement the pastor's ministry.[8]

This lay ministry has continued for fifteen years, helping that congregation become a healing community for many bereaved persons.

The third part of a strategy for helping the bereaved is for the pastor to set up and lead (or co-lead) a grief healing group periodically. Such a group is both an efficient way of deepening the grief ministry of a congregation and a means of beginning the training of a lay crisis and grief team. Participating in such a group can help one both finish one's own grief work and learn to help other grieving persons. I cannot think of any one thing that a pastor or congregation could do that would have greater healing impact than providing regular opportunities for grieving people to participate in such a grief group.

The capacity of human beings to turn miserable minuses into at least partial pluses—to use crises and losses as challenges to grow—is one of the great things about being human. But to use bereavement in this way requires two things—being in relationships of mutual caring and finding spiritual meaning in the loss. Grief healing groups are settings within which these two transformational experiences often occur.

Grief groups are relatively easy to set up and lead.[9] In a congregation, a group can be drawn together simply by the minister's inviting all those who have experienced losses within the last two or three years to attend. Personal invitations by phone and a general invitation in the church bulletin or newsletter to reach others is all that is usually necessary to assemble a group. Persons with a variety of types of losses can be included in the same group, although it is helpful to have at least two persons with similar losses (e. g., divorce, death, retirement) in a group to give each other the special empathy that comes from persons who know each other's loss from the inside.

Several grief group formats have been used effectively in churches. The most common model is a series of weekly one and a half or two hour meetings, for four to eight weeks. Such groups often recontract at the end of the agreed-upon time to extend the length of the group to deal with unfinished issues.

A second format is to meet for a longer time on a single day or a weekend retreat. Bob Kemper, pastor of a church near Chicago, reports that a three hour grief sharing session in his church was remarkably effective. Twenty-six people attended the session.

> The name of the group was 'Alone/Together' and so I spoke of the loneliness we feel in coping with a loss and the power of fellowship in helping us cope with losses. Then I spoke of the anxieties we all have in facing a new experience, suggested that most of us did not want to be h e r e . . . I suggested that they had already done the hardest part of the day, namely, just coming to the gathering... Finally, I announced the ground rules, explaining that each was free to respond as they were moved to do so. Here it would not be necessary to play the part of the brave widow, or the one who always had their feelings in check. Here it would be all right to cry or even to laugh if that is what their feelings required.[10]

After this introduction, the pastor led a brief worship service in the church's chapel, including the singing of hymns, appropriate scripture and a short meditation on the promises of God. Then the group returned to the church parlor for Bible study of I Corinthians 15. Following this, each person was invited to write a letter to a friend beginning, "Last week at church we studied St. Paul's writings and the new insight that came to me was_____ ." A few of the letters were shared with the group. Next Kemper presented the stages of grief as outlined in Granger Westberg's book *Good Grief.* He paused between each stage for a reality check, asking if something like that had been a part of their experience. This offered opportunity for dialogue, shared tears, and mutual support to develop within the group.

Lunch together was a time of rich informal sharing around the tables. When the dishes were cleared, Kemper

invited the group to describe resources—books, people, activities—they had found helpful or disappointing. At the close, the group decided to meet again and agreed upon a time. The session was closed by joining hands around the table for shared prayers for each other and thanksgiving for their experiences together. In describing the group, the pastor declares: "Of all the many activities I have participated in this year, none has given me more personal satisfaction or made me feel as useful or more like a minister than the establishment of a grief growth group in our congregation. "[11] This model demonstrates that healing *can* occur even in a relatively large group that meets for a relatively brief time.

Pastoral Care of the Dying and Their Families

Ministering to the terminally ill and their families is a vitally important pastoral care opportunity. I remember vividly the pain and the richness of being with individuals and families as their pastor, during the last weeks, days, and hours of a terminal illness. Their heartfelt appreciation was a clear indication of how much they needed supportive pastoral care. Frequent brief calls in the hospital or (if the dying person is fortunate) in the home or hospice facility, are needed. If possible, it is important to stay with a family who desires the minister's presence during the final hours of the person's dying.

Since writing the first edition of this book, I have learned much about the experience of dying. My teachers have been five dying persons—my parents and Charlotte's parents, and a dear friend, Lois, who died in her mid-years after a long struggle with cancer. Shortly before her death, I asked Lois if she would be willing to talk in detail about her experience, so that I could learn from her and share her insights about dying with others (as I am doing here). She was glad to do so.[12] In our conversation, she spoke of the intense need she felt to have people *really* listen to her swirling and changing feelings as her malignancy gradually spread. She described how let down she felt when some of her friends and one of her doctors changed the subject or tried to give her superficial reassurances, because of their own discomfort with her feelings. She said that among her many feelings, the five identified in terminally ill persons by Elisabeth Kiibler-Ross (denial, anger, bargaining, depression, acceptance) would come and go, not following a particular sequence.[13] Lois told of experiencing fresh anger at each new stage of her progressive illness and of the help of a friend who hugged her (after she had been told that the cancer had spread to her vital organs) and exclaimed, "Damn! Damn! Damn!, " thus sharing her anger. She described her multiple grief at "losing everything, " and how this made experiences such as touching her children, talking with friends, and looking at the beautiful mountains both urgent and very special. The preciousness of being alive made little things very important, she said. Lois talked of her fear of the possible pain and loss of control she might experience during her dying and her feelings of jealousy when she saw an old couple walking together (and her embarrassment about these feelings). She spoke of the importance of not postponing dealing with issues between herself and others. I shared my perception that she had in recent months become even more vital and alive than she had been before. She responded that when you know your future here will probably be short, it makes the present more important. As we concluded our conversation, she said it had been very meaningful to her to talk about her experiences so fully. I told her how deeply I had been touched by all that she had shared. Louis helped me see more clearly that the process of dying *can be,* for some, an important stage of their continuing growth as persons!

Each person's dying is as unique as his or her living. But five things seem to help some people use their dying to gain wider perspectives, mobilize new strengths, and thus die well: (1) *Having a small caring community* of persons who will listen and give warm support. Dying is both a very private and an intensely interpersonal experience. In our lonely society, the richness of one's interpersonal network makes a tremendous difference in the quality of one's dying. (2) *Completing as many of the unfinishedissues* as possible in their lives, especially in their close relationships (e. g., expressing love or asking and receiving another's forgiveness). Ted Rosenthal points out, "I don't think people are afraid of death. What they are afraid of is the incompleteness of their life. "[14] (3) *Doing the complex grief work of dying* so that they can reach the experience of acceptance (Kiibler-Ross). (4) *Having a faith system, a sense of trust and at-homeness in the universe* that gives some meaning that transcends the multiple losses of dying. (5) *Having a setting where one can die with dignity.* The hospice movement is the most humanizing development in recent years so far as dying is concerned. A Christian physician, Cicely Sanders, who started the first modern hospice St. Christopher's Hospice, in a suburb of London in 1967, states: "A modern hospice, whether it is a separate unit or a ward, or home care or hospital team, aims to enable a patient

to live to the limit of his potential in physical strength, mental and emotional capacity and social relationships. "[15]

Hospice programs enable some terminally ill people to die in their homes surrounded by family members rather than in the impersonal atmosphere typical of many hospitals. They do this by attending carefully to the control of pain and by frequent visits by a trained volunteer to give both the dying and their fmily support and caring. The hospice volunteer continues to stay in touch with the family as they do their grief work after the death.

The pastoral care program of a congregation should learn from and cooperate fully with the hospice program in its community, or take the initiative in helping to launch such a program if none exists. Pastors should encourage members of their congregation to take hospice training and participate in its program. The people close to a dying person are simultaneously struggling with severe anticipatory grief and bearing the enormous emotional and often physical load of caring for the dying person. They need the pastor's caring expertise as well as massive support from a lay caring team and/or from a community hospice program.

The Crisis and Grief of Divorce

Divorce is one of the most widespread grief experiences in Western societies. In the United States, for example, over one million couples terminate their marriages each year. This means that nearly three million people (including children) are directly involved in the trauma of the death of a marriage and the rupturing of a family system. If current trends continue, over 40 percent of all marriages will end in divorce. A study of the similarities and differences between the experiences of divorced and widowed women revealed that the divorced felt significantly less social support and more sense of restriction and isolation than did widows. They also suffered from more physical and mental health disturbances than the widows. Yet, our society has few organized resources for helping divorcing women and men do their grief work, learn and grow from their painful experiences. Churches have a strategic opportunity to develop innovative pastoral care programs to help divorcing people use their losses as occasions for emotional, spiritual and interpersonal growth, including helping step-parents learn the difficult but essential skills of co-parenting a reconstituted family. [16]

To be effective in establishing a healing ministry to divorcing people, clergy who have not been through divorce must develop heart understanding of the experience. Divorce is usually an ego insult, an experience that diminishes self-esteem. Women are programmed to feel especially responsible for the success of interpersonal relationships including marriage. Thus their sense of failure and guilt is often intense. Both men and women feel the painful wound of being rejected by their ex-spouse, particularly if they did not initiate or want the divorce. Feelings of failure and rejection are reinforced by the judgmental attitudes of some church people. Unresolved anger, bitterness, resentment, loneliness, self-doubt, and depression swirl together producing the infected grief wounds that frequently result from divorce. Even if the individual wanted and needed to be freed from a miserable, mutually destructive relationship, there is usually pain and grief intermingled with the sense of relief and release.

The ministry of pastoral care and counseling with divorced persons should aim at accomplishing three closely related objectives. The first is to help *them work through and resolve the grief and the pain.* If people remarry before their grief work from an earlier marriage is completed, the new relationship is almost certain to be complicated by unresolved feelings and conflicts from the earlier relationship. Some people are not open to pastoral divorce counseling because they fear that they will be judged or at least not understood by ministers. When a couple in marriage counseling decides to divorce, it is important to encourage them each to continue in individual counseling aimed at helping reduce the emotional damage of splitting a family.

The second closely related objective is *to help divorcing people learn and grow from the experience.* To do this is the best preparation for either remarriage (which five out of six divorced men and three out of four divorced women in the U. S. do) or creative singlehood. Helping persons identify and change whatever they contributed to the death of their marriage and coaching them as they learn new communication and conflictresolution skills are two essential parts of this learnng-growth process. The scores of new decisions a divorcing person must make are likely to be more constructive if she or he has an opportunity for reality-oriented crisis counseling around these complicated issues. Participating in a creative divorce retreat or group, or in a grief growth group can be a valuable experience for those going through separation and divorce. The third objective of divorce counseling—*to reduce emotional damage to children to a minimum*—will be discussed in chapter 13. The decision to end a destructive marriage is often a first and essential step toward a new, more constructive life. The possibilities that it

will be so can be increased with the aid of a skilled pastoral counselor and/or an effective growth group.

The minister of a church in North Carolina contacted each of the divorced members of his congregation to explore the possibilities of their helping each other cope with the problems and issues of divorce.[17] The response of those he called was an enthusiastic yes. The first meeting was held at the parsonage. After a brief statement by the minister concerning the purpose of the meeting, sharing began spontaneously and continued for over two hours. A strong *espirit de corps* developed almost immediately. The group decided to meet twice a month. Subsequent meetings dealt with topics chosen by the members, including child rearing, jobs, sex, personal growth, finances, and legal problems. The group has provided mutual support and a place to share feelings and problems with others who understand. The minister reports, "The group continues to meet after 17 months because it has been *koinonia* for these people. " Among the books used for discussion starters are Krantzler's *Creative Divorce* and Nouwen's *Reaching Out.* [18]

Numerous churches have developed creative responses to the largely unmet needs of divorcing people for mutual support, caring, and encouragement to not waste the growth possibilities of their painful experience. Divorce and remarriage are becoming an increasingly common pattern in Western societies. It is appropriate that more and more churches take the initiative in reaching out in healing ways to a group of people who have often felt kept at a distance and judged by the church.

Suicidal Crises and Grief

Suicidal persons are more likely to turn to clergy than any other profession except physicians. Yet, many ministers are less able to recognize suicidal lethality than are those in other helping professions.[19] It is crucial for ministers to know how to respond in suicidal crises. The pastor's role in such crises has four facets: (1) recognizing suicidal persons; (2) providing emergency help until a referral to an appropriate mental health professional or suicide prevention center can be made; (3) continuing pastoral care and counseling of the person and the family to help them deal with the underlying causes of the suicidal behavior within the individual and in the family system; and (4) helping the family deal with the destructive consequences of an incomplete or a completed suicide.

Suicide is seldom a sudden, unpremeditated act. Before attempting suicide, most people send out cries for help.[20] These distress signals include: *Obvious suicidal threats*—The old belief that "People who talk about suicide don't kill themselves" dies much more slowly than the countless people who demonstrate its falsity. The only safe axiom to follow is this: *All* suicidal threats must be taken very seriously! Even if persons are only trying to manipulate others, with no intention of self-destruction, the fact that they use such a deadly threat indicates that they and their relationships are profoundly disturbed. *Covert suicidal threats*— Those who articulate feelings that life is empty and meaningless, who believe they are no longer valued or needed by others, who wish they could go to sleep and not wake up, or who feel trapped and powerless in a no-exit situation, often are expressing pre-suicidal feelings. *Depression*—Psychiatrist Karl A. Menninger declares, "All deeply depressed people are potential suicides!"[21] Psychodynamically much depression is rage turned inward on the self. Depression has many faces including marked retardation in speaking and moving; severe agitation; feeling that there is "a ton of lead on my mind"; severe feelings of hopelessness and worthlessness; chronic insomnia; loss of appetite or interest in other previously enjoyed activities; severe apathy and chronic exhaustion; withdrawal from relationships; a brittle facade of chronic cheerfulness. *Crushing losses and pathological grief-*— Shattering blows to self-esteem and other traumatic losses may produce suicidal behavior during the reactive depression that follows. The greater the anger and frustrated dependency, the more likely is a suicidal response. *Psychological disturbances and chronic illnesses*—Some mentally ill persons are suicidal, but most suicidal persons are not mentally ill, though they experience agonizing inner disturbance. Anyone in a disorganized, chaotic mental state who feels rejected and/or hopeless, should be regarded as a suicidal risk. Those in chronic pain and/or those suffering from incurable illnesses may become suicidal, especially if they have intense fear of dependency, helplessness, or financial disaster.

In counseling with persons who are known or suspected to be suicidal, it is crucial to ask about suicidal impulses, fantasies, or intentions. The fear that by asking about it, one will suggest suicide to persons who are not considering it is largely unfounded. The suicide prevention center where I had some clinical training, gives these

instructions to its counselors:

> Your own openness and willingness to confront the patient directly with the problem of suicide is very helpful in reducing the patient's anxiety. Inquire about the suicidal aspects of the behavior matter-of-factly. Ask about prior attempts and when they occurred; whether he is presently planning an attempt, and, if so, specifically what his plans are; and whether he has the means available to carry out his plans.[22]

One reason for asking such questions is to get information to evaluate the degree of danger involved in suicide threats. The presence of any of the following factors increases the statistical probability that persons will actually destroy themselves: *male*—men attempt suicide less frequently but succeed more often than women; *older age*—older persons who threaten suicide are more apt to attempt it than younger persons; (However, suicide *is* the second highest cause of death among teen-agers.) *a specific suicide plan; the means necessary to implement the plan* (e. g., a gun or sleeping pills); *prior suicidal behavior; recent severe losses or medical problems; depression; alcoholism; lack of a strong support system; mental illness; poor communication with significant people; and defensive reactions by family members.*

The higher the lethality probability, the greater the need for the pastor to use whatever approach is necessary to prevent suicidal action. In a caring and accepting but a very firm manner, the minister should use persuasion, theological arguments, staying with the person, driving her or him to a physician or hospital emergency room, or—if nothing else works—phoning the police and using physical restraint. An appeal to at least postpone suicide is sometimes effective. *Minister:* "Killing yourself may seem to you in your present despair, to be the only way out. But I'm sure we can find a better way. If you end your life, you'll deprive yourself of any possibilities of our finding a better solution to your situation. At least wait until we've tried!"

During the first conversation with suicidal persons, obtain the names and phone numbers of close relatives, friends, and physician, and explain why it is necessary to let them know that he or she needs extra emotional support during this crisis. The family should be told not to leave persons alone during their acutely suicidal phase. Involving the family physican as soon as possible is also important, in case antidepressant medication or temporary hospitalization is needed. An evaluation by a psychiatrist of persons making a suicide threat can be helpful in deciding whether hospitalization and psychiatric treatment are needed. The methods of crisis counseling described earlier are relevant in working with suicidal people.

Most suicidal persons need three forms of help once they are beyond the acute suicidal crisis. First, they need ongoing, supportive pastoral care; second, psychotherapy and/or family counseling to resolve the underlying intrapsychic problems (e. g., pathological guilt) and the interpersonal pathology that fed the suicidal behavior; and third, help with the spiritual and value problems at the root of their sense of meaninglessness and despair. At its deepest level, the suicidal person's problem is a theological problem. As one with some expertise in spiritual growth, the minister has a unique and indispensable contribution to make to the longer-term healing of suicidal persons and their families.

In working with suicidal persons, it is helpful to remember that only a small portion of those who threaten suicide actually attempt it, and that of those, only a fraction actually kill themselves. It is also important to remember that the ultimate decision and responsibility for suicide remains with the person. If they have decided *unequivocally* to end their lives, (which 5 percent or less of suicidal persons actually have), they will probably do so, no matter how competent the persons who attempt to prevent it.

Suicide is often the tip of the iceberg of deep problems in a family system. The whole family needs pastoral care and often conjoint family therapy. Following an incompleted suicide attempt, it is important for the whole family to receive help in opening up their communication and resolving destructive interaction that probably contributed to the suicidal behavior. The family of a completed suicide almost always needs extended pastoral care and counseling to deal with the swirling feelings of unhealed shame, guilt, and rage toward the dead person. Their grief wounds are almost always infected. The family's shame, denial, and self-protective hiding often prevent them from being open to help. Patient, persistent pastoral initiative is essential to help them lower their defenses and gradually become open to the help they desperately need. If they will join, a grief group experience can be especially helpful for family members after a suicide.

Counseling with suicidal pesons often is threatening and demanding. It confronts us with the ultimate issues of

life and death, and with our own suicidal tendencies (included protracted suicide such as killing ourselves by chronic overwork and self-stressing). Our effectiveness in dealing with the existential issues with which the suicidal person is struggling will depend on how we deal with these issues ourselves and whether we have found meanings in our own lives that enable us to transcend and transform, to some degree, the pain and tragedies of our existence.

The Pastor's Own Losses and Crises

Go back in memory, now, and recall a painful personal failure, rejection, defeat, or loss of someone (or something) you felt you couldn't live without—or some awful crisis where you felt as if the rug had been pulled out from under your life. Take a few minutes to *relive* that awful experience, letting yourself exprience again the agonizing feelings you felt when it happened. / Now, reflect on what you have just relived; become aware of what is still unfinished about that experience; what you learned from it; and how it altered your faith, your real beliefs, and your relation to God, what was and was not helpful to you. /

You may have just gotten in touch with your most valuable potential asset in pastoral care and counseling with people in severe crises and grief. Whatever your crisis counseling and bereavement skills, their ultimate usefulness will depend on how you cope with your own crises and losses, and what you learn about yourself, life, people, and God from those unwelcome intruders. People who feel shattered need your supportive strength, but they also need to sense that you know something about how it feels to be shattered. They need your faith and hope, but they may also need to sense that you have known doubt and despair firsthand. In short, they need to experience the strength in you that comes from admitting your weaknesses and failures, from accepting your vulnerability and your deep need for others.

During the past decade, life has brought me a series of heavy losses and wrenching changes. Henri Nouwen's apt phrase "the wounded healer" has acquired fresh meaning for me. In working with people in crises, I've noticed that I often feel more connected with their inner world than I have in the past. The image that best communicates what I hope for myself and for you (when you deal with your crises and losses) is of the sharp blade of a painful loss as a plough that cuts a deep furrow in our souls, becoming a channel through which a healing stream of understanding and caring flows into the broken lives of others going through crises and losses.

Reality-Practice Session

PARISHIONER'S ROLE: If you have had a painful loss in your life (perhaps the one you relived above), go to the minister for help.

Or: Attempt to get inside the feelings of someone you know well who is in the process of dealing with a severe loss. Role play that person seeking the minister's help.

Or: You are Jane Carey, a woman in her mid-forties whose husband Dick died unexpectedly two months ago from a heart attack. You feel the loss intensely and find it almost impossible to go into social situations, especially to the church where you were active as a couple. You feel very depressed and would like to hide from people.

PASTOR'S ROLE: Use what you have learned from this chapter about facilitating grief work as you counsel with one of these parishioners. Be aware of the person's need for help with particular grief work tasks.

OBSERVER-COACH'S ROLE: Interrupt the session periodically to give the pastor feedback on her/his effectiveness in facilitating the grief work process—especially the pouring out of unfinished feelings.

Recommended Reading

Counseling the Dying and the Bereaved

Howard Clinebell, "Growing Through Loss, " (Nashville: United Methodist Communication, 1983). A video-cassette series showing six sessions of a grief healing group led by Clinebell, for use in learning how to lead such groups.

_____"Helping and Being Helped by the Dying. " Cassete Training Course II A in *Growth Counseling, Part II:*

Coping Constructively with Crises (Nashville: Abingdon, 1974). Includes an interview with Lois, a dying woman.

Glen W. Davidson, *Living with Dying* (Minneapolis: Augsburg, 1975). Insights about the various meanings of dying.

Paul M. DuBois, *The Hospice Way of Death* (New York: Human Sciences Press, 1979). Describes a more humanizing approach to dying.

Edgar N. Jackson, *Understanding Grief, Its Roots, Dynamics and Treatment* (Nashville: Abingdon Press, 1957). A comprehensive discussion of grief and methods of helping the bereaved.

Elisabeth Kiibler-Ross, *On Death and Dying* (New York: Macmillan Publishing Co., 1969). Can be used as a resource in grief groups for the dying and their families.

Kiibler-Ross, ed., *Death: The Final Stage of Growth* (Englewood Cliffs, N. J.: Prentice Hall, 1975). A variety of papers on the growth possibilities of dying and growth.

C. S. Lewis, A *Grief Observed* (New York: Seabury Press, 1961). A moving account of his self-observations following his wife's death.

Wayne E. Oates, *Pastoral Care and Counseling in Grief and Separation* (Philadelphia: Fortress Press, 1976). Describes the pastor's crucial role and suggests new approaches to both separation and grief.

E. Mansell Pattison, ed., *The Experience of Dying* (Englewood Cliffs, N. J.: Prentice Hall, 1977). Explores the experience of dying at the various life stages.

Granger Westberg, *Good Grief* (Rock Island, I11.: Augustana, 1962). Summarizes insights about the stages of healing of grief; useful in grief groups.

Colin Murray Parkes, *Bereavement: Studies of Grief in Adult Life* (New York: International Universities Press, 1972). Reviews the evidence of the detrimental effects of grief on physical and mental health; describes the author's understanding of grief and its treatment.

Ronald W. Ramsey and Rene Noorberger, *Living with Loss* (New York: William Morrow & Co., 1981). Describes "guided confrontation therapy, " a behavioral method utilizing the full reliving of the painful feelings related to a variety of losses (including divorce, death, and unemployment).

Bernard Schoenberg and Irwin Gerber, eds., *Bereavement: Its Psychosocial Aspects* (New York: Columbia University Press, 1975). Thirty papers on the basic concepts, process, and treatment of bereavement and the bereaved family.

Jack M. Zimmerman, *Hospice: Complete Care of the Terminally III* (Baltimore-Munich: Urban and Schwarzenberg, 1981). A description of the major dimensions of hospice care.

Divorce Counseling

Russell J. Becker, *When Marriage Ends* (Philadelphia: Fortress Press, 1971). Pastoral care and counseling approaches to divorce.

Howard Clinebell, "The Crisis of Divorce: Growth Opportunities, " Cassette Training Course III B in *Growth Counseling, Part II: Coping Constructively with Crises,* (Nashville: Abingdon Press, 1974). Includes segments from a divorce growth group.

Journal of Divorce, published by Haworth Press, 149 Fifth Ave., New York N. Y. 10010. Reports on research concerning the causes of and responses to divorce, and on counseling approaches.

Jim Egleson and Janet F. Egleson, *Parents Without Partners* (New York: Dulton, 1961). A guide for divorced, widowed, and separated parents.

Esther O. Fisher, *Divorce: the New Freedom* (New York: Harper & Row, 1974). A guide to divorcing and divorce counseling.

Richard A. Gardner, *Parents Book About Divorce* (New York: Doubleday & Co., 1977). Guidance for parents in helping children deal with divorce; *The Boys and Girls Booh About Divorce* (New York: Bantam Books, 1971). Deals with children's feelings about divorce, custody, visitation, and remarriage of parents.

Myrna and Robert Kysar, *The Asundered* (Atlanta: John Knox Press, 1978). Biblical teachings on divorce and remarriage.

Mary Ann Singleton, *Life After Marriage* (New York: Stein and Day,
1974). A guide for building a different and better life after divorce.

Jim Smoke, *Growing Through Divorce* (Irvine, Calif: Harvest House Publishers, 1976). A helpful book for divorcing people on growing and not just surviving divorce.

Emily B. Visher and John S. Visher, *Stepfamilies* (Syracuse, N. J.: Lyle Stuart, 1980). A guide to working with stepparents and stepchildren.

Women in Transition, A *Feminist Handbook on Separation and Divorce* (New York: Charles Scribner's Sons, 1975). Gives help from the feminist perspective.

Counseling Suicidal Persons

Howard Clinebell, "The Suicidal Emergency, " in *First Aid in Counseling,* C. L. Milton, ed., (Edinburgh: T. and T. Clark, 1968), pp. 148-159.

Norman L. Farberow and Edwin S. Shreidman, eds., *The Cry for Help* (New York: McGraw-Hill Book Co., 1961). A classic in the field of helping suicidal persons.

Doman Lum, *Responding to Suicidal Crises* (Grand Rapids: William B. Eerdmans Publishing Co., 1974). A guide to handling suicides in the church and community.

Paul W. Pretzel, *Understanding and Counseling the Suicidal Person* (Nashville: Abingdon Press, 1972). A guide to helping suicidal individuals and their families.

Howard W. Stone, *Suicide and Grief* (Philadelphia: Fortress Press, 1972). Explores the interrelation between grief and suicide.