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Contemporary Topics in Grief

THE GRIEF FIELD has evolved and grown dramatically over the last two decades, and many recent developments in grief research and theory are highly relevant to ministry. In this chapter we will look more closely at some possible sources, manifestations, and features of grief that ministers need to be aware of and sensitive to when offering care to people who grieve. We begin with three possible dimensions of the grief experience that often are not recognized: disenfranchised grief, chronic sorrow, and grief born of injustice.

Three Dimensions of Grief

Disenfranchised Grief

As measured by our responses, we can say that all losses are not created equal. We pay more attention to some losses than to others. And some losses never make it onto our radar screen at all. Given our limitations as humans and the vast scope of loss on the contemporary global scene, it cannot be any other way. For each of us, the losses that we notice and those that we don't are particular, based on such factors as our geographic location, our

histories, our cultures, our perspectives, and our values. Some losses may be neglected or ignored not only by individuals but also by entire groups, societies, or cultures. Author and professor of gerontology Kenneth Doka (1989, 2002, 2008) has offered the contemporary grief field the important concept of *disenfranchised grief*. Grief that is disenfranchised is “not openly acknowledged, socially validated, or publicly observed” (Doka 2002, 5). That is, there is no public or social acknowledgment of or support for one’s grief or even one’s “right to grieve” (Doka 2008, 225).

Doka suggests possible causes of such disenfranchisement. First, it may be due to how one grieves. For example, in a culturally diverse setting, one group may not understand how another person or group expresses grief and therefore assumes there is no grief or need for support. Another cause of disenfranchised grief is the sort of loss one has experienced. Even today losses related to pregnancy and childbirth, such as infertility, miscarriage, and stillbirth, are not always recognized as devastating losses for many, and therefore support for the grieving is not forthcoming. Sometimes the circumstances of a loss lead to disenfranchisement. When a death is due to suicide, survivors may not disclose the facts of the death, fearing judgment or stigma; their particular grief may then be disenfranchised.

Another cause of disenfranchised grief, according to Doka, may be the type of relationship that was lost. A gay person whose life partner has died may receive little acknowledgement or support from his or her faith community. This may be because the community did not approve of their homosexual relationship. It may also be that, fearing the community’s disapproval or rejection, the partners never acknowledged the true depth of their connection and so others do not know what has been lost. Also, when a death occurs, attention usually focuses on the surviving spouse, children, and parents, while friends of the deceased may feel disenfranchised in their grief. The grief of siblings, for whom the death may be profoundly painful, may also be neglected or ignored (Miller 2008c; Wray 2003).

By depriving people of the acknowledgment and support they most need in their time of loss, the disenfranchisement of grief may create additional grief and pain, which also may be disenfranchised (Doka 2008; Kuhn 2002). Ministers and faith communities have a particular

responsibility to ensure that no grieving persons in their midst go unrecognized and unsupported. In Matthew 5:4, we hear Jesus' all-embracing words of solace, "Blessed are those who mourn, for they will be comforted." Jesus did not single out certain groups of mourners as deserving comfort. He blessed all those who grieve. As the hands and feet of Christ on earth, so must we do. In order not to disenfranchise the grief of others, we must regularly ask ourselves these critical questions: Whose losses do we notice? Whose grief do we support? Whose grief might we ignore, invalidate, or minimize?

Chronic Sorrow

Some people experience losses that are ongoing, and these people may therefore experience ongoing or chronic sorrow. *Chronic sorrow* is a concept first introduced and developed by rehabilitation counselor Simon Olshansky (cited in Roos 2002) to describe the grief of parents of a child diagnosed with a serious developmental disability, such as mental retardation. For many parents, the child's disability constituted the loss of their fantasy of how their child would be and what parenting would be like. This was a "living loss" (Roos 2002, xv), since the child was alive and in need of ongoing care; for many parents, their grief or sorrow was therefore also ongoing.

Many people endure living losses. Family members of those with chronic mental illness may live with a lifetime of related losses, such as loss of the relationship that might have been if the person did not have mental illness, and loss of a freer life without the constant strain of worry and caregiving. A contemporary source of living losses is the wars in Iraq and Afghanistan. Due to excellent and immediate medical care and better protective equipment, many military personnel are surviving injuries that likely would have killed them in prior wars (Doll & Bowley 2008; Hoge et al. 2008). What this means in some instances is that men and women are returning to their families with severe and life-changing injuries, with which all parties must then cope. And by some estimates, as many as 25 percent of veterans of these wars report mental health struggles when they return home (Miller 2008a). For some people, such changes to their lives and expectations for the future may constitute a living loss.

Researcher and educator Pauline Boss points out that some ongoing losses are not clearly defined but rather are ambiguous, meaning they are “incomplete or uncertain” (Boss 1999a, 3). Families of kidnapped children or soldiers missing in action must live, sometimes for decades, without any clear knowledge of where their loved ones are or even whether they are still alive. Relatives of someone with Alzheimer’s disease might struggle with what Boss calls the “psychological absence” (Boss 1999a, 45) of the person, despite the person’s physical presence. With ambiguous loss, people may not know if or when they should grieve, or even what exactly they are grieving. As Boss suggests, “The certainty we hunger for in human relationships is most poignantly unachievable when a person we care about [is] neither clearly absent nor clearly present in our lives” (Boss 1999b, 4).

Psychotherapist Susan Roos proposes that people facing all sorts of living losses may experience the pain and challenge of chronic sorrow:

Chronic sorrow is about years upon years of living with the inevitability of loss, of continually negotiating reality demands required by the loss, and of contending with ongoing and resurgent grief responses. . . . Central to chronic sorrow is the role of fantasy—of what could have been or should have been (and maybe will be, after all). Activation of the fantasy intensifies painful emotions, as the disparity between the fantasy and current living reality can be cruel and wounding. (2002, 27)

According to Roos, there is some evidence that chronic sorrow may be on the rise, perhaps due in part to medical advances that allow people to survive traumatic injuries and to live longer with debilitating physical conditions. Therefore, ministers must be sensitive to the possible presence of chronic sorrow among those for whom they care. In the Gospel of Mark, a man asks Jesus to heal his son who has been possessed by a destructive spirit for many years. In a beautifully touching moment, Jesus asks the father, “How long has this been happening to him?” to which the father replies, “From childhood” (Mark 9:21). Jesus seems to care deeply about the long suffering of both the boy and his father, and he brings healing to the family. So we, too, are called to care deeply about those who suffer living losses and chronic sorrow.

Grief Born of Injustice

A critical area of grief about which ministers must be aware is what I call *grief born of injustice*. For natural reasons, the almost exclusive emphasis in both secular and pastoral grief care is responding to griever's once a loss has occurred. But as we know well, much grief never needed to happen in the first place. It is the result of injustice. By grief born of injustice, I mean the following: it is grief due in whole or in part to injustice. It is grief that is caused by unjust structures and/or by unjust actions or inactions of individuals, groups, and systems. It is grief that is not part of the "natural order" of things. It is grief that did not need to happen. It is grief that was preventable.

Perhaps the most stunning occurrence of the grief born of injustice is related to global poverty. According to the World Bank, 1.4 billion people live in extreme poverty (less than \$1.25 a day), while close to 2.6 billion people survive on less than two dollars a day.¹ As many as 155 million people were pushed into poverty between 2007 and 2009 due to soaring global food prices.² While worldwide food production is sufficient for feeding the world's population (Smith 2006), someone dies of starvation every 3.6 seconds; the majority of these are children under five.³ Every year, waterborne diseases such as dysentery and cholera kill five million people, most of them children, and more than one billion people do not have a source of safe drinking water.⁴ Sadly, we could go on and on. In the wake of all of this suffering and death, countless people grieve. This grieving is a direct consequence of injustice.

Because this area is largely neglected in the grief world, we know little about the possible features and costs of the grief born of injustice. For example, how does this experience shape a survivor's sense of self, sense of the world, and sense of God? Watching a loved one suffer or die due to injustice, some people may question God's role in this suffering or feel abandoned by God in their grief. They may resonate with the words of the psalmist: "For you are the God in whom I take refuge; why have you cast me off? Why must I walk about mournfully because of the oppression of the enemy?" (Ps. 43:2).

The grief born of injustice demands much of the minister. At the most immediate level, when we care for those who grieve because of

injustice, we offer comfort. We attend to them; we notice their suffering; we acknowledge the cause(s); we do not disenfranchise their grief. And critically, we make clear that God, too, sees their suffering and cares deeply for them. “From oppression and violence he redeems their life; and precious is their blood in his sight” (Ps. 72:14). I believe we are called to respond in another way also. While caring for grieving individuals or communities is essential, we must do what we can to prevent the grief born of injustice in the first place. Comfort after the fact may be of questionable consolation to someone whose grief was preventable. We must understand grief care as sometimes encompassing both pastoral response and prophetic action. Our efforts to balance both, while so very challenging, are necessary to address the grief born of injustice.

The Trajectories of Grief

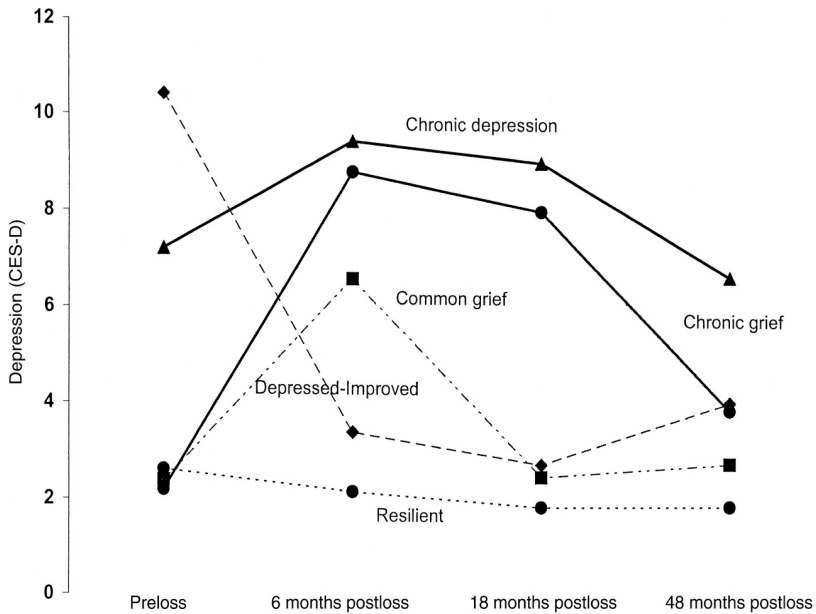
Traditional understandings of grief have often defined the grief experience in overly narrow ways. For instance, researchers have frequently maintained that there are three primary patterns of grief. The first, called *common* grief, is marked by an initial increase in distress following a death; this distress abates slowly with time. The second pattern, *chronic grief*, is marked by high distress following a death, and this distress remains high over time. And the third pattern, *delayed grief*, is marked by low distress after a death, with a rise in distress at some later point (Bonanno et al. 2002). Important new research is helping us to assess and challenge these assumptions regarding three basic grief patterns. In one study, people’s grief experiences could be sorted into five patterns or *trajectories* (Bonanno et al. 2002; Bonanno, Wortman, & Nesse 2004; Boerner, Wortman, & Bonanno 2005). Of course, we cannot extrapolate too widely from findings drawn from one sample population. At the same time, these findings help us to understand that there may be many patterns of grief, with important implications for care.

The research by George Bonanno, Kathrin Boerner, and colleagues on the trajectories of grief involved a sample of English-speaking older married couples (where the husband was at least sixty-five years old) in the Detroit area. Over the course of the study, some of the participants died, and the researchers examined the grief of the surviving spouses.

Importantly, the researchers began to get to know the participants an average of *three years* before the spouses died. They also followed the participants for *four years* after the death, interviewing the widowed spouses six months, eighteen months, and forty-eight months postloss. Before and/or after the death, the researchers inquired about matters such as what the marriage was like, whether the spouse had been ill before dying, whether the survivor had experienced strain in caring for the spouse, how much support the survivor received from others before and after the death, whether the survivor felt he or she had benefited in any way from being widowed (e.g., becoming stronger by learning to do more for oneself), how well the survivor felt he or she was coping, level of depression, level of grief (e.g., thinking a lot about and yearning for the deceased), how much he or she accepted the death before the loss, and to what degree the survivor felt that the world was basically just.

Over the course of the study, the researchers were able to differentiate five trajectories of response to the loss, which are shown in the diagram on p. 18. On the left-hand side of the chart, we see that the researchers were assessing the depression of the participants. It is important to note that grief and depression are not the same thing. Not everyone who is grieving experiences depression, and not everyone who is depressed is grieving. However, there is often significant overlap between depression and grief, at least initially, and that was the case with this sample; patterns of grief and patterns of depression were similar. Across the bottom of the chart, we see the measurement of time; we are looking at people's depression before the death happened (preloss) and then six months, eighteen months, and forty-eight months after the death. At the forty-eight-month mark, there were ninety-two people in the study; 90 percent were women, with an average age of seventy (Boerner, Wortman, and Bonanno 2005). After differentiating these five trajectories, the researchers were able to draw on both the prospective data and the data gathered at the various intervals to shape an understanding of the grief experience of those on each trajectory. Let us now consider each trajectory.

The first trajectory is *chronic depression*. As the chart indicates, the people on this trajectory (9.8 percent of the sample) had very high depression before the death occurred. By six months postloss, their depression had



The Trajectories of Grief from Boerner, Wortman, & Bonano 2005 ($N=92$)

increased and then began to lessen gradually. Importantly, this group had the highest depression scores at forty-eight months postloss. The participants whose grief followed this trajectory tended to have certain things in common. They were rather negative about their marriages and their spouses, and they derived the least comfort from positive memories of their spouses. At the same time, they demonstrated very high interpersonal dependency, both on their spouses and in general. They found widowhood quite difficult and they did not see themselves as coping well. They received low support. These participants also described a belief in the “uncontrollability of negative events” (Bonanno et al. 2002, 1159) and had the greatest struggle with meaning. Overall, their adjustment to the death seemed most problematic. In considering all these factors, including the participants’ very high depression preloss, the researchers suggested that those on this trajectory may have been struggling with emotional difficulties before the loss, and these difficulties were then exacerbated by the deaths of their spouses (Bonanno, Wortman, & Nesse 2004).

The second trajectory is *chronic grief*. We can see that the preloss depression of people on this trajectory (10.9 percent of the sample) was low; their depression then spiked by six months postloss and was still high at eighteen months postloss. By forty-eight months postloss, it had come down significantly but was still higher than it was before the death. Thus, this is a portrait of a long and difficult grief experience. Those whose grief followed this trajectory tended to have certain things in common. They described their marriages very positively, and they were also highly dependent on their spouses and in general. Their spouses were more likely to have been healthy before dying, and they experienced low strain as caregivers for their spouses. They had low support, and they also saw themselves as poor copers. After the death, they experienced high yearning and emotional pangs, thought a lot about the death, and searched for meaning. They expressed the most regret about their married relationship. In considering all these factors, the researchers suggested that those on this trajectory may have experienced significant and lasting turmoil because they lost a healthy spouse (i.e., the death may have been unexpected) on whom they were highly dependent (Bonanno, Wortman, & Nesse 2004).

The third trajectory is *common grief*. The people on this trajectory had very low depression before the loss. Their depression then peaked at six months postloss, came down steadily by eighteen months postloss, and was rather low at forty-eight months postloss. Interestingly, the common grief trajectory—named for what has traditionally been understood as the most common pattern of grief—captured only 10.9 percent of the sample. Those whose grief followed this trajectory tended to have certain things in common. At the six-month mark, they derived high comfort from their positive memories of their spouses. Their spouses had been seriously ill before dying, although the survivors did not provide direct care during the illness. They had good coping abilities, and they saw some benefits to their widowhood.

The fourth trajectory is *depressed-improved*. We can see that those on this trajectory (18.5 percent of the sample) had the highest depression before the death. Their depression then plummeted by six months postloss and was still low at eighteen months postloss. By forty-eight months postloss, their depression was starting to tick up a bit again, demonstrating

a “trend” in the direction of “adjustment problems over time” (Boerner, Wortman, & Bonanno 2005, 71). The researchers had many questions about this trajectory. Why would one’s depression plummet after a death and stay rather low? Were these people in unhappy marriages? Was the strain of caregiving taking a terrible toll, and therefore the death constituted a relief of sorts? Those whose grief followed this trajectory tended to have certain things in common. They were low in dependency both on their spouses and in general, took pride in their coping ability, and experienced some benefits of widowhood. Importantly, they were the most negative and most ambivalent about both their spouses and their marriages. Their spouses were ill before dying, and they received low support; therefore, the death of their spouses may have constituted “the end of a chronic stressor” (Bonanno, Wortman, & Nesse 2004, 268). Also, they struggled with some emotional instability, were somewhat neurotic, and “believed strongly that the world was particularly unjust to them” (ibid., 261). The fact that their depression seemed to be ticking up again at forty-eight months postloss was of concern. The researchers hypothesized that “subsequent depression may emerge after a period of well-being in those cases in which people are required to perform stressful caregiving duties for a spouse for whom they have negative or ambivalent feelings” (Boerner, Wortman, & Bonanno 2005, 72).

And the fifth trajectory is *resilient*. Those on this trajectory had very low depression before the loss, and their depression remained low right through forty-eight months postloss. Interestingly, this trajectory reflected a full 50 percent of the sample. Researchers had questions about the people on this trajectory. Was their “resilience” really an indication of delayed grief? Were they not terribly attached to their spouses in the first place, and is that why they experienced such low distress over time? Those people whose grief followed the *resilient* trajectory tended to have certain things in common. They had been married forty-four years on average and described their marriages as satisfying for the most part. They were not colder or more avoidant and actually derived the most comfort over time from positive memories of the deceased. They demonstrated low dependency and good coping. Before the death, they had the highest support, were more accepting of death, and described a greater belief in a just world. After the death, they had the fewest regrets, low yearning, low

emotional pangs, and low search for meaning. This did not mean they experienced no grief, however; “the majority *did* report experiencing at least some yearning and emotional pangs during the first 6 months of bereavement, and virtually all respondents reported at least some grief-related intrusion and rumination” (Bonanno, Wortman, & Neese 2004, 268). Thus, their resilience did not seem evidence of “delayed” grief; rather, it seemed to reflect emotional stability and adaptive adjustment.

Of course, there are limitations to this research (e.g., small sample size, not diverse in terms of age, gender, and culture/language). Nevertheless, the work on the trajectories of grief is helpful to ministers in at least three ways. First, it makes clear that, for many people, grief and its associated distress may endure for years after a death. We must consider how we and the faith community might acknowledge, ask about, pray for, and ritualize people’s losses in an ongoing way. Second, for this sample, the grief journey unfolded in numerous and varied patterns. These findings may help us challenge our assumptions about how grief ought to unfold and bring a more nuanced sensitivity to the grief experiences of others. With this understanding, we can tailor our responses appropriately. For example, the researchers suggest that those enduring chronic depression may benefit from attention to their ongoing emotional struggles, while chronic grievers, who were extremely dependent on their spouses, may benefit from attention to the enormity of their loss and the need to shape a new sense of self (Boerner, Wortman, & Bonanno 2005). Third, this research may help us anticipate one’s possible grief trajectory by noting such things as the sort of support one receives before a death and how one assesses one’s own coping ability. We may even create additional support for those who seem particularly vulnerable to an especially difficult grief experience.

Central Features of the Grieving Process

When a loss has happened, what does grieving then entail? Among the contributions of contemporary grief theory are two insights into the experience of grieving that are little addressed by traditional grief theory. One relates to coping with loss; the other concerns continuity of relationship with the deceased.

The Dual Process Model of Coping

When any sort of stressful event happens, people must somehow cope with it. There are numerous theories and models of how people cope with the stress of bereavement.⁵ Informed by many of these theories and models and in considering the death of a partner, bereavement researchers Margaret Stroebe and Henk Schut (1999, 2001) have proposed the *dual process model of coping with bereavement*. According to the dual process model, bereaved people must cope with varied stressors. Some of these stressors are *loss oriented*; that is, they have to do with the loss itself. Loss-oriented stressors include thinking a lot about the circumstances of the death and yearning for the person who has died. But these are not the only stressors that bereaved people must face; they also must cope with the changes and demands of their new postloss reality. These *restoration-oriented* stressors include having to take on new roles and responsibilities in the wake of the death (e.g., assuming financial tasks that were always handled by the deceased person) and beginning new activities (e.g., a new job) or relationships.

Many traditional theories of grief have maintained that successful adaptation to loss demands a focus on the hard work of grief, that is, confronting the reality of the loss and working through the pain of it.⁶ Stroebe and Schut concur that such loss-oriented stressors must be addressed, particularly early on, but they propose that this ought not to be done to the exclusion of the restoration-oriented stressors. In their dual process model, they propose that successful adaptation to loss requires a sort of balance in coping with the demands of both loss orientation and restoration orientation. They use the term *oscillation* to describe how one's coping efforts shift dynamically between these two orientations. "At times the bereaved will confront aspects of loss, at other times avoid them, and the same applies to the tasks of restoration. Sometimes, too, there will be 'time out,' when grieving is left alone" (Stroebe & Schut 2001, 395).

More study of the dual process model is needed; for example, how widely applicable is this model to various sorts of loss? How applicable is it to various cultures? But some preliminary research seems to suggest that those who oscillate between focusing on their loss and focusing on their changed life cope well over time (Frantz, Farrell, & Trolley 2001), whereas

exclusive emphasis on “grief work” (i.e., loss orientation) might be detrimental to recovery from grief (Silver & Wortman 1980). It appears that attention to both the pain of loss and the demands of a changed life may be necessary and that “oscillation between the two enables a balanced recovery to occur” (Archer 2008, 58).

Ministers can support and encourage grieving people in this oscillation. We can help them honor and attend to both the raw pain of loss and the need to move with hope and trust into the future to which God calls them. Both loss and life must be honored and balanced, as best one can. As we support those who seek and perhaps struggle with this balance, the familiar words of Ecclesiastes may be helpful: “For everything there is a season, and a time for every matter under heaven: . . . A time to break down, and a time to build up; a time to weep, and a time to laugh; a time to mourn, and a time to dance” (Eccl. 3:1, 3b-4).

Continuing Bonds

When a loved one has died, some people struggle to understand what, if any, sort of connection they now have with the deceased person. As we will see in the next chapter on the history of grief theory, traditional (psychoanalytic) grief theory has understood the goal of mourning as the withdrawal of psychic energy from the lost loved one to make possible the reinvestment of it in new relationships. According to this theory, any sense that one continues to feel a connection to the deceased loved one may be evidence of pathology (Hagman 2001). Of course, throughout time, many people, religions, and cultures have described some sort of continuity of relationship with those who have died. For example, Japanese ancestor rituals acknowledge the important and ongoing relationship of the living with their deceased family members (Goss & Klass 2005). In Mexico, *el Día de los Muertos*, or the Day of the Dead, marks the “enduring ties between the living and the dead” (DeSpelder & Strickland 2005, 114).

I offer two other examples. In his poignant 1798 poem “We Are Seven,” British poet William Wordsworth describes a child’s unshakable sense of ongoing connection to her deceased siblings (Van Doren 1950, 56–58).

. . . I met a little cottage Girl:
She was eight years old, she said;
Her hair was thick with many a curl
That clustered round her head.

. . . “Sisters and brothers, little Maid,
How many may you be?”
“How many? Seven in all,” she said
And wondering looked at me.

“And where are they? I pray you tell.”
She answered, “Seven are we;
And two of us at Conway dwell,
And two are gone to sea.

“Two of us in the church-yard lie,
My sister and my brother;
And, in the church-yard cottage, I
Dwell near them with my mother.”

. . . “You run about, my little Maid,
Your limbs they are alive;
If two are in the church-yard laid,
Then ye are only five.”

“Their graves are green, they may be seen,”
The little Maid replied,
“Twelve steps or more from my mother’s door,
And they are side by side.

“My stockings there I often knit.
My kerchief there I hem;
And there upon the ground I sit,
And sing a song to them.

“And often after sunset, Sir,
When it is light and fair,
I take my little porringer,
And eat my supper there.”

. . . “How many are you, then,” said I,
“If they two are in heaven?”

Quick was the little Maid's reply,
"O Master! we are seven."

"But they are dead; those two are dead!
Their spirits are in heaven!"
'Twas throwing words away; for still
The little Maid would have her will,
And said, "Nay, we are seven!"

A second example concerns Eleanor Roosevelt, the first lady of the United States from 1933 to 1945. Eleanor experienced much loss, particularly early in her life. Her mother died when she was eight, and her little brother died when she was nine. Eleanor was deeply attached to her inconsistent but beloved father, Elliott. He also died when she was nine but remained a very important figure in her life after his death. She wrote, "From that time on . . . I lived with him more closely, probably, than I had when he was alive" (quoted in Persico 2008, 25).

In recent years, important work has looked at the continuity of relationship with the deceased that so many people experience.⁷ Researchers Dennis Klass and Phyllis Silverman and psychiatrist Steven Nickman (1996) introduced the term *continuing bonds* to describe this experience. For many people, having a sense of a continuing bond with a deceased person is not pathological but rather seems to be a source of great comfort and healing. This continuing bond can take many forms. First, the person may live on in *memory*. This may seem a rather limited source of connection, but it need not be. We revisit our memories throughout our lives, sometimes coming to new insights or realizations in the process. For instance, as we age, we may remember deceased parents when they were the same age as we are now, and we may glean new insights about our parents from these memories. This understanding may help us to feel a new or deeper sort of connection to our parents, even long after their deaths.

A second sort of continuing bond is our sense of the *legacy* that a deceased person has left; that is, the many ways they have touched us and continue to touch and influence us. And we may actively engage this legacy, inviting it to define our lives in significant ways. For instance, we may choose to continue work that was important to the deceased, or we may raise money for causes that they espoused. We may also try to emulate

some of the qualities that we most loved or admired in them. In all these ways, “we blend what they have given, and continue to give, into the life histories we reshape and redirect” (Attig 2001, 51). Continuing bonds may take other forms as well. For instance, some people feel that their deceased loved ones watch over and protect them. Others continue to define themselves, at least in part, in relationship to one who has died. A father whose young child died has said, “The earthly bond with my child has been broken. . . . But in my mind and in my heart, I am her father forever” (English 2009, A6).

It is certainly not the case that everyone experiences a sense of continuing bonds with those who have died. And among those who do, this experience is not always comforting and healing. For instance, when a relationship with someone who has died was painful or deeply problematic, it may be hard to take comfort in memories or actively embrace the person’s legacy. Ministers want to bring great sensitivity to this area of grief care. Ministers can also support people in finding balance in the area of continuing bonds. While one may draw comfort and meaning from a sense of ongoing connection to the deceased, one must still move into one’s future with hope and trust in God’s promises, including the promise that we will all be raised on the last day and enjoy eternal life (John 6:40). And while continuing bonds with deceased loved ones may be both powerful and healing, we must remember that the Christian’s primary relationship is with the living Christ. The real and ongoing presence of Christ in our lives is the ultimate continuing bond.

The Balancing Act of Grief Care

The ministry of grief care poses particular challenges. While many feel drawn to this ministry as especially fulfilling at an essential level, it is often a delicate balancing act, both personally and professionally. I would like to suggest three efforts that might help ministers to maintain their balance as they offer grief care.

First, *ministers must be self-aware regarding their own history of loss*. Self-awareness is a critical cornerstone of all pastoral care and counseling. However, in grief care this self-awareness must pertain in an intentional way to one’s own history of and current experience of loss. Bearing witness to and responding

to the grief of others may affect or provoke ministers in powerful and sometimes painful ways. For example, hearing others describe their regrets after a loss may stir up our regrets from the past. Accompanying others who feel abandoned or punished by God in their suffering may prompt our own questions about God's presence and role in suffering. These responses may be terribly painful and could adversely affect the care we offer another. For instance, we may neglect or minimize parts of another's struggle that are too painfully close to our own. Self-awareness regarding our own experience of loss may help us in multiple ways as we offer grief care. It may help us to recognize and monitor our powerful responses to another's grief. It may help us to respond to others in free and nonreactive ways. It may also help us to recognize moments when we may not be the best person to care for another, given our particular experience of loss.

The second effort that might help ministers to maintain their balance as they offer grief care is *attending to self-care and particularly guarding against vicarious traumatization*. We are increasingly aware of the sometimes dangerous stress of working with others in need and of how essential consistent self-care is.⁸ In considering the experience of psychotherapists who work with trauma survivors, Lisa McCann and Laurie Anne Pearlman have described the phenomenon of "vicarious traumatization" (1990, 133). A terrible effect of trauma can be changes in basic cognitive schemas about what life is like and how the world works. For example, a trauma survivor may come to believe that the world is not safe or that others are not trustworthy. Over time, clinicians who listen to the sometimes horrifying stories of trauma survivors may experience parallel changes in their own cognitive schemas about life; that is, they experience vicarious traumatization.

Clearly, ministers who work with survivors of terrible loss, some of it traumatic, may be at risk of vicarious traumatization. Vicarious traumatization benefits no one and may render a caregiver less responsive to those needing grief care. Therefore, it is essential to avoid it or minimize its effects as much as possible. McCann and Pearlman offer suggestions for clinicians at risk of vicarious traumatization; their suggestions are helpful for ministers as well. For example, they describe the importance of having a peer group for regular support and processing of painful client material (with client permission). They also make recommendations that emphasize balance, such as "striving for balance between our personal

and professional lives” and “balancing a clinical caseload with other professional involvements such as research and teaching that can replenish us” (1990, 146). Ministers, too, must seek such balance as essential for self-care.

The third effort that might help ministers to maintain their balance as they offer grief care is *encouraging and allowing the larger community of faith to do its part in caring for those who grieve*. Sometimes ministers feel enormous responsibility to care for those made vulnerable by loss and grief. This sense of responsibility may blind us to the critical role that the faith community plays in caring for those who grieve. It is important to remember that “pastoral work with mourners is the work of the congregation, not just of certain professionals” (Mitchell & Anderson 1983, 11).⁹ Some congregations offer lay pastoral caregiving programs that might be helpful to those in grief.¹⁰ Even without such programs, however, the community of faith offers grief care through its supportive presence, its prayers for one another, and its witness to God’s fidelity and compassion. Understanding that the faith community serves in these ways can help ministers to feel more balanced. Grief care is the work of all the faithful; it is most definitely not all up to us.

The Mosaic of Grief

In eastern Turkey lie the remains of the ancient city of Zeugma, founded in 300 B.C.E. by one of the generals of Alexander the Great. Zeugma, strategically located along the Euphrates River, was a vital and prosperous center of trade and culture as part of the Greek world and later the Roman Empire. It appears that it was destroyed by fire in 250 C.E. and has largely remained buried under many feet of sediment ever since. In recent years, archaeologists and historians became fiercely interested in Zeugma because, as part of an elaborate national engineering project, the Turkish government planned to construct a dam that would flood the remains of Zeugma. Racing against the clock to excavate parts of the area and rescue what they could, archaeologists were stunned to unearth exquisite and elaborate mosaics from the ancient Roman world, depicting important scenes from literature and mythology in rich color and intricate detail. These priceless and historic masterpieces were saved just in time. But,

sadly, archaeologists were not able to excavate all of Zeugma before it was flooded in 2000. They feel certain that other ancient mosaic masterpieces now lie under the floodwaters of the Euphrates.¹¹

The experience of grief is particular, intricate, and nuanced. When we are not aware of the many dimensions of grief, another's grief experience may be utterly lost to us, like the mosaics of Zeugma now hidden beneath the Euphrates. Fortunately, the contemporary grief field offers us great riches to deepen our understanding of the grief experience and thereby to inform our care of others. When we understand such aspects as chronic sorrow, grief born of injustice, the trajectories of grief, and continuing bonds with the deceased, we are less likely to disenfranchise another's grief. We will see another's mosaic of grief in more color and detail. And this will help us to offer sensitive and appropriate care. But we must remember that grief care is challenging and requires that we be self-aware regarding our own experience of loss, attend to self-care while avoiding or minimizing vicarious traumatization, and celebrate the role of the faith community in caring for those who grieve. All of these efforts will help to sustain us as we pursue this challenging but tremendously important work.