

*‘It’s not surprising that as our culture advances in information and technology, we seem to become more inarticulate about matters of the heart. We quantify ‘human behavior’ and develop programs of therapy and treatment, and yet the procrustean trimming of the soul to fit our programs of science doesn’t have much effect. We still encounter the soul briefly, as a set of problems, rather than as a creative and constructive source of life.’—Thomas Moore*

---

## Introduction: A Declaration of My Intent

At the very heart of grief lies an irreducible mystery. I have come to discover that grief is a dimension of life experience that cannot be approached through rational thought. Instead, it responds more appropriately to humbled souls. In this spirit, I invite you to open your heart to what follows.

My tenets of “companioning” the bereaved were written several years ago as I sat in a gazebo on the sacred grounds of the Center for Loss and Life Transition. Since that time of grace in my life, which encouraged me to try to express in words what I do when I “companion” people in grief, I’ve been honored that many people have encouraged me to teach more about these tenets. I’ve written the following words with a humbled heart and a desire to help people help others during time of grief and loss.

This particular book has been long in coming; however, for that I take great pride. Many of my colleagues and students have urged me to write this book for some time. Yet, I felt a need to wait, listen and learn before I could express in words the art of companioning people in grief. It was important to me that I write this book in a manner and tone congruent with the ideas I am trying to communicate. I found I had to wait for my thoughts to coalesce in ways that would allow me to teach about my beliefs and how I try to “be” in my effort to help others come out of the darkness of their grief and into the light of living until they die. I believe this waiting was a part of my own maturation process.

I am very honored that there is now an international network of thousands of people who have trained with me surrounding the companioning philosophy of caregiving to people in grief. Yet, there



**Responsible Rebel:** One who questions assumptive models surrounding grief and loss and challenges those very models. Rebels are not afraid to question established structures and forms. At the same time, rebels respect the rights of others to use different models of understanding, and provide leadership in ways that empower people rather than diminish them. So, if the contents of this book resonate with you, please join me in being a responsible rebel!



seems to be a place for this book in that many of my colleagues have either had to imagine, question, project, and, honestly, at times even judge what I do. In part this book is a “coming out of the closet” as a “responsible rebel.”

In sum, my deep hope is that this resource will serve as a source of encouragement and help to those who want to learn more about the art of companioning people in grief. My experience suggests that few helping situations are more

challenging—or more rewarding—than the opportunity to assist people impacted by loss in their lives. Perhaps through deepening our human capacity to respond to each other in times of grief we can continue to enrich each moment of our living.

## Why A “Soulful” Guide?

When people have come to me for support in grief, the soul is present. When they try as best they can to wrap words around their grief, trusting me with their vulnerability, I know we are meeting at a soul level. To look into the eyes of someone mourning the death of someone precious is to look into the window of the soul.

Their willingness to allow me to walk with and learn from them has been an education of the heart and soul. “Soul” is discovered in the quality of what I’m experiencing when I’m honored to be present to

them. If my intent is anchored in truth and integrity, if they are discovering a reason to go on living (redefining their worldview and searching for meaning), then they are rich in soul, and so am I. Therefore, for me, companioning another human being in grief means giving attention to those experiences that give my life, and the lives of those I attempt to help, a richness and depth of meaning.

Soul really has to do with a sense of the heart being touched by feelings. An open heart that is grieving is a “well of reception;” it is moved entirely by what it has perceived. Soul also has to do with the overall journey of life as a story, as a representation of deep inner meaning. Soul is not a thing, but a dimension of experiencing life and living. I see soul as the primary essence of our true nature, our spirit self, or our life force.

Being soulful as it relates to companioning people in grief is, in part, to acknowledge a need for people to have “safe places” to authentically mourn. Then, in order to respond to that need, it is to go within yourself and nurture and develop your soul in ways that give expression to your compassion. My hope is that this book helps you do just that!

## Grief is Not an Illness: Inappropriate Assumptions Surrounding Our Modern Understanding of Grief and Loss

As a teenager who had come to experience my own life losses, I set out to discover the principles that help bereaved people heal in grief. I hoped to communicate those principles to anyone interested in honoring my story. To my dismay, I discovered that the majority of caregiving models for grief counselors were intertwined with the medical model of mental health care.

For many caregivers, grief in contemporary society has been medicalized and perceived as if it is an illness that with proper assessment, diagnosis, and treatment can be cured. This paradigm dictates that we as caregivers, having studied and absorbed a body of knowledge and become experts, are responsible for “curing” our patients. How arrogant!

The language we use to describe the practice of grief support exposes our attitudes and beliefs about counseling as well as determines our practices. Because numerous historical roots of psychotherapy are deeply grounded in a medical model, because the medical model appears more scientific than other alternatives, and because the economics of practice are interfaced in a healthcare delivery system, the natural tendency has been to adopt medical model language.

As I explored the words used in counseling the bereaved, I was taken aback: symptoms of pathology; disorders; diagnosis; and treatments. In my own search to learn so I could teach, I found that these more clinical, medical model approaches have limitations that are profound and far-reaching.

I discovered that our modern understanding of grief all too often projects that for “successful” mourning to take place, the person must “disengage from the deceased” and, by all means “let go.” We even have all sorts of books full of techniques on how to help others “let go” or reach “closure.”

At bottom, I discovered that our current models desperately needed what we could refer to as a “supplement of the soul.” It seemed glaringly obvious to me that as fellow travelers in the journey into grief, we needed more life-giving, hope-filled models that incorporated not only the mind and body, but the soul and the spirit! I found myself resonating more with the writings of people like Ram Das, Stephen Levine, Victor Frankl, James Hillman, Thomas Moore and Carl Jung.

Actually it was Carl Jung’s writing that helped me understand that every psychological struggle is ultimately a matter of spirituality. In the end, as we as human beings mourn, we must discover meaning to go on living our tomorrows without the physical presence of someone we have loved. Death and grief are spiritual journeys of the heart and soul.

Yet, our modern Western culture’s understanding of grief often urges mourners to deny any form of continued relationship with the person who died. For many mental health caregivers, the hallmark of so-called “pathology” has been rooted in terms of sustaining a relation-

ship to the dead. In reality, the mourner actively shifts the relationship from one of presence to one of memory. Or, as the playwright Robert Anderson wisely noted, “Death ends a life; it does not end a relationship.” In contrast, many other cultures throughout history have encouraged ongoing, interdependent relationships in some form after death. Beyond this recognition of a continued relationship of memory, most cultures provide bereaved people with rituals to encourage an appropriate relationship of memory, such as Mexico’s “Day of the Dead.”

Our modern understanding of grief all too often conveys that the end result of bereavement is a series of completed tasks, extinguished pain, and the establishment of new relationships. I discovered that many mental health caregivers, in attempting to make a science of grief, had compartmentalized complex emotions with neat clinical labels.

Our modern understanding of grief all too often uses a “recovery” or “resolution” definition to suggest a return to “normalcy.” Recovery, as understood by some mourners and caregivers alike, is erroneously seen as an absolute, a perfect state of reestablishment. We seem to want to go around any so-called “negative” moods and emotions quickly and efficiently. Yet, it occurred to me that if our role as caregivers is to first observe the soul as it is, then we need to abolish what I call the “resolution wish.”

Our modern understanding of grief for some is based on the model of crisis theory that purports that a person’s life is in a state of homeostatic balance, then something comes along (like the death of



**“Negative” Emotions**

The emotions of grief are often referred to as being “negative,” as if they are inherently bad emotions to experience. This judgment feeds our culture’s attitude that these emotions should be denied or “overcome.” In reality, these care-eliciting emotions are what alerts companions to the reality that the mourner has special needs that call for support and comfort. Emotions are not bad or good. They just are.



someone loved) and knocks the person out of balance. Caregivers are taught intervention goals to reestablish the prior state of homeostasis and a return to “normal” functioning. There is only one major problem with this theory: it doesn’t work. Why? Because a person’s life



### The Resolution Wish

We wish that grief would resolve. We wish that it was linear and finite. We wish that we could wake up one day and our painful thoughts and feelings would all be “over.” Grief never resolves, however. While we can learn to reconcile ourselves to it, grief is transformative and life-changing



that has dominated so much of our discipline results in a model of the human being lacking the positive features that make life worth living.”

Our modern understanding of grief all too often privatizes grief as an isolated, individual experience. Mourning, by nature of its definition—“a shared social response to loss”—must be viewed in the broader context of social and family perspectives. In fact, the person often perceived as “not doing well” in grief is usually the one who is trying to get help for the family system.

In sum, I discovered in my twelve years of university-based training and in reading the available literature on grief counseling that our modern understanding of grief all too often lacks any appreciation for and attention to the spiritual, soul-based nature of the grief journey. As authors such as Frankl, Fromm, and Jung noted years ago (and Hillman and Moore more recently), academic psychology has been too interfaced with the natural sciences and laboratory methods of weighing, counting and objective reporting.

is changed forever by the death of someone loved. We are transformed by grief and do not return to prior states of “normal” based on interventions by outside forces.

Our modern understanding of grief all too often “pathologizes” normal experiences. Traditional psychology has focused the majority of attention on the diagnosis and treatment of pathologies and in the quest for “fixes,” little attention has been paid to the nature of emotional or spiritual health. As one author observed, “The exclusive focus on pathology

Some of us, often through no fault of our own, but perhaps by the contamination of our formal training, have overlooked the journey into grief as a soul-based journey. We need to think and reflect about grief care differently than we now do. Because while its mission in our society is certainly important, our current misunderstanding of its essence misinforms our capacity to reflect on it wisely.

This book seeks to undermine those practices that oppress grieving persons and families and provide interested people with food for reflective thought surrounding the importance of questioning the traditional medical model of mental health care. More important, the content presents an alternative model based on “companioning” versus “treating” one’s fellow human beings in grief.

Critical self-observation would suggest that perhaps we rely too much on psychosocial, biological and psychodynamic constructs that we have been taught to “treat away,” such as depression, anxiety, and loss of control. In our attempt to gain scientific credibility, we may have become our own worst enemies! In our attempt to be respected as part of established mental health care, we may be disrespecting the very people who need our compassionate care.

Without doubt, the grief journey requires contemplation and turning inward. In other words, it requires depression, anxiety and loss of control. It requires going to the wilderness. Quietness and emptiness invite the heart to observe signs of sacredness, to regain purpose, to rediscover love, to renew life! Searching for meaning, reasons to get one’s feet out of bed, and understanding the pain of loss are not the domain of the medical model of bereavement care. Experience has taught me that it is the mysterious, spiritual dimension of grief that allows us to go on living until we, too, die.

## Additional Influences Impacting the Care of Grievors

There are also a number of other cultural, technological and demographic trends that have converged in recent decades and have shaped our modern understanding of grief and grief care:

- **We live in the world's first death-free generation.**

Many people now live into their 40s and 50s before they experience a close personal loss. Today two-thirds of all deaths in the U.S. each year happen to people 65 or older.

In the early 1900s, on the other hand, most children had been to many funerals by the age of ten. (In 1900 over half of all deaths in the U.S. each year were deaths of children 15 or younger.) Aging, illness and death were an everyday part of family life. While we certainly appreciate the medical advances that have helped lower the mortality rate and prolong lifespans, they are also distancing us from aging, illness, death and grief.

- **We live in a fast-paced culture.**

Have you also noticed how we like many things to be fast in our culture? It seems that efficiency or speed is often placed above effectiveness. But grief isn't fast, and it's not possible to "get over it."

- **We're disconnected from each other.**

For starters, many people have lost a sense of community. Not long ago, people shared their lives with those around them. Generation after generation, families lived in the same town or at least the same state. Neighbors visited on the front porch, gathered for meals and took care of each other's children. People knew each other. People cared about each other. Now, like no other time in history, many people feel alone and unconnected to groups.

One recent study found that 71 percent of Americans didn't know their neighbors. Adults and children alike live among strangers. The number of people who report they never spend time with their neighbors has doubled in only the last twenty years.

We have evolved from a country of primary relationships to one of secondary relationships. Primary relationships are ones in which people know each other in a variety of roles—as friends, neighbors, coworkers. Secondary relationships are ones in which people are merely acquaintances. We may sit next to someone at work, but often we don't know much about him—where he lives, if he has a family, what his hobbies are.

As we have connected to the internet, we have disconnected from each other. Our state-of-the-art technology has created a new kind of person, one who is plugged into machines instead of fellow human beings. Some of us talk more via e-mail than we do to our own family members.

- **We value self-reliance.**

Have you noticed that the biggest section in bookstores these days is the self-help section? We live in an era of rugged individualism and independence. We reward people for “doing it on their own.” How many of us grew up learning the North American motto, “If you want it done right, do it yourself”? Yet, when someone in your life dies, you must be interdependent and connected to the world around you if you are to heal. In short, rugged individualism and mourning don’t mix well.

- **We have lost the symbolism of death.**

Philippe Ariès, in his book *The Hour of Our Death*, identifies the symbols representing death in art and in literature, as well as in funeral and burial customs. He maintains, and I agree, that symbols of death are no longer prominent in contemporary North American culture, and that gone with them is a link that in previous generations provided meaning and a sense of continuity for the living.

In generations past, for example, the bereaved used to wear mourning clothes or armbands, often black, that symbolized their sorrow. In some subcultures, mourners also hung wreaths on the door to let others know that someone loved had died. Today we can’t even tell who the bereaved are. For some, memorial flowers, both at the funeral and at the cemetery, are becoming another ousted symbol. Today we opt for the more practical but less spiritual monetary donation: “In lieu of flowers, please send contributions to . . .”

Perhaps the ultimate symbol of death that we are tending more and more to forsake is the dead person’s body. When viewed at the visitation or during the funeral service itself, the body encourages mourners to confront the reality and the finality of the death. Of course, opponents of viewing often describe it as unseemly, expensive, undignified and unnecessary. Yet, seeing and spending time with the body allows for last goodbyes and visual confirmation that

someone loved is indeed dead. In generations past, the body often served as the very locus of mourning; the bereaved came to the dead person's home to view the body, pay their last respects and support the primary mourners. In fact, the body was often displayed for days before burial. Today, with our increasing reliance on closed caskets and direct cremation with no services, we are forgetting the importance of this tradition.

As Ariès writes, “The change (in death’s role in our society) consists precisely in banishing from the sight of the public not only death but with it, its icon. Relegated to the secret, private space of the home or the anonymity of the hospital, death no longer makes any sign.” As we eliminate the symbols of death, we also appear to be eliminating the rituals, historically rich in symbolism, that remind us of the death of others as well as our own mortality.

- **The deritualization of North American culture.** Beyond the loss of death symbols, the bigger issue is that we as a culture appear to be forgetting the importance of rituals surrounding life and death. Death rituals and ceremonies have been with us since the beginning of humankind. Those who have gone before us in this world—in fact, all of our predecessors—embraced both life and death in ceremony. Rituals were a central part of everyday life, whether it was acknowledging new life, sharing a meal together, celebrating the harvest or burying the dead. New life, loss of life and most every major life transition were met with ceremony.

Yet, in recent years, more and more North Americans are questioning the value of planning and participating in ceremonies that honor the “rites of passage” from life to death. There is an unfortunate perception that “educated” and “sophisticated” people are somehow above the need to openly express grief through public ceremony. A growing trend is to “dispose” of the dead and quickly return to “normal life.” The problem is that if we don’t acknowledge the significance of death, we don’t acknowledge the significance of life!

- **We deny our own mortality.**

One woman once said to me, “I don’t do death.” She is not alone. Many people in North America today deny their own mortality. Author Paul Irion reflects that, “Man knows that he is only assuming

invulnerability, that he is ultimately vulnerable, and yet to admit this fact totally is to be defenseless.” In other words, denying our own mortality is better than the alternative

Sigmund Freud also wrote of this theme in his *Collected Papers* when he concluded, “At bottom no one believes in his own death, or to put the same thing in another way, in the unconscious every one of us is convinced of his own immortality.”

In summary, death and grief were a common part of our everyday lives in past generations. Now they are unfamiliar strangers we are ill-equipped to greet and entertain when, from time to time, they come knocking on our door.

## Blessed Are Those Who Mourn Quickly: Managed Care and the Rapid “Resolution” of Grief

As many of you readers know from experience, managed care health plans have developed in recent years in response to the need of insurance providers to limit healthcare (including mental health) benefits. Utilization reviewers representing these various plans usually decide how many sessions counselors and clients will have together, then subsequently review the client’s progress and decide whether or not to authorize more sessions. A 1999 survey discovered that 80 percent of practitioners felt that they had lost complete control over aspects of care that they as clinicians should control (e.g., type and length of care).

Among other things, managed care has us wrestling with issues such as confidentiality, paperwork volume and control over type and number of counseling sessions. However, it is the deeper implications of managed care that keep coming up in my conversations with the many grief counselors and therapists I meet at my workshops or from whom I receive phone calls.

I’m more than concerned about how contemporary mental health care responds to the needs of the bereaved under our present managed care system. Obviously, we as caregivers cannot see people two or three times and “resolve” their grief. While our so-called “advanced culture”

would like to think humans can quickly and efficiently overcome grief, reality suggests otherwise. This popular short-term orientation to mental health care implies a rational and mechanistic understanding of what is actually a spiritual journey involving the heart and soul. As noted in the excellent text *The Heroic Client*, “The bottom line: the medical model of mental health prevails and is so much a part of professional discourse that we do not notice its insidious influence.”

Through no fault of their own, the general public has also been contaminated by this model. Some will approach the counseling relationship and essentially say, “I want you to fix me. The faster, the better. Tell me what I can do to resolve my grief and I’ll do it.” Yet, to heal in grief one must turn inward, slow down, embrace pain, and seek and accept support. I continue to see people at my Center for Loss and Life Transition who essentially believe they have come to find ways to get rid of symptoms. “Help me get rid of these feeling of confusion, numbness and self-doubt,” they seem to be asking. If I quickly moved to do what many in North American culture think I should do, I’d be taking normal grief and mourning symptoms away from people all day long. Instead, I try to “watch out for,” “keep and honor,” and nurture souls as they encounter the hard work of mourning.

Quick fixes may in fact achieve repression of normal symptoms of grief. But at what price? Repressed thoughts and feelings always return to haunt the human psyche. If we try to resist the overwhelming power of grief, it will inevitably express itself through fallout consequences such as difficulty in relationships, addictive behaviors, and chronic depression. I like to refer to these consequences as living in the “shadow of the ghosts” of grief (see page 31).

This current approach to mental health care is actually contributing to an epidemic of complicated mourning in North America. Rather than allowing for the creation of safe places, or sanctuaries, where hurting people can mourn in doses when their heads and hearts are ready, this current model encourages people to deny their feelings. Pain and feelings of loss are seen as unnecessary and inappropriate. Yet, only in having the safety of people and places where we can move toward our wounds do we ultimately “reconcile,” not resolve, death losses.

This current philosophy actually reinforces destructive societal messages such as, “carry on,” “keep your chin up,” and “keep busy.” It’s as if our current model of care shields its very self from acknowledging the human pain and loss, while not providing places for people to mourn.



### Sanctuary

A place of refuge from external demands. A space where the mourner is free to disengage from the outside world. A place where the need to turn inward and suspend will not be hurried or ridiculed.



Managed care has placed the focus on short-term, overt, measurable “progress” in grief. It’s as if getting the person back to work is more important than restoring the soul. In my experience, many utilization reviewers from managed care companies

advocate cognitive-behavioral therapy. A major problem with this is that we cannot help people heal in grief by simply thinking through the experience. As we have come to realize, in matters of life and death we must feel it to heal it. Managed care reinforces trying to “resolve” loss in one’s head, not one’s heart.

The experience of integrating loss into the depths of one’s soul does not take place in sound-bites. Healing doesn’t occur in billable units of time. The human heart doesn’t heal according to a time clock. When it comes to embracing grief, faster is certainly not better.

Caregivers cannot make instant rapport and safety like we make instant jello. What is often a critical ingredient to the integration of loss into one’s life is the active empathy of another human being. To make claims that you can understand another human’s raw grief too quickly is both a lie and an insult.

Of course, if grief were seen as a normal state of being (requiring long-term support and compassionate understanding) rather than as a disorder that needs to be eradicated, we could have even more problems. Why? Because at least now we can use the false language outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, APA 2000* called “Adjustment Disorder with Mixed Emotional Features” to procure reimbursement for a few sessions with grieving

## "BRIEF" THERAPY: A GRIEF COUNSELING METHOD FOR MANAGED CARE...



### 1. "Hi."

One of the shortest, friendliest words in our language. "Hi" develops instant rapport and acknowledges the mourner efficiently. (Avoid polysyllabic "Hellos" or "Good afternoons"; they consume too much time.)

### 2. "WHO DIED?"

THIS CLOSED-ENDED QUESTION GETS STRAIGHT TO THE POINT, ALLOWING THE MOURNER TO (QUICKLY) TELL HER STORY. ENCOURAGE THE MOURNER TO STRING TOGETHER ALL THE PERTINENT FACTS INTO ONE SENTENCE: "MY 42-YEAR-OLD HUSBAND OF 10 YEARS, FRED, DIED OF CANCER THREE MONTHS AGO, LEAVING ME TO CARE FOR OUR 6-YEAR-OLD SON JACK AND 8-YEAR-OLD DAUGHTER HANNAH." AVOID ASKING THE OPEN-ENDED "HOW ARE YOU?" - TALK ABOUT A PANDORA'S BOX OF THOUGHTS AND FEELINGS.

### 3. "I'M SO SORRY!"

This phrase communicates empathy and concern. You are sorry, after all. Look meaningfully into the mourner's eyes as you say this and if you've done a good job of building rapport in your 5 minutes together, reach out and pat her hand.

### 4. "THERE, THERE."

A USEFUL PHRASE WHEN THE "I'M SO SORRY!" LINE ELICITS WEeping. "THERE, THERE" DIPLOMATICALLY SAYS "AGAIN, I'M SORRY, BUT YOU DON'T HAVE TIME TO WASTE CRYING IN MY OFFICE, SO STOP."

### 6. "TAKE CARE."

A COMPASSIONATE YET FIRM CLOSER FOR THE SESSION. SOUNDS POLITE AND EMPATHETIC, BUT THIS PHRASE ALSO SUBTLY PUTS THE BURDEN OF HEALING BACK ON THE MOURNER, AS IN "YOU TAKE YOUR CARES AND WORK ON THEM ON YOUR OWN, BECAUSE WE'RE FINISHED HERE."

### 5. "TIME HEALS ALL WOUNDS."

This useful cliché promises the mourner that she will heal from this loss, giving her hope for the future. However, healing takes time and time is something the two of you don't have together, so move on to step 6.

"BRIEF" THERAPY, as described above, is economical, efficient and healing therapy for mourners in the managed care setting. TOTAL SESSION TIME: 10 MINUTES.

people. (While some may question the ethics of this practice, it happens every day in counselors' offices across the U.S.) If, on the other hand, we were to make the mistake of giving a V-Code for "normal bereavement," we may well get a phone call or letter from the utilization reviewer stating "no sessions authorized."

We all are familiar with the Biblical beatitude, "Blessed are those who mourn, for they shall be comforted." The new managed care version might read, "Blessed are those who mourn quickly and efficiently in response to abbreviated counseling techniques, for they shall meet our criteria for successful treatment."

## Foundations of "Companioning" One's Fellow Human Beings

I've always found it intriguing that the word "treat" comes from the Latin root word "tractare," which means "to drag." If we combine that with "patient," we can really get in trouble. "Patient" means "passive long-term sufferer," so if we treat patients, we drag passive, long-term sufferers. Simply stated, that's not very empowering .

On the other hand, the word "companion," when broken down into its original Latin roots, means "messmate": *com* for "with" and *pan* for "bread." Someone you would share a meal with, a friend, an equal. I have taken liberties with the noun "companion" and made it into the verb "companioning" because it so well captures the type of counseling relationship I support and advocate. That is the image of companioning—sitting at a table together, being present to one another, sharing, communing, abiding in the fellowship of hospitality.

Companioning the bereaved is not about assessing, analyzing, fixing or resolving another's grief. Instead, it is about being totally present to the mourner, even being a temporary guardian of her soul.

The companioning model is anchored in the "teach me" perspective. It is about learning and observing. In fact, the meaning of "observe" comes to us from ritual. It means not only to "watch out for"

but also “to keep and honor,” “to bear witness.” The caregiver’s awareness of this need to learn is the essence of true companionship.

If your desire is to support a fellow human in grief, you must create a “safe place” for people to embrace their feelings of profound loss. This safe place is a cleaned-out, compassionate heart. It is the open heart that allows you to be truly present to another human being’s intimate pain.

As a bereavement caregiver, I am a companion, not a “guide”—which assumes a knowledge of another’s soul I cannot claim. To companion our fellow humans means to watch and learn. Our awareness of the need to learn (as opposed to our tendency to play the expert) is the essence of true companionship.

A central role of the companion to a mourner is related to the art of honoring stories. Honoring stories requires that we slow down, turn inward and really listen as people acknowledge the reality of loss, embrace pain, review memories, and search for meaning.

The philosophy and practice of companionship interfaces naturally with hospitality. Hospitality is the essence of knowing how to live in society. Among the ancient Greeks, hospitality was a necessary element of day-to-day life. In a land where borders were permeable, it was important to get to know one’s neighbors as potential friends. One way to do this was to share meals together. First, the guest and host would pour a libation to the gods. Then they would eat (“break bread”) together. Then, after the guest was full, they would tell each other their stories with the guest going first. Often, tears were shed as their stories were highly personal; battles, family, histories and life tragedies all were a part of these stories. After the evening together, the host and guest were potential allies. Still today, oftentimes “breaking bread together” and then “telling personal stories” are key elements of companionship people in grief.

Henri Nouwen once elegantly described hospitality as the “creation of a free space where the stranger can enter and become a friend instead of an enemy.” He observed that hospitality is not about trying to change people, but offering them space where change can take place.

He astutely noted that “hospitality is not a subtle invitation to adopt the lifestyle of the host, but the gift of a chance for the guest to find his own.”

Also interesting to note is that the *Oxford English Dictionary* defines “companion” as “to accompany, to associate, to comfort, to be familiar with.” This definition is actually illustrative of what it means to companion. In one sense, the notion is of comforting someone, which relates clearly to what a mourner needs and deserves. In another sense, the notion is of knowing someone, being familiar with that person’s experiences and needs; this notion clearly relates to the process of becoming familiar (being open to being taught by another), which can take place through the “telling of the story.”

In sum, companioning is the art of bringing comfort to another by becoming familiar with her story (experiences and needs). To companion the grieving person, therefore, is to break bread literally or figuratively, as well as listen to the story of the other. Of course this may well involve tears and sorrow and tends to involve a give and take of story: I tell you my story and you tell me yours. It is a sharing in a deep and profound way.

The sad reality is that being a fellow companion in contemporary times seems to be a lost art. Many people (including trained mental health caregivers) may not know how to truly listen, really hear, and realize how to honor another person’s story. I often say, “It’s not so much what is new in grief care, it is what we lost that we once had.”

## Advocating for the “Companioning” Model of Grief Care

A not-so-secret hope of mine is that the philosophical model of companioning explored in this book will eventually replace the more traditional medical model, which teaches that grief’s goal is movement from illness to normalcy. The companioning philosophy empathizes with the human need to mourn authentically without any sense of shame. The companioning model encourages every one of us to discover how loss has forever changed us. The companioning model understands the normalcy of drowning in your grief before you tread



## Treatment vs. Companionship For Spiritual, Emotional, Existential Issues

### Treatment Model

To return the mourner to a prior state of homeostatic balance ("old normal").

Control or stop distressful symptoms; distress is bad.

Follows a prescriptive model where counselor is perceived as expert.

Pathology rooted in sustained relationship to dead person.

Positions the griever in a passive role.

Grieving person ranges from compliant to noncompliant.

Quality of care judged by how well grief was "managed."

Denial interferes with efficient integration of the loss and must be overcome.

Establish control; create strategic plan of intervention.

Provide satisfactory answers for all emotional, spiritual questions and dilemmas.

### Companioning Model

Emphasizes the transformative, life-changing experience of grief ("new normal").

Observe, "watch out for" "bear witness" and see value in soul-based symptoms of grief

Bereaved person guides the journey; "teach me" is the foundational principle.

Is a normal shift from relationship of presence to relationship of memory.

Recognizes the need for mourner to actively mourn.

Grieving person expresses the reality of being "torn apart" as best he can.

Quality of care monitored by how well we allowed the griever to lead the journey.

Denial helps sustain the integration of the loss from head to heart. It is matched with patience and compassion.

Show up with curiosity; willingness to learn from the griever.

Honor the mystery; facilitate the continuing "search for meaning"; no urgency to solve or satisfy the dilemma.



water, and that only after treading water do you go on to swim. The companioning model helps the caregiver acknowledge the responsibility for creating conditions that allow the grieving person to embrace the wilderness of grief.

## My Principles of “Companioning” the Bereaved

Outlined below are twenty principles that undergird my work with bereaved persons and families. My hope is that you will challenge yourself to write out whatever supports you in your own work with the bereaved.

For the Companion Counselor...

- 1...bereavement, grief and mourning are normal experiences; however, they are often traumatic and transformative.
- 2...the helping process is seen as a collaborative, companioning process between people. The traditional medical model of mental health care is seen as inadequate and as a complicater to mobilizing the resources of the bereaved person. As a companion, I try to create conditions that engage people actively in the reconciliation needs of mourning.
- 3...true expertise in grief lies with (and only with) the unique person who is grieving. Only he can be the expert of his grief. The companion is there to learn from the griever and to bear witness to and normalize his grief journey.
- 4...the foundation upon which helping the bereaved person takes place is in the context of an encouraging, hope-filled relationship between the counselor and the bereaved person. The widely acknowledged core conditions of helping (empathy, warmth and caring, genuineness, respect) are seen as essential ingredients in working with bereaved people and families.
- 5...traditional mental health diagnostic categories are seen as limitations on the helping process. The concept of “gardening” as opposed to “assessing” better describes efforts to understand the meaning of the death in the bereaved person’s life. I strive to understand not only the bereaved person’s potential complications of the grief journey, but also individual strengths and levels of wellness.

- 6...the counseling model is holistic in nature and views bereaved people as physical, emotional, cognitive, social and spiritual beings. Each person is unique, and seeks not just to “be,” but to become.
- 7...the undergirding theoretical model is systems-oriented and sees the bereaved person as being impacted by interdependent relationships with persons, groups, institutions and society.
- 8...the focus of companioning the bereaved person is balanced between the past, the present and the future. Learning about past life experiences (particularly family of origin influences), and the nature of the relationship between the bereaved person and the person who died helps me understand the meaning of the death and the grief and mourning process for this unique person.
- 9...a bereaved person’s perception of her reality is her reality. A “here and now” understanding of that reality allows me to be with her where she is instead of trying to push her somewhere she is not. I will be a more effective helper if I remember to enter into a person’s feelings without having a need to change her feelings.
- 10...a major helping goal is to provide a “safe place” for the bereaved person to do the “work of mourning,” resulting in healing and growth. A bereaved person does not have an illness I need to cure. I’m a caregiver, not a cure-giver!
- 11...people are viewed from a multicultural perspective. What is considered “normal” in one culture may be perceived as “abnormal” in another culture. On a shrinking planet, my caring and concern must be global in its perspective.
- 12...spiritual and religious concerns and needs are seen as central to the reconciliation process. To be an effective counselor, I must be tuned into helping people grow in depth and vitality in their spiritual and religious lives as they search for meaning and purpose in their continued living.
- 13...men and woman are seen in androgynous ways that encourage understanding beyond traditional sex role stereotypes. Artful companions understand that bonded relationships can exist beyond the bounds of traditional male-female partnerships acknowledged only by marriage.

- 14...the overall goal of helping the bereaved is reconciliation, not resolution. As companion, I have a responsibility to help the bereaved person not return to an “old normal,” but to discover how the death changes her in many different ways. Traditional mental health models that teach resolution as the helping goal are seen as self-limiting and potentially destructive to the bereaved person.
- 15...right-brain methods of healing and growth (intuitive, metaphoric) are seen as valuable and are integrated with left-brain methods (intentional, problem solving approaches). This synergy encourages a more growth-filled approach to bereavement caregiving than do historical mental health models (primarily based on left-brain methods) of caregiving.
- 16...“complicated” mourning is perceived as blocked growth. The “complicated mourner” probably simply needs help in understanding the central needs of mourning and how to embrace them in ways that help him heal. Most people are where they are in their grief journeys for one of two major reasons: 1) That is where they need to be at this point in their journey; or, 2) They need, yet lack, an understanding, safe place for mourning and a person who can help facilitate their work of mourning in more growth-producing, hope-filled ways.
- 17...helping avenues must be adapted to the unique needs of the bereaved person. Some people are responsive to group work, some to individual work, and some to family systems work. Many people are best served, in fact, by seeking support from lay companions who have walked before them in the grief journey.
- 18...there is a commitment to using educational, primary prevention efforts to impact societal change because we live in a “mourning-avoidant” culture. I have a responsibility to inform other people throughout the world of the need to create safe places for people to mourn in healthy ways.
- 19...there is a responsibility to create conditions for healing to take place in the bereaved person. The ultimate responsibility for eventual healing lies within the person. I must remember to be responsible *to* bereaved people, not responsible *for* them.
- 20...excellent self-care is essential, for it provides the physical, spiritual, emotional, social and cognitive renewal necessary for the counselor to be an effective, ongoing companion in grief.