DEATH, DYING, AND GRIEVING:
PROVIDING A MINISTRY OF CARING

By

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B.Min., Luther Rice Seminary, 1983
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ABSTRACT

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R. L. White, Jr.
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This project dissertation, entitled Death, Dying, and Grieving: Providing a Ministry of Caring, approaches the issue of establishing a ministry of caring for parishioners who are experiencing grief. Also included in this work is how the disciplines of sociology, anthropology, archaeology and psychology have attempted to address the issue of death and grief. A biblical history of death, dying, and grief is discussed and a theological framework for grieving.

The dissertation gives a description of the development of a counseling group, support group and all of the intricacies involved in the institution of a ministry of caring for the Mount Ephraim Baptist Church in Atlanta, Georgia.
DEDICATION

This dissertation is dedicated to my parents, Rev. and Mrs. R. L. White, Sr., who first taught me about the kingdom of God; my wife, Lorraine, who is my constant companion and bulwark support in my ministry; and my children, Patrina, Chris, Lawrence, Eudora, and Tiffany, who have continued to love me in spite of the demands and constraints that we have experienced.
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Without the extensive support of so many people, this dissertation would not be a reality. Special thanks to the following persons to whom I will always be grateful:

The members of Mount Ephraim Baptist Church, who for the last nine years have been very understanding and supportive during my educational pilgrimage. I thank God for them daily.

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Dr. Benjamin Hinton, who drove from North Carolina upon request without hesitation, and above all, for being a friend;

The members of the ministry of caring, a by-product of this dissertation, for their willingness to become transparent in the preparation for this ministry and their willingness to share their identity and personal experiences to be used in this project;

The members of the pilot support group which guarantees that countless people in grief will experience healing and resolution;

Finally, the invaluable support given by Ms. Donnie Griffin, a devoted member of our church who consented to be a research assistant; for her time and talent in locating resources for this project. During her involvement in the research process, she also experienced a healing.

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INTRODUCTION

If there is one thing that has become apparent to me, it is the fact that one of the greatest challenges that individuals face is the question of how do we deal with death. The very word, death, is suppressed by the majority of those with whom we talk. Even sympathy cards try to avoid using the word death. A study of sympathy cards showed that only 3% mention the word death, but words such as "leave taking," "going home," "expired" are all used to get around even dealing with the word dead.¹ Dying is something we all must face, but it is also something that we refuse to talk about. Whenever there is a subject that is only approached when it strikes in our homes or the homes of our acquaintances, it is inevitable that there will be misunderstandings about the subject. Death fits into that category. After being in ministry 27 years, the one facet of ministry that has been most difficult for me is ministering to the bereaved parishioners.

In the pursuit of the D.Min. degree at Interdenominational Theological Center, one of the first seminars I was required to attend focused on identifying my model of ministry. Having gone through the process, I identified my model of ministry as a counselor-healing ministry. The guiding principle for my ministry is based on two individual beliefs:
1. Everyone you meet is hurting from something emotionally.

2. It is not God's will for anyone to continuously hurt without resolution.

Because of my model of ministry, much of my effort has been toward emotional healing. One of the areas that has been staring me in the face, like a big elephant, is in the area of grieving. Over the years, after a death in the church family I would say to people, "If you need counseling, stop by and I'll be glad to talk with you," but never was I deliberate in providing a ministry of care that addressed specifically death, dying and grieving.

During the last quarter of 1993 and the first quarter of 1994, there were more deaths in our church family, the Mount Ephraim Baptist Church, than at any time in our church's 24 years of ministry. It was during this time that the requests for counseling escalated, and as I would counsel family members I began to notice that much of the grief being expressed was not just for the present loss, but in many instances, the present death aggravated grief that remained from previous losses. This "big elephant" began to materialize. It was during this period that the magnitude of the problem became apparent. My desire to approach this area of ministry became more of an imperative with each experience and this imperative has been the driving force that has caused me to choose this area of ministry—death, dying and grieving—to be the focus of my doctoral dissertation.

Since my ministry is a healing ministry, the content of the entire ministry should be directed toward physical and spiritual healing. Hence, in every auxiliary,
Christian education class, Sunday school class, choral presentation, and sermon, there should be a healing component. Recognizing that the area of death, dying and grief is a priority now, I will be more deliberate in providing a visible care ministry for our congregation. Here I will list the broad approach and the dissertation will narrow the approach to the training of lay counselors for the task of effective counseling and the implementation of a support group and its results.

From a broad perspective, beginning in January, there was a permanent announcement placed in our church bulletin that gave the instructions of who to call in the event of the death of a loved one. In our annual stewardship seminars, there will be an inclusion of a discussion on the subject of death, grief, wills and other pertinent issues that surround this issue. At some period each year, each of our auxiliary heads will be required to either present or have one of our care ministry participants to present helpful information on how we can learn to cope when death strikes one of our family members. We will also begin our active counseling ministry using the newly trained lay counselors and we will initiate our first support group. The focus of this dissertation will be on the counselors and the support group.

In Chapter I we look at the setting for ministry, autobiographical reflections of the student, the goals of the project, and the working definitions of words used in this project.
In Chapter II we study grief from a biblical perspective. We examine a theological framework for grieving, and we delve into the discussion of how different disciplines of sociology, psychology, anthropology and archaeology have attempted to address the issue of death, dying and grief.

Chapter III includes a study on the question of ethics in death, dying and grief. We also look at the issues of euthanasia, suicide, and truth-telling.

In Chapter IV the development of the process, as it relates to the training of the counselors and instituting the grief support group, is reported. This includes a report of each teacher's and student's personal reflections following each session, and reflections from the students who made their observations during one of the scheduled classes. This chapter also includes an evaluation of the component of counselor training using the results of the questionnaire and the evaluation from the instructor's standpoint.

In Chapter V we examine the entire ministry of caring, how it is organized, the expectations of each component, how the support group is expected to function, and the information that is included in their training process with the intention of maximizing the effectiveness of the process.

In the sixth chapter the entire process is examined to determine whether or not the goals of the project have been met. Included in the evaluation are the results of the questionnaire that objectively measured the success of the process, reflections on the process by one of the members of the support group who was helped, and
weekly assessments by the two group coordinators (trained counselors) who showed exceptional abilities and interest in the entire ministry of caring.

Chapter VII focuses on the need for continuous evaluation and modification of the process.

Chapter VIII, the conclusion, gives a recapitulation of the content of the material found in each chapter of the dissertation.

The appendix includes the following:

1. the syllabus used in the lay counselor training;

2. information used in counselor training sessions;

3. the results of the pre-test and post-test;

4. a copy of the questions and answers discussed in the qualifying examination; and

5. other pertinent information that helps to make this dissertation fully comprehensible.

Finally, the bibliography includes primary sources, secondary sources as well as other suggested readings.

It is hoped that this introduction will inspire the reader to examine this dissertation with eager anticipation.
NOTES

CHAPTER I

THE MINISTRY SETTING

The City

The ministry setting in its larger context is located in Atlanta, Georgia. Historically, the geographical location of Atlanta was inhabited by the Creek and Cherokee Indians hundreds of years before the Europeans came. A Creek settlement at the Chattahoochee River called "Standing Peachtree," and the land south of the river are said to have been won from the Cherokees in a ball game competition played with land rights at stake. In 1814 Europeans build a small military outpost on this location that developed into an active trading post.

The railroads put Atlanta on the map. In 1837, railroad interests decided to build a line that would connect Chattanooga, Tennessee with rails already in place in Augusta, Georgia. They needed a midway point to link up the two locations. Atlanta first became known as Terminus, then Marthasville to honor the then governor's daughter. The town that grew around the railroad depot was renamed Atlanta, for the Western and Atlantic Railroad, in 1845. It was from the start, as observers note, potentially more successful and had a "hustle" uncharacteristic of southern cities.
During the Civil War, Georgia was one of the states that seceded from the Union, and Atlanta had already become a major transportation hub. Its developed industry made the city critical for supplying the Confederacy. This was in 1861.

Union General William Tecumseh Sherman rightly theorized that a crippling blow to Atlanta would mean crippling the Confederacy, and with that he began his campaign in 1864. He felt that Atlanta was too important a place in the hands of the enemy to be left undisturbed. Sherman later sieged Atlanta for 75 days, crippling the city. General John Bell Hood surrendered the city on September 2, 1864. Even though the terms of the surrender were to leave the city, its citizens and property unharmed, General Sherman ordered the city evacuated. He, then, burned it down, uprooted the rail lines, and continued to burn a 60-mile wide line across Georgia to the Atlantic Ocean. The rampage accomplished its goal—the South surrendered the following year. When Sherman left Atlanta, every business was leveled as were most homes. Only 400 of the city's 4500 buildings were left standing.

Atlanta rebuilt quickly and was named the capital of Georgia in 1867. It is said that Atlanta was named capital of Georgia when the owners of the motels/hotels in the old capital of Milledgeville refused to rent rooms to black constitutional delegates.

In the 1880s, tiny Southern Bell opened the city's first switchboard; a local drug store began selling a new "headache-and-hangover" tonic called Coca-Cola.
The start of Atlanta's solid business base took hold. In 1867, Atlanta University was founded as the first of six schools devoted to educating former slaves.

During the Civil Rights Era, the population had grown to 50-50 (whites to blacks), and while segregation was the official policy over 60 years, for the most part, it gave way quietly to integration in the 1960s. Due to Atlanta's then emerging coalition of the progressive whites, the Black elite, politicians and industrialists, as well as the strong influence of Dr. Martin Luther King, Jr. and the Southern Christian Leadership Conference (SCLC), Atlanta's racially progressive reputation was established in the early days by such mayors as: Ivan Allen, Jr., the only southern mayor to support federal civil rights legislation in 1963; William B. Hartsfield, who in 1959 proclaimed Atlanta "the city too busy to hate." In 1973 Atlanta elected the first black mayor of a major southern city, Maynard Holbrook Jackson. This writer had the privilege of serving on his Religious Advisory Committee. Following Jackson, former United Nations Ambassador Andrew J. Young served as mayor. Jackson then served as mayor for a second time. In 1993, Bill Campbell was elected mayor, becoming the third successive African American mayor. The strong mayoral leadership has ensured strong participation in the city's economic base by African-American firms and has helped Atlanta gain a reputation for economic opportunity across the board.¹

Today, 2.8 million people live in the 18-county expanded metropolitan area; 394,000 live within the city limits. Atlanta distinguished itself by competing for and
being awarded the 1996 Summer Olympic Games that will convene July 20-August 4. In 1995, the city's baseball team, the Atlanta Braves, won the coveted World Series. This great accomplishment has brought much satisfaction to a city formerly known as "Losersville."

Atlanta has a strong economic base with Hartsfield International Airport, the world's largest airport, and the Metropolitan Atlanta Rapid Transit Authority (MARTA) rail system. The city has attracted more than 1,000 U.S. companies, 300 international firms and added 500,000 metro-region jobs since 1980. Its population growth during that period catapulted it into the top ten list of America's largest cities. The business environment is supported by 38 colleges and universities, the Centers for Disease Control and Prevention (the only federal agency not headquartered in Washington, DC), and innovative public/private partnerships such as President Jimmy Carter's humanitarian "Atlanta Project" that also reveals the city's strong community connection. As a resident of Atlanta for the past 26 years, this writer has witnessed the massive growth and opportunities as they have proliferated during the last quarter century.

The Community

The community in Atlanta where the ministry setting is located is known as the Howell Station Community. Howell Station is an aged community located within a mile of downtown Atlanta. This community recently applied for and received the status of "historical community" from the United States Government.
It is a community of 2,693 persons and is approximately 55% white. The remaining population is African American with the exception of 22 residents of other ethnic origin.³ Howell Station is essentially a blue-collar neighborhood. Its housing is old and there is not a great deal of building nor renovation evident.

It is in this neighborhood that the Mount Ephraim Baptist Church is located. The relationship between the church and the community has not been ideal. The African Americans in the community have been generally passive, while the white community has been cool to downright bitter toward Mt. Ephraim. The church moved into the community in 1986 amid efforts to keep the church out by the white residents. As a strategic decision, a proposal written by the pastor (this writer) and accepted by the church, Mt. Ephraim opted to stay within the general vicinity where it had already ministered for 16 years. The Howell Station Community is only 1.9 miles from the former location. It was/is the position that the church is a stabilizing factor in any neighborhood, and to uproot and move to the suburbs where many of its constituents could not attend would be detrimental to both the church and community. After almost two years of searching for a suitable location, the Howell Station site was found. The members were anxious to move because we had outgrown the current location and were having problems accommodating the membership growth. The community, mostly white, decided to fight the move. We needed zoning changes which required public hearings. We also had variance
hearings, and at each hearing the Neighborhood Planning Unit (NPU) was there to oppose. In each instance, the church prevailed.

The white community has been, to say the least, adversarial. An example of this can be seen from this experience. When the variance was granted because of the lack of adequate parking, one of the stipulations of granting the variance insisted upon by the NPU was that as soon as possible, the church would purchase additional land for parking. Three lots became available. Mt. Ephraim bought the lots in an effort to comply with the stipulations for parking; however, the community showed up to oppose the lots being used for parking. Again, the church prevailed. A year later, the NPU searched all of the permits and found one violation. In turn, the community sought to block cars from parking in our own parking lot. Again we prevailed. This kind of harassment has been revealing as to the community relationship between Mt. Ephraim and the whites in the community. Presently, there are plans by the church to begin a public relations project to help improve the relationship with the immediate neighborhood.

The Church

The Mount Ephraim Baptist Church was founded June 15, 1970 by its present pastor, R. L. White, Jr., in his living room. Thirteen members joined at the first meeting and that began what was to become one of the largest and well-known churches in Atlanta. Through 25 years of growth, the church has distinguished itself as the first African-American church to become the fastest growing church in North
America⁴ in 1988 and was in the top 1% of all churches in 1990. The church is
guided by the theological viewpoints generally accepted by Baptists universally.
The Baptist Church is undergirded by eighteen Articles of Faith,⁵ and while there
is a comprehensive statement of faith, Baptists are principally known by their views
concerning Baptism by immersion, the priesthood of all believers, the eternal
security of the believers, and the fact that the Baptist Church is a free church. Each
Baptist church is its own sovereign power, and there is no hierarchy. There are,
however, associations, districts, state conventions, national Baptist conventions, and
the World Baptist Alliance. These are voluntary organizations and congregations
join them to stay amid the mainstream of the Baptist doctrines. None of these
organizations can exercise any authority over any Baptist church.

Within our denomination, there are churches known as being conservative
or liberal. The conservative church is essentially fundamental in its biblical
interpretation, and rigidly enforces a system this student calls legalism. Mt.
Ephraim would be known as a liberal church in the denomination because of its
departure from some of the traditional views embraced by the majority of Baptists.
This congregation has embraced and ordained women in ministry, and has
appointed the church deaconess board within the same authority as their
counterparts, the deacons. Normally, the deaconess board consists of wives of the
deacons, but Mt. Ephraim has been intentional on deleting sexism from its structure.
The traditional Baptists of years gone by (and some present) would consider Mt. Ephraim as a renegade church, with a heretical pastor and would refuse to worship with our congregation because of these views. That is an advantage of the free church. We decide our powers as long as they are not in opposition to the Holy Bible.

The congregation is one with a lively worship service that, at times, resembles the high praise often seen in the charismatic movement. Mt. Ephraim has a strong sense of social ministry with ongoing care for the needy and homeless. It operates a program that feeds on the average of 100 homeless men per day. The church has a prison ministry, as well as a ministry to the nursing homes and Hollywood Courts, a housing project.

The organizational structure is that of an autonomous congregation that practices self-rule. Its policies and practices are within the theological framework of the Baptist doctrine. The church has a staff consisting of the senior pastor, the minister to the sick, the Christian education director, and a youth director. There are 29 other staff and support employees. Mt. Ephraim has an annual budget of $1.5 million.

The officials--deacons, deaconesses, and trustees--meet jointly each month for the purpose of the effective operation of the church. There is one general conference at the beginning of the year for the entire membership. It is at this meeting that the year's program for the church is presented. When approved, the
administration is then able to implement the approved plans for the year. When unforeseen needs arise, a special meeting can be called at any time. The official board deliberates on proposals and other business. When a consensus is reached, the recommendations are made to the congregation, which then accepts or rejects the recommendations by a majority vote.

The interpersonal relations are basically relaxed and informal. The members are constantly reminded that they are spiritual sisters and brothers in Christ who should show love and a genuine concern for each other as commanded by Jesus in John 13:34.

There are several significant factors that impact the church's present situation:

1. It is a comparatively young congregation.
2. The church has been located at its present site for only nine years.
3. The relationship with the community has been at times confrontative.
4. The ministry has to make special efforts to include large variations in programs since it is such a diverse group.

**Autobiographical Reflections**

The 1940s was not a good time for Blacks in the south, especially in deeply rural, southern towns such as Dudley (Laurens County), Georgia. It was in this environment that I was born March 31, 1944. My first memory was watching my father farm. During this time it was difficult to be a farmer and a preacher, but my
father managed to do both. I wanted to be like him—farmer and preacher. That was 
a notion from which I quickly recovered when I became old enough to pick cotton.

While I was very young, we left the farm and moved to Dublin, Georgia. The 
first school I attended was in a two-room building that was built by the Sandy Ford 
Baptist Church. Mrs. Ivery taught all six grades, moving from one grade to the next 
during the course of the school day. As a little boy in school, I could perform better 
than any other child my age. Mrs. Ivery skipped me from the first to the third 
grade. My elementary school experience was that of being very studious, but 
extremely poor; so poor that the other children would laugh at my clothing.

In 1955, my father decided to move to Macon, Georgia, 55 miles away. He 
felt that he would have a better chance of getting a good job. It was in Macon that 
I graduated from elementary and high school.

Religiously, I was fully aware of church as far back as I can remember. My 
mother taught my siblings and me to sing as a group, and I would also sing solos. 
I knew the 66 books of the Bible by the time I was eight years old.

The way my life unfolded causes me to believe that God was ordering my 
footsteps toward becoming what I am today. I became a shoe shine boy at Moon's 
Barber Shop by the time I was thirteen. This gave me a great experience in learning 
how to deal with and please different personalities. This asset would be invaluable 
for me years later. By then, my eldest brother had grown up and enlisted in the 
Army. Our family group stopped singing, and I organized a gospel group that sang
at different functions. I was always the manager or leader of the group. There were many disappointments; however, these experiences proved to be very good training. I continued to sing until I finished high school.

Shortly after graduation I married, moved to Washington, DC, and became deeply involved in the church. Again, I organized a gospel singing group, "The Mighty Wonders." We gained significant notoriety and traveled throughout the eastern United States.

It was at the height of my involvement with the group and the church that I was called by the Lord to preach. I did not want to preach, having seen the ordeals through which my father had gone. More than that, my wife was not interested in religion, and I knew if I started preaching that would be the end of our marriage. I was afraid to tell her about my call to the ministry. Strangely enough, she told me, "The Lord has called you to preach, and if you do I'll never spend another night with you." The fear of my home breaking up kept me from announcing my call to the ministry. Because of my desire to be obedient, I was in much turmoil for about two years. With a strong conviction I announced my call, knowing the possibility of a marital breakup.

After my announcement, I organized the Mt. Siloam Baptist Church. Within a year my marriage ended. I felt so humiliated and ashamed until I put in for a transfer to Atlanta with the U. S. Post Office. The transfer came through two or three years before I expected, and again I was devastated about leaving the church.
I loved so much. I attempted to reverse the transfer, but was informed that I would lose my job if I did not move to Atlanta. I came to Atlanta a broken man. Feeling that I had lost everything, I still knew that I had been called by God. I left Mt. Siloam, the church I had organized, to another minister. I grieved heavily about my situation.

After being in Atlanta for approximately six months, I became a musician for the National Independent Gospel Singing Group. Again, there was a large following. Robert Owens (Mt. Ephraim's first deacon), suggested to and prodded me to organize another church. I did not want to do this because I was hoping to return to Mt. Siloam Baptist Church in Washington one day. After a while I relented and organized the Mt. Ephraim Baptist Church with thirteen members. It began to immediately grow.

During this time I had remarried, not recognizing that I was emotionally and spiritually unready for another marriage. My second wife was totally different from the way she presented herself to me. She was insanely jealous, often accusing any female who called of being my "woman." The marriage became abusive, both physically and verbally. I almost became alienated from my family. She even accused my parents of "getting" women for me. During the next six years, things became progressively worse until I was ready to leave another church that was thriving because of my domestic situation. I decided to remain in the marriage for the sake of the church, but I became so wounded until it became evident to the
members of the church. I thought I was hiding everything, not knowing that she was talking to all of the heads of the auxiliaries and even to the state president of the General Missionary Convention. She had convinced all of them that I was a man without character.

At a point of breakdown, I prayed to God for deliverance and asked God, "If and when I was to leave, help me to know the time." The time came one Sunday morning when I was on my way to church and asked my wife if she had any money. She screamed and told our children that I was "leaving her for another woman." The pain of hearing her outburst caused me to know that the moment had come. I left and gave my future to God. By now I had matured and recognized that people could still need me in spite of my stormy domestic relationships. In 1978 when my divorce was finalized, the church experienced more growth in that year than the previous eight years. For two years I preached in shame, knowing the notorious things my ex-wife had said about me. The only thing that kept me at Mt. Ephraim was the strong support that I received.

During this time I received an invitation to preach at Mt. Joy Baptist Church in Washington, DC. The members were willing to call me as their pastor; however, I told them, "If you do not hear from me within a week, I am not interested." By then my faith in what God had been doing in my life caused these words to reverberate in my mind, "Ride the storm out." It was then I became convinced I was
where God wanted me to be. I decided to commit myself to Mt. Ephraim and began
to give it my all.

Two years later I married my present wife, and it has been most rewarding
having a mate who shares the same goals. We have been married for sixteen years,
and I pray that God will allow us to live out our lives together.

I have since pursued my education and have seen the need for healing in
others since I know the real meaning of pain. Through it all, I have not always been
right, many times I have failed miserably. It is because of God's "Amazing Grace"
that God has allowed me to rebuild my life and become a "wounded healer,"
helping people to realize that God is like a potter. God can put your life back
together again.

**Goals of the Project**

There are several goals that I would like to see accomplished with the
implementation of this project:

1. Set in motion an ongoing process that helps people who are grieving
   through the grieving period to resolution;

2. Train counselors to be familiar with the different stages of grief, the
   intricacies of planning a funeral, the different problems that surface
   surrounding death, and how to counsel someone grieving without
   adding the counselor's emotional "stuff";

3. Organize the counselors, along with others into a care group that speaks
   specifically to the needs of bereaved members;
4. Organize a support group of peers who are experiencing like trauma to be helpers of each other in the healing and resolution of the loss of a loved one;

5. Move death and dying off the list of taboos and present it in a way that our constituency can more readily discuss death without feeling threatened;

6. Examine thoroughly the possibility of other congregations using this model.

The goals stated above are ambitious goals that, in my estimation, are not unreachable, and I will vigorously pursue the desired outcome.

**Research Methodology**

The research for this project touches upon several areas. The normative data from authors who have written on death, dying and grieving of loved ones come from the Atlanta University Center Robert W. Woodruff Library, the Emory University Library, and the Cobb County Library. In every city that I visit that has a bookstore I have made it a practice to browse and purchase whatever books would prove helpful. Additionally, there were six to eight dissertations on the subject matter that were reviewed. Helpful information was suggested by the chairman of my dissertation committee and the director of the D.Min. program, Edward P. Wimberly and Stephen C. Rasor, respectively. They also provided books from their personal libraries. A total of 73 books were used in the research.
While perusing the books, the instruments that would measure the effectiveness of the project were developed. These instruments are in the form of questions that were used to pretest and post-test those participating in the project.

The training of our counselors focused on the counselors knowing themselves and they, too, were tested for their personal grief experiences because of the importance of knowing themselves. The primary focus, however, was on the information being taught. They were given so much information that the training period was extended from four to eight sessions with weekly quizzes (oral and written). At the end of the sessions a comprehensive examination was given and an evaluation of these classes was made. (See appendixes for information.) There were 26 counselors who participated and were faithful to the process.

For the support group, two facilitators were chosen. They were not required to have prior training in grief counseling, though it was made known that training would be helpful. The requirements for qualification were:

1. The facilitator should be one who has had actual experience with a painful emotional loss.

2. The facilitator should have the ability to help the group to focus on a particular facet of grieving in each session without allowing the discussion to be dominated by one or two persons.

3. The facilitator should be one who leads the group in making decisions about the particular group's direction.
These facilitators were chosen by this author and monitored closely for procedure. The results are discussed in Chapter VI. There were fourteen who enrolled in the support group.

**Definitions**

**Bereavement** - "to rob," "to plunder," or "to dispossess." The meaning is derived from the idea that death robs us from our loved ones.

**Bereavement Reaction** - the physiological or behavioral responses to bereavement. These responses vary in intensity, duration and frequency, from one individual to another.

**Complicated Grief** - when a person starts out in the normal grieving period and somewhere along the way becomes stuck or fixated in one phase or another, unable to move on to resolution.

**Defense Mechanism** - any enduring pattern of protective behavior designed to provide a defense against the awareness of that which is anxiety-producing.

**Denial** - the inability to face the fact that a loved one is dead.

**Ego** - the central core around which all psychic activities revolve. In the classical theory the ego represents a cluster of cognitive and perceptual processes including memory, problem solving, reality testing, inference making, self-requested striving and the like that are conscious and in touch with reality. It is a kind of psychological touchstone that serves as a basis of one's interests, values, attitudes and desires.
Euthanasia - the practice of allowing the loved ones of severely ill patients to end the patients' lives, either voluntarily or otherwise.

Grief - an intense feeling or emotional suffering caused by a loss through death.

Grief Process - the changes of feeling states over time. The reactions to grief are physiological (crying, sighing) and psychological (sadness, anger, guilt).

Grief Work - mourning. This phrase was coined by Lindermann (1944) who explained that the process of experience grief required a tremendous amount of both physical and emotional energies. He stated, "When grief work proceeds without complication, the griever is able to reach the point of resolution and reinvestment in living."

Guilt - the blaming of one's self for circumstances surrounding the death of a loved one.

Healing - to become healthy again; free from impairment.

Id - the deepest component of the psyche, the true unconscious. Entirely self-contained and isolated from the world about it, it is bent on achieving its own arms. The sole governing device is the pleasure principle. The task of restraining this single-minded entity is a major part of the ego's function.

Libidinal - any psychic energy independent of sexuality. The objective form of libido, hence, relating to the sexual energy derived from the id; high sexual distinguish form.
Libido - hypothesized mental energy, being derived from the id; is most fundamentally sexual.

**Mourning and Melancholia** - a composition by Sigmund Freud that became the first psychoanalyst to analyze what one goes through during the grieving process.

**Narcissism** - comes from the Greek myth of a young man's unfortunate emotional investment in his own reflection. In a most general sense, it stands for an exaggerated self-love. It is when the focus is on oneself, without regard to anyone else.

**Object Loss** - in psychoanalytic theory, the loss of an object who was perceived as benevolent and loved. The term is used for either the loss of the love, or the loss of the object.

**Superego** - an internalized code, or more popularly a kind of conscience, punishing transgressions with feelings of guilt. The superego is assumed to develop in response to the punishments and rewards of significant persons (usually the parents), which results in the child becoming inculcated with the moral code of the community.

**Truth Telling** - the ethical questions that ask: Should the patient be told his/her true condition even when it may be detrimental to the patient's mental well-being.
NOTES


2. Ibid., 62.


CHAPTER II

GRIEVING FROM A BIBLICAL PERSPECTIVE
AND HOW THE DISCIPLINES ADDRESS DEATH,
DYING AND GRIEF

The Oriental expression of grief has a two-fold relationship. Toward God it is marked by silent and reverent submission symbolized by placing the hand on the mouth. "The Lord gave, and the Lord has taken away" (Job 21). When grieving was directed toward relatives and neighbors it was different. It was something that love had to come to grips with. It was the passionate abandonment and the gathering of the ritual. Wailing and loud shrills were sounds that were understood. As these piercing shrieks were repeated, inquiries are made as to the locality and circumstances and these cries are considered as an invitation to proceed to the house of mourning.\(^1\) The references of mourning in the Bible show that there was/is a customary 10-day mourning period in Palestine. The announcement of death still uses wailing (Micah 1:8). Friends come to console (Job 2:11-13).

Funeral rites of mourning were considered as an obligation as important as the burial itself, and to be deprived of the rites was considered a curse (Jeremiah 16: 4, 6; 22: 18-19; 25:23). The mourning ritual was carried out by the deceased person's family (23:2; 50:10) and by all others that are affected by the death (1 Samuel 25:1; 28:3; 2 Samuel 1:12; 3:31). Their grieving was often aided by hired mourners (Amos
5:16) and women (Jeremiah 9:17-21; 2 Chronicles 35:25). The rites began while the body was being prepared for burial, or when news of death arrived (Genesis 37:34; 2 Samuel 1:17), and they usually continued for seven days. Whenever longer mourning periods were observed, such as 70 days for Jacob, with 40 days for embalming (Genesis 50:70), thirty days for Aaron (Numbers 20:29), this was considered as exceptional. These cases show Egyptian influence.

The customs used by the Israelites were also used by other peoples of the ancient Near East. They were characterized by different forms of self-affliction and by loud wailing. Mourners tore their garments and put sackcloth on their bodies (Genesis 37:34; 2 Samuel 3:31). They went barefoot (2 Samuel 15:30) and with heads uncovered (Exodus 24:17, 23), neglected natural care of the body (2 Samuel 14:2; 19:24; Daniel 10:3). They sat on the ground (Job 2:13), put dust and ashes on their heads (Joshua 7:6; 2 Samuel 13:9), beat their bare breasts (Isaiah 32:12), and restricted food and drink (2 Samuel 1:2). The practice, however, of shaving one's head and gnashing one's body for the dead, though known in Israel (Jeremiah 16:6), was forbidden in the law (Leviticus 19:28; 21:5; Deuteronomy 14:1).

The most prevalent mourning rite was the lamentation. Besides short repeated cries, there were longer cries composed and sung by professional mourners to the accompaniment of music on the flute (Jeremiah 48:36).

Some of the Israelite burial and mourning customs of Old Testament times continued to be practiced during the New Testament period. In fact, the Jewish
practices in the New Testament times were of little difference than those described in the Old Testament, even though further details are given. The body was first washed (Acts 9:37), it was then anointed (Mark 16:1), wrapped in linen garments with spices enclosed (John 19:40), and finally the limbs were bound and the face covered with a napkin (John 11:44). Weeping and wailing and beating the breasts are evidenced in the New Testament also. Professional mourners were also employed. Matthew 9:23 refers specifically to flute players. Jesus wept quietly at the grave of Lazarus (John 11:35). During this time, the period of mourning was seven days duration. The actual burial took place soon after death, normally on the same day.

Burial places and grounds were usually outside the city or town. Common burial grounds did exist (Matthew 27:7), but individual and family tombs were widely used. Some men, such as Joseph of Arimathea, prepared their burial place beforehand (Matthew 27:60). Coffins were not used to transport the dead to the place of burial; they were carried on simple biers (Luke 7:12, 14).

Cremation was never a Jewish practice, but there were several types of burial places. There were ordinary graves in the earth, some unmarked (Luke 11:44). Then there were rock-hewn tombs or caves, which might have monuments of pillars erected over them. Family tombs often had a number of separate chambers. In these chambers were fashioned ledges or niches to accommodate the bodies. Here, the bodies may be placed within receptacles, such as stone coffins.
Another practice of the New Testament period was to place bones in small stone coffers known as "ossuaries," a custom thought to be borrowed and adapted from the Roman boxes to hold ashes after cremation. Therefore, if a family tomb became overfilled, dry bones could be taken from the ledges and niches and placed in "ossuaries." Ossuaries might house the bones of more than one person. The various receptacles usually bore designs and motifs of various types, although among the very Orthodox Jews very little embellishment was permitted. The practice of adornment and embellishment of tombs appears to have been common in the time of Jesus, judging by his denunciation of the Pharisees in Matthew 23:29. He made condemning reference to the practice of whitewashing tombs (Matthew 23:27). The purpose of this was doubtless to make them conspicuous, thereby preventing passersby from touching them accidentally and so causing ritual defilement.

To prevent too easy access to tombs, in view of thieves, the doorways were formally closed by hinged doors, or less commonly by large flat stones like millstones which could, with difficulty, be rolled sideways from the tomb entrances. There are a number of tombs in and around Jerusalem which date from within one to two hundred years of Christ.

A Theological Framework for Grieving

When we look at the theological framework for grieving, theology has provided a helpful framework for grieving in that it helps the bereaved to accept the fact of death and cope with the pain brought on by the departure of a loved one.

Research has found that:

1. Religion is affected and particularly salient among older people; that is, among those who are most likely to be confronted with bereavement.²

2. Religious organizations function along with family and community, as significant support systems for many of their members.³

3. Religion has been conceptualized in the theoretical literature as a source of subjective meaning, a framework that helps to make reality understandable.⁴

4. Research has generally shown that religious commitment to be higher among persons in crisis situations and among persons confronted with subjective stress or anxiety.⁵

C. Geertz wrote an essay, The Definition of Religion, and asserted:

As a religious problem, the problem of suffering is, paradoxically, not how to avoid suffering but how to suffer. How to make of physical pain, personal loss, worldly defect, or the helpless contemplation of others' agony something bearable, supportable; something we say sufferable. Religions attempt to make bereavement sufferable by locating it within a symbolic context, an interpretive framework in which suffering becomes understandable and bearable.⁶

Belief in God

Fulton and Bendiksen, in their work on Death and Identity,⁷ state that as in any widely belief, there is variation in the beliefs about God, and these variations must be compared in order to determine their relationship with bereavement. There have
been some empirical studies done in these areas, and W. C. Roof found that two such distinctions appear particularly relevant:

The first distinguishes belief in God according to degrees of certainty about God's existence. Studies employing this distinction have demonstrated that certainty is significantly associated with a variety of other attitudes and values. As a result, measures of certainty of belief in God have become one of the most commonly employed empirical items in quantitative research on religious commitment.

The second variable concerns differences in images of God. A distinction that appears particularly promising is that between intimate and remote images of God; that is, images positing immediate and direct cognizance of an influence over the individual on the part of a divine being versus images positing only indirect or generalized influences.\(^8\)

To me, these quotations attempt to show empirically that the way one views God has a definite effect on how one goes through the grieving process. If God is a certainty, and there is no doubt, it has a positive effect in that the bereaved believes that he/she is not alone in his/her suffering. It also suggests that if one has an intimate relationship with God, as opposed to a remote God, that relationship with God has a direct bearing on how one will do the work of grieving.

**Belief in Life After Death**

Belief in life after death has also had an important connection with bereavement. This belief denies the finality of death. It may be mentioned here that, from a doctrinal standpoint, the connection between life and death could be either positive or negative, and that depends on one's belief system. In our discipline, we believe that God became incarnate in his Son, Jesus (Luke, chapter 2)
and came to atone for man's sins (John 4:12). It was through his death on the cross that is reported in the Gospels that all of humankind has an opportunity to an eternal existence in peace with God (John 3:16). This eternal existence is determined, not by good or evil works that one does, because the Christian is forgiven of all sins when a confession of faith is done before men (Romans 10:9-10). But when Christ is confessed before men and women, the one who confesses is then saved, thereby becoming eligible for eternal life. The place that is the eternal place of existence with God is called heaven.

The belief in life after death and heaven necessarily demands the opposite of heaven that we call the doctrine or belief that there is a hell, and hell is a place of torture (Matthew 5:22; 10:28; Luke 16:20). We teach that those who have not accepted this belief in Jesus by the time of death are unrepentant sinners, and will also have an eternal existence, but it will be one of eternal damnation where there will be eternal "wailing and gnashing of teeth" (Matthew 13:42). Hell is then seen as punishment for not becoming repentant of one's sins.

Additionally, the belief in punishments necessitates the opposite of punishment and that is reward. Heaven is not viewed as a reward, but a gift (Ephesians 2:8). To the question of rewards, we believe there will be degrees of rewards in heaven. "The same shall be called the least in the kingdom" (Matthew 18:4). We believe that there are some who are saved but do not do anything for the
fulfillment of the kingdom. They will go to heaven, but will not have as great a
reward in heaven as those who have worked hard to upbuild the kingdom of God.

Here, it would be good if we would look at another theological view as it
relates to where the soul goes upon death. The Roman Catholic Church believes
that all baptized souls who have died without repentance for venial sins or who
have not paid their punishment for sins, the guilt of which has been removed, go to
a place called purgatory. Purgatory is not, despite popular misunderstanding, a
period of probation. It is for those who already are partakers of supernatural grace
and therefore destined to be saved, but who, for the reasons stated above, cannot
enter into heaven directly. The sufferings of purgatory are said to be embraced by
the believer with joy because the soul wants to do all in its power to serve the
Almighty and to hasten the day of final bliss.⁹

Protestants reject the doctrine of purgatory for several reasons:

1. It is without scriptural foundation.

2. It retains the idea of punishment after forgiveness.

3. It implies that the satisfaction of Christ is not fully sufficient.

4. It vitiates the Gospel of a complete forgiveness of sin.

Our discipline believes that when one is saved, and dies, to be absent in the body
is to be present with the Lord (1 Corinthians 5:3).

Whatever the doctrinal stance may be, the theological discipline has
contributed a valuable conceptual framework that has brought much relief to untold
numbers of grief-stricken loved ones who need something positive in the midst of their grieving, to give hope of seeing their loved ones again.

**How Different Disciplines Have Attempted to Address the Issue of Death and Grief**

**Sociology**

When we look at the question of how the discipline of sociology has dealt with death, dying, and bereavement, we must look at how the entire community deals with the issue of death when it experiences the loss of one of its members. Death poses immense tasks that strike closely to the basic organization of the community and the larger society. Associated with these tasks are normative definitions of bereavement behavior, an extensive industry for funeral arrangements, and fairly elaborate divisions of labor that bear upon several major professional and quasi-professional groups; for example, physicians, ministers, and undertakers.\textsuperscript{10} The physical remains must be processed, the deceased placed in a new status, vacated roles filled and property disposed of, group and community solidarity reaffirmed and the bereaved re-established and supported.\textsuperscript{11}

Historically, it was relatively recent since the American sociologists began to see the phenomenon of death as a focal point. European sociologists of the 19th century, early American sociologists, as well as the interwar sociologists (from 1930 to 1945) all demonstrated a regard for the subject.\textsuperscript{12} Many of the attitudes of the
United States have come from what many of the Europeans wrote between 1875 and 1920.

In 1876 Herbert Spencer authored *The Principles of Sociology* and traced the relationship of the world of the living to the world of the dead and argued that the advancement of civilization brings about increasing separation of the two spheres. The world of the dead, he speculated, was originally a mirror image of the world of the living. While early beliefs held that the spirits of the deceased have qualities to those of the living, increasing evidence about the physical world required modification of such beliefs.

In 1881 Thomas G. Masaryk authored *Suicide and the Meaning of Civilization*. While he did not dismiss the environmental aspects of suicide, he believed that modern man was more reflective than primitive man, and placed a great deal of emphasis on moral decay in explaining suicide rates. He contended that suicide tendency gradually increases among people who have progressed in their development. He concluded, "the contemporary social mass phenomenon of suicide results from the collapse of a unified world-view that has consistently given Christianity its view among the masses in all civilized countries."

In 1897 Emile Durkeim was most known for his beliefs that death had a social impact in social life, and demonstrated an interest in human orientations and reactions toward death that death itself engenders. In suicide, Durkeim attempted to identify the quality of social relationships that result in varying orientations of
suicide. He proposed that individual dispositions toward suicide cannot be explained as a function of climate, biology or psychology, but must be conceived as resulting from prevailing conditions within the social structure. For Durkeim, the nature of one's integration into social life had an important effect on how an individual viewed the dispensability of life.\textsuperscript{18}

Robert Hertz, one of Durkeim's students, felt that death always presented a dilemma for society. The difficulty was not for the individual survivor who may be suffering from grief, but for the life principle of the collective itself. He suggests the beliefs in a spirit world resulted from, among other things, the need for the collective to assert its dominance over the powers that it cannot control. He wrote:

Because it believes in itself, a healthy society cannot admit that an individual who was part of its own substance, and on whom it has set its mark, shall be lost forever. The last word must remain with life; the deceased will rise from the grip of death and will return, in one form or another, to the peace of the human association. This release and this reintegrative constitute, as we have seen, one of the most solemn actions of collective life in the least advanced societies we can find.\textsuperscript{19}

Arnold Van Gennep examined the nature of ritualized behavior in promoting and maintaining social forms. In \textit{Rites of Passage},\textsuperscript{20} he assigned the greatest importance to the rituals that associated with death (rites of incorporation), because he found that funeral rites that had as their express purpose of the deceased into the world of the dead were characteristically the most elaborate. He believed that rites of reintegration, that is those actions taken in support of the survivors, were of less importance than other behaviors following a death because reintegration was less
problematical for the community. A belief system that provided specific information about the future following death minimized the issue of the social community.\textsuperscript{21}

Another sociologist, Max Weber, wrote on death, but was not specifically interested in the problems that death posed for the social life, but the problems for the modern physician. He also discussed death in the context of war. He stated,

Since death is a fate that comes to everyone, nobody can ever say why it comes precisely to him just when it does. As values of culture increasingly unfold and are sublimated to immeasurable heights, such ordinary death marks an end where only a beginning seems to make sense. Death on the field of battle differs from this merely unavoidable dying in that war, and this massiveness only in war, the individual can believe that he knows he is dying for something. The why and the wherefore of his facing death can, as a rule, be so indubitable to him that the problem of the meaning of death does not even occur to him. At least there may be no presuppositions for the emergence of the problems in its universal significance, which is the form in which religions of salvation are impelled to be concerned with the meaning of death. Only those who 'perish in their calling' are in the same situation as the soldier who faces death on the battle field.\textsuperscript{22}

These were the Europeans and their views on death as a social phenomenon. Much of their focus was on suicide, and how death affected the community as a whole. Between 1890 and 1930, American sociology reflected many of the current thoughts of the Europeans. It can also be said that their views on death were readily received by American ministers and ministers' sons, for whom sociology was a second vocation. The information during this period was sparse.

In 1894 Albion W. Small and George Vincent wrote on death, but neither of them treated the subject extensively but their insights provided ideas and insights
to a later generation of sociologists. They presented a paper on *An Introduction to the Study of Society.* They took note of the difficulty that a rural family goes through when they lose a child. By doing so, they called attention to the importance of social supports involving consolation and aid for the bereaved family. Elsewhere they addressed the issue of grief following the loss of a parent. They said,

in the normal family, parents live until children are mature enough and sufficiently equipped for independent existence. The death of either parent or both before such a point has been reached produces a manifestly pathological condition. Remarriage and the adoption or guardianship of orphans are means for restoring or replacing the complete family relations, but except in rare cases, such expedients fail to secure normal results.

Edward Allsworth Ross, in 1901, offered a partial explanation of contemporary changes in self-imposed standards of moral behavior. He wrote: "When loved ones gone are thought of as looking down upon this life with their former interest and concern, we have a powerful motive to do only that which will please them. With us today, in non-religions as well as in religious circles, the influence of this thought in fostering family piety and strengthening family bonds is certainly very great."

In 1910 William Graham Summer presented a four-volume writing entitled *The Science of Society,* though it was not published until 1927. He was considered the most prolific of early American sociologists concerned with death. He wrote:

The death of a wife is an incidental matter, as it appears, compared to that of the husband; and the provisions as to the behavior and destiny of the survivor leave the man, for the most part, out of account. Almost never is he forced to accompany his wife to the spirit world; he mourns but little, he is not much
limited in the matter of a second marriage. His lot, in short, is not materially changed by the event.27

From 1930 to 1945 the field of sociology dealt with the question of death from a family standpoint. During the period of World War II, there was a new concern with preserving or rebuilding the foundation of the American social structure, the family. During this time, such authors as Thomas D. Eliot,28 Meyer F. Nimkoff,29 Willard Waller,30 David Morton Fulcomer,31 Ernest W. Burgess and Harvey Locke,32 and Reuben Hill.33 All of these authors focused on the aspect of the way the family structure dealt with death as a result of war.

It was not until 1958 that the appearance of Faunce and Fulton's article, "The Sociology of Death: A Neglected Area of Research," brought about the call for a contemporary sociology of death. Death was conceptualized as a primary focus of a vast cultural complex around which revolved an array of beliefs and practices, rich in variety and awaiting sociological investigation. As a subdiscipline, the sociology of death assumed the task of investigating, empirically, the individual and collective responses to death, as well as the human orientations toward mortality that particular social and cultural systems engender.34 Talcot Parsons, in 1963, presented "Death in American Society," and it helped lend credence to the proposed sociological examination of death and death-related issues. Parson's article, in addition to calling attention to the new discipline, explored contemporary attitudes and behaviors in relation to death. He regarded these as responses to a world in
which death, like other natural phenomena, had been brought under secular and
temporal control. He saw these temporal and secular developments as the basic
cause taboo of death and its denial, rather than the result of fear and anxiety as
others had claimed during this period.\textsuperscript{35} Other literature that appeared during this
time was Robert Fulton, "Death and Identity" (1965); John W. Riley, Jr., "Death and
Bereavement" (1968); Glen M. Vernon, \textit{A Sociology of Death: An Analysis of Death-
Related Behavior} (1970); Robert Fulton, Eric Markusen, Greg Owens, and Jane
Sheiber, \textit{Death and Dying: Challenge and Change} (1978); and Robert Fulton with
Margaret Reed, \textit{Death, Grief, and Bereavement} (1981).

These authors are just a portion of those sociologists who have helped
develop the discipline of a sociological perspective of death. With the foregoing
discussion, one can see the progression on the amount of research conducted in the
area of sociology, and it helps us to see how the community is affected by and reacts
to the loss of one of its members.

Here I would like to take a look at how a particular segment in our society
handles death culturally, and that is from the African-American perspective.
Having discussed the general sociological effect, it becomes relevant to look at our
particular social understanding of death.
The African-American Way of Dealing with Death, Dying and Grief from a Sociological Perspective

When my research began for this D.Min. project, one statement that I made was the positive help that the church and community does during the loss of one of its members to death was minimal. I now see the valuable help that comes forth from the community and church that, in fact, is very therapeutic for bereaved loved ones. However, it does not go far enough to effect healing on a long-range basis. Too often after the funeral, the loved ones are basically left along, and all those who have shown so much love and concern have returned to their regular routines. The grieving loved ones are left to try and work through their grief as best they can. It is at this point where I see this project helping to fill the void. I have elected to include this discussion at this point, knowing that there is some overlapping between the discipline of sociology and the religious perspective. The lines in the African-American perspective (often blurred) and the treatment of the loss of one in the community join hands in handling the demise of its members.

In the publication, Ethnic Variations in Dying, Death and Grief, there is a chapter by Hosea L. Perry entitled "Mourning and Funeral Customs of Africans." In this chapter, Perry is very convincing as he discusses the issue. He makes the point that "death, often violent death, is a familiar experience to African Americans, but this issue has been all but ignored by academic studies. The limited studies prevent anyone from making a definitive statement about how blacks die and
mourn. He cites the diversity that exists across such a wide and varied community.\textsuperscript{38} Perry also notes the following:

1. At some funerals, a great deal of wailing, crying and strong emotions happen.

2. Much of what is done at the funeral strongly resembles funeral practices of West Africa.

3. Some funerals seem to try to be more efforts to grieve in the way of white people.

He makes the claim that the kind of mourning done has to do with the economic, educational, and prominence of the person who dies. The difference is the more educated and wealthy blacks are, the more they tend to have a more sedate and quiet mourning period. He further states,

Descriptions of the African-American mourning practices exemplify some of the most organized and elaborate efforts to aid mourners during their various stages of grief. From the moment the news is out about a death in a black community, help arrives in the home of the mourner or mourners. From the church 'sisters' who come to bring and prepare meals and 'do what their hands can find to do' to the members of the church who say their words about the death, the church nurses who accompany family members to view the body individually. These people, along with the pastor and the funeral director and assistants all assist the mourners to work through their grief.\textsuperscript{39}

One can clearly see the interaction between the church and community coming together to perform these actions to effect a healing in the community. William H. Willimon in his book, \textit{Worship As Pastoral Care},\textsuperscript{40} states that the community usually has a number of ways of reincorporating grieving persons into
itself. He states that friends will encourage such persons to get hold of themselves and to get back into things.41

After reading the works of Perry and Willimon, what is clearly shown is the actions of a community can be very effective in its effort to aid in the separation and transition of a loved one, and reincorporation of grieving persons within itself. While studies are not as plentiful concerning African Americans, I believe the information regarding the sociological approaches to death and dying has a great significance in helping African Americans understand the dynamics that are at work in the community and family upon the death of a loved one. Though the African-American community at large may not have volumes of literature that deal with our specific situation, our communities are satisfied to do whatever it can to heal bereaved loved ones from a social perspective. It is hoped that after studying this chapter concerning the sociological contributions to death, dying and grieving, one can gain a clearer understanding of the development of this discipline over the years.

Psychology

When we look at how the field of psychology has attempted to address the issue of death and grief, Sigmund Freud's name must be considered. Why? Because the clinical literature on grief begins with Freud in 1917 when he authored an essay that continues to be very influential in different schools addressing the issue of death and grief. Freud's composition is entitled "Mourning and Melancholia."42 In
this essay, Freud contrasted normal grief following the actual death of a loved one with pathological melancholia. He said melancholia gives the appearance of grief but is stimulate by psychological, rather than real, object loss or disappointment. He emphasized that in the normal process of bereavement the goal of recovery is the relinquishment of the mourner's ties to the love object.43

Freud used two terms that I believe are significant in understanding what happens during the life and death of a loved one. These words are *cathect* and *decathect*. To cathect, according to Freud, is the infusion of psychic energy onto a love object over the course of life, a connection that is strengthened by a thousand links. To decathect is to detach from the original love object so that the libido is available for investment in a new object.44 The process of decataxis is detachment from a love object that no longer is present in reality and therefore offers no more gratification. With all of the resources that I have researched, without exception, they all mention Sigmund Freud when the discussion of the psychoanalytic aspects of death and grieving is approached.

**Toward a Systemic Developmental Theory of Adult Bereaved**

With Sigmund Freud's composition on "Mourning and Melancholia," many people in the field of psychology and psychiatry were inspired to do studies and research on the issue of death and grief. One influential researcher in this field was Erich Lindemann. "After World War II, there was a surge of people who had been traumatized by the deaths and there were massive problems."45 It was one of the
first times psychologists studied normal grief reactions to the crisis of death. Lindemann did a study on the survivors of the Coconut Grove nightclub fire in Boston, and noted the symptoms of uncomplicated grief that may seem quite different from the traditional perspective, but are normal following the experience of a death. He found that the symptoms include:

1. somatic distress
2. often pain in the chest and throat
3. sensory distortions
4. auditory and visual hallucinations of the deceased
5. preoccupation with the image of the deceased
6. guilt
7. hostility
8. the loss of a person's usual patterns of conduct.46

One of the flaws with Lindemann's conclusions was the fact that he believed that resolution could take place in four to six weeks. He soon found that there were other factors that should be taken into consideration such as the bereaved person's social system plays a big part in the grief reaction, and many times the grief was still present as much as four to six years later. As I studied his claims, I can see how Lindemann reached his conclusion, and from a counselor I have found his symptoms to be accurate, but I do know that four to six weeks is much too ambitious as a sufficient time to overcome the symptoms and trauma caused by death. Yet Lindemann, like Freud, inspired other writers and clinicians in the field of psychology and psychiatry to do more studies in the psychoanalytic discipline on how to cope with the grief that comes with death.
Crisis and Coping Theories

A researcher named Gerald Caplan built on the work that Lindemann had done and came up with a theory of crisis. Caplan asserted:

The death of a close family member disrupts the survivor's adaptational equilibrium. In an initial period of disorganization, defensive coping strategies may be exacerbated and underlying personality problems may emerge. The crisis may afford the survivor an opportunity to recognize and transform an existing problematic coping style and create a new adaptation.47

There have been more recent works such as The Stress of Losing a Family Member by Figley and McCubbin (1983) and The Mitigating or Protective Effects of Social Supports in Reducing the Mental Health Risks for Adults in High Stress by Stroebe and Stroebe (1987). Stroebe and Stroebe argue that "the death of a spouse creates a significant deficit in social support for the surviving spouse, since most couples rely heavily on each other for instrumental, emotional and validational support."48

Attachment Theory

John Bowlby did extensive work in applying the attachment theory. He proposed that infants are biologically motivated to the establishment of an attachment to a significant caretaker, usually the mother, and when this bond is threatened by a separation, the child responds by crying, protesting, and a concerned search for the lost attachment figure.

Bowlby and his colleagues believe that adulthood attachment bonds to spouse and children are derived from the same emotional system underlying attachment in children.49 They found that the characteristic features of grief in
adults resemble many elements of the childhood attachment and separation sequence, including an initial stage of numb disbelief; a stage of pining and searching for the lost person, including restlessness and resentment; a stage of depression and acknowledgement that searching is useless.

Object Relations Theory

Object relations theory in psychoanalysis views the inner life of the individual as composing internalized representations of real relationships with early caregiving figures. Researchers say, "in addressing bereavement directly, there is the impact of the loss on these internalized self and object representations, and suggest that the death of an important person requires a rebalancing of them." Object relation theorists tend to associate the final resolution of grief with a decathexis of the lost object.

Another theorist, Volkan, describes "linking objects and linking phenomena that sustain the attachment of the bereaved to the deceased." In cases that require such linking, he considered them to be complicated or pathological grief, and is not needed in healthy or uncomplicated mourning.

The above discussion on how the discipline of psychology and psychiatry has traditionally dealt with death, dying and bereavement helps us to see the evolution of the different views of schools of thought beginning with Sigmund Freud's composition on "Mourning and Melancholia." In my opinion, the above discussion necessitates a further discussion on how psychology plays out in individuals who
have been diagnosed with a terminal illness, and the effect the impending death has upon the loved ones of the dying patient. Additionally, I would like to deal with the coping mechanisms used by the bereaved, whether expected or unexpected death has occurred.

Here, it is necessary to discuss what the dying patient feels. Even while I write this paper, my mother recently had what was diagnosed as a light stroke, and I was trying to know what she was feeling within as she began to express herself. She said, "The Lord has shown me that my time isn't long." Immediately my father interrupted and prevented her from completing what she felt. To me, it underlined the fact that many of us are uncomfortable with the discussion of death especially when the one we love is the person that is ill. I believe that many people have died without having conveyed their true thoughts; not because they could not face death, but because of the denial of their loved ones, who themselves are ambivalent about their own death.

When we look at the thoughts and feelings of people facing imminent death, from a clinical perspective, the clinician realizes that there are three levels of reality: (1) the subjective reactions of the patient to a situation; (2) the gross behavioral responses to that situation; and (3) the situation itself.52

There is an essay written by three clinicians—Stephen V. Gullo, Daniel J. Cherico, and Robert Shadick. They did an objective study on stages and response
styles in life-threatening illnesses; in this case cancer patients. In this study, they were concerned with:

1. Patient's feelings about having cancer
   
   a. when first given diagnosis
   b. during hospitalization
   c. after hospitalization

2. How patient is coping with illness

3. His/her most important concerns at the present time

4. Future expectations. How does patient deal with life threat?

5. Has patient made any promises to self, family, God which he/she hopes to carry out if he/she recovers?

6. Has patient noticed any changes in his/her attitudes, response to illness and so on?

7. Patient's reaction to surgery; its effect on him/her.53

This study was done with five subjects, all of whom had been diagnosed with life-threatening cancer. The cancer was not definitely terminal, but the possibility existed. The outcome of this study showed variations with Elisabeth Kübler Ross and her stages of dying.54 Out of these tests appeared a series of successive stages which can be characterized as follows:

**Stage 1: Shock**

While many patients harbor suspicions about the nature of their illness, or are "sensitive to a sense of impending doom," they are still shocked when their
suspicions are confirmed. It is not so much of a feeling of surprise as a sense of being "totally overwhelmed" and incredulous "that this could happen to me."

**Stage 2: Anger**

The "how could it happen to me" of Stage 1 quickly changes to "Why me?" in most patients.

**Stage 3: Grief and Anticipatory Grief**

When the patient enters the hospital, grief becomes the predominant experience of the patient. The reality of cancer and cancer surgery take on a personal meaning and sense of threat.

**Stage 4: Bargaining or Promissory Note Behavior**

The recognition of the gravity of the situation and the suffering grief and anticipatory grief very often overwhelm the person, and he feels that his own strength is inadequate. He has been "brought to his knees" and now must turn to a strength greater than himself. This external source of strength is often God. All patients reported praying to God for strength, even those who did not consider themselves "religious" or members of any formal religion. Three made promises to God of life changes if God would help to cure them, and two made promises to self and someone else.

**Stage 5: The Period of Uncertainty**

It is at this point in the course of the illness that a major external intervention takes place. The patient is operated on and now begins the process of recovery from
surgery. The nature of this psychological experience is very much tied to the extent of any disfigurement, the degree of discomfort, present and projected disabilities, and whether or not the operation has been successful.

Stage 6: Renewal and Rebuilding

This stage is characterized by a renewal of life aspirations. As the recovery continues and the patient can resume caring for himself and the other functions of a normal life, he returns to the plans and goals that had been set aside due to illness. He has not forgotten the possibility of death or further treatment, but has made his own adjustments to these risks. A recurrent theme in the thoughts of most of the patients is "I've got to go on living--I will."

Stage 7: Integration of the Experience

All of the subjects were interviewed six months after their hospitalization to determine if and how they had integrated the confrontation with serious illness in their lives. Certainly to face death from cancer does not leave a life untouched. It is the type of experience which alters one's sense of past and present and one's approach to the future. All patients but one reported positive benefits from the confrontation with a life-threatening illness.

Another factor that emerged from this study was the Predominant Response Style (PRS) to life-threatening illness. Five different responses identified how patients tend to deal with the diagnosis. They were:
Type 1: Death Acceptor

The patient tends to be a realist. He confronts the reality of the illness and acknowledges that his life is in danger. He will fight to get well, but if death becomes inevitable, he will find the strength to accept it.

He makes plans to deal with continued illness and even death. Yet, he vigorously follows all medical procedures for him. He wishes, he hopes for, and anticipates a long life but he is aware of the cancer statistics. He grieves for the loss of health and the suffering endured, and he experiences anticipatory grief about changes in his life which may result from the operation.

Type 2: The Death Denier

The patient acknowledges the nature and gravity of his illness. He may even acknowledge the nature and gravity of his illness. He may even acknowledge that his prognosis is poor in most cases.

While acknowledging illness and even the possibility of his own death, the patient insists, however, that he will definitely be one of the "lucky ones." "I just know it."

Type 3: The Death-Submitter

The patient confronts the fact that he has a life-threatening illness and this realization leads to a feeling of being overwhelmed, abandoned, and completely helpless. The patient tends to be a pessimist. While noting that death is only a possibility, he is convinced he will die.
Although the patient acknowledges the illness and its gravity, he cannot accept death as a reality which is an unfortunate part of life. He can only express resignation or submission. He feels so totally overwhelmed and helpless that it is impossible to cope with the prospect of death.

The patient becomes unmanageable and uncooperative at times, even refusing needed medication. The patient shows a weakening of the will to live and to recover from the illness.

**Type 4: The Death Defier**

The patient acknowledges illness and the possibility of death. The patient seeks and welcomes favorable information, but he is a "cold realist." He recognizes that even with a favorable prognosis, recovery at this stage of the illness may be questionable.

The patient hopes that his intense will to live, his intense fight to recover and his refusal to accept or to be overwhelmed by death may "turn the tide." While the patient anticipates and perhaps even looks forward to the struggle for survival vs. death or be overwhelmed by death, he recognizes that medical treatment may ultimately prove futile.

The patient experiences grief and anticipatory grief, but does not allow himself to become depressed. The patient is filled with anger and rage, which he directs at conquering the illness and death.
Type 5: The Death Transcender

The patient acknowledges illness and the possibility of death. The patient can confront the prospect of death, which all people must face sooner or later. The patient views death as an integral link in the plan of creation. He feels that an individual's life may end but that person's life force continues to live through offspring and family. In addition, the patient may also explain death in terms of the religious concept of immortality. He believes that death cannot really destroy life since the soul is immortal.

The death transcender is not just an acceptance of death, although this is part of the response. The individual goes beyond acceptance to a point where death is viewed in terms of a broader concept of life. In addition, the patient sees death as the logical completion of his efforts in this life.

As we compare the findings in the study reported, the findings vary with those reported by Elisabeth Kübler Ross in her stages of dying.55 Her stages were developed from studies done on patients who were not just diagnosed as life-threatening, but terminal.

<table>
<thead>
<tr>
<th>Life-Threatening Studies</th>
<th>Death and Dying Stages</th>
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<tr>
<td>1. Shock</td>
<td>1. Denial</td>
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<td>2. Anger</td>
<td>2. Anger</td>
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<tr>
<td>5. Uncertainty</td>
<td>5. Acceptance</td>
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Here, it seems appropriate to discuss the use of coping mechanisms one uses in attempting to cope with the tragedy of losing a loved one. In my research of 63 sources for an in-depth discussion on the self-defense mechanisms that one employs during grieving, the most comprehensive discussion seems to be, in my estimation, from Yorick Spiegel. He conducted his study, presented it in German, and was later translated by Elisabeth Duke. The discussion that follows on coping mechanisms comes from his presentation in *The Grief Process; Analysis and Counseling*. Spiegel is extensive in his discussion and I have selected segments of the discussion of coping mechanisms that are and will be relevant in my institution of a process of proper grieving at Mt. Ephraim Baptist Church.

Defense mechanisms focus on the kinds of mechanisms used by the ego in order to defend itself against pressures brought on by trauma. There is no consensus in literature with respect to numbers, identification, and classification of defense mechanisms. Spiegel lists eleven defense mechanisms in his book, *The Grief Process*[^56] and categorizes them into three groups:

1. The Narcissistic Coping Mechanisms
   a. The breakdown of reality testing
   b. Denial and repression
   c. Searching
   d. Mania

2. The Aggressive Coping Mechanisms
   a. Protest
   b. Search for the culprit

[^56]: "Grief Process" by Yorick Spiegel, page 56
c. Identification with the aggressor

3. Object-Libidinal Coping Mechanisms

   a. Helplessness
   b. Recollection
   c. Incorporation
   d. Substitution

All of these coping mechanisms have various functions, depending upon whether they serve to connect with the dead. At the same time the memory is distorted, mostly the positive features are recalled; the deceased is glorified.

Narcissistic Coping Mechanisms

The Breakdown of Reality Testing. This mechanism is characterized by three perceptual disorders: (1) visual hallucinations, (2) auditory hallucinations, and (3) sensations that the deceased is present. Distortion of reality represents an attempt to keep the dead in the common world. This mechanism may reveal itself in daydreaming. The sufferer hears the steps of the deceased on the stairway, hears the sand crunch in front of the house and believes that the door opens. "I saw her standing there." "I stretched out my arms and he was gone."

Auditory hallucinations. A creak at night or a sound at the door is interpreted as a loved one moving in the house or coming home. One person reported that while sitting in a chair the deceased one caressed her ear and whispers that she should rest.
Sensations that the deceased is present. The feeling that the dead person is present is even a more common phenomenon. Some are heard to say, "I still have the feeling he is near and there is something I ought to be doing for him or telling him." He is with me all the time. I hear him and see him, although I know it's only my imagination.

Denial and Repression. Denial is considered one of the most important coping mechanisms. The denial defense may well preserve the individual from complete disintegration under full impact of the blow. Psychoanalysis says that denial is a mental device. When an event on the outside world has unpleasant consequences for the ego, it is completely blotted out, not recognized, or devaluated in its significance.

The combination of denial and repression are observable in death and is characterized by:

1. Avoidance - the bereaved can only further deny the reality of death by avoiding everything that could remind him/her of the loss.

2. Mummification - death is accepted, but it is so denied that this results in a change of the environment. The dead is mummified.

3. Cognitive denial - death is not accepted intellectually; however, a sadness appears whose origin does not become conscious.

4. Emotional repression - death is recognized intellectually, but the survivor is incapable of feeling any pain.

5. Displacement - the loss is intellectually accepted, but coping with it emotionally is impossible and is therefore displaced by secondary grief symptoms, including those of a somatic nature.
6. Denial or fantasy - even though death is accepted intellectually and partially emotionally, at the same time a wild fantasy develops that death did not occur.

7. Ego splitting - death is fully accepted, but denied in a disassociated part of the psyche organization. The deceased is largely isolated from it.

Searching. The defense mechanism of searching implies a separation, but this separation is not considered final. In the assumption of the bereaved, one love object is only temporarily absent. He/she is still motivated by waiting for the return of the lost one, or by unconsciously or half consciously pursuing the active search for him/her.

Mania. Mania is a mood disorder characterized by a variety of symptoms including inappropriate elation, hyperactivity, impulsiveness and excessively rapid thought and speech. The basic affect of mania is euphoria. The patient feels happy and unconcerned, even heavy strokes of fate do not affect him/her.

**Aggressive Coping Mechanisms**

Protest and Lamentation. If the bereaved see the cause for painful condition primarily in the deceased and therefore brings reproaches against him, this is considered to be a re-activation of separation anxiety. The abandoned child primarily sees in the absent mother the cause for his/her loneliness. He/she cries to bring back Mother; he/she develops hostile feelings; he/she reacts angrily to the returning mother in order to prevent her from leaving him/her again. The purpose of all these reproaches and accusations is, "Let us find the quality; they seem to run
away. Let us set right what is wrong; let us restore what had been lost; let us make
sure that it is never repeated.

Search for the Culprit. Beside protest and complaint, the search for the
culprit constitutes an aggressive defense mechanism. It is experienced as helpful
and consoling to know who caused the death or who has contributed to it.

The craving for an acceptable explanation can lead the bereaved ones to ask
repeatedly for a detailed description of all the counter measurements undertaken
by the physician. The craving for an explanation makes it possible in the regressive
stage to make a shift in the range of causes with regard to their significance. During
the regressive stage, it can be more important in some cases to let the mourner find
a helpful or conceivable cause than to insist on the objective reason which led to
death.

Identification with the Aggressor. Identification with the aggressor not only
contributes to the development of the superego, helping it to cope with undesired
instincts, but also constitutes one of the most significant means in the confrontation
with anxiety producing objects of the external world. In mourning, the aggressive
is not directed at the dead or other persons, but against one's own self.

**Object-Libidinal Coping Mechanisms**

Helplessness. The general feeling of helplessness of the depressive is the core
of all types of depression. Depression can involve the additional component of
aggression as well as regressor to oral behavior. However, the control issue in depression is a feeling of helplessness.

Helplessness is the awareness of one's inability to carry on and give up. The helpless individual no longer exerts control over himself and his environment. This brings him/her to the edge of dying him/herself. Many manifestations of helplessness—exhaustion, apathy, muteness—indicate a symbolic death. At the same time, helplessness is a gesture of submission and appeal, not to obtain any profit or triumph from the defeat or suffering the loss. It hopes to win love. It is the plea to God for ending the suffering and to the social environment to accept the bereaved again in the community of the living.

Recollection. The mourner recognizes step by step that the love object no longer exists, gradually dissolves the individual ties, and invests the libido in other relationships. This takes place through the process of remembering. Every time one remembers an individual feature of the deceased, on a happy day spent together, the mourner becomes conscious of the fact that this has passed away forever and there is no way of repeating it with this beloved person.

The mechanism of recollection plays an important role in the grief process. Mourners in most cases are extremely occupied with recollections of the deceased. At first, the memories concentrate on the last days and then gradually stretch out over a longer period. Even though very often there is a need to talk about the deceased, this at the same time provokes memories, painful and hurting. These
feelings can be so overpowering that the mourner breaks off the conversation, often abruptly, or seeks to avoid it completely in anticipation of the stress. There is no escape from pain. There are too many things, places and people who awaken the memory and thus the experience that all this is irretrievably lost.

Recollection results in an image of the deceased adequate to reality with all its merits and disadvantages. Essential and unimportant memories are separated, and the bereaved no longer links his memories to the deceased only, and is freed from compulsive repetition.

Incorporation. The term incorporation indicates that in this coping mechanism, the deceased is accepted in his entire personality. Incorporation has both a regressive and stronger adaptive aspects. The regressive stage is marked by an obvious change in eating habits. This reaction to loss can result in loss of appetite, and therefore decrease of weight, whereby the derealization symptoms are not limited to seeing, but affects taste as well. Not to eat after the death of a loved one may have an obligatory meaning for the bereaved. It signifies in fasting that one observes a special obligation. The unembarrassed participation in the funeral service and the return of the appetite are, on the contrary, signs of adaptive coping.

Substitution. Substitution serves the purpose of coping with the impact of loss of an emotionally significant object. The lost object is replaced by another object when offers a comparable gratification, which is usually less valuable than the lost
object. Nevertheless, in order to make such a transference possible, it often must display a similarity to the lost object.

If the bereaved one uses the mechanism of substitution in a regressive way, he tries with great intensity to find a substitute for the lost love object. He can quickly remarry just because the new partner has a faint resemblance to the former spouse, or he can engage himself in an intense nursing of other people, after he is no longer able to nurse the love object. The adaptive mechanism of substitution is no longer determined by the compulsion to replace this lost person but sets one free to see the potential new marital partner in realistic perspectiveness and in his/her own peculiarity or uniqueness.

In the beginning, narcissistic coping mechanisms prevail in the grief process since they are primarily focused on the support of one's own ego. The aggressive coping mechanisms presuppose a certain interaction between the ego, the lost love object, and the social group. In the last stage of the grief process, however, the object-libidinal defense mechanisms dominate the picture. They are more strongly aimed at the use of the social environment and the lost love object in order to start the restoration of psychic organization.

Regressive coping mechanisms primarily have functions of relief. They permit postponement of full emotional recognition of the object loss that took place. It is possible to escape for some time from the nagging problem of feeling guilty about the death by blaming the physician who treated the patient. Glorification of
the dead allows for the postponement of working through hostile feelings the bereaved harbored toward the deceased until a time when the ego is capable of realistic judgment and can accept the negative as well as the positive features of the deceased as part of his/her humaneness.

The denial of death allows the full recognition of what is lost to come about only gradually. The bereaved cannot rely on regressive behavior finding social approval over a long period of time. Someone who does deny recognized realities, who does not accept a clear distinction between an internal and external world, who defers psychic energies all too much, and concentrates on an egocentive way only in his/her own suffering must expect in the long run that he/she will be characterized as a pathological case and will be treated accordingly.

The field of psychology has given us much in the area of death, dying and the grief process, and has become invaluable in helping the grieved loved ones deal with the crisis of bereavement. I hope this discussion on the contribution of psychology in this phenomenon called death will provide an understanding of its effects on bereaved family members.

**Definitions**

Ego - conceptualized as the central core around which all psychic activities revolve. In the classical theory the ego represents a cluster of cognitive and perceptual processes including memory, problem solving, reality testing, inference making, self-requested striving and the like that are conscious and in touch with reality. It is a kind of psychological touchstone that serves as a basis of one's interests, values, attitudes and desires.
Id - regarded as the deepest component of the psyche, the true unconscious. Entirely self-contained and isolated from the world about it, it is bent on achieving its own arms. The sole governing device is the pleasure principle. The task of restraining this single-minded entity is a major part of the ego's function.

Libidinal - any psychic energy independent of sexuality. The objective form of libido, hence, relating to the sexual energy derived from the id; high sexual distinguish form.

Libido - hypothesized mental energy, being derived from the id; is most fundamentally sexual.

Narcissism - comes from the Greek myth of a young man's unfortunate emotional investment in his own reflection. In a most general sense, it stands for an exaggerated self-love. It is when the focus is on oneself, without regard to anyone else.

Object Loss - in psychoanalytic theory, the loss of an object who was perceived as benevolent and loved. The term is used for either the loss of the love, or the loss of the object.

Superego - frequently characterized as an internalized code, or more popularly as a kind of conscience, punishing transgressions with feelings of guilt. The superego is assumed to develop in response to the punishments and rewards of significant persons (usually the parents), which results in the child becoming inculcated with the moral code of the community.

**Anthropology and Archaeology**

As we look at death, dying and grief from an anthropological and archaeological approach, it would seem wise at this point to define these two terms so that we will be able to understand why a discussion in this discipline is both necessary and wise.
Anthropology is a science that deals with man and his origin. It deals with man's development and culture. For this discussion, it helps us to see the development of burial practices.

Archaeology is the study of past human life as revealed by relics left by ancient peoples.

When we look at these definitions, our goals for this discussion become clearer. Over the years, there have been archaeological finds that give clues to how ancient peoples lived and died. What anthropology does is to analyze these finds and put into a recognizable and reasonable theory as to how certain beliefs, rituals, and cultures dealt with certain issues. In this case, death and dying.

In this discussion, the focus is on the funeral rites, their significance, and how they reveal primitive peoples' belief about death, dying and grief. Since an exhaustive discussion on the anthropological and archaeological aspects of death, dying and grief would consume too much time and space, in this discussion I will look at how a selected few primitives viewed death, and trace the themes to our present-day practice of grief and mourning.

The basic anthropological observations are, first, of the universality of burial procedures; secondly, the diversity of ceremonies, customs and beliefs. Gennep says man is often thought to be composed of several elements whose fate after death is not the same: body, vital force, breath-soul, head-soul, etc. Some of these souls survive forever or for a time. Others die. Variations of these beliefs affect the
formal complexity of rites of passage but not their internal structure. Gennep saw mourning as a complex phenomenon in that it is/was a transitional period for the survivors, and they enter this transitional period through rites of separation, and emerge from it through rites of reintegration into society.

When we look anthropologically at burial customs, different customs, practiced by ancient human beings, give us a glimpse of what they believed about life and the afterlife. These customs reflect the various ways which men have attempted to scan and penetrate the limitations of death, as they interpret cues from the universe, which suggest a way through which to penetrate these limitations can be found.

Bowker states,

Burying a body gains suggestive confirmation from the burying of a seed and the growth of a new plant. Burning anything gains confirmation from the observation that the burning of anything releases something (visibly in smoke) into the air, and leaves only a changed and much smaller part of whatever was there in the ashes. Floating a body out to sea, or committing it to a river, gains confirmation from the observation that salt dissolves in water, but from the taste of the water, it is apparent that it has not wholly disappeared.

Care and variations in burial, from at least as early as the Paleolithic period, suggest that men set themselves against the limitation of death, even though no reconstruction of their belief is impossible. The discussion by Bowker in the above paragraphs suggests that the disposition of the corpse after death reveals the beliefs of ancient peoples.
Cremation is an ancient practice that was found in primitive societies. One of these societies was known as the Kol of India. They practiced cremation as part of their funeral rites to prevent the deceased's return. The men would then gather the burned bones in a pot and would carry the pot back to the deceased's house where it hung from a post. The litter created by the rites are also burned to prevent the deceased from having any reason to come back. ⁶⁷

Today, cremation is practiced in the United States and is on the increase. Those who tend to use cremation are those who tend to use cheaper caskets and less elaborate ones as well. The idea is to get away from expensive funerals. ⁶⁸ Cremation is sanctioned by all religions, although frowned upon by Catholics and some branches of the Jewish faith. Cremation appeals to the nature lovers who visualize their remains being scattered over hillsides or in the sea. It is supported by rationalists, people concerned with sanitation, land conservation and population statistics, and by those who would like to see an end to all the ritual surrounding a usual funeral. ⁶⁹

The burial of the body reflects another view that is theological, and that is to preserve the body. Whenever we think of preserving the body, our minds almost always are directed to the Egyptians. Archaeological finds confirm the fact that the Egyptians believed in eternal continuity in the hereafter, and the body could be preserved for such a life. ⁷⁰ In 1 Thessalonians 4:13-18, it reads that the dead in Christ shall rise first and the remaining living Christians shall be "caught up" to meet Jesus in the air. It is believed that on this scripture rests the basis for preserving the body, so that it will be again inhabitable in order to rise from the
grave. The primary objections to cremation were voiced by some of the clergy who thought it would interfere with the resurrection of the body.71 Today, embalming and preservation of the body is a normal practice in the United States, seldom questioned by many who have accepted this mode of disposing of the corpse as a proper way of dealing with death. Most people sacrifice precious little time deliberating on the efficacy of burying the body.

The floating of the body to the sea, or a river, is found in the belief that there is an isle of the dead. This was a belief found in ancient Egypt, Assyro-Babylonia, the Greeks, in various times and regions, the Celts, Polynesians, Australians, and others. These beliefs are probably the reason for the practice of giving the deceased a real or miniature boat and oars72—to go to the isle. Even though there is a continued practice of burial and cremation prevalent today, I am unaware of a continued belief system that still uses the practice of floating bodies out to sea.

In the past, anthropological works have been primarily concerned with the mortuary practices outside the United States. More recently, cultural anthropologists have started to look at the mortuary practices of Americans. Karen L. Krepps, in her dissertation on "Black Mortuary Practices in Southeast Michigan," makes the point that cultural anthropologists have a tendency to look at death as one way—the American way of burial. She suggests, however, that the basic list of (1) removing the corpse to a funeral home as quickly as possible for preparation of the body, (2) embalming, (3) viewing of the decedent after preparation, and (4)
proper disposal is a correct list. The ethnic and religious variations as practiced in
the United States have been for the most part overlooked by anthropologists.73

In the next paragraphs, specifically, some of the cultural practices of African
Americans will be examined. One cannot make definitive statements that could
accurately describe how African Americans die and mourn because there are wide
variations across such a wide and varied community. Hosea L. Perry did a study
on "Mourning and Funeral Customs of African Americans."74 While he appreciates
the works of Jessica Mitford, who makes the claim that the funeral customs of black
Americans have become similar to those of the white majority, Perry questions these
conclusions and asserts that much of the practices of African Americans have
survived the African customs among black slaves in America.75

J. L. White gives us an insightful writing on how death is perceived in the
black community:

Death in the black community is perceived as a celebration of life, a testament
to the fact that a life has been lived, that the earthly journey is completed. Those
who serve as witnesses in the presence of death, extended family, friends, and
church members, to affirm the essence of the person's existence, are ready to
testify to the fact that the deceased has fought the battle, borne the burden and
finished the course. They are ready to say well done.76

The above quotation shows the importance that blacks attach to death and
mourning, while the following response within the white community, as reported
by Coffin, was an example of the difference in the typical way whites responded to
a funeral in the 1800s:
Everyone, as he entered, took off his hat with his left hand, smoothed down his hair with his right hand, walked up to the coffin, gazed down upon the corpse, made a crooked face, passed up to the table, took a glass of his favorite liquor, went forth on the plat before the house, and talked politics, or the new road, or compared crops, or swapped heifers, until it was time to lift.77

One can immediately see the importance of the death ritual to African Americans, and the apparent difference that the white community assigns to funerals and mourning as opposed to the funerals of African Americans.

E. D. Genovese confirms the importance of the funeral to the slave in his work, Roll, Jordan, Roll.78 He said this importance was highlighted during the 1800s after the insurrectionary plot associated with Gabriel Prosser in Virginia, which was organized by the slaves at a child's funeral and especially following the Nat Turner Revolt of 1831. Genovese refers to the decisions to bar black preachers and to forbid public funerals that were not officiated over by white men. He describes the barring of black preachers:

Never did white reaction succeed in suppressing big slave funerals. Too many planters considered the repressive regulations inhuman, and others noted that they either could not be enforced or would so embitter the slaves as to increase, rather than decrease, the threat of violent resistance. The significance of proper funerals for the slaves lay not in the peripheral, if real, danger of conspiracy, but in the extent to which they allowed the participants to feel themselves a human community unto themselves.79

The attempt by white slaveholders to repress slave funerals dates back to 1687 in Virginia. In 1772 a New York City law restricted slave funerals to daylight hours, and limited to number of people attending to 12.80 The slaves often preferred night funerals, and this desire existed throughout the South, but especially in
heavily populated regions where there were many slaves. These areas held a close cultural continuity with Africa and it suggests strong African patterns. There were several logistical reasons why blacks preferred night funerals: they allowed friends from neighboring farms and plantations to attend, and did not interfere with their required hours of work. Genovese states that this practice continued long after the Civil War.81 I have witnessed several night funerals in northern states where this practice still exists. My uncle was funeralized in New Jersey this year (1995) at night. I am sure this practice has continued since the days of slavery. There are many strains that are visible at present-day funerals that have survived since slavery, and these strains have helped African Americans synthesize the American way of funerals, along with much of what has survived since slavery.

Even though there is no complete history on death, dying and mourning, we are helped to reconstruct the beliefs toward death by the ancients. Archaeology has added its help by excavating and finding artifacts that suggest religious beliefs in God, and makes its contribution to our discussion by providing evidence for anthropologists to put together and produce as closely as possible how our cultures evolved to where they are today.
NOTES


11. Ibid.


16. Ibid., 144.


18. Ibid., 445.


21. Ibid.


24. Ibid., 110.


27. Ibid., 608.


38. Ibid., 51-63.

39. Ibid.

41. Ibid., 105.


44. Ibid., 32.

45. Ibid., 33.

46. Ibid.

47. Ibid.

48. Ibid., 35.

49. Ibid.

50. Ibid., 36.


53. Ibid., 55.


55. Ibid., 22-37.


59. Ibid., "Archaeology."


62. Ibid.

63. Ibid.


65. Ibid.

66. Ibid.

67. Gennep, *The Rites of Passage*, 151.


69. Ibid.


74. Perry, "Mourning and Funeral Customs for African Americans," 52.

75. Ibid., 54.


79. Ibid., 194-195.

80. Ibid.

81. Ibid., 197.
CHAPTER III

ETHICS IN DYING

It is inevitable that, given today's advances in technology, the new knowledge attained about the human body will allow so many people to live longer, and this knowledge will also raise some ethical questions. There are four basic types of policy questions which will be crucial:

1. What level of technological intervention is appropriate for a given problem?

2. Who should determine whether a particular technology should be funded, or should be applied in a specific case? Pressures for governmental controls, even though they threaten the traditional physician-patient relationship and personal autonomy, will increase due to tightening economic constraints.

3. Should these new technologies be equally available to all persons?

4. What impact on society will be the use of each new technology?\(^1\)

It is a great responsibility for anyone to have to decide when it is the proper time to intervene with technology that will decide who or when a person or group of persons die. There are illnesses that can be healed, but the government or some agency is given the responsibility of deciding which illness or disease is researched. Such decisions are based on demographics. How many people are affected by a certain illness if it is decided that there is not a significant enough number of people
affected, or funding such research will be undertaken. Whoever makes those decisions have just decided what group or segment of a given group will die. How do you decide and be ethically correct? Such decisions are left to those who are in charge of government, and the political climate at any given time can have a definite effect on policies deciding what does get funded.

Another problem to be considered when we examine the ethical dimensions of death is the question of organ transplants. While it is admirable that we have come to the point that an organ can be taken from one person and implanted in another human and that person lives, there are some ethical concerns that we must address. One is that there should be no hint of pressure in bringing about a decision to donate an organ. Second, care must be taken to avoid any direct inducement of the hastening of death itself. Even a feeble life may not be terminated for another. Third, while the initial cases of transplants must always be taken with great risk, advances in medical science should not be used to justify unnecessary haste and inadequate preparation. Life must always be treated with respect. As we investigate the ethical considerations surrounding death and grieving, we are obliged to look at euthanasia, suicide, and truth-telling. These three considerations have brought about much discussion in many circles as humankind struggles to arrive at an ethically correct position, when it concerns the issue of death and the grieving process. Below, we will look at these considerations.
Euthanasia

Our working definition of euthanasia, as defined by Karl Barth, is the sonorous Greek term indicating a gentle, painless, almost beautiful death by means of which those whose lives are intolerable to themselves or others are ended.\(^4\) A more simple working definition for us would be one who has an incurable illness to the point that the quality of life is no longer present and that person's life being taken as a favor, designed to putting that person out of his/her misery, and thereby relieving the suffering of the one hopelessly ill, and the burden of care by his/her loved ones.

The basic question that goes to the heart of the controversy concerning euthanasia: When a person is already dying and is obviously miserable and does not want to prolong the agony, should that person be able to end his or her life? Should doctors be able to decide that the quality of life is no longer a prospect?

The question of euthanasia is not a new question by any means, but thousands of years old. According to Plato, "If a man had a sickly constitution and intemperate habits, his life was worth nothing to himself or to anyone else; medicine was not meant for such people and they should not be treated, though they be richer than Midas."\(^5\)

In our present-day dilemma, there are many questions that, I suggest, can only be answered by ones who are placed into that situation by fate. Several years ago in our congregation, a nine-year old boy while riding a bicycle was hit by an
automobile. While he held on tenaciously to life, a determination was made by doctors that if he lived he would be a vegetable. They could not, however, disconnect the life support system unless the boy's mother gave consent. Naturally, she turned to me for advice: "What should I do?" Not having been faced with this decision before, I was at a loss. My policy has long been not to make a decision for someone else, but try to explain the ramifications of their actions, whatever they may decide. I watched with agony as that brokenhearted mother painfully made the decision to disconnect the life support system. Her concern was, "If I give the permission to disconnect the life support system and my son dies, then I have killed him." Almost as fast as the life support system was turned off, the little boy died. My counseling to her was that she did not create the situation that had left him helplessly injured, and whatever she decided she had to come to grips with the fact that her decision would have to be a decision that was made according to her best and honest opinion. Since that time I have been present at many such situations and have watched grieving loved ones struggle to make the right decision. This is indicative of the relevance of this discussion on euthanasia in that it would help those who are affected by such circumstances to make an informed decision.

As my research has continued, I have found that there are categories of euthanasia which I would like to further explore. The term "passive" has to do with the omission of measures to prolong life, and "active" has to do with the direct inducement of death.
## Categories of Euthanasia

1. **Voluntary**  
   With patient's expressed and informed consent.

2. **Passive Voluntary**  
   Conscious, rational patient refuses life-prolonging treatment and patient's request granted.

3. **Active Voluntary**  
   Conscious, rational patient requests and is given lethal injection.

4. **Speculative**  
   Without patient's expressed and informed consent (e.g., infant, comatose, or mentally retarded person).

5. **Passive Speculative**  
   Cessation of life-prolonging treatment for comatose patient, or patient otherwise unable to give consent.

6. **Active Speculative**  
   Lethal injection administered to comatose patient, or patient otherwise unable to give informed consent.

7. **Involuntary**  
   Against patient's expressed consent.

8. **Passive Involuntary**  
   Cessation of life-prolonging treatment to conscious, rational patients against their will.

9. **Active Involuntary**  
   Lethal injection administered to conscious, rational patient against patient's will.

Let us examine the position of the proponents of euthanasia and the opponents of euthanasia. First, I will list some of the objections to euthanasia, and secondly, I will list the arguments of those who are proponents of euthanasia.
Objections to Euthanasia

1. Who, if anyone, can make irrevocable decisions to die or let die?

2. If patient asks to die or to be helped to die, opponents consider this as suicide.

3. If a patient asks to die, is that patient his/her own master?

4. The possibility of mistaken medical judgment remains.

5. When consent is given to discontinue medical treatment by the patient’s family, are the motives good?
   a. Is the motive really for the sake of the patient?
   b. Is the consent for the convenience of those who are caretakers?
   c. Can a close relative consent to a patient’s death without betraying the ones whose lives we relinquish?

These are some of the questions that those who raise objections to euthanasia would like to have answered before being able to support euthanasia.

Let us now look at the position of those who have no big problems with granting the wishes of those who wish to die, or deemed by the next of kin as useless to continue life.

1. Once the quality of life has been diminished, it is useless to perpetuate one’s existence, and death wish or consent should be granted.

2. Of what use is a life that is punctuated by extreme disability, age, and sickness?

3. When there is no will to live, and life has presumably run its course, what good is accomplished by continuing their lives by force

4. An individual should have autonomy with the freedom to choose whether or not to die.*

*Note: These arguments for and against euthanasia are the synthesis of reading Death and Identity by Fulton and Bendiks, Perspectives on Death by Liston O. Mills, and from this student’s observations from ongoing public debate.
Probably the classic example of the ongoing ethical controversy surrounding euthanasia in this country is the Michigan doctor, Dr. Jack Kevorkian, who, between 1990 and 1994, helped 20 patients kill themselves.\(^7\) (He has helped others since then.) His bold manner in which he goes about assisting in mercy killings and suicides has brought about a huge public outcry by the opponents of euthanasia. Such was the outrage that his home state of Michigan passed a law in 1992 that said, "Anyone who provides the physical means" or "participates in a physical act," to help another commit suicide could be prosecuted by the law. Kevorkian continued to assist patients in suicide, and in 1993 two judges dismissed two of the charges on grounds that the law was unconstitutional. Judge Thomas E. Jackson, however, refused to drop the charge in the death of Thomas Hyde, a 30-year old man suffering from Lou Gehrig's disease (amyotrophic lateral sclerosis [ALS]), which has paralyzed him and caused great pain. In 1994 a jury acquitted Kevorkian of the charges, expressing skepticism and resentment that the legislature would intrude into what they felt was a private decision. Lynn Mills, spokeswoman for Michigan Right to Life, insisted that the jury "has just unleashed the floodgates. There will be no stopping him or other doctors who believe that they are God."\(^8\)

This shows the intensity of the controversy surrounding euthanasia. There are organizations organized pro and con and they are very vocal and determined to be victorious on their stand, for or against euthanasia. One such organization that support euthanasia is the Hemlock Society whose general principles state:
1. Hemlock seeks to provide a climate of public opinion which is tolerant of the rights of people who are terminally ill, to end their own lives in a planned manner.

2. Hemlock does not encourage suicide for any primary emotional, traumatic or financial reasons in the absence of terminal illness. It approves of the work of those involved in suicide preventions.

3. The final decision to terminate one's life is ultimately one's own. Hemlock believes this action, and most of all its timing, to be an extremely personal decision, wherever possible, taken in concert with family, close friends, and personal physician.

4. Hemlock speaks only to those people who have mutual sympathy with its goals. Views contrary to its own which are held by other religions and philosophies are respected.

A group that staunchly opposes euthanasia is the National Right to Life Committee, Inc. Below is their resolution on euthanasia.

1. With limited exceptions, competent persons have the right to consent to, request, or refuse medical treatment.

2. A competent person's decision to request or refuse medical treatment should be operative after that person becomes incompetent.

3. Nutrition, hydration, warmth, and nursing care are not forms of medical treatment and must be provided to patients.

4. Adequate safeguards must be provided to ensure that a person's directive to refuse medical treatment is not a result of duress, coercion, or undue influence and has been made after receiving sufficient information in order to give an informed consent.

5. The third-party decision-maker must be subject to appropriate standards and procedures that recognize the limited power of a third party to refuse appropriate medical treatment for an incompetent patient.
6. Appropriate medical treatment shall not be withheld or withdrawn from an incompetent patient who is not in the final stage of a terminal illness or injury.

7. Incompetent patients who, while competent, had not made a medical treatment directive should receive appropriate medical treatment.

8. No person should be permitted to cause or assist the death of another person through mercy-killing or assisted suicide.\(^9\)

One can readily see how, when presented with these options, it can add to the pain that one's family goes through, having to decide or stand helplessly by and watch that decision be made. I have to admit that I am ambivalent about euthanasia. I do think that only God should be the one who decides whether one lives or dies, yet in nearly 26 years of pastoring I have seen scores of people with the quality of life obviously gone and the only way they are existing is through the utilization of machines.

I have agonized with families who have wrestled with the idea of stopping medicine and treatment, knowing if treatment is stopped the person dies immediately. I have also seen people whose whole financial base has been destroyed, even though they are willing to give everything for their loved ones. I believe euthanasia should be avoided whenever possible. On the other hand, I would also be able to understand it when euthanasia is accepted and practiced in extreme cases.

Since the objective of this dissertation is to look at all aspects of grief, the entire grieving process can easily be complicated by the way one dies. When loved
ones have to make decisions that they feel are not theirs to make, and their decisions result in the death of their loved one, it has a definite effect on the severity of the grieving one's loved one's experience. It serves to further complicate the grieving process and healing is then slow in becoming a reality.

**Suicide**

As we turn our attention to suicide, one of the most difficult deaths that one has to deal with is suicide. The majority of authors assert that suicide is the precipitant for the worse kind of grieving experiences, and the most disturbed mourning.\(^{10}\)

Suicide is seen by some as

the final act of despair, a judgment not only upon the uselessness of life taken, but upon the supporting fabric of those about him. Even when explanatory notes are left behind, true motivation and intent remain shrouded in mystery, inviting interpretation. Suicide is inescapably unethical, not only because it is a taking of life, but because it is invariably social. Suicide cannot but be a negative condemnation of the whole of life, and thus of the relations of those who live after.\(^{11}\)

Our congregation has experienced the tragedy of suicide several times in our 25 years of existence, and from a personal experience I have been called on to counsel families who have been affected by the tragedy. I do believe that the totally unexpected death has a more devastating effect on families who are left with questions such as:

1. How much did I mean to the one who committed suicide? If I meant so much why would he/she leave (die) by choice?
2. Why has the loved one consciously and deliberately chosen death over life with the mourner?

3. How does one deal with the feelings of inadequacy, lowered self-esteem, shattered self-worth, and feelings of failure?¹²

Even as a counselor, I have felt feelings of failure. Below I will discuss three actual deaths from which I suffered deep emotional trauma because of my association with the families.

**Case #1**

There was a young woman who was a member of our church who was a very dear friend of mine. She was a loyal friend who credited me with having led her to Christ. I performed her wedding ceremony. Several years later she unfortunately became involved with another man, and she felt terrible about the situation. She said to me, "I feel like he (her lover) has some kind of hold on me, and I do things that God know I don't want to do." She continued, "I'm through with it. If I do it again, I'll never go back home again." I said to her, "Never get so far out that you can't go home." Her response was, "You don't know what I mean." I then recognized that she meant that she would rather commit suicide than to be caught in that situation again.

After counseling her, I left and the next evening her husband, who also was my friend, called me and said, "Rev., I'm home and she is not here. What am I going to do?" I tried to reassure him and pacify him until I helped her through this problem. Even though he promised to stay at home, apparently he was so
devastated that he went looking for her and somehow he found them together. His account was that he had no plans to kill her, but had his gun. When she saw him, she was so ashamed to have been discovered, she told him, "Go on, shoot me because I'm never going home again." He said he begged her to come home but she began taunting him, "Shoot me. If you don't you're not a man." He said that her taunting was so intense that he lost it and started it firing. His story was consistent with her prophetic words to me, "If I do it again, I'll never go back home again." She in effect committed suicide. I was affected both as a counselor and as a friend. I felt that I had failed and apparently was inadequate as a counselor and as a friend. I was grieved as much as a family member. So from a personal standpoint, I can see how the totally unexpected death of one who commits suicide complicates mourning with negative added emotional baggage.

Case #2

This case involved another young lady who came for counseling and never disclosed how depressed she really was. By her reactions I felt that she was making progress in resolving her situation. I had assured her that if she ever got to the point that she felt she would harm herself I would make myself immediately available to talk with her. One night during the Christmas season she just took a gun and put it to her head and blew her brains out. While I comforted her family, I still felt a nagging sense of failure.
Case #3

The third case involved a young man who called and was relating his feelings of suicide. I responded by asking him to come to my office, and he agreed. However, before he came he killed himself. Again, that nagging feeling of failure began to nag at me.

Over the years, I have had many opportunities to try and talk suicidal persons out of committing suicide, and have a good amount of success. There are several people who directly credit my work as a minister and counselor for having talked them out of doing such a horrific deed. It was the failures, however, that have taught me much about the pain of suicide and how it complicates grieving. With the gained insight, as I begin to re-train our lay counselors I will attempt to make them sensitive to the difficulty suicide brings to the work of mourning.

When we look at the negative emotions that suicide heightens within grieving loved ones, we will find that anger, guilt and shame play a large part in the difficulty of the work of grieving within the family of the bereaved. When counseling focuses on the negative emotions brought on by suicide, those who have been exposed to informed counseling have shown marked healing. In instituting our process of caregiving at Mt. Ephraim, we will be deliberate and sensitive to help those who are responsible for caregiving to be able to address the question of suicide in a positive and purposeful manner.
Truth-telling

As we turn to the last of our discussion on ethics in questions surrounding death, dying and the grief process, we must deal with the question of truth-telling. The main question that comes to the forefront is this: Do patients have the right to know the truth about their condition as others, especially physicians, see it?

It is said that while truth is always the desired end, dying patients are a special case in that the truth can be harmful, demoralizing, and actually accelerate their deterioration. The other side of the coin is dying people most of all must know the truth since they need desperately to get their affairs in order.13

William May in his article entitled "The Sacral Power of Death in Contemporary Experience,"14 sees the whole question of truth-telling as a breakdown of communication between the dying patient, the doctor, and the next of kin. He states that many times a substitute diagnosis is given and justified on the grounds that the substitute diagnosis establishes an emotional equilibrium essential to the health and comfort of the patient. But justification ignores the fact that evasiveness can itself be emotionally disturbing. Mays continues, it is demoralizing for everyone concerned to get stuck with a lie. He believes that the family grows accustomed to the diagnosis and enmeshes itself more deeply in the demands of make-believe. Isolated by evasion and lies, the patient is driven out of the community before his time. A premature burial is forced upon him. While trying
to avoid the fact of death, the community actually reeks of death, for it has already
excluded him.\textsuperscript{15}

Another factor that we are forced to look at in truth-telling are the emotions
and belief systems of the attending doctors. There was a study done in the work,
\textit{Death and Dying: Attitudes of Patient and Doctors}: 69\% to 90\% of physicians
(depending on the specific study) were not in favor of informing the patient in cases
of mental illness. On the other hand, 82\% of patients in terminal cases actually
wanted to be informed of their true condition. Some psychiatrists explained this
discrepancy between the apparent desire of patients and the actual performance of
doctors by considering the psychological defects and/or faults in their training:

1. They are more afraid of death than other professional groups.

2. They shy away from dealing with chronic and terminal cases because
such cases are a blow to the doctor's professional self-esteem.

3. They receive inadequate preparation in medical school for coping with
the problem of handling terminal cases.\textsuperscript{16}

The American Hospital Association has done an in-depth study on the issue
of the patient's right to know his/her true condition, and has produced what is
known as the "Patients' Bill of Rights."\textsuperscript{17} I will list these bill of rights below, and
hope they will bring insight on the medical caregivers and their views on truth-
telling.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know by name the physician responsible for coordinating his care.

3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent, should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
8. The patient has the right to obtain information as to any relationship of his hospital to other health care and education institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.

9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

11. The patient has the right to examine and receive and explanation of his bill regardless of source of payment.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

As I struggle to find a solid position on which to take on the issue of truth-telling, an experience that I had with an official board member of our church becomes noteworthy. I noticed he started having a rapid weight loss, and being concerned I inquired about his health. He responded that he had been diagnosed with a disease that was terminal in nature, and what I was seeing was the effects of the disease. I was as understanding as possible and gave him as much emotional support as possible.

A few months later I noticed a radical turnaround in this member. As fast as he had been losing weight, he began to regain his weight. Again, I inquired, this
time it was about his gaining weight. He answered that he had gone to another
doctor who confirmed the medical condition, but advised the patient that it was not
a terminal situation. When the officer realized that it was not terminal his whole
condition changed. It was a bit humorous to me, but it shows how much credence
some patients give to doctors, and will tend to act out the expectations given by the
doctors whether the expectations are real or false. Because of this kind of
expectation, I would tend to endorse truth-telling to patients, but that whatever is
told them should only be told after the caregivers are overwhelmingly sure that
their diagnosis will be accurate.

Even when the truth is given by the doctor or doctors, there are some whose
belief systems are so brainwashed until they could not accept the truth even when
it is told to them. This can best be illustrated by another incident that happened
several years ago. We were in an anniversary program at the church. I was dressed
in white which was the uniform for the day. A young woman, who was almost
hysterical, came to me urging me to go to the hospital to keep her grandmother from
dying. I was shocked that she felt that I could stop her grandmother from dying.
She went on to explain that her grandmother had suffered a heart attack, and the
doctors had concluded that she could recover from the heart attack. However, her
condition was growing worse and worse because she believed in her heart that
somebody had worked witchcraft on her, and she was going to die. She was acting
out her belief system.
I consented to go to the hospital, but on my way there I reasoned that if I tried to convince her that she was not "fixed," if she truly believed that in her heart, nothing I said would stop her from believing she was dying. So I decided to approach her within the framework of her belief system. When we arrived at the hospital, the nurses would not allow me to see her until she woke up on her own. I decided to wait.

Finally, the nurse allowed me to go in the grandmother's room. She seemed to be semi-delirious, but when she saw me with that white suit on, she had a little difficulty focusing, but she seemed to think that white symbolized something positive. I pretended to be the one who could negate the evil influences around her, and therefore I could save her life. When I fully had her attention I gave her the gospel message and before leaving I told her, "I will be doing something on your behalf and you must never tell anyone." Within a few days, she re-acquired the will and the belief that she could live and went home from the hospital.

This incident shows that not all patients are ready nor able to deal with the truth. I may be criticized for letting her think that I was a person who could undo the witchcraft that she believed had her fate, but Soren Kieerkegard once advanced his theory of the "Teleological Suspension of the Ethics," that said, in effect, there comes a time when there is no clear right or wrong, but an evil and the lesser of the two. It is then wise to choose the lesser of the two.
I have shared these experiences to suggest that patients should be always be
told the truth when they are able to receive truth; however, in some cases the
insightful caregiver should be wise enough to ascertain whether the patient will be
able to process truth in a meaningful manner, and act accordingly.

In this chapter on "Ethics in Dying," I have tried to discuss in a coherent
manner the ethical considerations that should be considered by family members, the
medical professional caregivers, and the public at large in trying to reconcile this
issue that we all must face sooner or later, death. It is plainly noticeable that the
decisions that are forced to be made by a patient's particular situation can
complicate the mourning process, and we who would offer help in recovery must
be sensitive to these issues when we counsel the bereaved loved ones.
NOTES


6. Fulton and Bendiksen, *Death and Identity*, 337.


8. Ibid.

9. Ibid.


15. Ibid.

16. Ibid.

CHAPTER IV

EQUIPPING COUNSELORS AND INSTITUTING THE GRIEF SUPPORT GROUP

Training the Lay Counselors

The procedure for training our lay counselors in the grieving process was first announced through our church bulletin, requesting a response from the lay counselors that were previously trained and those who wished to be trained. There were 26 respondents who met on October 19, 1995. At that meeting I gave an overview of the plans to implement a program at Mount Ephraim designed to aid grieving loved ones to resolution during the grief process. I also explained that I would be the facilitator of the training for this program which would also be my project for the D.Min. degree.

At this meeting several tasks were accomplished. A questionnaire was distributed that focused on how a person grieves. Those in attendance were asked to complete the questionnaire which served as a primer for their recognition of their own style of grieving. They were also given the requirements for becoming a grief counselor (see appendix). The schedule of meetings was announced: four (4) two-hour sessions that would meet weekly for four weeks. Two persons were selected to assist in making sure the classroom would be in order for our meetings, all

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printed material would be printed and disseminated at the facilitator's request, and to get the material to persons who arrived late to the sessions.

It was explained that the information given was to be studied and a quiz would be given each week to monitor the retention of the material being taught. The goal of the program was to have the members of the class to become so familiar with the grieving process that they could actually counsel with a person and detect where that person was in the process.

Positive comments were received from the trainees stating their support of the project. Some indicated that they had family members who were not handling the grieving process very well to the stage of resolution.

The video tape ministry of Mt. Ephraim was asked to tape each class session, edit and prepare the tapes which would be used as instructional tapes for future counselors. These tapes would also be available for other churches to use in their grief ministries.

Class #1

October 28, 1995 3:00 p.m. - 5:00 p.m.

The syllabus was presented and explained. Questions concerning the syllabus were entertained. The focus of the first class, "Counselor, Know Thyself," was on the counselor. Each member of the class was asked to give their experience of losing a loved one. One cannot become an effective counselor unless he/she understands his/her hurts and the psychological baggage that he/she may be
carrying. It was made clear what psychological baggage is, labeled in the class as "your stuff," which means recognizing your own pain and not allowing one's personal pains and problems to affect one's objectivity in counseling.

What followed when the students began to talk about their experiences with death was something for which the facilitator was unprepared. As the students began to talk about their experiences, some began to sob, some uncontrollably. Those who were not crying felt so much sympathy for those who were that it ended up being one large crying session, including the facilitator.

It was difficult to comprehend that there was so much pain being carried by some of those who, by their outer appearance, seemed well-adjusted. It was then recognized that this program was well overdue.

When the tears subsided, the first lesson on normal and complicated grief was presented. "Lights going on" among the students could be seen because this was the first time they had begun to recognize some of the things they were experiencing. For some, a self-diagnosis of complicated grief took place (see appendix). The first class was, to say the least, both painful and rewarding.

As facilitator, I reflected on what had occurred. I felt overwhelmed, not sure if I had properly handled the painful revelations. I did not want to "cut them open and leave them open." Prayerfully, I hoped that their verbalizing their own pain had been therapeutic.
Class #2

November 4, 1995

At the second class meeting, there was much anxiety as to how the atmosphere would be considering the high emotions of the first class. As facilitator, I was in a very upbeat mood in order that the class members would approach the work from a positive standpoint. Jokingly, I stated: "I've got a present for everyone."

It was a quiz.

At the end of the quiz, the second session began with a discussion of complicated grief and normal grief. This second session proved to be as astounding as the first one. As the class members discussed the terms, it was evident that they had engaged in a great deal of introspection, trying to apply their own situations to what they had learned about normal and complicated grieving. It was as if their healing was taking place right then. One by one the students began to verbalize how discovering that they themselves had not reached resolution, and at the same time learning about complicated grief had helped them, for the first time, to begin to deal positively with their own grief. They were allowed to talk freely about their feelings. The amount of resolution reached in a week for the class was almost miraculous.

As reflection occurred, it was heartwarming to see the healing that the class was experiencing. It was gratifying.
Class #3

November 11, 1995

In lieu of a quiz, the students were asked to share their reflections of what had occurred to this point. Their permission to share their responses with grief classes was obtained (see appendix).

A new lesson on "Mechanisms for Coping," was begun. A discussion took place on the self-defense mechanisms employed by the mind to cope with painful realities. We went into detail of the categories for coping mechanisms: adaptive coping mechanisms, regressive coping mechanisms, and narcissistic coping mechanisms. It was clear that we could not complete the discussion in this session; however, we would continue it during Class #4.

As facilitator, I was becoming frustrated. I now recognized that four sessions would not be enough to cover all the necessary material. I needed to be reasonably sure that the students would be an aid in the healing process and not become a hindrance to that process. The class members were eager to lengthen the number of sessions. An additional four (4) two-hour sessions were added. I indicated that the additional sessions would help them become more proficient in helping those to whom they would be assigned to help. The addition was unanimously received.

During the interim period between the classes I counseled a parishioner whose father, a truck driver, had been missing for four or five days after leaving Los
Angeles. As best she could, she had called all the known stops on his itinerary, alerted the police, but received no help. She went to California, retraced her father's route, and found him in his truck at one of the places she had called. He was already dead. If they had only taken the time to investigate when she placed the call, perhaps he could have been helped. The manner in which she was grieving was the aggressive coping style. She was writing letters to the police, to talk shows, and to anyone who would expose the "don't care" attitudes she had encountered while searching for her father. I recognized her style of grieving. Her anger was fiery. I counseled her. Recognizing that she needed more attention, I invited her to come to our training class for two reasons: (1) the class could see the aggressive coping style at work and (2) the grief stricken parishioner could have an opportunity to vent her hostilities. It was a great sharing experience. Those class members who had begun to heal were able to comfort her in a positive manner.

Reflecting on this class session, it was confirmed that it was God's will that had dictated the implementation of this program to me. The success of the sessions made me much more eager to begin the next phase of establishing the support group, which will be invaluable in the emotional well-being of our members.

Class #4

November 18, 1995 1:00 p.m. - 3:00 p.m.

This session began as usual with a quiz. The tests helped to monitor the progress we were making in terms of learning the material and indigenizing the
process. During this session, the class members were asked to communicate what they had learned in an acceptable way. It was pleasing to see the progress being made. A discussion of the quiz material ensued.

The parishioner whose father had died was present. This time her mother accompanied her. Again, she shared her grief with the class. Even though this kind of sharing was to be addressed in the support group, it was good experience for the future counselors to see the positive effect that listening has for the person who is bereaved. As in the last class session, a miraculous improvement in this grieving parishioner was evident.

The following handouts were distributed to the class: (1) a form that can be used to make out a will and (2) a list of things to do within 48 hours after a loved one dies (see appendix).

In the next session an actual case study which the facilitator had witnessed will be given to the class. The future counselors will be asked to identify what may be causing the grief to be complicated and to make observations of all pertinent details. They will also be asked to engage in role-playing. An assessment will be made of the future counselors' readiness to assume the duties of helping others in their bereavement. The following section contains personal reflections of several class members of the Grief Counselors Class to this point.

Class #5

November 20, 1995 7:00 p.m. - 9:00 p.m.
This class began in its normal way with prayer and the now usual quiz. After the quiz we discussed the previous quizzes, making sure that the information was not being taken lightly. We discussed each quiz thoroughly. We then began to engage in role playing. Some of the students were told to act as grieving loved ones, and others were asked to act as counselors. At first, they didn't seem to take the role playing seriously, but as important issues began to rise during the role playing, the mood began to change to a very serious one. Whenever a statement was made that was not conducive to mourning, the students were to point out these statements.

I left the class feeling a sense of accomplishment after seeing the students trying to give all they could in learning the information that was being disseminated in the class.

**Class #6**

**December 12, 1995**

This class was one in which more information was given. I was deliberate in my presentation because of the amount of information that I wanted to present. It was during this class in which the atmosphere became somewhat "heavy" because of the chords that were struck. Tears began to flow. By now I had learned that it was healthy for the students to show emotion and express their pain. It was a very good time of sharing. I could feel the therapeutic effect of what was happening.
I invited to this session the young lady whose father was found dead in California. I had noted that her style of grieving was the use of aggressive coping styles. The manner in which she was dealing with her father's death was by waging a campaign to show how police and others who could have helped failed to help during her crisis. One of the national trucking magazines had picked up her story, printed it nationally, and we could see that she had a feeling of accomplishment, thus aiding in her grieving. She had copies of the magazine's story and we shared it with the class. I was grateful for this modeling of one of the styles of grieving.

Another important thing I thought about was the fact that people also grieve over the loss of pets. This started a lively conversation that had some participants ridiculing the notion, while others considered the notion as real as I stressed the legitimacy of the pet grieving. The class again took on a serious note, which was a good learning experience for those who had ridiculed the notion at first. I was very gratified with this session.

Class #7

January 4, 1996

A comprehensive test was given covering all of the information shared during the class. Evaluation forms were distributed with a request for anonymity. This was my way of urging them to give their true observations without fear of being perceived as someone unduly negative. For the most part, they were upbeat.
As in every class, those who were conscientious about study were confident, while others were apologetic that they did not perform better than they did.

After the class, one of the students shared that their family cat had died, and because of the grief of her daughter, she had a funeral for the cat to facilitate the grieving process. The entire family shed tears. She told me that the class had helped her treat the cat's death with legitimate expressions of death to her daughter. She said, "My daughter was helped."

Class #8

January 8, 1996

Graduation exercises were conducted. Examination papers were returned, and each student made her/his expressions; most of which were positive. Refreshments were served. The class was challenged to be faithful in service to the Lord as they helped to alleviate undue pain being experienced by grieving loved ones.

I thank God for the new grief counselors at Mt. Ephraim Baptist Church.

Reflections of Grief Counselors Class

Mary Ashhurst
November 11, 1995

My reflection on this class thus far has been helpful. First, it has helped me to understand my own mother. I now know that she is in complicated grief. It has also helped me understand others and things they are going through.
Eva Bates  
November 11, 1995

The class has been another eye opener for me. I often wonder why so many cry or seem as if they are hurting. To be given the opportunity to open up to each other and share hidden pain and suffering can now go on to uplift and motivate others. To understand why death is, what causes a death is important in how a person reacts to his/her own life situation.

The class is needed so that the word itself, death, can be discussed and addressed in a manner that now I feel relieves knowing that if it is not a conflict or complicated, we all can live a normal life.

Gerald W. Boyd  
November 11, 1995

I believe the grief classes will be very helpful now and in the future toward helping some one. I know that it is better to help someone than to hurt them. I feel very positive about being in the classes, yet a little timid because fewer males want to become involved in the classes. I pray that my time and efforts will not be in vain.

Sandra J. Brown  
November 11, 1995

The Grief Counselors Class thus far has given me the first insight needed to function as a counselor. My purpose for taking this class was to refresh my mind on the different types of social and physical problems related to death and dying.
I have become acquainted with the different types of grief and the healing process. I have learned the symptoms of grief and ways to overcome them. I have also learned the ways different people handle death and how to talk to people about death. This class is also teaching me how to deal with my psychological hurt and pain.

Arthur Collins
November 11, 1995

This class has meant a lot to me, especially the interaction between those who have been bereaved and those coming to be trained to help those who are suffering from the grief process. I've enjoyed the instructor and how he articulates the various symptoms, mechanisms that we should be able to assess so that we can counsel those facing grief. I've enjoyed understanding the difference between normal grief process. Also, to understand that it can be complicated when one does not go through the normal grief process. I've enjoyed understanding the various definitions: denial, grief process, bereavement, euthanasia, truth telling, guilt, mourning, etc. so that I can assist those displaying these reactions. I've also learned how to identify the grief mechanisms above based or body language.

I'm looking forward to the remaining course to understand funeral procedures, ways to assist families facing bereavement of loved ones.

It's been a pleasure working with Rev. White. This class has been very practical and hands-on where one can actually put themselves in the place
(empathize) of the bereaved and see how they feel going through death and overcoming it. I've learned how to know my "own stuff," review my limitations, understand the phases of grief, physiological and psychological symptoms of grief, etc. It's been fun!

Doris Corbin
November 11, 1995

Since I've been attending these classes they (counselors) have given me the opportunity to walk back over the past two years since my mother's death. I was still grieving and did not know it until I have to talk about it. Talking and reading about grief, and especially complicated grief, has helped me tremendously. I am praying that God will give me the power to keep getting stronger.

Johnnie Davis
November 11, 1995

As I reflect on the classes to this point, I feel that I will be able to help others, and be helped as well. I feel that I can be strength as well as an informant.

I feel that these classes will be most effective to the grieved and hurting. Realizing that time is of essence, but knowing there is someone to share and care about our hurts is medicinal.

Vernell W. Douglas
November 11, 1995

The class has been very helpful to me in many ways. I came so that I may learn to help others. In my doing so, the class has helped me. I thought I have dealt
with some of the hurt in the past, which I guess you would call prolonged grief. But it was so much as I had placed it on the shelf to only retrieve it later (now).

I learned to deal with the death of my grandmother. I wasn't saddened but I was happy; not because she died but because of all the relatives not wanting to do their part to help after the stroke. My grandmother always felt so peaceful when I came to help her. Some of my family always became angry because they had to help. To make a long story short, I have been helped in many, many ways. Now I feel I can help so many more as I have done in the last four days. I don't know if I want to be a counselor. I just want to be here when needed.

Bettye Ferguson
November 11, 1995

The class has been very motivating for me. I understand I have some phases of grief to work through. I understand I am reacting to the death of my loved ones in a different manner. I also understand where I was (personal level), level at the time of the deaths (before the class) has affected the resolution. For me as I work with others I hope I am able to identify this also. I want to stay focused on the analysis that God wants us to heal.

Studying Lindemann's nine symptoms of complicated grief has helped me.

Ann Flowers
November 11, 1995

My overall reflection is that we all are grieving, and are grieving different circumstances that have happened in our lives. I noticed that some of us are
shocked to know that we are still grieving, and that our grief is complicated grief.

I have noticed that the ones that are crying about their grief are getting comfortable in class and with others. Sharing our grief is helpful for all of us.

Paulette C. Harris
November 11, 1995

Thus far, this class has enlightened me on the process and complications of grieving. I never knew grief could change people to the degree I have learned.

Through the class I have been personally ridden of false guilt of a loved one's death. For this, I truly thank God. It makes me see how easily others may fall in this trap. Also, I have recognized other family members who are now going through their own complicated grief. With God's help, maybe I can point them in the direction for help.

Overall, this class is a God-send to the church family and our extended family and friends as well.

Ernestine H. Lattimore
November 11, 1995

This is a class for which I'm truly grateful. There are so many people grieving today which I'm involved with directly and indirectly, personally; on the job, in the church, daily. The sermons have helped me to understand the grief process; however, this class has helped me tremendously. The words given to us have helped. The explanations have clarified many questions I have. The direct explanation of the instructor plus the teaching we're getting help me to understand.
and to help people daily. These lessons already given have enabled me to help others. It has made me pay closer attention to what is and is not being said. I look into people's eyes when they are around me. I'm able to read, be sensitive to others. I have shared the definitions with several friends and acquaintances due to their needs. I must confess that with all things involved with my life presently, I have not studied as I should. However, I do go back and because of my intense interest in being a lay counselor, I will study much, much harder immediately.

I'm so very happy that you have made yourself available to us to teach this class and provide us with the information. God bless you. I'm not through, but I'll stop.

Bernice Pitts
November 11, 1995

I have discovered that I haven't dealt with my grief process physiologically like crying and sadness. The outlook on this class helps a grieving person to stand to help and to become stable as any grieving person can.

Margaret Ragin
November 11, 1995

My reflection of the class so far is that I find it to be very interesting. Although I missed the session on last Saturday, I have looked over the handout that was passed out and the information is very good. From that information, I hope to be able to retain it for use whenever I am in a situation to do so. I thank God for the teacher (Rev. R. L. White) to offer a class of such at this time.
Reatha Shipman
November 11, 1995

Through this class I have learned the importance of the grief process, even though the study of death and dying was incorporated in the school of nursing I attended. I have learned that it is not until one is truly faced with grief (loss) that full comprehension can be realized.

During this particular class time I am grieved because of the loss of a mother figure, my favorite aunt (within three months), and for the last year, my son's predicament.

This class has helped me a great deal so far. Thank you. God bless.

Rev. Paula Singleton
November 11, 1995

I have found this class to be very helpful in the fact of my trial in dealing with the death of close ones and others. It has let me know that I have been on the right road for a long time, or I should after my mother's death. I thank God for this.

E. L. Stevenson
November 11, 1995

I have come to a higher level of understanding some of my own unresolved conflict due to the teaching of the lay counselors grief class. I have an increased awareness of the numerous factors that can impact the grief process, and can now be more helpful and sympathetic to bereaved loved ones. It has been a truly insightful experience to be able to reflect on my past tragedies, deal with them
accordingly, and translate that knowledge into a positive experience to benefit others. I've been both counseled and trained to be a counselor; also, the best of both worlds.

Barbara Williams
November 11, 1995

This class has inspired me to want to learn more about lay counseling. I have learned the different stages of grief which I was not aware of before the class started. I also learned that different people handle grief in many different ways. It is important for a counselor to know how to handle a person or persons during bereavement. A counselor should also know when one is experiencing grief that needs additional help beyond my level of expertise.

Betty W. Williams
November 11, 1995

Although this is my second session, I feel this class has opened my mind and thoughts regarding death. Rev. White has been quite clear in explaining areas of grief which I simply did not understand. Of course, when we don't understand certain things we always clear it up in our own minds with some negative thoughts. So far, this class has allowed me to be more positive in my thoughts just by understanding the stages of grief.
Jessie Williams  
November 11, 1995

The class has been very educational and very informative. I have been helped tremendously by the information offered and the insight I have received will be of great benefit during a period of grief.

As I studied the material provided last week, I could certainly identify with the normal grief process. It makes me very thankful that I have established an intimate, personal relationship with the Lord because without Him to bring me through the death of my father and the death of a relationship could have been too intense to bear. Thank you for offering the class.

Conclusions Drawn from the Counselors' Class

The method used for evaluation of the progress of the lay counselors was to give weekly quizzes with a comprehensive examination at the end of the classes, reflections the students on how they were interpreting what was being achieved from each counselor, and an evaluation of the class by the students in the closing session.

The weekly quizzes were employed to urge each student to recognize the need for study of the material. The overwhelming majority responded positively by giving evidence of study for each quiz. Subsequent discussion of the quizzes served to reinforce the material that was presented, and the discussion was aimed at the counselors becoming conversant about death, dying and grieving.
comprehensive examination revealed that these students were serious about comprehending the material. While there were five who were just attending for personal reasons and four who terminated, there were seventeen who completed the course. Sixty percent scored in the upper range, thirty percent in the mid-passing range, seven percent in the lower range, and three percent in the failing range. This was an indication that the class work was successfully taught and received.

A sample of the reflections of the lay counselors is included in this chapter, and one can easily see that the students were excited about the classes by the comments made in the reflections.

The class evaluation proved to be revealing as the following results indicate:

1. Seven strongly agreed that the course met its objectives; nine agreed that the course met its objectives; and one strongly disagreed. However, the comments by that individual contradicts the conclusion the student circled.

2. Twelve strongly agreed that they now know much more about grief than they did when the class began. Three agreed, one disagreed, and one refrained from responding. The results indicate that the class was very successful.

3. Ten strongly agreed that they had been helped in their own grief; three agreed, two disagreed, and two refrained from responding. Conclusion: goal accomplished.

4. Referring to statement number four, "This whole class was a waste of time," fourteen strongly disagreed and four disagreed. These responses indicate that the students unanimously believed the class was not a waste of time.
5. Fourteen strongly agreed that the instructor knew the material well. Two agreed, one strongly disagreed. The students believed that the instructor was well-informed about subject matter.

6. Almost without exception, those who responded to the question, "What would you suggest to improve this class?", said the same thing: the allotted time for the class should have been longer.

7. The students also felt that the amount of material to digest in the time frame was too heavy. I have responded by recalling the counselors to a bi-weekly class--four more sessions, studying the same material, which began March 13, 1996.

8. Included in the responses to the strong points were: role play, definitions, excellent material, instructor knew the material well, and strong presentation. The weak point dealt with the time allotment element.

9. To the question, "Do you believe you can help grieving loved ones through their pain?", all seventeen said "Yes."

10. "Are you better able to talk about death now?", sixteen said "Yes," while one answered, "Does not apply."

When we look at the responses of the course evaluation, allowing for some bias, the strong indication is that the classes met the objectives given, even though the grief counselors requested more time. Honesty constrains me to confess that the initial time allotted was governed by the completion of this project. The classes were scheduled in order to attain the results for the dissertation. I thoroughly agree with the students, and the next class will be given the equivalence of a semester so that the students will have ample time to digest the material.
The Grief Support Group

On January 6, 1996, history was made at the Mt. Ephraim Baptist Church. After an extensive amount of preparation and discussion, the first grief support group became a reality. In this section, we will look at the results of this group through the analysis of the pre- and post-tests, reflections and personal assessments by the facilitators, and conclusions drawn from the entire term of the grief support group.

Before bringing the grief support group together, I felt it necessary to select the facilitators for the group. They were to be chosen from the lay counselors because of their ability to discuss the different phases of bereavement. The two facilitators chosen were Bettye Ferguson and Betty Williams. Both are trained counselors in drug abuse and Ms. Ferguson is a former school teacher. They showed an appreciable interest in the process. I saw the effect of healing within them and the sensitivity they exhibited toward fellow lay counselors when they were overcome with emotion during the training session.

During the first two sessions, I served as facilitator in order to set the process of conducting the sessions into motion. Ms. Ferguson took the helm of leading the third session. At the end of this meeting the facilitators and I met to discuss the format of the remaining sessions. They were reminded to call each participant before each session to encourage their attendance. There was concern that some of the trainees would not complete the process. The facilitators were instructed to
begin to prepare their observations of the participants and their reflections on the process. They were also reminded to complete the administering of the pre- and post-tests for the purpose of objective evaluation.

The grief support group began with fourteen members who stated their need to be healed; however, only nine completed the term. Some of the persons who did not complete the term indicated there was a conflict of schedule and other reasons. However, I believe some of them were experiencing a great deal of pain and were not ready to deal with the pain.

The pre- and post-tests were composed by Donald Porter during the implementation of his project dissertation, "A Grief Support Group As an Element of Pastoral Care in an African-American Church." Even though the results from the tests were objective, the post-test, in my opinion, could have been more effective had it been structured in a different way. The post-test questions should have been posed in such a way that the answers would have clearly indicated the change that the respondents experienced during the six-week period. For example, "After your experience in the grief support group, can you detect a difference in the way you relate to God?" The questions should have helped the participants focus on their experience in a reflective manner. The post-test was sufficient to give adequate measurement of progress during the grief support group term.

In the analysis of the results, it is evident that the process had a positive growth effect on the participants. Some persons were unaware of the grieving
process. On the issue of guilt on the pre-test, six said they sometimes felt guilty, two said they seldom felt guilty, and one always felt guilty. During the grief support term there were conversations about guilt in grieving, which was enlightening to the participants. This was reflected in the post-test responses to the same question: five answered that they did not have any feelings of guilt, three answered that they seldom had guilt feelings, and one answered "often." These responses indicate positive growth. Other areas where growth was demonstrated were: (1) acceptance of the death of a loved one, (2) admitting denial, (3) establishment of new relationships or friendships, (4) strength gained from Bible study and preaching, and (5) stronger faith in God.

On the pre-test, six respondents had established new relationships or friendships and three had not. The post-test results indicated eight had established new relationships and only one had not. Seven responded on the pre-test that they had gained strength from Bible study and preaching and the post-test results indicated a positive unanimous (nine) response. To the question, "Has your faith in God been weakened since the death of your loved one?", two persons responded positively on the pre-test, while six responded negatively. On the post-test, there were eight negative responses to the same question.

The responses to the questions that were theologically related to the issue of death indicated little or no growth. The majority of the responses were positive on
both tests concerning their strength and faith in God and prayer, their church attendance, and the Bible and preaching as sources of strength during bereavement.

When we look at the results of the questionnaires we can see that there was definitely positive growth during the sessions which was very encouraging (see Appendix for actual results). Because of the significant role that the facilitators played in the process, the next section includes their assessments of participants in the grief support group. The facilitators' assessments also indicate their ability to recognize the various problems which the participants were experiencing during the sessions as well as their inability to recognize when a person is experiencing complicated grief and needs individual attention. Included also are the facilitators' conclusions and recommendations about the grief support process.

Facilitators' Assessments of Grief Support Participants

Assessments by Bettye Ferguson

Mary Banks is fixated in delayed grief over the death of her grandmother (October 1993), waiting for her mother to reach a resolution. Mary's mother still refers to the grandmother in the present tense. Mary is unable to discuss the deceased without crying or her voice cracking. She is also experiencing displaced grief and psychological distancing with family members. She took pictures of the deceased in the casket without the support of the family which caused some unresolved conflict. Mary was using regressive coping mechanism by looking at the pictures to reassure herself that her grandmother was ready (101 years old) for
death and she is at peace. This brought her some relief, but not a resolution. Now she does not have the support of the pictures because she cannot find them. She has some unresolved conflicts that occurred before the death of her grandmother. "My grandmother didn't want to go to a nursing home, but my mother was not able to continue to see about her." The "but" indicates some guilt. She continues, "Grandmother lost the interest to live. She went into the hospital just for tests; she was fine." The "just" indicates more guilt. Maybe if they had not put her into the hospital, she would be fine today. By the end of the sessions, Mary could talk about her grandmother without crying as much. It was suggested that she continue to work through the grief process and not wait for her mother. Once she reaches a resolution, she can help her mother deal with her grief.

Mary Ballard, with son Gary (10 years old), lost her husband November 25, 1995. She was already experiencing complicated grief surrounding the deaths of her mother, father, and siblings. With the death of each one, she had to be strong for others. All the people for whom she had to be strong are now gone. There is some displaced grief. The loss is intellectually accepted, but coping is emotionally impossible. Now that she is the last member of her family, who is going to be strong for her? This can be referred to as narcissistic coping mechanism. She is concerned about her (last surviving member of her family) immortality. There is definitely some displaced and delayed grief present. With her husband's death, at the time it's not complicated, but some unresolved conflict is present. Even though he was very
ill, his death was unanticipated; he showed signs of improvement. Her storytelling is centered around the morning of her husband's death. The hospital went against her wishes that she did not want euthanasia. Morphine was injected to hasten his death after she left the hospital for two hours. She feels hopelessness and helplessness because her husband was reaching out to her when she walked through the door just before he died. Her unresolved conflict is the narcissistic coping mechanism used to protect her ego against the trauma of her husband's death by looking for the culprit. She carries a copy of the funeral program in her purse; preoccupied with the death of the deceased. The program is a comfort for her denial and she uses the program to reassure herself that Mr. Ballard is dead. She is experiencing displaced grief by channeling her feelings toward the hospital of their wrongdoing. This is the use of the aggressive coping mechanism to set right what is wrong. She wants to make sure that it does not happen again. She is also experiencing some regressive coping mechanism because at this time she appears to be more upset with the hospital than the actual death. The following suggestion was made for Mary: Since grief requires work, she should write down her feelings in the form of a letter to the hospital. This is another way for her to channel her energy. Not only should she write the letter, but if she wants to she should talk with the administrator of the hospital. Additionally, since she has retired from the catering business, it was suggested that she consult with Mrs. Daniel about assisting with the feeding the homeless program. After the sessions, Mrs. Ballard was able
to tell her story without crying. When she began the class she was taking sleeping pills. At the end of the session, she indicated that she has thrown the pills away.

Marla Coomb is in complicated grief over the deaths of her mother, grandmother, and aunt. She is experiencing symptoms that are not psychosomatic but are directly related to the illness of her mother. There is some unresolved conflict concerning her immortality. Her mother has been dead for ten years. In a one-on-one conversation, there is a great amount of anger with a surviving aunt. Her deceased aunt was nice, her grandmother was nice, and her mother was nice. To her, all the nice people in her life died. There are a lot of unresolved conflicts she has with the surviving aunt, who "did not help with my grandmother." Marla did all of the work. Once her grandmother was admitted to the hospital, her aunt did not consult with her about her grandmother. Because of this anger there is hostility and separation from the aunt. Narcissistic coping mechanism is present because Marla feels her aunt was unfair to her after all she had done for her grandmother. Marla has not reached closure concerning her mother's death. She was at the funeral service physically, but not emotionally because she was heavily sedated. She is also experiencing some unresolved conflict because she prayed that her mother would die. Maybe if she had not prayed her mother would be alive. The day before her mother's death, she asked Marla would she be all right. She kept assuring her mother she would be fine. We talked about the possibility of her mother hearing her prayer and, knowing she would be all right, gave up the will to
live. She could rest in peace knowing that Marla was fine. She smiled and said she had not looked at it that way. Marla has two children—a son who is very sensitive and a daughter who is indifferent. The son is just like Marla so she does not want him to get too close to her and have to hurt like she did. She was very close to her mother. When she is around her son, she postpones her feelings. It's all right for the daughter to see her express her feelings. Marla is also upset because she was the last person to find out about her aunt's death, even though she feels it was to protect her. She is in the second phase of conflicts (stress, crying, anger, guilt, frustration and fear). The third phase is also present and they both vary in intensity. The regressive coping mechanism helps her to escape from reality by focusing on what the aunt did not do. Marla is also minimizing her grief. She loves her mother-in-law, but wishes she would not call her her daughter. She is preoccupied with the death of her mother and is not ready for a replacement or substitution. She had good days during the sessions, days when she did not cry. At other times the deaths were fresh as if they occurred yesterday. I think these tears were the tears she did not get a chance to shed at the funeral. Marla's brothers make her feel guilty when they want to borrow money by reminding her, "if Mother were alive, she would give us some money." The brothers are definitely using narcissistic coping mechanisms. Marla indicated that the doctor had prescribed a medication to relax her; however, because of the support class she had not taken the medicine. I think Marla will make a resolution so she can live a productive life. However, it was
suggested that she continue the group sessions along with some one-on-one therapy as we continue to work toward a resolution.

Regenia Price is in complicated grief over the death of her mother (February 7, 1995). Her husband's death is more recent (December 7, 1995). She has placed her grief on hold (delayed grief) because she is caught up in the moment. She has diverted her energy into the planning and implementation of her retirement party. In a sense this could be postponing the grief process. In the beginning of the session and even now, Regenia is still experiencing problems dealing with important papers surrounding her husband's death. She believes if she postpones the grief it will go away. If it does not vanish, it will be safer to experience the pain at a later time. There are some unresolved conflicts with a family member concerning both deaths. There is a change in relationship with other significant persons following the death of her husband—some separation anxiety—because her husband was "in charge." The world seems to be a threat (in the business sense) now that she must take charge. She is off balanced, unable to conceive of a world without her husband. We may want to refer to this as the narcissistic coping mechanism, the breakdown of reality testing. There is some denial and repression about her retirement party. It was fine, but one important person was missing—her husband. There are some unresolved conflicts concerning a sibling. Because they both lost a mother, their anger turned outward, resulting in furious hostility against specific persons. In this case, against each other. Regenia is now able to tell her story without crying as much as she did.
at the beginning of the sessions. It was suggested that she conduct a profile and continue to work through the business papers of her husband. Delaying this could be more harmful. I know she will be able to reach a resolution and make a positive investment in society. She has mentioned the desire to do volunteer work and possibly join the drama ministry. I think she will be an asset.

Donnie Griffin is in complicated grief over the death of her fiance. She is experiencing unanticipated grief because this was her high school sweetheart. After several years of separation they were reunited by fate or it was "God-sent." She saw a future in this relationship. There was some anger as to why God brought them back together just to separate them forever. The repression coping mechanism of displacement is evident. The loss is intellectually accepted, but coping with it emotionally is impossible and therefore displaced by secondary grief symptoms (anger and hostility toward others). There is some unresolved conflict since she was unable to attend the funeral. She did not have a chance for closure. In order to keep him alive, she "enshrined" a pair of pajamas and a robe of her fiance. She wears the robe everyday because it was comfortable and it was her comforter. She used the mechanism of substitution in a regressive way. If she could not have her fiance present for comfort, she would use his robe. She also stays in very close contact with his sons. This could be considered replacement grief. At the end of the sessions, she is now able to talk about her feelings in the past tense. She has discontinued wearing the robe on a daily basis which means there has been some
resolution. She says she is not looking for a man, but looking at men again. She is in the fifth phase of the grief process with a new sense of self-awareness. I believe that Donnie is ready to reinvest into society as a grief counselor; therefore, I suggested that she take the lay counselors' class first which will help her to have a humanistic approach to grief rather than a "bookish" approach.

Felecia Dugger, Carol Dugger and Elizabeth Racks are sisters who lost their mother on December 1, 1995. Since bereavement reaction varies in intensity, duration and frequency from one individual to another for the same deceased loved one, their responses are not the same. Therefore, we can have empathy but we cannot assume to know what a person is going through based on our experiences. It does make a person open up because of the similarity. Elizabeth finds it very hard to open up in the group sessions, yet she comes to the meeting which means she believes the class can help her. There are some unresolved conflicts that she has to work through first. She is going to do a profile. For the group's reception, she volunteered to bake a cake. This was a positive sign.

I think Carol and Felecia are moving through the phases of grief on target. There is a certain amount of being in a state of shock. Carol is withdrawing from a special friend because "he doesn't understand what I am going through." She wants him to attend the class. She has been suffering from insomnia, waking up at odd hours of the night. Restlessness is normal. The world is a threat and unsafe place for her. A part of her life has been removed. Now she has to make choices to
fill that space. Felicia feels that she is moving toward healing. I think Felecia anticipated the death of her mother which means she had already begun the grieving process while her mother was still alive.

Tommie Brooks is minimizing his grief through the rationalization that not only did he lose his wife, but his children also separated themselves from him. He was concerned about himself which is the narcissistic coping mechanism. He blocked out the realization that the children were also hurting. Tommie's wife has been dead almost two years. He is definitely in complicated grief. He attended two sessions and felt he had reached a resolution. He used the objective libidinal coping mechanism to reinvest into society. He said the children in the group who had lost a parent (the social environment) "made him realize how thankful he was." In group settings, listening and talking play a major role in the healing process. I am concerned that he reached a resolution so soon in the group sessions, or whether he was intimidated by the young children. He did not want the children to see a grown man hurting.

Wanda Phillips is in a state of complicated grief. She is angry that God did not give her the opportunity to say "Good-bye" to her parents who died approximately one month apart. Both were in a coma when they died. She is in denial with aggressive coping mechanism. She says, "God was unfair who took the healthy parent (father) first, which made it easier for my sick mother to lose hope." She feels no one can really help her due to the lack of self-experience (parents' death
so close together). She is definitely in chronic grief. It has been almost two years without any signs of healing, closure or resolution. It was very hard, or it is very hard, for her to talk about the deaths without anger and crying. I believe if Wanda had remained in the group some healing would have taken place. She is using the aggressive coping mechanism with a great deal of conflict in the interaction between her ego, the lost loved objects and the social group which makes it very hard for the grief process to begin.

**Conclusion**

Each session began with an overview of the previous session. This was done to see whether there were any changes in the group members' state of feelings in regard of their deceased loved ones as they worked through the grief process. Since this was a "talking" and "listening" process, each participant was allowed to speak and their peers were allowed to respond—"Each one helping each one." Each person's feelings were addressed individually before moving on to the next person. This was done to let each person know that her/his feelings were important. If they had enough courage, an immediate statement was made to bring consolation before moving on to the next person. This is a form of nurturing listening.

As the facilitator, I realized that the majority of the participants probably had never discussed their personal feelings in a group setting, especially their pain resulting from the loss of a loved one. It did not matter whether it was the facilitator, minister, doctor, lawyer, lay person, I wanted to introduce an atmosphere
of togetherness. In order to do this I shared some of my personal experiences of
grief and my efforts toward reaching a resolution. This was very important because
even though I was the facilitator, they saw me as one of them, and they could also
help each other. Not only did I share personal experiences, but sometimes I
complemented the sessions with educational material. This worked! We became
a team, a family helping each other.

Each session lasted from 1½ to 2 hours. We were never in a hurry. We gave
each person enough time to express her/his feelings. During the last fifteen
minutes, the participants were given the opportunity to discuss anything that we
had not talked about during the session, and/or additional comments. Since
"talking out" is good therapy, I did not want to rob anyone of that chance. This
could have hindered the process of working through the grief and end up in more
unresolved conflicts.

We also validated that it is all right to cry. In the movie, "Waiting to Exhale,"
Angela Bassett was crying when she burned her husband's clothes. Society
understands that in anger we sometimes cry. If we hurt our finger, society
understands that with a flesh pain, we sometimes cry. But when we cry because of
pain from grief, society says, "Don't cry, be strong," probably because society does
not fully understand the phenomenon of death. Tears just remind us of how
vulnerable we are. In our sessions, we made sure that it is okay to cry.
Recommendations

Meetings should be six consecutive weeks plus six sessions every other week (bi-monthly) and open-ended one-on-one sessions, when needed. The participants do not want to start over bonding with a new group. Sharing their feelings with new persons would be too devastating, and they would not do it again. Also, it may not be feasible and advantageous for the new participants.

Assessments by Betty F. Williams

Elizabeth Racks' appearance and behavior is relaxed and comfortable in the group session. She talks when called upon, but rarely volunteers. She is having problems perceiving her mother's death. She states that she will not visit her mother's grave because she does not want to believe that her mother is dead. There is assessable emotional distress. She is depressed. Elizabeth is in a complicated state of grief at this time due to some domestic concerns. She states that she has so many other problems that she does not have time to grieve for her mother. Elizabeth will need additional sessions and some one-on-one therapy in order to deal with issues regarding domestic concerns.

Carol Dugger appears to be in a state of disbelief and shock. Her behavior is quiet and she does not volunteer at any time. She will talk openly about her feelings when called upon to do so. Carol realizes her mother is deceased, but she is having difficulty perceiving the loss. She spends a great deal of time wondering and alone. Her affect is depressed. She has completed an eight-week group session
and has progressed to some extent as far as discussing her feelings openly. Carol will need additional sessions and some one-on-one therapy to help bring the loss of her mother into focus.

Felicia Dugger appeared closed and unconcerned. She would only respond when called upon; however, as the sessions progressed she became more relaxed and open about her feelings. Felicia denies depression and there is no abnormal thought process noted. She is comfortable talking about the death of her mother. Affect is appropriate to mood. At the last session, Felicia stated that she looked forward to the meetings and she was very happy that there was a place to which she could go and talk among others who were experiencing some of the same feelings of grief. She would like to continue the sessions for support. The bonding with others has been an asset to her healing process.

**Evaluation of Grief Support Group**

The grief support group is an asset to our church family. Not only has it allowed an outlet for expressing pain from grief, it has also created a bond among the clients and facilitators. We find ourselves stopping each other in the corridors, expressing concern about various problems or good that we have experienced during the week. We can also make calls during the week to discuss concerns that may arise before the next session. The Bible tells us, "without a vision, the people perish." We feel especially blessed because the vision of our pastor, Rev. R. L.
White, Jr. has been duplicated among those of us who want to help make the grief process easier.

We often think of grief as being the loss of a loved one, but in these sessions we find grief covers all aspects of life such as loss of a job, a limb, and material things that we find ourselves cherishing. These losses are sometimes just as traumatic as the loss of someone we love dearly who has had a great impact on our lives. Because we now have this outlet, we by no means can stop the losses, but we can exercise our vision and help make the process of grief a little easier for all. When we talk we show concern for ourselves, when we listen we show concern for others.

**Participants' Assessment of Grief Support Process**

In this section are assessments of the grief support process by two participants. One of the participants was asked to assist in the research for this project. While conducting the research, she recognized her own grief, became interested in the process, began reading the material, and became one of the participants in the grief support group. By profession she is a librarian and a very perceptive person who easily grasped what we were trying to do. Because of her progress, she has been asked to work in the ministry of caring.

The second participant remains anonymous; however, the remarks are revealing.
Participant #1

Long before the prescribed number of sessions with the support group had gone by, healing noticeably began for some of us during the first or second session. This was evidenced by being able to talk about the death of a loved one even through the tears. We returned the following week aware of what was to be faced. Some of us were in various stages of loss, from one month to as much as ten years of compounded grief; from the first stages of shock and denial to being stuck in depression or vacillating back and forth.

In my case, it had been three years since the death of the man I was to marry; my childhood sweetheart, rediscovered after twenty-nine years, then lost forever after only one year and eight months. I thought I had gone beyond the severe hurt experienced in earlier years, but Christmas 1995 brought on a deep depression. I relived unpleasant memories like vivid pictures of his illness and the hospital stays. My thoughts were also of shattered dreams, what did not happen and what could never happen. A royal "pity party" was taking place. Before the holidays I had come to grips; or so I thought, with other conflicts in my mind associated with the death that I needed to face. The majority of these surfaced and were identified as I helped to research the subject for my pastor.

Part of the guilt existed because I did not attend "Mack's" funeral, but left the country even at his insistence. Maybe I should have realized early on that he was gravely ill long before he told me. Perhaps if aware of the nature of the illness sooner, more aggressive help could have been provided. Did the doctors do all they could have done for him? Were the other problems facing me just placing blame elsewhere to help make sense of this unknown called death?

Sharing with the group helped to remove the feeling of being alone in your grief; not feeling stupid in that you still feel this pain after some time has passed. There was the opportunity to open up and bond with others as you let them see you at your lowest. You realized that there are times when you feel this hurt momentarily or for a longer period of time. A song, a person, or a place can trigger this hurt. But it's all right. You come to realize that even in our individual weakness we can find strength in others while at the same time
impair a strength or our own to them. No one is censored by any feelings they might have, dreams dreamed, or visions experienced.

As a gathered church from all parts of the metropolitan area, coupled with many of us living away from our hometown, family and long-term friends, the support group brought a sense of "family." That inner circle that gives you permission to be yourself. And it's all right. Knowing that others understand what you are going through, including our pastor who started the group and the facilitators/counselors that he had trained. Faces that had previously been seen in a large church congregation were now recognizable by name. Greeting each other with genuine warmth, often in settings outside the support group. Fostering a strong sense of community, some even talking to each other over the telephone as a result of bonding in the group.

After the prescribed number of sessions, the group was loathe to disband since there were some who were a long way from acceptance or the loss was yet so new. We decided to extend the time, but meet bi-weekly. We further wanted to stay with the same group since group dynamics were so strongly at work during the six-week period. Reticence was keenly felt by participants when counselors not involved with the group from the outset came to observe and comment.

I had progressed much farther and faster than at first anticipated. This was so much evidenced that I entertained thoughts of withdrawing from the group. In fact, I reduced the amount of participation. I was encouraged by a facilitator to stay and be a blessing to others. The book compiled by our pastor, Rev. R. L. White, Jr., entitled Healing Beyond the Darkness: A Collection of Poems and Writings for Bereaved Families was a powerful little volume to be read in part or in total; to read and re-read. Having a counselor call me on the anniversary of the death of my loved one was really touching. Someone cared.

Perhaps the regression that I experienced during the holidays will be triggered from time to time, but it's all right. For there will always be a place in my heart for "Mack." At times I remember his laughter and sense of humor. The jokes he told on himself and others still make me chuckle. Memories surface of how he ministered to others from his sick bed when they had come to encourage him. I remember and am thankful for the good days and quality time we were allowed after all those years. The need to wear his robe for comfort during the down times no longer exists. Neither do I cringe with guilt when casting an appreciative eye at a member of the opposite sex. For above all, I remember the love he had for me, his family, and most of all for God.
Whatever hurt and pain we are going through
Whatever questions and anger that arises
We have indeed taken a big step, a first step.

We came to the group as part of our church life
And our believe in a loving God
Knowing that grief shared is grief diminished.

Keep the anointing, Pastor.

Donnie C. Griffin

Participant #2

The sharing and caring sessions at Mt. Ephraim have been most beneficial in helping to talk about some of the hurt we have experienced from the deaths of our loved ones. It has allowed us to see that we are not unique in feelings, but there are others going through the same kinds of pain and hurt.

In sharing with others and showing compassion, it has helped to release some of the pent up frettings of hurt and anger we have kept buried deep within. The bonding has made it easier to share. Being comfortable with the group has enabled us to know that we have so much in common.

While some have not come full circle with all of the hurt, pain, and/or anger, we have made great strides and will continue to do so through prayer and care. I am most grateful to my "family" for allowing me to be myself with them.

Conclusion

Reflecting on the grief support group component of the ministry of caring, the positive benefits of the initiative can be seen. The participants indicated that the number of six sessions initially set for the component is not enough; therefore, the sessions have been extended to bi-weekly sessions. These sessions will continue
until the participants' healing will be complete. While these sessions have continued, a new grief support group has begun.

In this chapter, a comprehensive account of the training of the counselors and the grief support group has been given. It is hoped that the reader can grasp the total picture of the ministry of caring as it occurs at Mt. Ephraim Baptist Church.
CHAPTER V

THE MINISTRY OF CARING FROM AN ORGANIZATIONAL STANDPOINT

Introduction

Much prayer, research and effort was put into the organization of the ministry of caring for our church, and much interest was shown by those who participated in the beginning phase. It is expected that this process will bring unmeasurable relief to untold numbers of parishioners who will need the care and assistance that the ministry of caring will provide. The entire process is designed to take place with the initial call of notification of a death. Following is a detailed account of how the process is organized.

The Ministry of Caring Process

There is a permanent notice in our church's bulletin directing calls to the ministry of caring upon the death of a member (or family member). There are two coordinators who are instructed to field these calls and promptly notify the pastor and the church's minister to the sick. Contact is then made with the bereaved family from the ministerial staff to assess the situation. The lay counselor is then assigned to the family for the duration of the arrangements and funeral services for the deceased. During this period, the counselor is equipped to provide details of what
needs to be done. The lay counselors give leadership concerning every phase of preparation, and have been made aware that bereaved loved ones should actually participate in the arrangements. This is a part of the grieving process. The counselor plays more of an informational and supportive role with his/her presence.

One of the tragedies of our time is the fact that a significant number of our people die without insurance. This is a sign of difficult economical times when persons either cannot afford insurance or are victims of disease or physical illness which prevents them from qualifying for insurance. In some cases, they are uninsured because of neglect. These persons almost always appeal to the church for financial assistance. This cry for assistance has been anticipated at Mt. Ephraim. An organization is operational within the church to assist persons who qualify. Qualification for assistance entails joining a group known as "My Help," where there is a $5.00 enrollment fee and dues are set at $1.00 per week. There are two benefits: (1) In case of an emergency, the members of the group can receive an emergency loan up to $300 without interest and (2) members qualify for $1,000 toward burial expenses in the event of death. Since its inception, there have been several requests for loans, and one parishioner, who was a victim of AIDS, received financial help for burial expenses. His family was very grateful for the monetary assistance.
The ministry of caring is keenly aware that care should not end with the depositing of the body at the grave site. Too many instances have been reported as to how supportive the church and community will be during the time prior to the funeral. However, after the interment very little support is given. Seemingly, this is the loneliest and most painful time for the bereaved family when adjustment takes place that could last for months and in some cases years. Therefore, provision is made for the family to receive counseling upon request, and periodically there will be a grief support group initiated whereby persons who are grieving can help each other through this emotionally draining time.

The care group also has the responsibility of collecting data from the family, including special days such as birthdays, anniversaries, date(s) of death, and dates of other occasions that were significant to the deceased. On the anniversary of the death and other occasions, the care group is expected to make contact with family members by telephone or by sending cards, acknowledging the special day and the fact that the ministry of caring does live up to its name. We do care!

While research for this project was being conducted, it became apparent to this writer that the subject of death is a taboo topic. People do not like to talk about death. Consequently, there are so many false notions that people often believe about death. They, in turn, repeat these notions as if they were factual. Many times, these notions only increase the agony, anxiety and difficulty that loved ones experience at the time of death. The Christian education department of Mt. Ephraim
offers seminars periodically whose subject emphasis is death in order to educate the members. At these seminars, professional speakers are invited to discuss topics dealing with death and dying.

As an often requested eulogist, I include in each message a segment on the grief period. Often at funerals, I have overheard statements that persons have made with the intent of comforting the bereaved. However, these statements can be the cause of a prolonged period of grief, or literally force one into complicated grief. Such statements are "Don't cry," "You have to be strong," "Where is your faith?" Instead, the eulogy should include comforting statements that assure the bereaved persons that tears are not necessarily a sign of weakness, but a sign of pain. Crying is not a sign of a lack of faith, but is an indication of pain that comes with losing the presence of a loved one. The eulogy may also include a listing of the different stages of grief. The writer has had an unusual amount of positive results from such eulogies.

The model of ministry of the writer is a healing ministry which led to a change in the motto of the ministry of caring--"A Ministry of Healing and Reconciliation." Therefore, all facets of worship and activities at Mt. Ephraim Baptist Church include an element of healing. The way in which one relates to death and dying is no exception.
The Grief Support Group

As we look at the grief support group component of the ministry of caring, the primary function is to provide a forum in which bereaved members may share their experiences in a small group setting. There are two coordinators who are responsible for leading the group in the following decisions: (1) frequency of meetings, (2) closed or open structure of the group, and (3) whether the group is organized for a fixed term or for a continuing existence.

Term support groups may have a fixed termination point or may be open-ended with participants free to join or leave the group at any time. Fixed term groups, for example, of six- or eight-week sessions may be offered at intervals throughout the year.

In Mount Ephraim's initial grief support group, the members opted for a six-week term. Once the group members had bonded, they observed that new persons entering the process could inhibit the openness that the group had achieved. With several available counselors, it was decided that a new term would begin when 12-15 persons expressed a desire to become members of the grief support group.

The first two coordinators of the grief support group were neophytes in their role and it was a beneficial learning experience. They were later paired with other coordinators to assist them through the process. While each group has things in common with other groups, there is a uniqueness about each group. This can be
a plus because the process itself will have some mobility in order to indigenize the process for each individual group.

One of the most important acts in a grief support ministry is the gathering of family dates and records, which include wedding anniversary dates of members, birthdates of members, and death dates of members.

Since the counselors will be called upon to help with the support group, the following information was included in the training component of the ministry of caring: (1) developing good listening skills; (2) understanding the grief process, including normal and complicated grief; (3) familiarity in planning a funeral; and (4) planning and scheduling continuing pastoral care of grieving families.

The ministry of caring meets periodically for the purpose of addressing any difficulties and recurring problems to the point of resolution.

**Format of the Grief Support Group**

The grief support group sessions usually begin with an invitation from the group facilitator (coordinate and facilitator used interchangeably) to participants to introduce themselves and state their name and the cause of death of the family member or friend. Members are free to say as much or as little as they choose about the deceased person and the circumstances of the death.

If new members are present, the facilitators may remind the group of guidelines that have been adopted. The format and content of the session are non-structured, meaning that members are free to share their personal experiences of
grief and their efforts toward resolution. At the discretion of the coordinators, sharing of individual experiences may be complemented by brief, important comments; however, they should not distract from the main purpose of the session; namely, the sharing of individual stories.

The facilitators are responsible for group development and maintenance as well as the development of care and trust within the group. This is achieved by assisting participants to clarify and understand their feelings and needs. Group coordinators are also responsible for maintaining structure and guidelines for the sessions.

**Guidelines for Grief Support Group Sessions**

It is wise to begin and end meetings at the agreed times, not only because it is more orderly, but because persons in grief may find it difficult to re-establish structure in their lives.

It is important to anticipate a variety of possible situations that may inhibit group interaction. For example, one person's needs to monopolize the group's attention, or another's introduction of material that distracts from the group's purpose, requires sensitivity on the part of the group leader. Members should feel free to express how their personal faith helps in working through their grief. At the same time they should not expect other members to adopt their method of resolution.
If the sessions have a fixed term format, it is important to decide from the outset whether persons will be admitted to sessions once they begin. One advantage of the open-ended group session is it allows the acceptance of new members at any time.

Members should be committed to attend all meetings. Coordinators should be notified by members when unable to attend. When termination from the group is necessary, members should be informed of the co-member's intention to leave the group.

**Discussion Topics**

The following are topics that may be discussed during grief support group sessions:

1. Events associated with the death;

2. Recollections of the course of a fatal illness;

3. How the survivor is coping (or not coping) with grief;

4. Relationships with other family members from the perspective of the grieving person;

5. How to discuss death with children;

6. Specific issues that address decisions that must be made following a death;

7. The wisdom of selling a family residence; and

8. Disposing of clothes and other memorabilia.
Conclusion

When each of the component parts of the ministry of caring are successfully functioning, the results equal an effective ministry that helps to alleviate much pain. Locating working models of an effective ministry of caring was difficult. One resource, however, that provided helpful information was Ron Sunderland's book, *Getting Through Grief: Caregiving by Congregations*. Many of the suggestions offered by Sunderland, combined with Mt. Ephraim's context, has helped to make the ministry of caring a viable process.
CHAPTER VI

AN EVALUATION OF THE GOALS OF THE TOTAL PROJECT

Introduction

When we take the entire project into account, an assessment of the success or unsuccesfulness of *Death, Dying and Grief: A Ministry of Caring* occurs. We look at the data gained through research, the introduction of the project to the congregation of Mt. Ephraim Baptist Church, the training of lay counselors, the grief support group, and the introduction of the entire process to other congregations who would like to begin a ministry of caring as it relates to a grief support group.

An abundance of information was located that could provide the foundation for a grief support system. The material procured was carefully gathered and presented in a manner that is coherent and clear, and can serve as meaningful resources for those who seek information on how the different disciplines have dealt with the issue of death, dying and grieving.

The point was made in this dissertation that death is a taboo topic in America. One of the goals of this project was to educate the members of Mt. Ephraim Baptist Church in order for us to begin to fully discuss the issue of death, dying and grief. We began to introduce the idea of a ministry of caring for the bereaved by public announcements of the formation of such a ministry. Initially,
the response was almost null, but when the lay counseling class became a reality the
notice of this process began to grow as the lay counselors became an excellent public
relations group, as they became excited and began to talk about how they were
being helped in the classes. Repeated mentioning of the process by the pastor
caus ed the topics of death, dying and grief to become mentionable, rather than
unmentionable, subjects. It began to remove some of the mystique concerning
death. This goal has been partially met; however, a process such as this will take
more time in order for it to have the full opportunity for effectiveness.

In a previous chapter a detailed report of the lay counselor training and the
grief support ministry was presented. These two components have been successful
in that the lay counselors have already been called on to counsel grieving members,
and they have done so with confidence and competence. There has been one term
for the grief support group. For those who participated, there is a marked
difference in their ability to cope with the painful reality of the loss of a loved one.

Several ministers, in conversation with the writer, have indicated that they
would like to share the process with their congregations. Once the process has been
refined and complications that have arisen out of the implementation of the ministry
of caring have been addressed, it will be shared with other ministers.

The Implementation of the Ministry of Caring

The full implementation of the ministry of caring as an organized system
designed to provide comprehensive help to bereaved members became a reality in
January 1996. Each component of the ministry of caring is operational. The permanent announcement that was placed in the church bulletin, outlining the procedure that should be followed when there has been a death of a member, or family member of Mount Ephraim Baptist Church follows:

In case of a death of loved ones, please contact our *Ministry of Caring* coordinators, Ms. Ernestine Lattimore (phone no.) or Mrs. Betty Williams (phone no.). There are also lay counselors available to talk with bereaved parishioners who are still in grief, and periodic grief support groups are in session. You may inquire for information.

After the initial call is made, or notification of death has been accomplished, each component of the ministry is mobilized. The following chain of events is put into action.

1. The coordinators contact the pastor.

2. The pastor contacts the family, acknowledging the death, and secures information regarding the general and specific needs of the bereaved family.

3. A grief counselor, who is compatible with the family, is contacted by the pastor and assigned to the family.

4. The counselor, equipped to answer questions concerning business procedures to be followed, makes him/herself available to the family; not to do the work, but to assist the family in making arrangements.

5. If the family wishes to have a wake, a staff minister is given the assignment of being present. At the close of the service, an appropriate scripture and prayer are offered, with encouraging remarks as deemed necessary.

6. On the day of the funeral, the pastor meets the procession at the door and follows the order of service. Within the eulogy, words of encouragement are given family members, advising them to grieve.
properly and not to listen to those who would give advice that inhibits healthy grieving.

7. Also on hand are church officials, care ministry ushers, nurses, and members of the Mothers' Board. These persons are present at all funerals. Many times the deceased may not be well known by the church family and the support may not be as it would with a well known member. These auxiliary members give the message to the family that the church cares about their pain.

8. After the funeral ceremony, the procession is accompanied to the grave site by the minister, officers, and nurses (available to provide comfort) for the committal of the body to the earth.

9. Upon request, the kitchen staff will prepare and serve the traditional meal at the church following the interment. This meal is usually a dinner where family members reassemble to be greeted and consoled. Acquaintances are renewed and unforgettable stories are related by the family concerning the deceased. The traditional meal offers a significant amount of therapeutic value.

10. The counselors will focus on the care of the families in their first year of bereavement, provide follow-up care when indicated, and be willing to share with the grieving family the things that are common to grief in families.

11. As early as possible, the counselors will gather family data, such as wedding anniversary dates, birth dates, and dates of death of family members. When significant dates occur, usually the bereaved persons experience some pain. The ministry of caring will contact or send cards to family members reminding them that "we care."

12. A follow-up meeting between the pastor and counselor is held as soon as possible after the funeral, making the pastor aware of ongoing problems that might have surfaced during the bereavement period.

13. Stewardship lectures on death, dying and grief are held periodically to educate the congregation on the issue of death and dying.
When all of the components of the ministry of caring are functioning, emotional healing will be easier to accomplish by family members. This process was proven to be effective during a recent death in the church family. It was heartwarming to see the full implementation of the ministry of caring at work.
CHAPTER VII

THE NEED FOR CONTINUOUS EVALUATION AND MODIFICATION OF THE PROCESS

Whenever there is a new process or system being put into effect, it is inevitable that there will be components that will not perform as expected. Much of any system is theoretical until praxis becomes a reality. Many times praxis uncovers surprising results, positive or negative, that could not be anticipated in theory. The wise leader will be able to recognize these results, analyze them and modify the process.

The ministry of caring for Mt. Ephraim has a component built in that directs the entire group to meet periodically and discuss what has been most successful and rewarding. Also discussed are the problems that have surfaced while the act of ministry was being fulfilled. The positives are reinforced and the negatives are studied, deliberated upon and corrected. An example of a surfaced need for modification became evident in our first support group. Those who responded to the announcement came to the group accompanied by children who were also grieving. While the thought had been entertained, there was no special provision made for grieving children. When I noticed the obvious need, it was painful not to have already addressed the situation. We permitted the children to remain in the
group. Those who stayed were helpful in assisting their relatives by reinforcing what they heard during the support term. There were other children, however, who did not complete the term.

Upon evaluating the question of children in grief, two things became apparent. First, there should be a process that speaks specifically to the needs of children who are experiencing grief. It is equally recognized that coordinators who will be assigned to this group will need additional training. Second, the children who were faithful to the process were helped, and they provided added encouragement to their parents or guardians.

We plan to initiate a youth grief support group. With proper deliberation, a modification of the existing process can be accomplished that will speak to the needs of children and utilize their positive presence in incidents that will warrant their help.

It is expected that observations such as these will continue to surface as the process evolves into what we pray and hope will be a proficient ministry of caring, blessed and used by God.
CHAPTER VIII

CONCLUSION

If there is a single thing that has become apparent in this project, it is the fact that one of the greatest challenges that individuals face is the question: How do we deal with death? At the very mention of it, the word death, itself, strikes fear in the hearts of some people. Consequently, the grief that some people never work through adds up to being emotional pain that could be healed more thoroughly and expeditiously if the bereaved were much more informed about Death and Dying: A Ministry of Caring.

The process that has been put into effect at Mt. Ephraim Baptist Church attempts to address the entire matter of death, dying and grieving in an effort of becoming an agent of healing in a congregation that deserves the best when it comes to a ministry of caring.

In Chapter I we described the setting for ministry, gave autobiographical reflections of the writer, the goals for the project, and working definitions of terms used in the dissertation.

Chapter II shared grief from a biblical perspective. We examined a theological framework for grieving and discussed how the different disciplines of
sociology, psychology, anthropology and archaeology have attempted to address
the issues of death, dying and grief.

We studied in Chapter III the question of ethics in dying. A discussion of
euthanasia, suicide and truth-telling is also included in this chapter.

In Chapter IV was an extensive description of the processes of equipping the
lay counselors and instituting the grief support group. Included were an overview
of the classes, reflections by participants, results of the pre- and post-tests, and
assessments by facilitators.

The ministry of caring from an organizational standpoint was given in
Chapter V, along with information that was made available in the training
component.

Chapter VI evaluated the goals of the project and Chapter VII focused on the
need for continuous evaluation and modification of the process.

As stated in the Introduction of this document, there are two beliefs that
serve as a basis for this writer's ministry: (1) everyone you meet is hurting from
something emotionally and (2) it is not God's will for anyone to continuously hurt
without resolution. Because death, dying and grief are inevitable issues of life, it is
hoped that this project--Death, Dying, and Grieving: Providing a Ministry of Caring--
will have far-reaching benefits for not only members of Mt. Ephraim Baptist Church,
but for persons in our communities-at-large.
APPENDIXES
Appendix 1

MT. EPHRAIM BAPTIST CHURCH
1202 W. Marietta Street, NW
Atlanta, Georgia 30318

Rev. R. L. White, Jr., Pastor

SYLLABUS FOR LAY COUNSELORS

Course Title: "Counseling the Bereaved and Grieving Parishioners"

Instructor: R. L. White, Jr.

Rationale: Because of the pain of so many parishioners who are in the grieving period, there needs to be a process initiated at Mount Ephraim to help ease the pain of hurting people.

Objectives:

1. Helping the counselor to know self;

2. Helping counselors become aware of the procedures to be followed when helping families plan for a funeral;

3. Helping counselors identify when grieving is normal or complicated;

4. Helping counselors become knowledgeable of the different stages of grief;

5. Helping counselors to know their limitations.

Resources:


Cook, Alicia Skinner and Daniel S. Dwarkin. Helping the Bereaved.
Sunderland, Ron. *Getting Through Grief: Care Giving by Congregations.*

Werner, Irving B. *Grief: The Mourning After.*

**Definitions:**

1. **Bereavement** - "to rob," "to plunder," or "to dispossess." The meaning is derived from the idea that death robs us from our loved ones.

2. **Bereavement Reaction** - the physiological or behavioral responses to bereavement. These responses vary in intensity, duration and frequency, from one individual to another.

3. **Denial** - the inability to face the fact that a loved one is dead.

4. **Euthanasia** - the practice of allowing the loved ones of severely ill patients to end the patients' lives, either voluntarily or otherwise.

5. **Grief** - an intense feeling or emotional suffering caused by a loss through death.

6. **Grief Process** - the changes of feeling states over time. The reactions to grief are physiological (crying, sighing) and psychological (sadness, anger, guilt).

7. **Grief Work** - mourning. This is coined by Lindemann (1944) who explained the process of experience grief required a tremendous amount of both physical and emotional energies. He stated, "When grief work proceeds without complication, the grieve is able to reach the point of resolution and reinvestment in living."

8. **Guilt** - the blaming of one's self for circumstances surrounding the death of a loved one.

9. **Mourning and Melancholia** - a composition by Sigmund Freud that became the first psychoanalyst to analyze what one goes through during the grieving process.

10. **Truth Telling** - the ethical questions that ask: Should the patient be told his/her true condition even when it may be detrimental to the patient's mental well-being.
Overview of Classes:

Class #1 - "Counselor, know thyself."

A. Introduction
B. Our experiences at grief
C. Definition of terms in course

Class #2 - Quiz

A. Becoming knowledgeable of the symptoms of:
   1. Normal grief
   2. Complicated grief
B. The counselor's awareness of his/her limitations
C. Role Play - "What to do when you are assigned to a family"

Class #3 - Quiz

A. Exploring the group dynamics at work in grief support groups
B. Discussions on empathy and sympathy being present; good listening skills
C. Coping mechanisms used by grieving loved ones

Class #4

A. Discussion of procedures to be followed on the event of a death
B. An overview of church policies concerning funerals
C. Course evaluations
Appendix 2

GRIEF COUNSELING TECHNIQUES

1. Meet people where they are. This is very important.
2. Be present with the bereaved when possible.
3. Counseling is more listening than talking.
4. Learn to keep the person talking.
5. Be an active listener (clearly understand what they are saying).
6. Make sure people know all sides of the issue.
7. Be objective, acting independent of personal feelings. Know your stuff.
8. Make sure you are not including your own agenda when counseling.
9. Do not become judgmental.
10. It is better to show up personally than call.
11. Do not become part of the problem. Be sensitive. Do what you came to do.
12. Show humanness. Do not be a robot.
13. Help the person know the power of their words.
15. Do not let a family be dependent on you.
16. Understand that story-telling is a form of handling grief.
Appendix 3

Check List of Things to Do When a Loved One Dies

Decisions/Tasks That Should Be Done Within 48 Hours:

Notify:
► The doctor or coroner
► The funeral director
► The cemetery director or memorial park
► The minister and church
► All relatives
► All friends
► Employers of mourners who must be absent from work
► Organist and singers
► Pallbearers
► Insurance agents
► Union and fraternal organizations
► Newspapers

Tasks:
► Provide vital statistics about the deceased
► Prepare and sign necessary papers
► Provide addresses of all interested persons who must attend
► Answer innumerable sympathetic phone calls, messages, and letters
► Meet and talk with everyone about details
► Greet all friends and relatives who call
► Provide lodging for out-of-town guests
► Clean and renovate homes
► Plan funeral car list

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<th>Financial Obligations:</th>
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<td>▪ Doctor</td>
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<td>▪ Memorial estate and actual space</td>
<td>▪ Nurse</td>
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Appendix 4

Personal Grieving Style Inventory

Grief is a natural response to a felt loss, our way of repairing emotional damage. Each of us grieves differently from everyone else, and each time our grief is different than before. But a pattern forms, and becomes a person's grieving style.

The purpose of this worksheet is to help you, in somewhat systematic way, reflect upon and better understand your own grieving style. To accomplish this goal it is important that you be honest with yourself, even if some of the memories are difficult and painful to recall.

Take your time; this worksheet is yours to keep. If it is not completed at the first sitting return to it later.

The information you provide on this worksheet is confidential; you will determine with whom, if anyone, it will be shared.

Responses to Past Losses

Please complete the following sentences. In case you have not yet had a traumatic loss from death in your life, think of another major loss from divorce or separation, a broken romance, a relocation, etc.

A. The First Remembered Significant Loss

1. The first death (major loss) I experienced was that of my ______________. I was _____ years old.

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2. When I heard of the death (loss) I was (e.g., at work, studying, awakened from a sleep) ____________________.

3. I responded by (e.g., continuing what I had been doing, crying, swearing) ____________________________________.

4. My predominant emotional tone for the next few days was ____________________.

5. The other major change in my life that occurred just before or soon after my first experience of death (loss) was ____________________.

B. The Most Recent Loss

1. The most recent death (loss) I experienced was ____________________.

2. When I heard of the death (loss) I was ____________________.

3. I responded by ________________________________________.

4. My predominant emotional tone for the next few days was ____________________.

5. The other major change in my life that occurred just before or soon after this death (loss) was ____________________.

6. My reaction to this death (loss) compared to the first were similar in that ________________________________________.

7. My reactions were different in that ____________________

______________________________________________________

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C. How I Respond to Losses

Sit back for a moment, close your eyes, and try to recapture other losses in your life. You may think of an incident from childhood when a favorite toy was taken from you, or when you moved from one house to another. Memories of teenage romance or the loss of a job may come to mind. Try to remember as many losses as you can and as many details as possible. Focus especially on the feelings that were evoked. Can you discern any patterns to your reactions?

When you are ready, complete these unfinished sentences.

1. Usually when I first hear of a death (loss) or impending death (loss) I react by ____________________________.

2. After a while my initial reaction is replaced by feelings of ____________________________.

3. My predominant emotional reaction for the next few days is ____________________________.

4. Upon reflection, I would describe the way I grieve as ____________________________.
Appendix 5

COMPLICATED GRIEF

Complicated grief is when a person starts out in the normal grieving period, and somewhere along the way the individual becomes stuck or fixated in one phase or another and is unable to move on to resolution. When the emotions of grief are unduly inhibited, blocked, or suppressed, or when the normal process is blocked, partial, or absent, then the normal bereavement response may not occur.

Eric Lindemann lists nine alterations in an individual’s grief reaction that would indicate complicated grief:

1. Overactivity without a sense of loss;
2. Acquisition of symptoms belonging to the last illness of the deceased;
3. Psychosomatic conditions such as ulcerative colitis, rheumatoid arthritis, or asthma;
4. Alteration in relationship to friends and relatives;
5. Furious hostility against specific persons;
6. A wooden, formal affectivity or conduct resembling schizophrenic reactions;
7. Lasting loss of patterns of social interaction;
8. Acting in unusual ways that are detrimental to social or economic existence;

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Other Signs to Help Diagnose Complicated Grief:

1. A depressive syndrome of varying degrees of severity, beginning with the death;

2. A history of delayed or prolonged death;

3. Symptoms of guilt, self reproach, panic attacks and somatic expressions of fear, such as choking sensations and breathing attacks;

4. Somatic symptoms representing identification with the dead person, often the symptoms of the terminal illness;

5. Physical distress under the upper half of the sternum accompanied by expressions such as, "There is something stuck inside" or "I feel there is a demon inside of me."

6. Searching behavior;

7. Recurrence of depressive symptoms and searching behavior on specific dates, such as anniversaries of the death, birthdays of the deceased, and holidays, especially Christmas;

8. A feeling that the death occurred yesterday even though the loss took place months of years ago;

9. Unwillingness to move the material possessions of the deceased;

10. Change in relationships following the death.

11. Diminished participation in religious and other activities;

12. The inability to discuss the deceased without crying or the voice cracking, particularly when the death occurred over one year before interview.

Several of the foregoing clues seen in the same individual would act as a flag to alert the caregiver to the complication in the situation and the possibility of poor resolution.

**Source:** A. Lazare, *Unresolved Grief: Outpatient Psychiatry Diagnosis and Treatment* (Baltimore: Williams & Wilkins, 1979), 114.

**Phases of Grief**

**Phase I - Shock** - The impact of grief--disbelief.

**Characteristics of Phase I:**

**A. Disbelief** - functions as a buffer that permits the bereaved to process the reality of loss gradually. Without this protection, the emotional assault experienced in early bereavement would be too intense to bear.

**B. The Shock** of final separation from a loved one leaves the bereaved confused and off balance, unable to conceive of a world without that person.

**C. Restlessness** - Because the world has become a threatening and unsafe place, defensive systems keep the bereaved in a constant state of alert.

**D. Feelings of unreality** - How death happens makes a difference in how once can possess the reality of the event. The way death occurs, whether it is sudden or expected, whether the bereaved one is told in a gentle understanding manner, or jarred abruptly into the knowledge of death, all these things make a difference in the way death is processed and the grief survived.

**E. Regression and helplessness** - Shock brings about feelings of helplessness. The uncontrollable events of bereavement lead to feelings of helplessness. Nothing can be done to bring back the deceased.
F. **State of Alarm** - Bereaved person is in a state of intense physiological alarm. This response is governed by the sympathetic part of the nervous system, causing physical changes that mobilize the energy resources for action. When energized, this system acts to move blood away from the hands and feet causing icy fingers, sweaty palms, and even some trembling in the entire body.

**Physical Symptoms:**

A. Dryness of mouth  
B. Need for sighing  
C. Loss of muscular power  
D. Weeping  
E. Uncontrolled trembling  
F. Startled response  
G. Sleep disturbance  
H. Loss of appetite

**Psychological Symptoms:**

A. Egocentric phenomenon  
B. Preoccupation with thoughts of the deceased  
C. Psychological distancing

**Phase II:**

**Characteristics of Phase II:**

A. Separation anxiety  
B. Conflicts  
C. Acting out emotional expectations  
D. Prolonged Stress

**Physical Symptoms:**

A. Yearning  
B. Crying
C. Anger
D. Guilt
E. Frustration
F. Shame
G. Sleep disturbance
H. Fear of death

Psychological Aspects:
A. Oversensitivity
B. Searching
C. Disbelief
D. Denial
E. Sensing the presence

Phase III: - Conservation-Withdrawal

Characteristics of Phase III:
A. Withdrawal
B. Despair
C. Diminished social support
D. Helplessness

Physical Symptoms:
A. Weakness
B. Fatigue
C. Need for more sleep
D. Weakened immune system

Psychological Aspects:
A. Holding pattern
B. Obsessional reactions
C. Grief work
D. Turning point

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Phase IV - Healing-The Turning Point

Characteristics of Phase IV:

A. Turning point
B. Assuming control
C. Identity restructuring
D. Relinquishing roles

Physical Symptoms and Physical Healing:

A. Increased energy
B. Sleep restoration
C. Immune system restoration

Phase V - Renewal-General Description

Characteristics of Phase V:

A. A new self-awareness
B. Accepting responsibility
C. Learning to live without

Physical Symptoms:

A. Revitalization
B. Functional stability
C. Caring for physical needs

Psychological Aspects:

A. Living for oneself
B. Anniversary reactions
C. Loneliness
D. Reaching Out
E. Time for the process of bereavement

STUDY QUESTIONS FOR COMPREHENSIVE EXAMINATION

1. What is complicated grief?

2. List seven (7) signs of complicated or unresolved grief.

3. List the phases of death as given in this class.

4. What does it mean to be in a state of alarm?

5. What are the physical symptoms when in a state of alarm?

6. What are the psychological symptoms?

7. What is the second phase of being in a state of alarm?

8. What are the symptoms of Phase II?

9. The third phase--Conservation-Withdrawal--symptoms?

10. (a) Physical symptoms? (b) Psychological aspects?

11. The fourth phase--Healing, the turning point. What are the characteristics?

12. What are physical symptoms and physical healing?

13. The fifth phase--Renewal--general description?
14. Physical symptoms of Phase V?
15. Psychological aspects of Phase V?
16. What do we mean by your "stuff"?
17. List as many grief counseling techniques as you can.
18. What do we mean by self-defense mechanisms?
19. Why are self-defense mechanisms important?
20. List the "Do nots" when we are seeking to help others overcome their grief.
21. List statements we should avoid when we are seeking to help others overcome their grief.
22. Why is listening important in grieving?
23. Explain anger in grieving.
24. What task will you need to help grieving people accomplish?
25. What do we mean when we say narcissistic coping mechanisms?
26. Name some narcissistic coping mechanisms.
27. What are aggressive coping mechanisms?
28. Name some aggressive coping mechanisms.
29. What are object-libidinal coping mechanisms?
30. Name some object-libidinal coping mechanisms.
31. Know definitions.
Appendix 7

GRIEF SUPPORT GROUP QUESTIONNAIRE

Pre-Test

This questionnaire is designed to determine the theological, psychological, and physiological needs of a person who has had a loved one claimed by death.

Please circle the answer that comes closest to expressing your feelings.

1. Have you accepted the death of your loved one?
   Yes     Most of the time     Sometimes     Seldom     No

2. Have you denied the death of your loved one?
   No      Seldom     Sometimes     Often     Yes

3. Have you isolated yourself from others?
   Not at all     Seldom     Sometimes     Often     Always

4. Have you felt lonely or experienced a void in your life since the death of your loved one?
   Not at all     Seldom     Sometimes     Often     Always

5. Do you feel that God has not been with you in your grief?
   Not at all     Seldom     Sometimes     Often     Always

6. Has your faith in God been shaken during your grief?
   Not at all     Slightly     Somewhat     Seriously     Severely

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7. Have you stopped attending church regularly and/or religious activities since the death of your loved one?

   Not at all   Seldom   Sometimes   Often   Completely

8. Have you withdrawn from participating in social activities since the death of your loved one?

   Not at all   Seldom   Sometimes   Often   Completely

9. Have you experienced difficulty sleeping since the death of your loved one?

   Not at all   Seldom   Sometimes   Often   Always

10. Have you experienced feelings of guilt during your grief?

   Not at all   Seldom   Sometimes   Often   Always

11. Have you experienced friendships with others since the death of your loved one?

    Yes   No

12. Have you deepened friendships with others since the death of your loved one?

    Yes   No

13. Have you established new relationships or friendships since the death of your loved one?

    Yes   No

14. Has your faith in God been strengthened since the death of your loved one?

    Yes   No

15. Have you experienced gaining strength from prayer since the death of your loved one?

    Yes   No
16. Have you experienced gaining strength from Bible study and preaching since the death of your loved one?
   Yes                   No

17. Has your faith in God been weakened since the death of your loved one?
   Yes                   No

18. Have other isolated themselves from you since the death of your loved one?
   Yes                   No

19. Have you denied the death of your loved one?
   Yes                   No

20. Have you found support from the church since the death of your loved one?
   Yes                   No
GRIEF SUPPORT GROUP QUESTIONNAIRE

Post-Test

This questionnaire is developed to seek out significant theological, sociological, psychological, and physiological changes which have occurred since persons have participated in a grief support group.

Please circle the answer that comes closest to expressing your feelings.

1. Have you accepted the death of your loved one?
   Yes    Most of the time    Sometimes    Seldom    No

2. Have you denied the death of your loved one?
   No    Seldom    Sometimes    Often    Yes

3. Have you isolated yourself from others?
   Not at all    Seldom    Sometimes    Often    Always

4. Have you felt lonely or experienced a void in your life since the death of your loved one?
   Not at all    Seldom    Sometimes    Often    Always

5. Do you feel that God has not been with you in your grief?
   Not at all    Seldom    Sometimes    Often    Always

6. Has your faith in God been shaken during your grief?
   Not at all    Slightly    Somewhat    Seriously    Severely

7. Have you stopped attending church regularly and/or religious activities since the death of your loved one?
   Not at all    Seldom    Sometimes    Often    Completely
8. Have you withdrawn from participating in social activities since the death of your loved one?

Not at all    Seldom    Sometimes    Often    Completely

9. Have you experienced difficulty sleeping since the death of your loved one?

Not at all    Seldom    Sometimes    Often    Always

10. Have you experienced feelings of guilt during your grief?

Not at all    Seldom    Sometimes    Often    Always

11. Have you experienced friendships with others since the death of your loved one?

Yes    No

12. Have you deepened friendships with others since the death of your loved one?

Yes    No

13. Have you established new relationships or friendships since the death of your loved one?

Yes    No

14. Has your faith in God been strengthened since the death of your loved one?

Yes    No

15. Have you experienced gaining strength from prayer since the death of your loved one?

Yes    No

16. Have you experienced gaining strength from Bible study and preaching since the death of your loved one?

Yes    No
17. Has your faith in God been weakened since the death of your loved one?
   Yes  No

18. Have other isolated themselves from you since the death of your loved one?
   Yes  No

19. Have you denied the death of your loved one?
   Yes  No

20. Have you found support from the church since the death of your loved one?
   Yes  No

Note: These questions, pre-test and post-test, were used by Donald Porter in evaluating his test group during the implementation of his project and the writing of his dissertation.

Appendix 8

RESPONSES OF GRIEF SUPPORT GROUP QUESTIONNAIRE

Pre-Test

This questionnaire is designed to determine the theological, psychological, and physiological needs of a person who has had a loved one claimed by death.

1. Have you accepted the death of your loved one?
   Yes - 1  Most of the time - 1  Sometimes - 4  Seldom - 2  No - 1

2. Have you denied the death of your loved one?
   No - 2  Seldom - 3  Sometimes - 4  Often - 0  Yes - 1

3. Have you isolated yourself from others?
   Not at all - 0  Seldom - 1  Sometimes - 6  Often - 2  Always - 0

4. Have you felt lonely or experienced a void in your life since the death of your loved one?
   Not at all - 0  Seldom - 3  Sometimes - 3  Often - 1  Always - 3

5. Do you feel that God has not been with you in your grief?
   Not at all - 1  Seldom - 3  Sometimes - 2  Often - 1  Always - 1

6. Has your faith in God been shaken during your grief?
   Not at all - 5  Slightly - 3  Somewhat - 1  Seriously - 0  Severely - 0
7. Have you stopped attending church regularly and/or religious activities since the death of your loved one?

Not at all - 7 Seldom - 1 Sometimes - 1 Often - 0 Completely - 0

8. Have you withdrawn from participating in social activities since the death of your loved one?

Not at all - 2 Seldom - 2 Sometimes - 4 Often - 1 Completely - 0

9. Have you experienced difficulty sleeping since the death of your loved one?

Not at all - 2 Seldom - 0 Sometimes - 3 Often - 3 Always - 1

10. Have you experienced feelings of guilt during your grief?

Not at all - 0 Seldom - 2 Sometimes - 6 Often - 0 Always - 1

11. Have you experienced friendships with others since the death of your loved one?

Yes - 7 No - 2

12. Have you deepened friendships with others since the death of your loved one?

Yes - 4 No - 5

13. Have you established new relationships or friendships since the death of your loved one?

Yes - 6 No - 3

14. Has your faith in God been strengthened since the death of your loved one?

Yes - 8 No - 0 Yes and No - 1

15. Have you experienced gaining strength from prayer since the death of your loved one?

Yes - 7 No - 1 A little - 1
16. Have you experienced gaining strength from Bible study and preaching since the death of your loved one?
   Yes - 7    No - 1    Yes and No - 1

17. Has your faith in God been weakened since the death of your loved one?
   Yes - 2    No - 6    Yes and No - 1

18. Have other isolated themselves from you since the death of your loved one?
   Yes - 6    No - 3

19. Have you found support from the church since the death of your loved one?
   Yes - 8    No - 0    Sometimes - 1
RESPONSES OF GRIEF SUPPORT GROUP QUESTIONNAIRE

Post-Test

This questionnaire is developed to seek out significant theological, sociological, psychological, and physiological changes which have occurred since persons have participated in a grief support group.

1. Have you accepted the death of your loved one?
   Yes - 4  Most of the time - 2  Sometimes - 3  Seldom - 0  No - 0

2. Have you denied the death of your loved one?
   No - 7  Seldom - 2  Sometimes - 0  Often - 0  Yes - 0

3. Have you isolated yourself from others?
   Not at all - 1  Seldom - 0  Sometimes - 8  Often - 0  Always - 0

4. Have you felt lonely or experienced a void in your life since the death of your loved one?
   Not at all - 1  Seldom - 1  Sometimes - 4  Often - 1  Always - 1

5. Do you feel that God has not been with you in your grief?
   Not at all - 6  Seldom - 0  Sometimes - 1  Often - 1  Always - 1

6. Has your faith in God been shaken during your grief?
   Not at all - 5  Slightly - 3  Somewhat - 1  Seriously - 0  Severely - 0

7. Have you stopped attending church regularly and/or religious activities since the death of your loved one?
   Not at all - 7  Seldom - 2  Sometimes - 0  Often - 0  Completely - 0

8. Have you withdrawn from participating in social activities since the death of your loved one?
   Not at all - 4  Seldom - 3  Sometimes - 2  Often - 0  Completely - 0

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9. Have you experienced difficulty sleeping since the death of your loved one?

Not at all - 3  Seldom - 0  Sometimes - 6  Often - 0  Always - 0

10. Have you experienced feelings of guilt during your grief?

Not at all - 5  Seldom - 3  Sometimes - 0  Often - 1  Always - 0

11. Have you experienced friendships with others since the death of your loved one?

Yes - 7  No - 1  Don't know - 1

12. Have you deepened friendships with others since the death of your loved one?

Yes - 6  No - 3

13. Have you established new relationships or friendships since the death of your loved one?

Yes - 8  No - 1

14. Has your faith in God been strengthened since the death of your loved one?

Yes - 7  No - 1  Yes and No - 1

15. Have you experienced gaining strength from prayer since the death of your loved one?

Yes - 8  No - 1

16. Have you experienced gaining strength from Bible study and preaching since the death of your loved one?

Yes - 9  No - 0

17. Has your faith in God been weakened since the death of your loved one?

Yes - 0  No - 8  Not any more - 1

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18. Have other isolated themselves from you since the death of your loved one?

Yes - 6  No - 3

19. Have you found support from the church since the death of your loved one?

Yes - 8  No - 0  Sometimes - 1

Note: These questions, pre-test and post-test, were used by Donald Porter in evaluating his test group during the implementation of his project and the writing of his dissertation.

Appendix 9

COURSE EVALUATION

Course: The Grieving Process
Instructor: R. L. White, Jr., Pastor
Date: January 4, 1996

Sample of Actual Response

Circle One

1. This course has met its objective.

   Agree  Strongly Agree  Disagree  Strongly Disagree

2. You know much more about grief than you did before taking this class.

   Agree  Strongly Agree  Disagree  Strongly Disagree

3. You have been helped in your own grief.

   Agree  Strongly Agree  Disagree  Strongly Disagree

4. This whole class was a waste of time.

   Agree  Strongly Agree  Disagree  Strongly Disagree

5. The instructor knew the material well.

   Agree  Strongly Agree  Disagree  Strongly Disagree

6. What suggestions would you make to improve this class?

   ________________________________________________________

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7. What were the strong points?

8. What were the weak points?

9. Do you feel that you can now help grieving loved ones through their pain?
   Yes  
   No  

10. Are you better able to talk about death now?
    Yes  
    No  

Other Comments

During the training classes I was able to use class material to help my family through the loss of a loved one. The handouts were very helpful. I was able to recognize and address the various phases and symptoms of grieving and to recognize what is normal or complicated. I feel I can assist anyone with the normal grieving process, eventually complicated with enough training. I was healed of some grieving pains I did not know were still there. The training and handouts were exceptional.

I just wanted to comment on the domestic situation with the husband killing his wife and his complicated grief. Also, his son who is parentless now that he is incarcerated. I have helped my niece to deal with the emotional process of grieving
with both parents incarcerated due to an accidental killing. Constant questions of what she was feeling, how she is feeling, what does she think, how does she think she's coping, etc.

Please do not judge my test by my willingness to learn and help. My last two weeks of class were spent making funeral arrangements and grieving. I know the material, but study time was off. This is no excuse, I know. Thanks.

Pennye
Appendix 10

COURSE EVALUATION RESULTS

1. Strongly Agree - 6; Agree - 9; Strongly Disagree - 1

2. Strongly Agree - 13; Agree - 3; Strongly Disagree - 1; Disagree - 1

3. Strongly Agree - 9; Agree - 5; Strongly Disagree - 1

4. Strongly Disagree - 14; Disagree - 14

5. Strongly Agree - 15; Agree - 2; Strongly Disagree - 1

6. Fifteen (15) made the observation that they felt the class should be longer.

7. Comments ranged from excellent presentation by teacher, role play, sharing of experiences, and much needed study material.

8. Those who did comment, almost unanimously stated that it was a heavy amount of material to be digested in such a short period.

9. Yes - 17; No - 0

10. Yes - 17; No - 0
Appendix 11

REQUIREMENTS FOR LAY COUNSELORS

1. Must submit to four weeks of intensive training for ministering to grieved families.

2. Must become thoroughly familiar with procedures for planning a funeral.

3. Must know own limitations, and when to refer.

4. Must be a good listener.

5. Must know the church's policy concerning the funeral.

6. Must be willing to help make contact with those who need to be contacted.

7. Must be willing to do needed homework assignments from training sessions.

8. Must be able to talk about your own pain.

9. Must be willing to do whatever you reasonably can to alleviate suffering of newly bereaved loved ones.

10. Must be able to relate the faith you have that God will do the healing.
Responses to Qualifying Examination

In September 1995, a proposal for a Doctor of Ministry project was presented to the committee chairperson, Dr. Edward P. Wimberly, and committee members: Dr. Charles J. Sargent and Dr. Benjamin Hinton. Each committee member scrutinized the proposal and then submitted a question that would constitute the qualifying examination. This document is the response to those questions.

Dr. Wimberly: "I am aware that there are several D.Min. dissertations on the grieving process in African-American churches. Find these resources and give a review of them. This review will become your section of the final proposal entitled "Literature Review."

Dr. Sargent: "How do you view grief as a communal concern? How is an entire community affected and involved in the 'break in the chain'? What role does the type of death (sudden traumatic, natural result of having lived, murder, suicide, etc.) and the age of the deceased play in the communal grieving process? How can communal grief become a healing and reconciling, emotional and spiritual experience?"

Dr. Hinton: "In your bibliography you list references expanding at least four decades beginning with the 1960s. In your review of this literature, tell how the knowledge and methodologies of dealing with grief and the grief process have evolved over the years. In addition, what do you propose to do similar or different from these previous methodologies in your project?"

This paper will not only respond to each of these questions but will also include some of the evaluative questions to be used during this project per verbal
agreement with Dr. Wimberly. It is hoped that the responses provided will be satisfactory. A copy of this document will be sent to each committee member.

Response to Dr. Wimberly's Question

In conducting research for dissertations on grieving in African-American churches, I did find three that referred directly to churches, and three that had direct mention of grieving and the church's involvement. These dissertations include:


For purposes of interest that could directly affect my project, I will review six of these dissertations that will have an impact on the formulation of my dissertation.

Dissertation #1

"A Grief Support Group As an Element of Pastoral Care in an African-American Church"
by Donald Porter

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Dr. Donald Porter is a minister who received the Master of Divinity degree from Interdenominational Theological Center, later moving to Cincinnati, Ohio and joining the Zion Baptist Church under the leadership of his former dean at Morehouse School of Religion, Dr. Edward Wheeler. While in Cincinnati, Porter decided to further his education at United Theological Seminary in Dayton, Ohio. He recognized the fact that very little writing had been done in the area of death, dying, and grieving from an African-American perspective; therefore, he chose for his research project and dissertation, "A Grief Support Group As an Element of Pastoral Care in an African-American Church."

In his dissertation, Porter reports extensively on his life's history and his motivation for wanting to start a grief ministry. He notes that the common thread that runs through his life is grief (pp. 13-14) and sees himself as the "grieving shepherd."

Dr. Porter states that pastoral care is a ministry in the African-American church because the church has tried to visit the sick, comfort the bereaved, visit those in prison, and minister to persons involved in crisis situations. He sums up his position by saying, "I am convinced that pastoral care is done any time persons reach out to help others in the name of the Lord" (p. 29).

Porter includes in his discussions a pastoral theology for coping with grief, the nature of God as Creator, the essence of God. He deals with the ecumenical and interdisciplinary involvement from a physical standpoint by having professionals
such as funeral directors, nurses, and an attorney participate in a grief seminar. At another meeting, psychologists, a counselor, and a pastoral counselor led discussions on the grieving process (p. 100).

Also presented in this dissertation is extensive information on the actual process as it was implemented at the Zion Baptist Church in Cincinnati. As I investigated the instruments used in evaluating the success of the program, I discovered that they will be a valuable resource as I evaluate my project. I would like to have seen more information from the different disciplines in terms of how they approach the issue of death and dying.

Dissertation #2

"An Examination into the Process of Grief As Experienced by African-American Males"
by Wayne R. Davis

In my opinion, this is a very good dissertation. It deals with a subject that is of deep interest to me. Mr. Davis does an admirable job of putting into writing the results of his research, reaching back to Africanism and its cultural devastation. He also looks at the effects of slavery and discusses (a) estrangement and disenfranchisement, (b) deterioration of family, (c) demoralization of the African-American male, and (d) presence and practice of racism.

Davis analyzes the contemporary expressions of African-American maleness; what it means to be male. He then measures reactions to the male movement.
I found his discussions to be well-researched with an extensive collection of resources. This dissertation will be helpful and valuable as I carry out my D.Min. project.

**Dissertation #3**

"The Training of Local Church Members in Bereavement Counseling"
by Aurther C. Sperry

The training of church members in bereavement counseling was undertaken to meet the needs of persons with ongoing support during a time of bereavement. The training program consisted of six sessions which made the counselors aware of the feelings of grief and how they might effectively relate to persons experiencing grief. After training, seven of the ten persons trained were willing to be assigned to bereaved persons who they contacted on a regular basis. These contacts proved to be helpful to the bereaved persons during the six- to twelve-month relationship. This program proved that laypersons can effectively minister to the needs of others with adequate training and support.

**Dissertation #4**

"Communication Processes Among Black Embalmers:
A Qualitative Study"
by Edith Churchman

This is a study that involved twelve urban Black embalmers using ethnographic research techniques in order to determine how they approached the
preparation of human remains as a final and public communication to the family and friends of the deceased.

While this dissertation will offer a limited amount of help in my work, it does offer a look into what happens with African-American embalmers as they approach the preparation of bodies for funerals. I believe those who are unfamiliar with the process of embalming will be helped by this dissertation. The analysis of the findings focuses on six themes which emerged in the course of observing communication activity:

1. The activity of the embalmer determining when, if and how often to take breaks during embalmings or between embalmings;
2. The presence of others in the embalming room;
3. Whether or not the embalmer received praise from families of the deceased;
4. The "look" embalmers desired the remains to have if they did not previously know the deceased and had no available photograph;
5. Factors used to determine if the remains were viewable or nonviewable; and
6. If the embalmer was seeking to achieve an asleep look in the remains.

Dissertation #5
"Burial and Funeral Practices in Ciskei;
An Enquiry into Present-Day Practices and Associated Grief"
by Gordon Ndodomzi

This dissertation was written to look at the funeral and burial practices among the Xhosa in the Ciskei. This is an interesting look at how death and burial
practices take place in South Africa. The writer examines the religious cosmology of the Xhosa. He explains the belief of the Xhosa in ancestor worship. He also discusses "Qamata," as God was known to the Xhosa in earlier times, and "Thixo," as God is presently known. The author feels that one has to know the practices of history. He contends that the funeral and burial practices that existed among the Xhosa in the past help one to understand the changes that came about, especially after the advent of the missionaries.

Ndodomzi discusses present-day practices that indicate that the ancestor cult and the belief in God are essentially a belief in the continuing relationship between the departed and the living.

Perhaps the reason for my interest in this particular project would be strains of tradition that coincide with practices in the United States. The dissertation proved to be interesting reading.

**Dissertation #6**

"Death and Grief: A Proposed Cycle of Compassion"

by Frank J. Lee

This project hinges on two hypotheses: (1) The church is the important place for teaching grief awareness and resolution and (2) A cycle of compassion is a process that the minister can develop with the congregation to overcome death and grief. The significance of this study for other congregations lies in the fact that it brings together a coalition of several ministry emphases (evangelism, missions,
worship, and Christian education) through which the cycle of compassion may find development and fruition. It also moves immediately to settle down with the griever in an extended period of grief sharing and healing. Through it all, God takes the initiative in putting shattered lives back together again.

Response to Dr. Sargent's Question

I see grief as a communal concern in that when a person dies, not only is the family affected, but the community at large is affected. Just as the family is allowed to grieve, so must the community have an official announcement of one's demise. The ritual, the funeral, is the vehicle that signifies public recognition of the status transition the dead has gone through.\textsuperscript{1} We live in a society that largely seeks to deny the reality of death. Even when death is imminent in many cases, the public at large and the bereaved families have problems accepting the reality of death. This amounts to massive denial.

What the funeral does is confront the bereaved and the community with the reality of death. The separation that death brings requires a visible presentation so that every attempt of denial is prevented. Therefore, the presence of the casket during the funeral is important.\textsuperscript{2} A ritual is a way of recognizing a rite of passage, and a rite of passage is a ritualized journey across life's most difficult boundaries. They give meanings to the changes in the status role of persons, they re-establish equilibrium in persons and communities after the crisis of change, and they serve the educational function of educating and transmitting to future generations what
the community believes to be the meaning of that change. 3 Hence, the funeral, as a rite of passage, is important as a symbol to the community as well as a family indicating that a person has moved to a new status. Van Gennep looked at rituals related to death and said that there are three phases in this rite of passage: separation, transition, and reincorporation. 4

When a loved one dies, the bereaved experience a feeling of separation. Some psychiatrists feel that an important act of the separation process occurs when grieving persons first view the body in the casket, particularly when the grieving loved ones (the public as well) were away from the person when death occurred. 5

During the transition activities, the actions of the people within the community are important. At the time of death, a community often rallies in support of bereaved persons: (1) meals will be brought, (2) arrangements will be made, and (3) persons who have experienced similar bereavement will offer advice and empathetic support to the grieving persons.

When we look at reincorporation, Willimon states that the mourners are separated from their loved ones who have died and are separated out for a time of special attention in which the community works in formal and informal ways to help the mourners make a painful transition. This is the final goal: to achieve reincorporation of the mourners into the mainstream of life. Willimon further states that the community has a number of ways of reincorporating grieving persons into themselves and get back into things, such as: (1) the formation of grief recovery
groups to provide support to aid in reincorporation; (2) an attempt to recognize mourners as people who need special attention and care; and (3) rituals within the church can help people to keep moving on after a death as the resumption of day-to-day rituals at home help the living to stay in the mainstream of daily life.⁶

To me, without the communal aspect entering into the death of one who belongs to the community, the family will have a harder time dealing with the grief brought on by death. It has been said that the funeral offers a sanctioned time where one can grieve publicly, and the recognition by the public of the bereaved to do so.

We live in a society that has tried to do away with mourning, at least from a public standpoint. Elisabeth J. Clark says that mourners no longer wear special clothes, nor engage in any extended mourning behavior that would make other people uncomfortable. After the funeral, the bereaved persons are usually expected to return rapidly to their usual level of functioning and they are only allowed a very brief period to express their grief openly.⁷

There are several special circumstances of death that receive even less consideration and support from others: violent death, death from suicide, fetal loss, children and widows. Murder and suicide bring on very strong reactions and discomfort among friends and acquaintances. Violent death is accompanied by unspeakable horror, and friends try hard not to mention it because they are afraid it will remind the bereaved of the tragedy. When there has been a violent death,
usually anger and hatred can bring on painful procedures, especially if the death was the result of a crime. Suicide is stigmatizing and results in anguish, guilt and shame. Suicide is still considered as a taboo topic in our society. Because of social disapproval, discussion regarding a death from suicide remains limited, if not entirely prohibited.8

When a fetus is lost it is treated as an incident too soon to be forgotten. The loss of a fetus is a genuine loss and needs to be mourned. Since opportunities to express grief in a failed pregnancy are severely limited, unresolved grief may follow.9 In my own practice of ministry, I have noted how the caretakers at the hospital will now bring the remains of the unborn fetus to the mother if the child is formed. They allow her to hold the child which helps to bring finality to the miscarriage.

Children and older widows are often not permitted adequate mourning for different reasons. With children, expression of grief is often limited in an attempt to protect them from hurt. They need to have an intellectual understanding of death before they can react to it emotionally.10

For the widow, grief is not seen as serious or problematic, but as an expectable, normal part of the aging process. It is generally agreed that widows must go through the mourning process in order to relinquish the bonds to the spouse that will then permit the re-establishment of new relationships.11
In my practice of ministry I have noticed that when death comes from a tragedy, the funeral is well-attended, and while the bereaved ones are able to grieve publicly, questions of our own mortality surface. When we have questions about our own mortality, it is easier not to talk about it. It would be a great help if we would allow more public sanction of grief by bereaved ones at the time of tragic death. The lack of opportunity to grieve in such a loss can prolong the grieving process indefinitely.

Response to Dr. Hinton's Question

In my research for this project I elected to use books that span over four decades. In my investigation of sources I was pointed back to what is considered as the beginning of meaningful modern research to Sigmund Freud who wrote on death and dying in his work, *Mourning and Melancholia.* From Freud's observations came others who used his research as a foundation from which to work. Since Freud, there have been writers such as Eric Lindemann who did research after World War II. There were surges of persons who were traumatized by deaths, presenting many problems. It was one of the first times psychologists studied normal grief reactions to the crisis of death. The flaws that showed up in his work was in the belief that resolution could take place in 4-6 weeks. He did his study on the survivors of the Coconut Grove nightclub in Boston, offered the field and the symptoms of uncomplicated grief.
Following Lindemann, studies began to proliferate with such authors as Gerald Caplan who came up with the theory of crisis. Two other sources are *The Stress of Losing a Family* by Figley and McCubbin and *The Mitigating or Protective Effects of Social Supports in Reducing the Mental Health Risks for Adults in High Stress* by Stroebe and Stroebe. John Bowlby presented "The Attachment Theory."  

My approach to using this information is to first study the evolvement of the knowledge of the difficulties with which persons and groups have to deal. Secondly, I plan to use one of the latest models that employs the knowledge gained over the years of research and also identifies with what my sincere desire is for Mt. Ephraim Baptist Church. In studying this material, I have come up with a model that is closely parallel to that of Ron Sunderland's in his book, *Getting Through Grief: Caregiving by Congregations.* Many of the questions that will be used in the evaluative process will be from several sources:


Lee, Frank J. "Death and Grief: A Proposed Cycle of Grief."

Porter, Donald. "A Grief Support Group As an Element of Pastoral Care in an African-American Church.

Sanders, Catherine. *Grief: The Mourning After: Dealing with Adult Bereavement.*

I intend to methodologically approach this project by using the latest known printed material that reflects a cumulative body of relevant material from Sigmund Freud to today's modern approach to death and dying. In addition to the latest
available material, I will attempt to indigenize the approach, by data collected, to the Mt. Ephraim Baptist Church.

In this response I have attempted to answer the questions and concerns posed by the committee members, and hope these concerns have been properly addressed. I will be glad to clarify any remaining questions that arise out of this approach to the qualifying examination.
NOTES


2. Ibid.


6. Ibid., 105.


8. Ibid.

9. Ibid.

10. Ibid., 198-199.

11. Ibid., 199.


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