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# HELPING BEREAVED PARENTS

A Clinician's Guide

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## CHAPTER

# A General Framework for Intervention

*Today, the road all runners come,  
Shoulder high, we bring you home,  
And set you at your threshold down,  
Townsmen of a stiller town.*

A. E. Houseman, "To an Athlete Dying Young"

With some knowledge of models of the grieving process and the experience of grieving parents, the reader is ready to learn some basic principles of intervention with this population. In this chapter, we first describe the general approach and processes involved in the central clinical stance we suggest should be taken when working with bereaved parents. We also describe how clinicians can adopt a growth perspective and we identify some of the specific issues that can emerge when providing assistance to bereaved parents.

## The Central Clinical Stance: Expert Companionship

Given how bereaved parents respond to their loss, as described in chapter 1, it is important for the clinician to maintain a way of relating with them that promotes a sense of safety and trust. Remember that bereaved parents often feel isolated, misunderstood, and feel great despair, especially as the realization gradually sets in that for them the pain of grief may

extend for a very long time. We have found in our clinical work that *it is generally best to approach parents as companions in this journey, and downplay professional clinical expertise*. Even if you happen to be a bereaved parent yourself, this is a good stance to take. We call this clinical style “expert companionship.” It is focused on the clinician’s understanding of the bereavement experience, and it allows bereaved parents to feel safe and validated, when so many others seem to misunderstand them.

## The Primacy of Expert Companionship

Unlike much other clinical practice where you might be working with people with certain psychiatric disorders, most bereaved parents are psychologically healthy people who have been struck by tragedy. Therefore, as a clinician, you will find that you can trust them to find their own way to grieve and survive. You usually will not have to provide psychological treatment in the same sense you might with depression, anxiety, and other kinds of similar difficulties. However, there are parents who have had preexisting psychiatric disorders, including substance abuse and personality disorders, and this will demand a more active style of intervention. In addition, there are parents whose children have died in circumstances that produce posttraumatic stress symptoms for the bereaved parent. These are usually situations where the child’s death was the result of a violent cause, when the parents have witnessed elements of the child’s death, or when they create their own horrific images of what they think might have happened. Some elements of effective treatments for posttraumatic stress might be indicated in these cases. We suggest becoming familiar with trauma treatment approaches (e.g., Herman, 1992) in order to be prepared for these clients, but most of this chapter focuses on the situations clinicians are most likely to face with bereaved parents. We also suggest that *expert companionship* is of primary importance for these clients and is the most suitable style to employ with most bereaved parents.

There are several reasons why this clinical style of expert companionship may be the best one to adopt. First, by being a companion, you do something that many others are unwilling to do: stick with parents as they talk about their children’s lives and their deaths. Some people are willing to do this in the immediate aftermath of the loss, but few friends and family can do this for the long haul. Bereaved parents usually have the feeling in short order that the world has gone on functioning as if nothing has happened, and even those who are most concerned become less solicitous as time passes. Parents may also assume that they may wear out their welcome with people who have been particularly helpful and sensitive, and they do not want to lose the support they have. Therefore,

*as a clinician, your greatest gift is to be there for the long haul, always showing clear signs of willingness to listen to and actively engage the parent in every session.* This can be a tough task for clinicians who usually operate in a short-term therapy model. Current therapeutic paradigms (e.g., “brief therapy”) may emphasize rapid and efficient intervention, and larger social and economic forces (e.g., managed care) can push clinicians in the direction of short-term work as well. Therefore, as time wears on, clinicians may start to doubt their effectiveness, or the appropriateness of their work with bereaved parents. We recognize that some clinicians operate in settings where long-term contact with such clients is not supported financially or philosophically. It is best in these circumstances to acknowledge the truth. Say to the bereaved parent,

Your tragedy may take a long time to heal. Unfortunately where I work, we aren't able to work with you for the length of time you might need. It would probably be best for you to work with someone who can stick with you over the long haul.

Be ready to refer parents to a person or agency that does just this. We believe that without urgency to terminate work with bereaved parents, both the clinician and parent can settle into their best work. It is a therapeutically safe environment from the start.

There is another reason why it is good to downplay the expertise of facts and interventions, and emphasize expert companionship. This is because every life or death is different, and clinicians will find that parents appreciate therapists who take the time to get to know what is special about their child, and their specific circumstances. It is most important to get to know the child through the parent's eyes in order to appreciate the particulars of what the parent has lost. Instead of a generic understanding of this loss, find out the special qualities of the child that made him or her unique. Find out what the character of the parental-child relationship was. Find out what the problems might have been in the relationship, that the parent may be regretting or feeling guilty about. Find out about special talents and interests, that now are reminders, both painful and comforting, of the child's death and life. Find out about the specific circumstances that made the death difficult, or perhaps a relief, and how these circumstances continue to be played out after death. We discuss these kinds of circumstances later in this chapter.

Parents will feel close and safe with you as a clinician if they have a sense that you knew their child, and the parent indeed can introduce you. Remember that here again, you are not the expert, but the companion. *The parents are the experts on their children, so have them teach you.* Say something like,

In order for me to get an understanding of your grief, I need to know about who you lost. I would appreciate it if you could tell me more about Bobby.

Ask them to bring photos, even if the parent cannot bear to look at them. We have not run into any parents yet who are not willing to share photos, even if they have difficulty looking at them. They may get someone else to choose some, or they will grab a framed picture they are familiar with and bring it with them, hardly looking themselves. But they will do it because they want you to know their child. Photos from all different ages are helpful, from baby pictures to those taken in recent times. Some parents will bring those that are less painful for them to look at, perhaps those from long ago rather than recently. Look carefully at these photos, and try to imagine the personality of that child, and talk together with the parents about what you see in their child. Notice the expression, the action of the picture, who else is there, how they are dressed. Much information may be revealed about the child and the parent's relationship in such a conversation. The talk about the child's life can also be a bit of a relief from the pain of their death. For a moment there may be a pleasant memory. The parent may tell an amusing story. The two of you may laugh together. This in particular may be a revelation for a parent. For example, one parent said,

When we looked at Danny's picture and laughed together about that day at camp, I realized that I hadn't laughed since he died. I guess it was more than I couldn't, it was that I didn't want to. Someone might think I no longer hurt. But I knew you knew that wasn't the case, so I guess it was safe to laugh with you.

Some parents might wish to bring in videotapes, so it is good to have equipment to view them. Videos seem to be harder for most parents than photographs. Their child's movement and voice make what has been lost even more painfully clear. At the same time, these videos can show a clinician even more about the child, so it is useful to let the parents know that they can bring them in when they are ready. Some parents have given us videos to watch outside of clinical sessions, because they cannot bear to see them yet. We have honored such requests, and then talked with the parents about what we viewed, just as with still photographs. Other ways parents introduce their deceased children to us include their children's writings and drawings, eulogies and poems written about them, and other pieces of memorabilia. All these things have a story behind them, and encouraging this storytelling is a great way to build your relationship with bereaved parents, to help them feel emotionally secure with you, and to advance the healing process. Sometimes you may feel that you are going slowly by focusing on such things, but it is all helpful. *Avoid short-cuts.* Bereaved parents can be quite sensitive and vulnerable, and

can pick up slights and disinterest, especially if they sense that you are not wanting to know about their children. The expert companion is patient with this process.

## □ The Expert Companion in Multicultural Context

The expert companion must also learn how to accompany people from different cultures, who have differing expectations regarding the grief process and professional help. Recognizing and appreciating cultural differences will become increasingly important in order for clinicians to be effective in helping bereaved parents.

The United States and other countries in the Northern Hemisphere have become, and will to continue to become, increasingly diverse. Greater variations and changes in the ethnicity, religion, skin color, and primary language of the population are expected to continue well into the 21st century. Although not new (e.g., Kanfer & Saslow, 1969; Lewin, 1936), by the end of the 20th century there was a welcome emphasis on the importance of understanding individuals, especially clients, as part of a diverse and multicultural world (American Psychological Association, 1993).

Although definitions of culture vary, it can be thought of, at least in a rather general way, as the behavior that individuals acquire as part of their membership in a social group. Multiple *cultural influences and cultural contexts*, then, can be thought of as the means through which individuals are shaped and influenced by their participation in social groups. In this section we suggest some of the cultural elements that can be useful to consider in order to better understand grieving parents in their own unique multicultural contexts. Although accurately identifying and attending to the static demographic characteristics (e.g., gender, nationality) of the individual parent is important, it is even more useful to obtain a good understanding of the dynamic cultural factors that are of importance to and have influence on the individual parents a clinician is trying to assist.

### Identifying Primary Groups: Reference and Support

*Primary reference groups* are those groups that have social influence on an individual. An easy way to assess primary reference groups is to consider, "Who does the individual want to please or whose opinions does the person value?" For most individuals, the answer would include many persons belonging to several different social groups: the person's close friends, family members, teams, clubs, religious organizations, gangs, and

so on. In colloquial language, primary reference groups tend to be those whom the person “identifies with.” Although not universal, persons who belong to demographic groups that are minorities or who lack significant social and political power may also see themselves as belonging to the broader, more abstract group that constitutes a particular social class, ethnicity, or nationality. So, in trying to understand a particular parent, it is useful for the clinician to listen for clues indicating the persons and groups that are important to parents, and who have the ability to yield social influence over them.

Many bereaved parents see themselves as belonging to an additional reference group: bereaved parents. As fellow citizens of this particular “country,” other parents may become important sources of information, guidance, support, and comfort.

There can be much overlap between the groups that can have influence and the groups from which support can come in times of difficulty. It is also highly useful for the counselor to understand who the parent’s *social support groups* are. Which important groups can provide useful services, and emotional, informational, and perhaps even material help for the parent? When individuals experience a loss, social groups can be a powerful source of comfort. An excellent source for parents is other persons who have experienced a similar loss. For some parents the most appreciated source of support will be other parents who have lost a child under similar circumstances.

A very helpful thing that clinicians can do is to make the grieving parent aware of groups of other parents who have themselves lost children. Although we address the issue of support groups in more detail in other sections of the book, it is good to be reminded that something very useful a clinician can do is to help a grieving parent connect to other parents who have lost a child. To do this well, however, the clinician must have accurate information about the quality and availability of such resources.

## Social Rules and Norms

We tend to regard the words *rules* and *norms* as interchangeable, although in more technical writing significant distinctions are drawn between the meaning of these two words. *Social rules or norms* are the guidelines that tell an individual what should be done, what can be done, and what should not be done in particular social situations. For example, what rules do you assume to be in place when you meet for the first time with an adult friend who has recently lost a parent? What do you think you are supposed to do or say, what are you not supposed to do or say, and what do you think it would be acceptable to do or say, even though it is not

required by the situation? Many of us in North America probably assume the first time we see a friend after the death of a parent that we should, in some way, express condolences by saying something explicit, such as "I was sorry to hear about your mother's death." And in this same context, we probably also believe it is against the rules, and inappropriate, for us to ask direct questions about the cause of the parent's death. The rules we assume to be applicable may tell us that we should *not* ask a question as direct as "Could you tell me exactly what caused your mother's death?" It is very helpful for clinicians to understand the social norms that guide the individual's behavior, particularly those social norms that parents share with members of their primary reference groups.

Social rules regarding funerals and death rituals are highly relevant, especially when the parent comes for help in early bereavement. There are variations in if and how the parent is expected to have contact with the child's body, who "prepares" the body, the conditions under which the family is expected to "receive" those who wish to express condolences, and a wide variety of other matters. For some religious groups, there are clear prescriptions about how a body should be prepared, who should do it, and the time frame within which rituals or funerals must be completed.

Social rules governing the expressions of the emotions associated with grief can also be of great importance, and their relevance can last long after funeral and death rituals have been completed. There may be general expectations about the expression of emotions in general, but there may also be separate rules for different members of particular subgroups. For example, among some cultural groups it is expected that women will cry and wail, whereas men are expected to maintain a quiet stoicism. In other contexts, which may be the predominant ones in many regions of North America, some expression of emotion is tolerated and even anticipated, but adults are generally expected to express their emotions, if they do so at all, with some degree of decorum. As one person described it: "I think they [survivors] should try to control their emotions. . . . It could be a more proper way. . . . Try to keep themselves under control" (Perry, 1993, p. 58).

Parents immersed in some sociocultural groups may experience a great need to appear "strong," much as the person just quoted who wishes mourners to be controlled. In other social settings, for example, among some Mexican communities, "the emotional response . . . is perhaps more open and demonstrative than it is in" many Anglo communities (Younoszai, 1993, p. 77).

Social rules governing the behavior of members of the parent's wider social group can also have an impact on the parent. It is not uncommon for persons in the United States to express some degree of social discom-



fort about interacting with bereaved persons, in part because of the lack of clarity of the social rules for the provision of comfort and support. This particular discomfort may be aggravated when the potential comforter is considering how best to interact with grieving parents. Many potential comforters probably ask themselves: "What can I possibly say or do when I talk to them? I have no idea what to say, how to act, or what to do. I certainly do not want to say the *wrong* thing." In turn, this potential discomfort on the part of members of the parent's primary social groups may somehow get communicated to parents, making their already extremely difficult situation a bit more awkward and stressful for them. This sense of social awkwardness, enhanced by the lack of clear social rules indicating how potential comforters can provide support for grieving parents, may in turn lead the parent to feel even more disconnected from persons who might otherwise be perceived to be the source of bountiful help and support.

## The Clinician's Status and Social Role

Doctor, you are an expert on sadness and loss. I feel very bad. Tell me what I should do so that I may begin to feel less sadness over my loss.

This was a request from a client from a country other than the United States, in which "doctors" are expected to utilize their expertise to offer an expert solution to the patient. For this client, the clinician was seen as having high status, because of his education and knowledge, and his role was seen as that of a wise and knowledgeable person who could offer a potential solution for this man's deep sadness. The clinician's style of expert companionship may need to differ for parents in different cultural contexts.

There are variations among sociocultural groups as to what the role and status of the "psychotherapist" or "counselor" is, and each clinician should develop a general awareness of how he or she is viewed by individual parents, and also how mental health professionals in general are viewed by the parent's primary social groups. In contrast to the high status accorded to the psychologist in the illustration just given, many practicing clinicians have experience with clients who describe members of their social groups as assuming psychological interventions are ineffective and a waste of time. Clinicians must make a decision about the degree to which their approaches may be changed, given different assumptions clients have about what their status is and what their roles should be. But it is important to at least try to understand what those

assumptions and expectations are—both what the parent’s view is and the views that predominate among the parent’s primary social groups.

A very important element for understanding the cultural context of clinical work is *for clinicians to remember that they themselves have reference groups that influence them and how they approach the task of trying to be of help to grieving parents*. In addition to the typical primary reference groups that we all have—for example, families and friends—practicing clinicians, trained in typical North American and Western European psychological traditions, tend themselves to share a subcultural set of assumptions about what “good” therapy should be in general, and how to assist grieving persons in particular. For example, clinicians tend to see accurate and intimate disclosure, by the client, of emotions and thoughts as a desirable component of the therapeutic process. Many clients, and in North America these may be more likely to be men (Shay, 1996), may have strong sociocultural influences that discourage or inhibit such disclosure. Such cultural influences on clients tend to stand in opposition to what the subculture of clinicians typically regards as the best way for the therapeutic process to unfold. The clinician should respect parents’ ways of thinking about death and bereavement, and the particular ways in which the parents choose to express, or not, their grief during counseling sessions.

Clinicians may also have some sociocultural assumptions about the appropriate and desirable ways in which grieving parents should behave in the world outside the confines of the treatment session. It is important to be aware of the potential differences between how bereaved parents in their sociocultural contexts, and practicing clinicians in theirs, view the clinician’s role, the grief process, and the therapeutic relationship.

## Assumptions about What Helps

As a psychologist, counselor, social worker, or whatever professional training you have, *what main assumptions do you make about what the helpful ingredients of the psychological interventions you provide to bereaved parents are?* Most clinicians can readily articulate some general ideas about this. However, if we were to ask each bereaved client, particularly parents, with whom you work this same question, to what extent would there be agreement between you and each of your clients?

The parent’s view of what may or may not be helpful about psychological interventions is influenced by the sociocultural groups and communities to which the parent belongs. The assumption that counseling and psychotherapy are about “getting in touch with your true feelings” is one that is common in popular culture and may represent, at least in some

ways, the views of many practicing clinicians as well. But some parents may have significantly different expectations—they may be seeking expert advice, reassurance, words that they hope may directly provide comfort and solace, or, in a more general sense, wisdom. It is useful to be aware of what ideas parents have of how counseling can be helpful to them, and how those ideas may differ from the ideas the therapist has.

## **Sociocultural Consequences of Change**

To the extent that psychological interventions produce good results, those results usually involve some kind of change on the part of the client. Although the desired ends of intervention may differ between client and counselor at the beginning of the counseling relationship, greater congruence of goals is likely to occur over time. Another important aspect to consider then, in order to understand the parent's grief in sociocultural context, is the social consequences of therapeutic change. How will the parent's primary social groups respond to the changes the parent undergoes as a result of counseling? Consider, for example, a "reluctant male" (Shay, 1996, p. 503) bereaved parent who learns to value self-disclosure and expression of emotion as a result of his experience in psychotherapy. We might well imagine that this new skill will be highly appreciated by some of his important others, but in some of his cultural contexts—for example, with his male friends who are also reluctant to engage in self-disclosure—ready expression of intimate feelings may result in awkwardness at best and perhaps significant social sanctions (such as derision or ridicule) at worst.

Although a therapeutic process that encourages the expression of inner states and painful feelings may be a good choice, even for a highly reluctant man, the clinician should try to obtain the best understanding possible of what may happen if the man does indeed practice his new-found skills outside of the therapeutic session.

## **Religion and Spirituality**

In the United States a very large percentage of the population identifies itself as having a belief in God, and a lesser, although still considerable, percentage identify themselves as religious in some ways. Although many North American psychologists view "spirituality" as an important part of life, they are less likely than their typical clients to regard themselves as religious. The beliefs of North American psychotherapists, even when they include a belief in some form of higher power, are not likely to conform

to the traditional assumptions of the world's major religions (Calhoun & Tedeschi, 1999). It is helpful for clinicians to identify and understand the spiritual and religious ways of thinking and doing that bereaved clients have. Such beliefs can include various versions of the major religions of the world, but in the Western "developed" countries such beliefs are also likely to include agnosticism and atheism (Parkes, 1998). Given the ever-increasing multicultural and pluralistic demographics of countries in Western Europe and North America, it is highly likely that clinicians' views on the spiritual or religious elements of grief will differ from many of the bereaved parents they see.

Some, perhaps many, clinicians may have assumptions that can be called secularism or secular humanism (Dees, 2001; Parkes, 1998). Secularism is characterized, in part, by agnosticism or atheism, a reliance on logic, reason, and empiricism, and a general disinterest in, and sometimes direct antipathy toward, traditional beliefs about gods and an afterlife. Some clinicians who are secularists may regard beliefs about God and the afterlife as "wish-fulfilling nonsense" (Dees, 2001, p. 19). In the United States there is also a minority of clinicians whose views are in many ways the opposite of those held by secularists. Such clinicians hold strong religiously orthodox views, which they incorporate directly into their clinical practice, making the assumption that the best clinical interventions represent a direct implementation of their religious orthodoxy. For example, some North American clinicians identify themselves as "Christian counselors" who specialize in implementing their own interpretation of the Christian Bible as part of psychological treatment.

In understanding bereaved parents and their spiritual assumptions (or lack of them), the viewpoint that we prefer is what we have called *pragmatic religious constructivism* (Calhoun & Tedeschi, 1999; see also Pargament, 1997, for a detailed examination of this and other issues). Bereaved parents will have a variety of beliefs, held with differing degrees of certainty and conviction, about the prospects of life after death and the continued existence of the child, possibilities about maintaining bonds and contact with the deceased child, possibilities about contacting the child, and the general role of God or gods. A similar statement about the variety of beliefs among clinicians can also be made. *Pragmatic religious constructivism* assumes quite simply that "it is desirable for the clinician to enter, respectfully, into the client's religious worldview and help him or her utilize . . . spiritual understanding to recover, grow, and develop" (Calhoun & Tedeschi, 1999, p. 110). It may be a challenge to put such abstract goals into practice, but we believe it is useful for the clinician to try.

Such an approach to the bereaved parent's religious and spiritual life does not leave room for the imposition on the client, by the clinician, of rigid orthodox views, whether they are religious, spiritual, or completely

secular. But in order to respectfully work within the parent's worldview, the clinician must make systematic efforts to include this dimension in the framework for understanding the individual parent's way of trying to come to terms with the death of a child. Listening carefully to parents' use of language to describe their experience will reveal much about their spiritual and religious context.

## **Idioms of Distress, Death, and Grief**

Different sociocultural groups tend to develop particular ways of talking about and conceptualizing death and the associated distress and grief. Although not specifically referring to death, some cultures talk about psychological distress as reflecting "bad nerves" or in Portuguese, "ataque de nervos." Even as clinicians who have extensive experience in the area of loss and grief, we are experiencing some degree of idiomatic constraint, now, as we write this very book. Look back to the last paragraph before the current heading on idioms. We have avoided using any version of the word *death* in association with the word *child*, at least in part because the phrase "dead child" seems cold and harsh, given the particular sociocultural groups in which we are ourselves currently immersed.

Clinicians need to exercise significant cultural sensitivity about the ways in which bereaved parents think and talk about their particular loss. This is another way to be the expert companion, rather than merely the expert. *Listen carefully to the language of grief that parents use, and judiciously join them in this form of communication.*

A phrase that is quite common in some groups in the southeastern United States is the verb "to pass" as a way of talking about a person's death. "Their child has passed," for example, is the typical way in which some social groups describe a child's death. "He's gone to be with the Lord," "God just called him home," "she's in heaven with her Gramma," and "she has left us" are examples of some of the phrases used by some social groups to talk about a person's death.

Generally, the term "died" may be the safest for a clinician to use, because it is virtually universally accepted. But the clinician should be highly sensitive to the ways the death of a child is conceptualized and the words and idioms used to talk about it. If the parent says that the child returned to her maker, for example, this might invite you to say,

I notice that you said that Maria 'returned to her maker.' I gather that this means you have a clear sense of her relationship with God and where she might be now.

Then, you will probably develop a discussion about spiritual matters that are important to the parent. This kind of discussion is explored in depth

in chapter 6. But we wish to point out here that it is important that you show you are willing and able to talk about such matters, and learn the parent's cultural perspective on them in relationship to their child's death. With regard to spiritual matters, we can recall a few parents who had a strong reaction to the use of the word "lost" to mean that their children had died. For them, this term had an important religious significance. One parent said,

I didn't "lose" my child. I know just where he is; DeShawn is with God. God has him safe at home with Him.

There are other words commonly used in relation to the grief experience that can produce strong reactions in some bereaved parents. One of these is often used by media people: "closure." We have found that many bereaved parents hate that word. To them it means that their child's death has been put aside, and that there is no longer a recognition or emotional memory of them. Many bereaved parents do not believe this is possible or desirable. It is also important to appreciate the variability among parents in reaction to certain words and phrases. When you are the expert companion who listens carefully, you can avoid offense by using these phrases only when you understand their meaning and impact. For example, just as the mother quoted earlier was comfortable with the idea that her son was with God, another said,

I hate it when people say Carlo is "in a better place" or that God is caring for him. I'm his mother, and I'm supposed to be caring for him. I'm sorry, but I still think that's my job, and I want to be doing it.

We are not suggesting that the clinician parrot back the particular phrases that a parent uses. We are suggesting that the clinician should attend to how each parent speaks about grief and loss, and that the clinician respect those concepts and idioms and, to the extent that it is reasonable and appropriate, also speak to the client within the general framework of those words and concepts.

## **The Parent's Sociocultural Context: Summary**

All persons are immersed in a complex network of social influences. The various cultural and subcultural groups from the individual's past and present have the potential to influence him or her in a variety of ways. The diverse, pluralistic, multicultural worlds of contemporary bereaved parents may be quite different from those of the clinicians to whom they come for help and support. Knowing what the bereaved parent's primary social groups are, the social norms the parent shares with those groups, the linguistic traditions used to talk about distress, death, and grief, the

assumptions the parent makes about the clinician's status and social role, what the clinician is expected to do to be of help and support, understanding the social consequences for the parent of experiencing therapeutic change and the parent's spiritual and religious perspective—these can provide the clinician with a good grasp of the parents' experiences within their unique social contexts.

General knowledge about the general cultural patterns of people belonging to broad categories such as nationalities or ethnic groups can be very useful. It is important, however, to keep in mind that even for familiar and well-established broad conceptual categories (e.g., men and women), where general characteristics and average statistical differences may have been described by reliable observations, clinicians should always follow an admonition that is widely acknowledged and quite familiar: *Focus on the individual parent and his or her unique experience and sociocultural context, not the group(s) to which that person belongs.* It is important for the clinician, in order to provide the best help of which he or she is capable, to learn about the individual parent and that parent's *unique* sociocultural influences and environments, and to acknowledge, understand, and respect the differences between the world of the client and the world of the clinician.

## The Expert Companion in the Uniqueness of a Parent's Grief

Another reason to avoid trying to be the “expert” on matters of cultural context is that there is so much to learn about bereaved parents' particular situations that might play a role in their reactions. For example, predicting with any confidence when they will be feeling better is fraught with difficulties. Some parents do not want to feel better, because they feel that this would be a betrayal of their children, and the world might take this as an indication that it is all right to forget them. Some parents are in the midst of legal battles that require them to be careful about what they say, limiting their ability to express grief in a way that might be helpful to them. Some parents have children die under mysterious circumstances, prompting them to spend much time being detectives, finding out what these circumstances really were. Who murdered them? Could the physician have saved them? Did the seat belt fail? Being the companion as the parent goes through such searching, wondering, questioning, and data gathering is an important service. Again we repeat—avoid shortcuts. Even though you may think parents are torturing themselves by pursuing such questions, the vast majority seem to have a good sense of when this is necessary, and when they are satisfied with the answers or

ready to give up, accept what they know, and decide what to believe about the rest.

*For those of us who are not bereaved parents, it is dangerous therapeutically to claim expertise in this area,* given how many parents are clear that only another bereaved parent truly understands. We believe that they are right. It is probably impossible to know the particulars of this pain without going through this, even if you have heard many stories as we have, or try your hardest to be empathic. Even if clinicians themselves are bereaved parents, their own experience and cultural contexts can diverge from that of other parents. There is no reason to invite the reaction, "I don't think you really understand, you've never gone through this." Although the same might be said about many clinical problems, like substance abuse, obsessive compulsive disorder, or bipolar disorder, because parental bereavement deals with the loss of the most precious person, empathy born of direct experience is usually more of an issue for the client.

Given this stance of expert companionship, rather than expertise, is there any place where expertise in facts and interventions comes in? After all, you are probably reading this book in hopes of becoming more expert in helping bereaved parents. *Yes, there is expertise involved in this work.* We are making the case that the expertise is primarily involved in being a high-quality companion in bereavement, and that the expertise is woven into your interactions, rather than revealed through knowledge of facts or intervention procedures that heal the pain of grief. However, there are ways to help parents with some facts, suggestions, and the like from time to time. Indeed, they will ask for this kind of knowledge sometimes. You will be asked such questions as, "Should I read the autopsy?" "Should I tell his little sister the truth about how he died?" "Is it OK that I don't wish to visit the grave?" "What should I do on her birthday?"

In responding to such specific questions, we acknowledge that the real experts are parents who have survived this grief. Their experiences have informed us enough that we felt drawn to and capable of writing this volume. All of what we know about this process, and what is helpful, comes from listening to parents directly, or by listening to them through our research or that of others. So, we often find ourselves introducing suggestions and facts with:

Some bereaved parents have told me that. . . . Has that been the case for you?

First, such a statement says that we do not know this through personal experience, and admit that. Second, it says that some parents have this perspective, but that it is not the only one—the parent's personal experience may be different, and just as valid. We find that bereaved parents are usually eager to learn from others who have been enduring similar



circumstances, and by invoking the perspectives of other bereaved parents, we can give credibility to the information we share. In chapter 8 you will find some recommended resources that will help you learn about various ways that bereaved parents handle the situations and decisions they face. But all of this must be tempered with a consideration of the parents before you—what are they ready for, what fits their cultural context, and what just feels right for them.

Of course, another way to handle the problem of expertise and credibility is to conduct mutual support groups for bereaved parents. But these parents also recognize the limitations of their hard-won “expertise.” One mother had friends whose son was killed about five years after her own son had died in a similar accident. She said:

We got up the next morning and went to them. And it was really strange from the standpoint that I thought that I should have some great words of wisdom here. I’ve been there, I should know something. And I found myself sitting there thinking I have no clue, as most people do not have a clue who want to say something to somebody in a similar situation. And if I could tell anybody anything if they are faced with a friend who is going through this, all you can do is say “yeah I’m here, if you talk, we’ll talk, if you don’t, we won’t.” That’s all you can do, you cannot take that pain from another person.

## A Growth Perspective

In addition to expert companionship, another part of the clinical stance that we recommend is a growth perspective. We have been working since the early 1980s investigating how people report that the struggle with difficult life crises has changed them in positive ways. We coined the term *posttraumatic growth* to represent these changes. As we described earlier, we have discovered that posttraumatic growth can be expressed in one or more of five domains: improved interpersonal relationships, new life paths, a greater appreciation for life, a sense of personal strength, and spiritual development (Tedeschi & Calhoun, 1996). Some of our research has focused on growth in the aftermath of bereavement (Calhoun & Tedeschi, 1989–1990; Tedeschi, Calhoun, Morrell, & Johnson, 1984), including bereaved parents (Calhoun, Tedeschi, Fulmer, & Harlan, 2000; Tedeschi & Calhoun, 2001). We have heard parents say frequently in the midst of their grief that they recognize certain ways they have changed for the better. These parents are unaware of our research into posttraumatic growth, and they volunteer such statements without being prompted from us. Our research and clinical experiences have convinced us that the reports of growth in bereaved parents are valid and important for the heal-

ing process, and we encourage clinicians working in this area to include this perspective in their central clinical stance.

To illustrate how bereaved parents refer to the five domains of post-traumatic growth in their reports of their bereavement experience, we again let some parents speak for themselves.

## **Spiritual Development**

If I had any question about heaven, it has been strengthened because of Kim's death. And I don't know I'm not sure if that's wishful thinking on my part, I don't think it is. And people who are not as fortunate as I am, there's got to be something better for them. In life hereafter, there's got to be purpose for them. So all of that has kind of come together for me in that I don't have any question about life hereafter. And I have no question about Kim being there. So that's the assurance that has come through this experience.

## **New Paths**

After spending all that time in the intensive care unit with Katie, I recognized how hard those nurses worked. I appreciated how they took care of us, and I guess I figured, since I did a lot with my own child, I could do it for someone else's. And I felt so empty after taking care of Katie all that time, it was like I had become a nurse already, but had no job. So I went back to school, and here I am, doing for others what was done for me.

## **Stronger Interpersonal Relationships**

Although we had a pretty good marriage before, I think this forced us to look at what we meant to each other. And even if we didn't grieve the same way, we both loved Mario so much that we had to share that. It was like if we let this break us up he would be diminished somehow. We sort of vowed to make ourselves a better couple for the other kids, like a vow to Mario, as much as to each other. And it has helped us stay on track, and reminds us each day about what we are doing to be good partners and parents.

## **Appreciation for Life**

I sure don't assume anything anymore. I know now that in an instant it all can change horribly. I mean I still plan for the future, but I don't take it for

granted, either. I see other people operating like it'll be OK, and I think, they just don't realize. They'd better pay attention to their lives. And I do. I actually thank God every day. I realized in my head before about this, but this is a different kind of thing, I know it in my heart.

## Sense of Personal Strength

People say "You're so strong." Well, yes and no. They don't see the anguish, I do that in private. The shower is my favorite place for anguish. But, I agree that I am strong, because at the beginning, I didn't think I could make it. But I am surviving, and I really think that nothing could be as bad emotionally as this. I suppose if I got a disease and suffered great pain, that could be worse, but there is always morphine. This pain, this emotional pain, is different, and you have to live with it. I have not become a drug addict or anything, I faced it. So now anything else is pretty small potatoes.

## Working with Reports of Growth

We have found that people express such thoughts of posttraumatic growth at various times during the grief process, sometimes fairly early on, but usually after some time has passed. Acknowledgment of these positive changes does not seem to negate any of the negative aspects of grief, and certainly does not leave people with a sense that their child's death has ended up being a positive thing. A statement from Harold Kushner, who wrote *When Bad Things Happen to Good People*, is instructive:

I am a more sensitive person, a more effective pastor, a more sympathetic counselor because of Aaron's life and death than I would ever have been without it. And I would give up all of those gains in a second if I could have my son back. If I could choose, I would forego all of the spiritual growth and depth which has come my way because of our experiences, and be what I was fifteen years ago, an average rabbi, an indifferent counselor, helping some people and unable to help others, and the father of a bright, happy boy. But I cannot choose. (Viorst, 1986, p. 295)

*It is important to speak about growth as arising out of the struggle with loss, the aftermath of it, rather than the loss itself. Make sure that you say things like,*

Having to go through this terrible grief has changed you, and now you seem to recognize some of these changes as positive.

These positive changes are important to acknowledge and discuss because they allow parents to find some sense of meaning, not in the death itself, but in the life afterward. Because life as a bereaved parent can seem

so devoid of meaning and purpose, recognition of posttraumatic growth can reduce the distress of this existential challenge.

*Sometimes the positive changes arising from the struggle with grief can also act as living memorials to the dead child.* A clinician might suggest, for example, that

Each time you act with greater kindness, you can know that this is part of your child's legacy, making a difference in the world.

These are usually comforting notions, because they acknowledge something that is so important to bereaved parents: that their children are not gone and forgotten. They live in the memory and actions of those who have been touched by them.

For parents of infants who have died, or those who experienced miscarriages, it is sometimes necessary to live life in a way that their children did not have the opportunity to. And because other people may not have been directly touched by their children's lives, there is even more challenge in making sure that their children's existence was meaningful. You may need to help them find ways to have their child's name live in a memorial, a charity, or some other ongoing endeavor that becomes a new possibility that arises out of their terrible circumstances. But these actions are no simple matters, and there are complications that you may need to help them sort through. For example, even the naming of a child might be a problem among parents who have had miscarriages. Among parents who experienced a miscarriage, you may mention that many parents name their unborn children, even if these names are not legally recorded.

We have devoted a previous volume (Calhoun & Tedeschi, 1999) to a discussion of how to integrate this growth perspective into work with people struggling with the aftermath of major life crises. We summarize briefly some of the important aspects of this kind of clinical work as it applies to bereaved parents.

### **Focus on Listening, Not Solving, and Being Changed, Not Changing**

This focus on listening and being changed fits with the expert companionship approach that we introduced earlier. The clinician's role is to endure the stories of the death that are heart-wrenching, without reacting in ways that usurp the affect of the story from the parent. Quiet sympathy allows the client to speak the horrific details as necessary. For clinicians who feel the necessity to solve a problem or intervene to reduce emotional distress, this may seem strangely passive, perhaps even ineffective. But we believe this focus can be a building block toward growth.

The message in this is, "I trust you have the strength to bear this, and I will bear it together with you. I'm ready to learn what you need, and be changed myself." This kind of respect for the bereaved parent is powerful. With your attention and recognition of the limitations of your abilities, you acknowledge how profound this loss is, and how much it takes to endure it. And as parents endure it, they reap the recognition that it was a great struggle that they managed. By being willing to learn and be changed, you acknowledge the value in this experience, and that their child has left a legacy for you as well. And if you are open to listening like this, you will be changed in ways that you value greatly. That is one of the reasons why people can continue to do this bereavement work for so many years, because of the vicarious posttraumatic growth that can be experienced. And as the clinician experiences this, the client can use this as a mirror, and see the positive aspects of what he or she has become as a bereaved parent.

## **Notice the Growth and Time Its Acknowledgment**

Parents will say things in passing that you will recognize as posttraumatic growth, although they may not. We have often been struck by how often parents describe positive changes that have occurred during their bereavement experiences. Although it could be highly insensitive thing to point out that something beneficial has come from struggling with a child's death, parents themselves may see growth emerging from their struggle. *As a clinician, your job is to decide whether it is the right time for parents to acknowledge this more definitely*, and explore these changes. One way of judging if the timing is right for this is to wait for the second time this theme comes up, then say,

I remember you saying before that you have become more compassionate since Ronnie's death.

The parent will then decide if he or she would like to elaborate.

Sometimes parents do not label the growth themselves, but it is obvious to those around them that it has occurred. For example, one mother decided that she needed to speak to church groups about how to respond helpfully when children in their congregations died. She had had a severe public speaking anxiety that she overcame in order to do this. The clinician said to her,

I guess you'd still have the anxiety about speaking if you hadn't been so determined to be the voice for bereaved parents like yourself.

The parent responded,

I always feel like Demetria is with me when I get ready to speak. She calms me down and lets me do it. That's where I get my strength.

*In fact, one of the ways that strengths experienced in the aftermath of a child's death tend to be viewed by bereaved parents is as a legacy of that child.* Through this gift, the child lives on. This is an important perspective for parents to take. It allows them to view growth as a meaningful legacy rather than as a betrayal. Early on in the bereavement process, we have heard parents say,

I don't want to hear any of that junk that something good can come from this. My child is dead. What is good about that?

This is not the time to get into a debate. As a clinician, it is best to accept it. Members of support groups can respond differently than clinicians, because of their credibility. We have seen other group members clarify nicely the way that growth occurs in bereavement.

I know you feel that way now, but I have to say that this whole thing has forced me to dig down and find a me that I never knew existed. Sometimes it was an angry me, full of despair. But I also found a me that is a real survivor. I know pain. I know death. Neither one scares me anymore.

This kind of statement from another bereaved parent can be left to stand on its own, or examined a bit with the help of the clinician. A response to this might be,

So these have been the worst of times, but coping with this has also revealed the best of you.

*The important distinction here is that the death of one's child is not the reason for growth, but instead it is the necessity to cope that forces parents to find a way to survive.* It is often a side effect of the coping.

I wasn't looking to get anything out of this, but strangely enough, I like the person I am better than who I was before, even with all the pain in me.

Some parents make a decision to make something meaningful out of their experience, in order to honor their children.

"This is too horrible for something good not to come out of it." Or, "I want to do something that makes it easier on other families."

We point out that by coming to the group, and talking about their experiences, they are already accomplishing this. Each parent benefits from the others' presence, the others' ideas, and the others' ability to survive. This may not be something that many parents working in individual treatment can see, so the clinician might point out to them the terrible gift they have been given. After enough time has passed, you can point out

that they know a lot about the bereavement experience, but that they may not recognize this until they talk with someone else who is beginning it.

You now know some things about this process that those entering it have no idea about. Remember how confusing and frightening that was? So keep in mind that you have something to offer when you run across someone else that is going through this.

## □ **Stuck Points**

The process of grieving is in the short term unpredictable, although for most bereaved parents, in the long term it tends to be very predictable. In the long term, virtually all bereaved parents improve in their daily functioning, have a reduction in emotional turmoil, experience a restoration of cognitive functioning, and recognize that they are changed forever. Most also maintain some connection psychologically with the child who has died, although, as we saw in chapter 2, this is not always the case.

But most parents you encounter clinically will be mystified by what is happening to them, and perhaps frightened or disheartened by it. The emotional experience is so wrenching and so disruptive to daily functioning that they will ask early on, "How long will this last? Am I ever going to feel better?" Furthermore, they are usually unclear about *how* to feel better, because they have never felt such deep emotional pain before. One of the best descriptions we have heard was this:

I've heard other parents say this is like a roller coaster. Well, that's true, it has its ups and downs. But the thing about it is the ups and downs come out of nowhere. I never know how I'm going to feel from one moment to the next, never mind one day to the next. It's a roller coaster, all right, but I feel like I am riding a roller coaster in the dark. I never know when the next turn is coming, or when the next up or down is coming. I feel completely out of control.

This is just one of the several points in the grieving process that mystifies, and gives the impression to bereaved parents that they are unable to do anything constructive to influence the process, or that they are stuck in it, and not moving through it.

Part of this sense of being stuck also has to do with the myths that have been promulgated about the grieving process, as we discussed in chapter 2. One of these myths is that grief is relatively short term, that the "healing" begins soon after the loss, and that "closure" will be reached. Various time frames have been mentioned to us by bereaved parents. They have read or been told, or vaguely "heard," that one should feel better in a few

weeks, or six months, or a year. They have learned about stages of grief, and tried to figure out if they are in the “anger stage” or “bargaining stage.” They fear that their marriages will be destroyed, because they have heard that the death of a child breaks up couples. They are encouraged to take antidepressant or anti-anxiety medications by well-meaning people who fear they are too sad, or too upset (which is not to say that medicine is not appropriate in individual instances). All these myths contribute to anxieties about how they will manage this grief, how well they are coping, and whether they are “normal.”

*One of the most useful things to tell parents is that bereavement is idiosyncratic.* They will develop their own ways of grieving, and have their own experience, somewhat different from others’ experiences. At the same time, you can point out that because they were pretty healthy emotionally before this happened (and in our experience this is typically the case), they will likely find a way to survive, and eventually be able to function well. Yet they will be changed forever. Bereaved parents are to a great extent challenged by the paradoxes of bereavement, and as a clinician you provide a great service by helping them hold these paradoxical elements of grief together. You can say:

It makes sense that you wonder where this whole thing will lead you, what will become of you as you struggle through this. Life has just gotten more complicated, and you are learning some things about it at a gut level that many others don’t know. Strange things like you feel terrible, but this is normal, and a sign that you are actually OK. You will survive this, although you will wonder at times if you want to. You will at some point appear to be like everyone else again, but you really won’t be—you are changed forever. That there are certain efforts you can make that will allow you to feel better, primarily talking about it with supportive understanding people, but you will also need to let time and tears have their way with you. The whole thing has got to feel like a mighty strange process.

Some parents are impatient with the time frame because of the messages they have received about the grief process, but also because they wish to be done with the acute pain. They wonder, at the times the roller coaster takes them down, how they could feel several months later just as bad as, or worse than, they did at the beginning. Some parents have been helped by the message,

You may feel like you are stuck, getting nowhere with this, when these emotional outbursts come along, but this is actually part of the process. You are really moving forward when this happens, not back.

*We have heard from many parents that the second year of grieving is worse for them than the first year.* This can be frightening and disappointing. But there is a way to frame this as progress, too. In support groups, many parents



do this by pointing out that they were numb during much of the first year. One parent who was a support group member into the second year said to a person joining three months after her son died:

You are just at the beginning of this. I'm in the second year of it, and I feel worse than I did before. That numbness from the beginning is starting to wear off of you now, and I think it has totally worn off of me. Now it is clear that he's dead, and I will never see him as a physical being again. That is profoundly sad. It doesn't take my breath away like before. I really know it now, and it's just very sad for me.

Even this apparent worsening is progress that can be pointed out. As a clinician, you can direct the parent to memories of how it was the first few weeks. "Remember what it was like at the beginning? Do you notice any changes since then?" The answer to this is always yes, even though it is often, "I feel worse." Still, that is movement, not being stuck. The worsening and difficulty can make sense to parents in another way as well.

I've figured that this is the price I pay for having loved my child. If he weren't a treasure, then I wouldn't be reacting to losing him. My reactions tell me how much of a treasure he was. But sometimes I do wish for a little relief.

*When parents are faced with certain complications to the loss, they can experience a significant slowing of the process of grieving.* These complications can involve legal and financial matters, such as lawsuits, criminal prosecution, insurance issues, family conflicts, and the like. When emotional energy and attention is directed toward these circumstances, it is harder to focus on the loss itself, and the resulting sadness. Instead, parents may need to prepare for trials, and struggle with people or institutions that show little concern for their situation. For these people and institutions, it is business as usual, while for the bereaved parent it is anything but that. Your role as a clinician may be to help them make some decisions about managing these situations, and to prepare them for courtroom appearances, depositions, and other kinds of adversarial proceedings. A general and important point to mention here is that the diversion of the bereaved parent into these concerns should be counterbalanced by the clinician. Sometimes it helps to remind parents of the most important and enduring aspects of their grief with a comment such as:

Even though this situation with the insurance company is quite upsetting, it is important that David not get lost in all this. You still have your relationship with him, and your memories of him to look after.

With this, the parent may be able to reserve some time to focus on the sadness and loss, as well as the anger at those who treated their child

badly in life or who are seen as not treating the child with respect after death.

*Grief complicated by troublesome aspects of the relationship the parent had with the child can also result in a sense of being stuck in grieving.* This may be apparent to the parent or the clinician, or both. A very difficult complication is the circumstance of suicide, as discussed in chapter 5. Any aspect of the relationship or cause of death that results in great feelings of guilt and regret in the parent can complicate and slow the grieving process. Often, these parents are preoccupied with how they might have done things differently in order to have prevented what went wrong in their relationships with their children. Because it is too late to fix any of these things, this process is frustrating and apparently unproductive. Many professionals, especially researchers with a social psychology background, have called the rumination about what could have been done differently "*counterfactuals*." These seem to represent attempts to imagine a much better outcome by imagining taking the action that would have made a difference.

I often think that if I had just taken the time to talk with him when he came home that day, he wouldn't have been at that stoplight when the truck came through. It would have been a simple and easy thing to do, and I never would have known I had saved him. But now I know I *could have*.

Even though this kind of thinking appears to be unproductive, it is compelling for many bereaved parents. There is a momentary relief, when in the imagination the situation has been changed and their children are magically alive. Of course, this is quickly followed by the recognition that this is not so, and the nightmare is the harsh reality. These ruminations can be almost like waking dreams, daydreams, that mimic the affect of the wonderful dreams that parents hope for: to be with their children again, as they live in a dream. But upon awakening from such a dream, the recognition that this was only a dream brings with it the kind of pain that is similar to that felt when they first learned of their children's deaths.

Immersion in counterfactuals appears to be one of the many things that the clinician cannot talk a bereaved parent out of. You must engage the parent in the process of examining these ideas, not dismiss them. Here again, you are an expert companion in the grieving process. It does no good to tell parents that this thinking does them no good. Thought-stopping techniques of cognitive therapy are weak in the face of the emotional pressure that fuels this thinking in bereaved parents. Instead, take each counterfactual seriously and play it out with the parent. Do not try to protect them from the conclusion that perhaps if they had done some particular thing, it would have made a difference. Parents need you to be honest with them. They will come to these conclusions despite your wish to protect them from inflicting additional pain upon themselves.

One bit of perspective you can offer when parents engage in counterfactual thinking is to remind them that they are seeing things in hindsight, and to bring them back to what they knew at the time. Ask them to describe the situation they were in when they might have made the intervention that would have changed everything. You will often find that they are describing a day that at the time appeared ordinary, and so it was easy to do the ordinary thing.

*Bereaved Parent (BP):* It was late in the afternoon, and I was starting supper. Clark was talking to someone on the phone and I wasn't paying much attention. He said that he had to go out, and I thought that I'll be getting supper soon, so I said that he couldn't go far because it was almost time to eat. But he was almost out the door by then. Looking back, this was a little strange, but I dismissed it, or didn't even really give it much thought. I should have told him he had to stay home, that it was too late to go out then. Then maybe he wouldn't have gotten shot.

*Therapist (T):* Of course, this was pretty much a typical day for you at the time. You had no inkling then of what was about to happen.

*BP:* Right, but how I wish I had just said something.

*T:* Like what?

*BP:* Don't go!

*T:* What do you think Clark would have said?

*BP:* Well, I don't know, but with those boys he was mixed up with, he probably felt he had to. He probably would have said, "I'll be right back for supper," and gone out. So maybe I couldn't have changed it.

*T:* Of course, if you knew then what was about to happen you would have done *anything* to change it.

*BP:* I would have tied him up!

*T:* Of course, at that time, not knowing what you know now, that would have looked a little overboard.

*BP:* Yeah, of course. I guess I should have seen earlier what kind of things he was getting into, and taken a stronger stand.

*T:* You didn't think he was in this kind of danger?

*BP:* No, well, yes, I was worried. But I didn't know the whole story. I should have known better what was going on.

*T:* I remember you said he was always a good kid, and his grades were good. Maybe that helped you think that things were basically OK.

*BP:* I think so, but I was fooling myself, it turned out.

*T:* Fooling yourself? Like trying not to see reality?

*BP:* I don't think that so much. I guess I just trusted him, and thought that stuff like that wasn't happening to my kid. I guess I was naive.

*T:* Not anymore.

*BP:* But it's too late for Clark. I failed him. He needed a parent who was more in touch. Tougher, maybe.

*T:* You didn't get a chance to adjust your parenting to these circumstances. When those boys killed him, they took away your chances as well as Clark's. I'll bet you made plenty of adjustments over the years as Clark grew up, and you figured out what he needed. I think parenting is a lot of those adjustments.

*BP:* Yeah, I'd think I just had things under control and figured out with him, and then he'd be on to another phase. I hadn't figured out this teen age phase yet.

*T:* You might have with a little more time.

In this example, we can see the therapist acknowledging the bereaved parent's feeling of guilt and failure, but putting them into a realistic framework. That framework includes the context of the day Clark died—it appeared ordinary, and she had no reason to think anything so terrible was about to happen. It also includes the context of parenting—that parents are trying to figure out what to do, and usually have the time for trial and error with their kids. It is extraordinary to have to be a parent in a life and death situation, when you do not even know you are in one. Here is part of the further conversation about this.

*BP:* I know I am being too hard on myself for not seeing what would happen. But as a mother, I am supposed to know how to take care of my child, to protect him from danger.

*T:* Of course, good parents feel this way.

*BP:* That's it, how could I be a good parent. Clark's dead.

*T:* If you met another parent whose child had died because they had not prevented the child from doing something that led to their death, would you think of them as a bad parent?

*BP:* It depends on what they overlooked. Like, if they left a loaded gun out for a five year old to find, I think that is pretty bad.

*T:* Is your circumstance like that?

*BP:* No, not really. The gun thing is obviously a problem. You could see that coming.

*T:* So you don't think parents should be able to anticipate and protect against all dangers? Like maybe the school bus will wreck? Or that a plane will crash into the school building? Or a tree will fall on him?

*BP:* Some things are just so unlikely, you'd drive yourself crazy trying to worry about all of them. Probably drive your kid crazy too.

*T:* So, in your situation with Clark, with those boys and him being involved with drugs, was that more like the five-year-old and the gun, or the school bus crash?

*BP:* Somewhere in between, I think.

By the end of this clinical segment, the parent has been able to explore in detail the thinking that she is utilizing in concluding that she is guilty, and comes to a moderate position. That is enough for that point. As a clinician, it is important to recognize that time is necessary to process such material. So you accept things for the time being. The advantage to this therapeutic stance, expert companionship, is that you allow bereaved parents to speak frankly and fully, and by doing so, they are free to say to you the things others do not want to hear. In the example just given, the parent had not been able to process the counterfactual thinking and guilt very well because others had tried to make her feel better by saying to her that she was a wonderful, loving mother, and that neither she nor her son deserved this. All true, but not useful given what she was cognitively and emotionally attempting to process in her own way.

At some point, most parents are able to conclude one of the following with regard to the counterfactuals. They may be able to decide that they did what they could, given what they knew at the time. Others may conclude that they made mistakes, but they are not directly at fault for their children's deaths. What is usually a minor incident turned into a major tragedy due to the confluence of other factors besides their action or inaction. Or, they may conclude that they were at fault, but that they did not intend it, and will have to seek forgiveness from themselves. Consider the situation where a mother drove off the road, and her six-year-old daughter was killed in the crash. Her husband held her responsible and divorced her. She was badly injured and could not remember what happened, including whether her daughter was belted into her seat. The police investigation found that she was not, but the mother said she always made a point to check the belt.

*BP:* I guess I will never know the absolute truth about this. I have decided that I belted her in, but she took it off. That is the only sense I can make of it. Maybe some people would say I'm just trying to make myself feel better, but you know, I've punished myself plenty about this for the past three years. And Charlie will continue to punish me in any way he can, even though I don't plan to see him again. But, I still drove the car off the road, and I don't know what happened there, either. Maybe I swerved to avoid another car. Maybe I slid in the rain,

Maybe I was going too fast. Who knows? Nobody. Not me. And I'll never know.

*T:* You have worked on this a long time. You've put yourself on trial. Is this the verdict?

*BP:* I guess so.

*T:* Was it a fair trial?

*BP:* I think I was a pretty tough prosecutor.

*T:* The charges were serious.

*BP:* Yeah. To live with the verdict, given the charges, it had to be rough.

*T:* Charlie tried you, too.

*BP:* And found me guilty. But I don't think that was a fair trial. Or a trial at all. That was a lynching. I think I sifted through everything carefully, and put myself through hell.

*T:* So that is over.

*BP:* I guess I decided that either I live with this or kill myself—the death penalty. And the only thing that makes sense to me is that this was a pure accident or some unintentional neglect. I don't think I deserve the death penalty for either. I loved Carly, and always tried to give her the best. If I did something wrong that day, it was just horrible luck that it had that consequence. How many times do parents make mistakes and get away with it? And I think the life sentence I'm serving as a bereaved parent is punishment enough. So, I've decided to leave it at that. That's my thinking.

*T:* A three-year trial is a pretty thorough one. I'm glad that's over for you.

For many clinicians, seeing a client through three years of therapy on this issue of guilt and self-forgiveness may seem like slow and inefficient therapy. But that is sometimes the time frame you will deal with when there are complicated issues in bereavement. Seldom are bereaved parents really stuck. Usually, they have a great deal of cognitive processing to do about so many aspects of the grief experience, and so much emotional turmoil has to be managed, that the process is naturally lengthy. Spiritual issues, the relationship with the deceased child, guilt and responsibility, the disappointment in the responses of others to their grief, practical issues of insurance, burial, memorials, holidays, the reactions and consequences for various family members, existential concerns with meaning, anxiety, depression, or substance abuse secondary to the bereavement experience, how to manage responsibilities such as child care or work in the aftermath of the death—all of these require a great deal of time and effort to sort through. This is not usually a brief therapy experience. It is unfortunate that many clinicians expect that bereavement, being

“only” a *DSM-IV* “V-code,” does not merit appreciation as a very difficult life challenge that requires much time, effort, and subtle therapeutic work.

## □ Traumatic Grief

It might be useful to consider parental bereavement as a situation that triggers posttraumatic stress symptoms, perhaps to the level of a posttraumatic stress disorder (PTSD) in some parents. We have discussed how posttraumatic growth is a common outgrowth of parental bereavement, and we have stated that the processes that engender growth have much in common with those that are involved in PTSD, especially the breaking down of fundamental worldviews.

Certainly there are some situations where it is clear that parents have had to deal with death directly and have symptoms of avoidance, numbing, flashbacks, hypervigilance, and so on that are characteristic of PTSD. For example, one bereaved parent we worked with was an emergency medical technician. One day, her son was at the school bus stop one block away, where some road construction had been taking place. The children were playing on a large drainage pipe that was awaiting installation. The pipe rolled and crushed her son. She heard the screaming of the children, and ran down the street. She applied CPR and other measures in a futile attempt to save her son.

This parent displayed some of the classic symptoms of PTSD. Not only was she confronted with grief, but also the avoidance of many reminders of her son’s death. She could no longer work, because she could not tolerate the anxiety she felt in response to anything related to emergency situations, including hospitals, EMT trucks, and sirens. She had to shield herself from looking at the school bus stop one block away, and the other children in the neighborhood. She struggled with nightmares and flashbacks of her futile attempt to save her son, and was horrified at the images of his crushed skull. This bereaved parent needed a form of treatment that combined attention to the grief and also to its traumatic elements. To some extent, all parents are traumatized by their children’s deaths. But only a few need treatment for posttraumatic stress in a formal sense. This mother was one who did, because of the nature of her experience with her son’s death.

*Clinicians who work with bereaved parents need to be familiar with trauma therapy approaches for those parents whose grief also includes elements of trauma. Trauma therapies usually incorporate relaxation procedures, graded exposure, and cognitive reprocessing. The work done in therapy with bereaved parents involves some of these elements naturally. As parents tell*

the story of their children's lives and deaths, they expose themselves to the trauma again, and as they search for meaning and purpose in the aftermath of the trauma, or confront feelings of guilt and regret, they have to engage in significant cognitive processing. To this, specific relaxation techniques can be added, or parents can be encouraged to find methods outside of therapy, such as yoga or meditation, to achieve anxiety reduction. Usually, parents tell the stories of their children's deaths several times in therapy, and it is useful to notice how these stories change, and how parents' emotional reactions to them change. In support groups, these stories are retold as new members join the group, and this acts as an exposure technique. Retelling of the story reduces the sense that this event is unbelievable, and gives parents practice at revisiting details, finding the right words to describe it, and managing their emotions as they confront it.

Although we think it is good to emphasize that the various aspects of the grief process are normal and understandable, people who have particularly traumatic experiences with the deaths of their children also need to realize that their situations carry this extra burden. One parent whose son was hit by a car right in front of her had this exchange with her therapist.

*BP:* I don't understand why I'm having so much trouble with this. Here I am still crying and choking on my words in the group, while other people seem to be so calmed down. I can't get calm about this. I don't see how they do it.

*T:* There are some differences in what you and the other group members have been through, you know.

*BP:* I know it was horrible what I went through. But I can see how everyone in the group had their own horrible part. Betsy had to watch her son just waste away for months with cancer. At least it was quick for Marty. I don't think he suffered like Betsy's boy. I'm grateful for that.

*T:* So in some way, you are grateful that he died the way he did, compared to what he could have gone through?

*BP:* I have thought that. But, still, it was so horrible to see him get hit like that.

*T:* Right. There is no good way to have your child die.

*BP:* So why am I still such a mess? This is now into the second year.

*T:* One thing you have to deal with that is different, is the images of Marty's death. Others didn't have to watch their children die. Or, if they did, it was something more peaceful and expected like with Betsy. The shock that you encountered is so vivid, that it has power to override your attempts to suppress it. You are in a struggle with those images, while others aren't. Witnessing something like this often produces reactions



that are beyond grief, and include elements of what is called posttraumatic stress. Have you ever heard of that?

BP: Like the Vietnam vets had?

T: Yes, veterans exposed to violent deaths have often suffered this.

BP: So I'm like one of those veterans.

T: Yes, you witnessed something horrific happen to the person you loved most.

BP: So will I ever get over it?

T: Your grief and loss will always be there in some form, but not as painful. The images that come to you we can minimize, too. You have to make peace with them, be ready to look at them, rather than fear and avoid them. We can work on that together.

BP: I need some relief.

The clinician in this session is providing some basic information to the bereaved parent so that she can understand what they are going through, and not feel so crazy about it. He also gives her hope that something can be done about it, although probably not *undone*. *It is important not to promise too much relief from something so difficult*. You might have also noticed that the clinician was willing to share a bit more expertise here, because this is not about being a bereaved parent, but it is about a psychiatric disorder. In these unusual circumstances, it is appropriate to emphasize the expert part of the expert companionship you offer.

There are various strategies that may be useful for reducing the intrusive images based on the versions of trauma therapy that exist. The basic approach is gradual exposure and processing of the experience. Desensitization procedures can be utilized to address avoidance of activities, as was the case with this mother who had restricted her driving to avoid local hospitals, places where she would hear sirens often on routes to these hospitals, and so on. She could not avoid the scene of the accident, because it was a block away from her house, on the way out of the neighborhood, and she had developed ways to manage her anxiety at that spot.

Similar avoidance can be seen in most bereaved parents around things such as the child's room, possessions, or photographs. Here, too, gradual exposure or desensitization is useful. We do not necessarily recommend standardized systematic desensitization procedures, but rather the use of the gradual exploration of these anxiety-arousing situations, giving bereaved parents plenty of time. We emphasize that they are the experts of their own grief, and that in time things change.

## □ Time, Tears, and Talk

The combination of time, tears, and talk is a simple way for parents to keep track of the healing approach they can take. What we mean by this is patience with oneself and the process of grief, allowing emotional expression rather than suppressing it, and seeking out people who will be good, patient listeners. Good support groups allow for all three, and bereaved parents learn these lessons well in such groups.

In a culture of managed care, fast food, and individualism, this approach is frustrating for many parents, at least at some points in the process of enduring pain. And it can be frustrating for some clinicians, too. But we have found that most bereaved parents do better with a supportive, patient approach to grief that respects the nature of the process. Most bereaved parents do better when they can talk with others that have gone through a similar ordeal. Most bereaved parents do better when they have permission to allow emotional expression. If you can provide these elements, you will help the vast majority of grieving parents achieve their “new normal,” a changed life that they can find useful and fulfilling, while recognizing they have been informed about life in a way that has made them experts on existential concerns such as meaning, chance, choice, and acceptance of limits.