Understanding Parental Bereavement after the Traumatic Death of a Child

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Abstract

There is no more traumatic and life changing experience for a parent than the death of a child. The grief that follows such a tragic loss will have an impact on the parent for the remainder of his or her life. This parental bereavement is often misunderstood by society and professionals, due in part to a lack of grief education, but also because of the limitations in understanding possible without experiencing this type of devastating loss firsthand. For although most people recognize the pain of child death, they do not fully grasp the profound grief that accompanies this type of loss. And while grief is often superficially discussed in our culture – mainly in terms of “stages” – it is rarely understood in all of its complexities. For that reason, this paper is presented as a means of understanding the influences of child death on a parent, the factors that impact grief and healing, some theories for offering grief support, and effective techniques for working with this population.

This paper will also provide information on the limitations of grief theories and grief diagnoses, and provide useful ideas for supporting parents bereaved after traumatic child death. Adlerian concepts are included, along with implication from the research, and ideas for future research on this topic.
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Understanding Parental Bereavement after the Traumatic Death of a Child

**Introduction**

American president Dwight D. Eisenhower once said, “There is no tragedy in life like the death of a child. Things never get back to the way they were” (Eisenhower, n.d). Most people realize that the death of a child is the worst experience possible for a parent, but many do not consider the lifelong grief that resides within that parent after the traumatic death of their child.

When a child dies, there is an intense grief unlike all other forms of bereavement (Murphy, Johnson, & Lohan, 2003; Harper, O’Connor, Dickson, & O’Carroll, 2011; Floyd, Malick Seltzer, Greenberg, & Song, 2013; Goodkin, 2006). The parent grieves not only for the relationship that existed and ended, but also for the one that should have developed with the passing of time. There is an encompassing grief for the loss of dreams, hopes, and plans. The physical and emotional pain is indescribable in any language; there is an ache that can be felt every day for the rest of that parent’s life. The grief from the death of a child is a pain that “has the power to shake adult personality to its very core,” (Barrera et al., 2009, p. 497), and often the parent feels she has also lost a part of herself, as if a part of their very soul is missing (Keesee, Currier, & Neimeyer, 2008).

Parental grief is chronically misunderstood by both non-specialized professionals and lay people alike, and often leads to unnecessary diagnoses, needless medication, and stigmatization of symptoms, despite grief reactions being within the set of normal human responses to significant loss (Balk, 2012). The misunderstanding is due, in part, to societies fear of all things ‘anti-happiness’, which is based on the “broader conceptual incongruence [which] assumes death and bereavement represent what [society is] striving to avoid” [i.e. happiness, and improvements in health and wellbeing] (Gear, 2014, p. 173). There is also a fundamental lack in education on
the reality of grief and loss, and a deficiency in current longitudinal studies. Simply stated, as Elisabeth Kübler-Ross says in her renowned book, *On Grief and Grieving: Finding the meaning of grief, through the five stages of loss*, “Death has always been distasteful to man and will probably always be” (Kübler-Ross & Kessler, 2005, p. 92), especially when it is the death of a child.

To advance the investigation into parental grief, bereavement, support services, and therapeutic goals, this paper will define key features of traumatic grief, bereavement, and healing, outline elements that contribute to the traumatic experience of a child's death, the factors that contribute to parental grief, and provide appropriate therapeutic goals to implement when supporting this population of clients.

**Definitions**

**Grief**

Grief is the emotional response that comes from loss, specifically suffering, that is especially pronounced when the loss involves a permanent separation (Bissler, 2005). Although symptoms are similar, and the terms at times mistakenly used interchangeably, grief is distinct from depression, as “depression is predicted by individual factors, whereas grief is mainly predicted by bereavement-specific factors” (Wijngaards de Maij et al., 2005, p. 620). When related to death, grief is “explicitly and qualitatively different from trauma and depression” due to the universal presence of “separation distress”, a yearning and longing for the person who has died” (Goodkin, 2006, p. 31). There are variations in symptoms, but typically grief includes sorrow, anger, confusion, anxiety and loss of concentration, along with marked changes to a person’s physical, mental and emotional state of well-being, social interactions and relationships, and spirituality (Rando, 1991; Rando, 2000). In all cases, grief is known as a threat to an
individual’s health, both mentally and physically (Parkes, 2002).

Grieving parents present with a myriad of issues as compared to the general population. As a group, they are reported to have higher likelihood of medical symptoms, death from natural causes and non-natural events (Barrera et al., 2007; Parkes, 2002), more depression symptoms – beginning at the time of death, and up to nine years later (Meert, Thurston, & Briller, 2005), and display an increase in anger and hostility. Studies have also shown the death of a child to “shatter parent’s personal identity and self-concept”, elicit guilt and feelings of failure (over the apparent lack of ability to protect their child), and disrupt social relationships (Meert, Thurston, & Briller, 2005). Grief from traumatic loss may increase the intensity and longevity of these and other symptoms (Goodkin, 2006; Cacciatoro & Flint, 2012).

Bereavement

The period of grief and mourning after a death; specifically, the death of a loved one; “The actual life event [that occurs when] someone close to you has died” (Goodkin, 2006, p. 31). The duration of bereavement is dependent on a wide variety of subjective variables, including, but not limited to, closeness of relationship with the deceased, manner of death, social support, and personal belief systems (Harper et al., 2011; Goodkin, 2006; Sklarew, Handel, & Ley, 2012). Parental bereavement is the period of grief and mourning after the death of a child, and has many unique traits that make it hard to resolve (Rando, 1985).

An essential component of successful adaptation to life after the death of a child involves integrating this bereavement experience into daily life and coming to terms with the loss (Barrera et al., 2007). In most reported cases, the grief of child loss remains present in some form for the remainder of the parent’s life. “The impact of the death of a child is believed to be long-lasting, perhaps even lifelong”, states Harper, O’Connor, Dickson, and O’Carroll in their 2011 study on
the continued bonds between a mother and her child after death (p. 240). In another survey of bereaved families exploring the bereavement experiences of bereaved parents over time after the death of a child due to cancer, the father of a deceased 17-year old son stated in his questionnaire: “The pain of this loss will always be there…I don’t think time will change it” (Alam, Barrera, D’Agostino, Nicholas, & Schneiderman, 2012, p. 11).

Nevertheless, 80-90 percent of bereaved parents are able to integrate grief into their daily life by 18-months post loss, regardless of other factors (Barrera et al., 2007). The remaining 10-20 percent of bereaved families may require additional assistance to learn the skills necessary to integrate their loss.

During this state of bereavement, the individual has to relearn and “reinvest in” a new version of the world without the deceased (Wheeler, 2001). According to Wheeler in a descriptive study using qualitative methods to explore parental bereavement, “The assumptive world of the individual becomes obsolete and [they] have to establish a new set of assumptions about themselves and the world” (Wheeler, 2001, p. 52).

Wijngaards-de Meij et al. (2005) state that “it is unclear whether the elevated risks for psychological problems is due to the unexpected nature of these losses [traumatic child death], to other specific aspects related to violent deaths, to age differences, or to other relevant factors (p. 617), to acknowledge the extent that variables may influence outcomes. Among the many possible influencing factors are several known influences which impede positive bereavement adaptation. Based on the responses to self-report questionnaires, Keesee, Currier, and Neimeyer (2008) found several factors that may impact outcomes of parental bereavement: Being the mother of the child who died, losing a child to traumatic events, shorter length of bereavement, no living children/fewer living children, and a history of significant loss.
Traumatic Events

“An event that places a person at threat to life, or serious injury; experienced directly, witnessed happening to someone else, or experienced vicariously when it happened to someone dear, like a family member” (Drescher & Foy, 2010, p. 148). These events typically include “predictable human reactions” such as “fear, helplessness, and horror” (American Psychiatric Association, 2013), and are intensified when the victim perceives an inability to control the situation, along with the suddenness and unpredictability of the event. The death of a child due to traumatic events creates “an extra burden of grief and sorrow in their wake for family and friends who survive.” (Dresher & Foy, 2010, p. 148).

Traumatic Loss

The complex process whereby a bereaved person has experienced “multiple and varied turbulence in response to life-changing experiences…which reach traumatic proportions” due to the variety of features present (Witztum, & Malkinson, 2009, p. 135). In other words, any time loss involves an element of a traumatic event, especially those involving a sudden or violent loss (Green, 2000). Loss-related feelings can include: “depression, anxiety, fragile self-esteem, dysregulation, somatization, internalized aggression, emptiness, and hopelessness” (Sklarew, Handel, Ley, 2012, p. 153). Symptoms may be present for many years, and are intensified by the presence of triggering events such as birthdays, holidays, anniversaries, and other important life events. It may seem to the survivor that the world is “a frightening, out-of-control place that cannot be trusted” (Sklarew et al., 2012, p. 153).

The surviving person(s) may feel guilt over their inability to stop the death, and can be left with constant fear that another loved one (or themselves) may die. Shock overwhelms coping abilities, and due to the inability to “say goodbye” to the child, the bereaved parent may
describe feeling “robbed”, and even “enraged with angry impulses” (Skarlew et al., 2012). Most people who face this type of loss experience changes in perception, both self-view and world-view, similar to the changes seen in other types of trauma and bereavement (Witztum, & Malkinson, 2009). It is important to note that traumatic loss differs from generalized trauma in that traumatic loss revolves around the person who died, while generalized trauma revolves around traumatic circumstances (Green, 2000). Treating bereaved parents whose loss was traumatic requires first dealing with the traumatic elements, and then grief, as “the intrusive images and fears” associated with the trauma “interfere with the grieving process” as one can “mask the other” (Green, 2000, p. 5).

**Posttraumatic Stress Disorder - PTSD**

“Powerful negative affect experienced during the [traumatic] event itself, the pathological post-trauma syndromes that may subsequently develop, and the secondary mood, substance use and other disorders that so frequently come to accompany these syndromes” (Gerrish, Dyck, & Marsh, 2009, p. 226). This reaction to extreme stress is divided into three clusters of symptoms that emerge after involvement in a traumatic event or situation where the person actually experienced or witnessed or was faced with an event involving actual or threatened death of serious injury to self or others, or learns of an “unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or close associate (Gerrish, Dyck, & Marsh, 2009, p. 229). Cluster one includes intrusive memories; the trauma is ‘re-lived’ via memories that cannot be controlled. They spontaneously intrude, and are triggered through reminders that occur in daily functioning. It can include “flashbacks” and feelings that the experience is actually happening again, presently (Drescher & Foy, 2010).
The next cluster involves avoidance of these triggers (e.g. daily life, loved ones, etc.), and attempts to numb emotions, while, finally, the third cluster involves hypervigilance, or the attempt to “remain constantly alert to everything in the environment”. Other symptoms can include “loss of concentration, irritability or anger, excessive startle reactions, and sleep problems.” (Dresher & Foy, 2010).

Specific to child loss, PTSD involves the intrusive replaying of events leading to the child’s death, avoidance of life after loss, and symptoms of hypervigilance that impair normal functioning. Other symptoms include an intense ongoing fear, feelings of helplessness and horror, re-experiencing the loss, avoidance and numbing, arousal (Gerrish, Dyck, & Marsh, 2009), and intrusive memories or images of the death scene and the suffering – real or imagined – of the child (Green, 2000).

Compared to the general population, bereaved parents are significantly more likely to meet the criteria for a diagnosis of Post-Traumatic Stress Disorder after the death of their child - both immediately after the loss, and five-years later - according to longitudinal studies (Matthews & Marwit, 2004; Bogensperger & Lueger-Schuster, 2014), with varying reports of 33% (Bissler, 2005) to 50% (Dillenburger, Akhonzada, & Fargas, 2006) of parents meeting the criteria of PTSD. This is due in part to this ‘unnatural’ type of death shattering all or most illusionary-based assumptions about the world and life, held by the parents, which is a known pre-cursor to the development of PTSD. As Gerrish, Dyck, and Marsh, state in their 2009 study of Post-Traumatic Growth, “Should the death of a loved one present information that was radically inconsistent with [their] assumptions [about their life and the world, e.g. the death of a child] then they were prone to shattering, with potentially devastating consequences” (Gerrish,

**Complicated Grief**

Also known as Prolonged Grief Disorder, or Chronic Grief Syndrome, this is “A bereavement-specific syndrome characterized by traumatic and separation distress lasting over 6 months”, with the presence of acute “impairment in daily functioning”. Symptoms include overwhelming desire for “the presence of the deceased loved one, preoccupation with thoughts related to the loss, and intrusive memories” (Bui et al., 2013, p. 123), “difficulty trusting others, excessive bitterness or anger, emotional numbness, feeling empty, feeling the future is bleak, and agitation” (Dresher & Foy, 2010). It can be distinguished from ‘normal’ grief by the “lowering of the self-regarding feelings to a degree that finds utterance in self-reproached and self-reviling, and culminate in a delusional expectation of punishment” (Gerrish, Dyck, & Marsh, 2009, p. 228). The first discussion of this idea of prolonged (i.e. complicated) grief came in 1949 where “people with chronic grief did not show any signed of repressing their grief, rather they grieved intensely from the start and continued to do so long after they were expected to stop grieving” (Parkes, 2002, p. 371). From then to now, the diagnosis is based on a subjective ‘deadline’ for grief to ‘end’ (Dresher & Foy, 2010; Parkes, 2002).

This is a controversial diagnosis due to potential inaccuracies in diagnostic criteria, and a fundamental flaw in logic related to how a person experiences grief. Many grief clinicians, as well as bereaved parents, voice disapproval of labeling bereaved parents with a “disorder”, especially very soon after loss, and cannot agree on how grief should be classified in the most current version of the *Diagnostic and Statistical Manual* (Gerrish, Dyck, & Marsh, 2009). As Dr. Joanne Cacciatore states in a 2015 blog post, *The Death of Common Sense: When Greif becomes ‘Disordered’*, “Of course [bereaved parents] …experience an ‘impairment in daily
functioning’…this is a normal reaction to abnormal tragedies.” (Cacciatorre, 2015). And Marty Tousley (2011) states in her blog post, *What is Complicated Grief?* “[I]n a sense, all grief is complicated, because any significant loss turns our entire life upside down, and we are faced with learning to live in a world forever changed” (Tousley, 2011).

In fact, many aspects of parental grief that were formerly viewed as pathological – including those that make up the diagnosis of Complicated Grief, may instead be typical experiences for any parent whose child died (Barrera, O’Connon, D’Agostino, Spencer, Nicholas, Jovcevska, Tallet, & Schneiderman, 2009; Gear, 2014). For “although the loss of a child itself was previously considered to be a risk factor for [complicated grief], theories about bereavement have evolved to reflect the view that child death presents families with a tremendous challenge, not a universally pathological process” (Greene Welch et al., 2012, p. 336).

It is important to remember when deciding to use this diagnosis that all bereaved parents react in unique ways following the death of a child (Gear, 2014). There are some overlapping characteristics of mourning including, but not limited to: sadness, anger, longing, bitterness, physical ailments, anxiety, guilt, shock, and lack of energy, but each situation of loss has unique responses, based on the circumstances of the loss, the relationship with the child, social support, and personal abilities to cope and incorporate loss (Keesee, Currier, & Neimeyer, 2008; Rando, 1991). It is important to distinguish the normal, ongoing reactions to the death of a child “from chronic grief, which remains in an acute stage and never resides” (Rando, 1991, p. 169).

Due to the complex nature of parental grief, more research is needed to understand and support these individuals, and clinicians must proceed with ultimate care before incorrectly providing this diagnosis, as a key element in healing is affirmation from others that their
experience with grief is “normal” (Tan, Docherty, Barfield, & Brandon, 2012, p. 583). Receiving a mental health diagnosis shortly after the death of a child only compounds the feelings of guilt and shame that parents already feel, and erroneously ‘confirms’ to society that the death of a child is something to ‘get over as quickly as possible’ (Tan et al., 2012).

**Factors of Grief and Healing**

It is generally assumed that a child will outlive their parent. When the unthinkable happens and a child dies before a parent, overwhelming pain and suffering are felt by the surviving parent. Confusion, anguish, and rage are only some of the many feelings that surface after the initial shock and feelings of disbelief. The intensity of these feelings, and the wide range of reactions are often overwhelming and confusing (Wheeler, 2001), and are highly individualized (Greene Welch et al., 2012). The inability to see, touch, smell, and interact with the child that is loved and missed with every part of the parent’s body and soul causes massive damage to the belief system, psyche, and social relationships of the parent. Multiple studies have shown that parental bereavement, as compared to bereavement in other forms, is intensified, prone to complications, lasts longer, and has a higher likelihood of developing into a diagnosis of Complicated Grief, due to the unique issues related to the death of a child (Alam, Barrera, D’Agostino, Nicholas, & Schneiderman, 2012; Matthews & Marwit, 2003; Murphy, Johnson, Chung, & Beaton, 2003; Rando, 1985). As Alam, et al. states, “[The death of a child] symbolizes the reversal of the natural order of life and erases the dreams and hopes that parents have for their child” (p. 2).

There are many factors that contribute to the potentially lifelong grief that parents experience after the death of a child. As each child, each parent, and each relationship and circumstance will invariably be unique, so will the grief reactions of each parent, and as such, it
should never be assumed that grief will fit into neat categories where outcomes can be
determined based on simple circumstances. As noted in the study, Post-Traumatic Growth and
Bereavement, “There is no uniform response to death” (Gerrish, Dyck, & Marsh, 2009, p. 226).
There are, however, overlapping elements which can impact outcomes, and the following are
some of those factors.

**Traumatic Loss of Parent/Child Relationship**

The bond between a parent and child cannot be replicated by any other relationship. Similarly, the task of parenting is unique to the specific relationship between that parent and child. Parenting requires work, dedication, patience, and constant attention. The loss of this relationship, therefore, is the most traumatic loss a parent can suffer, as it drastically impacts the daily functioning of that parent (Greene Welch et al., 2012). At once everything changes and all tasks of parenting seem to disappear (Floyd, Mailick Seltzer, Greenberg, & Song, 2013). In time, the parent will re-learn how to incorporate parenting roles into their bereavement, but the initial loss of that relationship is jarring. This traumatic end of relationship, one that “violates the natural order,” forces the parent to face challenges that are uniquely impactful to their bodies, minds, and souls (Neimeyer, 2002, p. 935).

**Loss of Identity and Beliefs**

It is an assault to the parent’s sense of self when a child dies and their role as caregiver is no longer possible. The parent is robbed of the opportunity to carry out the goal of raising, protecting, and providing for the child. This assault can often lead to an intense despair reaction; the parent feels meaningless and life no longer worth experiencing (Bernstein, Duncan, Gavin, Lindahl & Ozonoff, 1989). The belief system of that parent may also be completely unraveled, as beliefs about ‘good things happening to good people’, or a higher power ‘watching over’ them
or ‘everything happening for a reason’ may no longer align with their personal experience. It will require great effort and time to sort through the resulting anger and confusion over the inability of these core personal beliefs to be so contrary to actual events. These feelings of anger, despair, guilt, and the newfound need to reframe meaning and beliefs can complicate the grief process further (Wheeler, 2001). As Keesee, Currier, and Neimeyer (2008) state, “When the loss cannot be fitted into the bereaved parent’s belief systems, parents are launched into a profound and typically prolonged struggle to adapt their personal world of meaning to ‘make sense’ of the experience” (p. 1147). Floyd, Mailick Seltzer, Greenberg, and Song (2013) explain that, “for parental bereavement, because the parent role is highly salient as a source of existential meaning and sense of purpose in life, the disruption of parental role identity is a significant strain for most parents” (p. 403).

**Pressure to Heal**

Counterintuitively, setting ‘limits’ and ‘timeframes’ and ‘stages’ for bereaved parents is not useful. In fact, pressure to ‘heal’ from well-meaning friends, family, and helping professionals may actually cause additional stress, guilt, and further pain (Gear, 2014). Due to a wide-spread misunderstanding of how true acute grief functions, bereaved parents are often chastised for ‘choosing to be sad’, ‘not moving on’, or ‘being stuck’ in grief. Actually, most times, these same parents are doing the exact things necessary to survive and heal, in their own ways, in their own time. In fact, most bereaved parents re-learn how to live in a world that no longer makes sense (Wheeler, 2001), with a proverbial ‘hole in their heart the exact shape of their child’, and may eventually even report positive changes (Barrera, D’Agostino, Schneiderman, Tallett, Spencer, & Jovcevska 2007). Providing space for healing as the parent dictates is more likely to produce positive outcomes, as the most pressing need of bereaved
parents is time, space, social support, and validation that their experiences are ‘normal’ (Floyd, Mailick Seltzer, Greenberg, & Song, 2013).

Age of Child at Time of Death

Numerous studies sought to define the relationship between age of a child at the time of death, and the expected grief outcomes of parents. Some expectation that grief intensifies as the age of the child progresses is present in clinical hypotheses, yet many studies have demonstrated that the death of a child at any age can result in lifelong grief (Sormanti, & August, 1997; Rando, 1985, Harper, O’Connor, Dickson, & O’Carroll, 2011; Alam, Barrera, D’Agostino, Nicholas, & Schneiderman, 2012). There tends to be a correlation between the most dependent ages of children at time of death and worse grief outcomes, most likely due to the loss of active parenting roles. Wijngaards-de Meij et al. (2005) states that “the youngest and oldest ages [of children at time of death as reported in the study] bring associated with comparatively less grief” (p. 621). Children past the age of adulthood tend to be living in separate homes, with lives and families of their own, and the active parenting of the child is long past. The parent may also feel less guilt over a loss of an adult child, as the responsibility to ‘keep them safe’ is no longer pronounced. As reported to Hunt and Greeff (2012) in their panoramic study on parental bereavement, one bereaved father of a deceased adult child stated he “was satisfied with her achievements and felt that she had attained her destiny in her short life,” while parents of babies or very young children reported feeling “cheated of knowing their child’s possibly destiny” because their lives had only just begun (p. 47).

Lessor grief reactions are also indicated in the death of unborn babies prior to full-term, for reasons relating to decreased time to form bonds (Hunt & Greeff, 2012). Other studies however, have shown “no significant differences in psychological distress” for those whose child
died before or after birth (Murphy, Shevlin, & Elklit, 2014, p. 59). Largely demonstrated in most studies on this topic, despite negligible differences in grief outcomes, the death of a child at any age has the potential to cause major physical and psychological damage to the surviving parent (Harper, O’Connor, Dickson, & O’Carroll, 2011; Hunt & Greeff, 2012; Alam, Barrera, D’Agostino, Nicholas, & Schneiderman, 2012; Cacciatore & Flint, 2012), because “the circumstances surrounding the death of a child form a unique context in each individual case” (Hunt & Greeff, 2012, p. 47).

**Circumstances of Death**

There is no way a child can die that is not traumatic for the surviving family. Some studies have indicated that certain manners of death can result in higher likelihood of negative outcomes (Wijngaards-de Meij et al., 2005; Rando, 2001; Green, 2000; Drescher & Foy, 2010; Lichtenthal, Neimeyer, Currier, Roberts, & Jordan, 2013). This includes instances where the child suffered/was under duress at the time of death, stigmatized manners of death (e.g. suicide, drug overdose, etc.), the loss of more than one child, the closeness of the relationship at the time of death, no forewarning of the impending death, and/or the inability of the parent to be with the child at or around the time of death (Hunt & Greeff, 2012; Green, 2000; Lichtenthal et al., 2013). “For the person who experienced loss without forewarning, there is no situation that feels safe – loss can come again out of the blue” states Wijngaards-de Meij et al. in their 2005 study of predictors of grief after child death (p. 621). However, parents whose child died after a long battle with illness, or those who knew of the impending death beforehand, will also suffer the damaging effects of Anticipatory Grief, which brings a set of stress and somatic symptoms all its own (Greene Welch et al., 2012; Floyd et al., 2013; Tan et al., 2012).
Other Living Children

Bereaved parents with living children are shown to have better grief outcomes than those whose only child/children died. A long-term developmental study of bereaved parents’ adjustment to midlife after loss demonstrated “the presence of other children born either before or after the death was associated with resilience in terms of recovery” (Hunt & Greeff, 2012, p. 47). According to one mother in the study, having no living children made the death of her child “completely permanent and devastating and final” (Rogers, Floyd, Seltzer, Greenberg, & Hong, 2008, p. 208) because she grieves for her child, and her motherhood. Wijngaards-de Meij et al. (2005) believes this can be attributed to the biological need to have offspring that continue the legacy of the parent: “parents with many children have more means of passing on their genes than parents with few children or parents who lost their only child” (p. 621). They also have other outlets for parenting and bestowing love, where parents of an only child who died are also grieving the loss of their active parenthood, loss of future caregivers, loss of all dreams for family, and must completely re-define their identity and goals for the future (Floyd et al., 2013).

Treatment Methods for Traumatic Bereavement

There are many support and treatment methods for working with traumatically bereaved families. While it has become increasingly known that most people can recover from loss through the eventual reconstruction of their lives, traumatically bereaved families tend to have extreme difficulties doing so on their own (Dillenburger et al., 2006). This phenomenon brought about the emergence of a plethora of new interventions and methodologies for working with this population, but their actual effectiveness is not clearly known. Cacciatore and Flint (2012) recognize that “for decades, researchers have attempted to define a model for the treatment of the
traumatic bereavement that fully support not only the client, but also those working with [them] (p. 61).

Many models of treatment focus on “stages of grief” and completion of “tasks”, but the experience of grief is not confined to stages or tasks as it is not linear in nature, and always changing in appearance, symptomatology, and outcomes (Tan et al., 2012). Most treatments methodologies also do not specifically address the unique situation that led to the child’s death, and other important exclusive factors that can drastically impact the outcomes of bereavement and posttraumatic growth. Many of these strategies are also lacking in information on the involvement in social support. As such, many bereaved families report feeling unheard, unsupported, and even worse, shamed or criticized for their normal grief reactions (Barrera et al., 2007). Failure to allow the universal truths of grief and bereavement to guide the treatment goals is a major problem that needs to be revised for the benefit of the large masses of newly bereaved parents seeking care after the traumatic death of their child.

These are some of those strategies for understanding grief, and working with the bereaved.

**Grief Work in Psychoanalysis**

The ‘father of Psychotherapy’, Sigmund Freud, observed grief as a solitary process “whereby mourners withdrew from the world so that detachment from the deceased could be a gradual process” (Buglass, 2010, p. 44). He believed the function of grief was to psychologically release the person from his or her bond to the deceased, or as he called it, decathexis; namely, “relinquishing the bonds with the lost object” (Witztum, & Malkinson, 2009, p. 131). By looking over the past interactions with deceased, and reliving special moments with that person, and revisiting memories, this was accomplished. According to Freud, the goal of
“detaching from the deceased” was obtained by working through the loss, and overcoming the grief (Parkes, 2002). He called this process doing “grief work”. The emphasis was on “letting go of, or detaching from, the deceased to accommodate grief”, and he believed that upon “completion” of grief work, “the ego can become free and uninhibited again” (Parkes, 2002, p. 370). This theory is still debated among theorists (Buglass, 2010, p. 44).

**Issues**

Since Freud’s theories about grief were founded on his personal clinical experience with depressed individuals, his understanding of grief, bereavement, and loss may be limited in scope, and may not applicable to the general population. Interestingly, the key idea of “detachment” is very commonplace in western culture, who use the phrase “get over it” widely in response to death and grief (Cacciatore, 2015), and who prefer grief work to be done “behind the scenes”. Since his time, evidence-based studies have revealed no support for his ideas of relinquishing bonds with beloved deceased. Instead, time and again studies show the opposite, that continued bonds encourage healing (Niemeyer, 2002; Witztum & Malkinson, 2009).

**Stages of Death and Dying**

Elizabeth Kübler-Ross personally witnessed the death of over 200 terminally-ill patients who were previously informed of their impending mortality via fatal diagnosis. She used her personal observations to construct a set of “stages” that she detected in all her patients, which she described in her book, *On Death and Dying* (Kübler-Ross, 1969). These “stages of dying” are useful in understanding the way a person will process his or her impending death, but unfortunately have become misinterpreted to indicate the “stages of grief” (a misnomer) a person will experience after the death of a loved one, or a significant separation (Kübler-Ross, 1969).

The stages of death and dying, mislabeled as the five stages of grief:
Denial and isolation: Originally observed by Kübler-Ross as the individual’s inability to process the enormity of their impending death. This is the initial reaction to hearing that death is imminent. This, “No, not me”, denial reaction functions as a “buffer” which allows the person to “collect himself” and “mobilize other, less radical defenses” after the initial shock of devastating news. (Kübler-Ross, 1969, p. 31). Isolation refers to feeling alone in their path. Basically, ‘I don’t want to talk about it’. It can be conceptualized as a psychological retreat to tend to wounds.

Anger: The second stage is the anger response, which Kübler-Ross postulates is a component of every grief experience (Kübler-Ross, 1969). This is where the person fights against the diagnosis by lashing out in anger. It may be due in part to feelings of injustice and the longing of the ego to be immortal. This portion of the stages is hard for others to handle, as it tends to be “displaced in all directions and projected onto all environments at times almost at random” (Kübler-Ross, 1969, p. 50). Essentially, the person is “angry at the world” for their lot in life.

Bargaining: What follows anger is a desperate need to seek help from a higher power. This is called bargaining, and involves attempts to “change God’s mind”, based on “pacts” or “social contacts” with the higher power of his or her belief system. Based on childhood learning where positive behavior begets positive rewards (e.g. If I am good enough, God will not allow me to die). This stage presents after anger reactions fail to change the outcomes (Kübler-Ross, 1969).

Depression: “When the…patient can no longer deny his illness…his numbness or stoicism, his anger and rage will soon be replaced with a sense of great loss” (Kübler-Ross, 1969, p. 83). This is the depression stage. It involves the overwhelming sadness that enters when
fate become clear. No past attempts at denial, anger, or bargaining have changed the outcome, and the individual must now sort through the enormity of their heartache related to losing all that he or she values, including life itself. For those reasons, two types of depression are present during this stage: First, a great sorrow for all that has happened, and second, the anguish over impending death. (Kübler-Ross, 1969). Societal reactions to grief involve an ‘effort to cheer them up’, but “If he is allowed to express his sorrow he will find a final acceptance much easier, and he will be grateful to those who can sit with him [during this time] without constantly telling him not to be sad” (Kübler-Ross, 1969, p. 85).

**Acceptance:** The final stage of this process, where the individual stops struggling with death, and accepts the outcome. This is not a ‘happy stage’, but instead is “mostly devoid of emotion” as the person rests in preparation for the “final journey” (Kübler-Ross, 1969, p. 110).

**Issues**

Kübler-Ross never intended her theory to explain bereavement. It is based entirely on her personal experience with terminally ill patients, and represents the overarching themes of their experiences with coming to terms with dying. As she later explained in her subsequent book *On Grief and Grieving* (2005), she largely regretted writing her observations in the way she did, as so many people misconstrued them to be what is now commonly – yet mistakenly – known as ‘the stages of grief’. Although there are overlapping elements of the experience of facing personal mortality and living after the death of a loved one, it would be imprudent to apply this theory to grief and bereavement, due to the fundamental differences in normal human reactions. The consequence of applying this ‘template’ to bereavement is an assumption of linear movement after loss, a feature absent from bereavement and grief since the first time a person lost a loved one to death, to now (Barrera, et al., 2009).
The Six R Process of Mourning

Dr. Rando’s work as a clinical psychologist overseeing the care of individuals with terminal or chronic or life-threatening illnesses and their loved ones formed her theory of grief called The Six R Process of Mourning, first introduced in the book, *How to Go on Living When Someone You Love Dies* (Rando, 1991). Each process begins with an R-word, and falls within three distinct phases of mourning. She specifically delineates grief – the involuntary reaction to loss – and mourning – the ongoing, active process that results from loss (Rando, 1991). She also clarifies the point that while others have mistaken grief to fall into stages, thereby implying grief is “an orderly and unvarying process [in which] all people grieved in the same way on a static, unalterable course”, when in fact personal experiences with bereavement and grief are as individual as the person themselves, and “influenced by a variety of individual characteristics and psychological, social and physical factors” (Rando, 1991, p. 20)

**Phase I -- Avoidance.** The initial shock of loss and feelings of denial and disbelief, where the survivor has an overwhelming desire to avoid the horrible reality that their loved one has died. “Just as the human body goes into shock after a large enough psychical trauma, so too does the human psyche go into shock when confronted with such an important loss. It is the natural reaction the impact of such a blow” (Rando, 1991, p. 20). The therapeutic goal during this phase is to **Recognize the loss**: Acknowledging and working to understand that death has occurred.

**Phase II – Confrontation.** Highly-charged emotions which result from relearning over and again that your loved one is gone; the most acute and intense portion of grief (Rando, 1991). During this phase, the survivor will **React to the separation**: experience the pain of separation in a real and intense way. “Each pang of grief, each stab of pain you feel whenever your
expectation or desire or need to be with that person is unfulfilled, ‘teaches’ you again that your loved one is no longer here” (Rando, 1991, p. 22) and extreme emotional reactions follow. The therapeutic goals of this phase is identifying, feeling, accepting and expressing natural reactions to the loss, as well as identifying and reacting to all secondary losses. Then, he or she must **Recollect and re-experience** the loss by realistically reviewing the relationship with the deceased, remembering him or her, and re-experiencing the feelings that come up during this process. Finally, he or she should begin to **Relinquish old attachments** by letting go of the old assumptive world, and facing the new world where the loved one is absent (Rando, 1991, pp. 21-22).

**Phase III – Accommodation.** The gradual decline of the acute grief of the Confrontation stage, and “the beginning of an emotional and social reentry into the everyday world in which you learn to live with your loss” (Rando, 1991, p. 19). The understanding that survival is possible, including acknowledgement of being “forever changed” (p. 23). During this stage, the survivor will **Readjust** by moving adaptively into a new assumptive world, without losing the experience and memories of the old, and by developing a new version of a relationship with the loved one who died, while adopting a new identity and way of living. He or she will then begin to **Reinvest** by expending emotional energy and time into new people, and goals for the remainder of life without the deceased.

**Issues**

Rando’s work is all-encompassing. Her theory can be applied to many different bereavement experiences with little complication. However, as she states, every instance of grief is inherently unique due to the vast array of specific circumstances present in a bereaved person’s specific loss (Rando, 1991) therefore, while the goals of relearning to live in a world
where the loved one is no longer present is the goal for all bereaved individuals, the process and manner in which this goal is achieved may vary.

**ATTEND**

According to Cacciatore’s case study, **ATTEND**: Towards a mindfulness-based bereavement care model, “the impact of traumatic deaths…are far reaching…violate the natural order, [and] forc[e] the survivor to face unique challenges that resonate in the [psychological, physiological, and psychosocial] realms” (Cacciatore & Flint, 2012, pp. 61-62). She states that, due to the traumatic nature of a death of a child, any clinician working with this population should make it a priority to develop an understanding of the impact of such trauma on the client, their therapeutic relationship, and on the situation, as a whole (Cacciatore & Flint, 2012). In her model, she recommends that clinicians provide “effective psychosocial care that is mindful, humble, and nuanced”, which has the “capacity to abate human suffering”, focus on “(a). Clinical research and experience, (b) patient concerns and well-being, and (c) best practice.” (2012, p. 63).

She attests that while there is a lack in literature on this “mindfulness-based bereavement care (MBC)”, several researchers have suggested that this type of “compassionate, mindful presence in the midst of the traumatic loss helps moderate long-term, negative psychiatric sequelae for both providers and clients” (Cacciatore & Flint, 2012, p. 63)


**Attunement**: Places the emphasis on empathy, self-awareness, responsiveness, and mindfulness. Using practices such as deep self-awareness, prayer/meditation, stress-reducing
activities, and altruism, the provider is enhanced in his or her ability to express compassion and empathy, despite the painful stimuli of traumatic death work. “Although being an attuned provider does not ‘diminish the enormity’ of the suffering…it does create a greater capacity to hold and tolerate emotional pain” and may illicit posttraumatic growth, affect tolerance, and resilience (Cacciatore & Flint, 2012, p. 65).

Trust: Accomplished in therapeutic relationships via compassionate communication with a mindful element. Trust creates a “positive feedback loop” where the patient feels “heard” as demonstrated by ‘a mindful awareness of personal space, compassionate facial expressions, touch and posture, eye contact, and voice intonation” (Cacciatore & Flint, 2012, p. 66).

Touch: Despite being often seen as imprudent by some providers, there is no more appropriate time for a compassionate gesture such as a hand placed on a neutral location -- such as the shoulder or arm, hand or back -- than when a family is facing the impact of their child’s traumatic death. Touch can reduce stress and improve therapeutic intimacy, particularly when used within the confines of “a [safe] trusting relationship that is sensitive to cultural idiosyncrasies” (Cacciatore & Flint, 2012, p. 66).

Egalitarianism: The relationship between provider and patient, based on humility, which balances the power between the two, resulting in “shared, informed decisions about medical procedures, end-of-life care, and death rituals” (Cacciatore & Flint, 2012, p. 66). This type of relationship requires fully-collaborative communication where the family is not pressured, their desires are not made out of fear, and always have priority.

Nuance: Instead of strict adherence to protocol, the practitioner accounts for the cultural differences and unique individuality of the client. Nuanced care “eschews arrogance and assumptions” and is universally appropriate as a tool as it places emphasis on “personalization
and adaptability”, tailoring care to the unique individuals and needs of the situation (Cacciatore & Flint, 2012, p. 67).

**Death education:** The actual psychoeducation from provider to the family, at the times of diagnosis or death, and throughout the course of care, dependent on current needs. The goal of which being fully present and aware of options that may impact outcomes.

**Issues**

The main issues with this theory is a lack of empirical evidence for posttraumatic growth within the context of Mindfulness-based Bereavement Care (MBC), despite “sufficient anecdotal date to warrant… exploration” (Cacciatore & Flint, 2012, p. 76). Just as mindfulness care has been documented to decrease depressive symptoms, elevate self-esteem, and enrich spiritual relationships, it could be ostensibly applied to traumatic bereavement, as these elements play roles in traumatic outcomes.

Many providers are strict in their rigidity to adhere to formal processes for care. This non-fluidity may be an impediment to application of this model of care. For that reason, many clinicians may not initially see the usefulness of this care model, devoid of timelines, stages, or strict goals. Thus, it falls to the bereaved family to seek out clinicians trained in this care model.

This model “represents a paradigm shift” in care for the traumatically bereaved families whose child died. It “offers hope to patients and providers suffering the inevitable and unavoidable experience of death that unites us all” (Cacciatore & Flint, 2012, p. 78). It may be seen as radical, but offers much in compassion, support, healing, and formation of new life, post loss.
Effective Therapeutic Support Techniques

As is widely known, parental bereavement has a large set of unique characteristics that make grief particularly hard to resolve. This group produces the highest intensities of bereavement, as well as the widest range of grief reactions, including somatic reactions, depression, anger, guilt and despair than others grieving the loss of a spouse or parent (Rando, 1985). For these reasons, supporting a bereaved parent has challenges that demand a highly-trained and skilled clinician. And while there is no one complete set of strategies for supporting the traumatically bereaved (Wijngaards-de Meij et al., 2005), as the “highly interconnected psychological, physiological, and psychosocial facets of treatment prove to be quite complicated at times” (Cacciator & Flint, 2012, p. 62), there are some well-documented techniques with positive outcomes (Gear, 2014). The following are support techniques that can be applied to most interventions with bereaved parents, with high success rates, and can be used by any support person encountering a bereaved parent. It cannot be overstated that any person interacting therapeutically with the bereaved should work diligently to understand the unique situation of losing a child to death, and should make thorough efforts to become trained in the care of this distinct population, because “without an understanding of these special dynamics, the clinician will often misapply techniques, sustain inappropriate treatment expectations, or possibly miss valuable opportunities for intervention leading to the successful resolution of [acute] grief” (Rando, 1985. p. 22).

Listening and Supporting

Most often, bereaved parents simply want to be heard. They want their child to be remembered and missed. They want to know they are not grieving ‘wrong’. As a support person to a bereaved parent, often the best thing to do is simply listen and affirm. Many parents express
that “the opportunity to talk about their grief and the deceased child [is] helpful.” (Barrera et al., 2009, p. 503).

Supporting the bereaved parent involves staying present as they process grief and re-learn how to live without their child, with no set time limits (Gear, 2014). Parkes (2002) suggests the care-model of Eric Lindemann, where “the essential task of the [clinician] is that of sharing the patient’s grief work” (p. 370), or coming alongside them as they process the enormity of their loss. Unfortunately, human response to grief in others tends to be abandonment, avoidance, and disregarding feelings (Rando, 1985). Even within the medical community it is widely accepted that a clinician should “respond to suffering with objectivity and detachment”, despite no empirical evidence supporting this tactic of stoicism (Cacciatore & Flint, 2012, p. 63). Most bereaved parents are faced with expulsion from social and family support after loss. Many report feelings of “abandonment, helplessness, and frustration in dealing with other parents after the death of their child” (Rando, 1985, p. 20). They are frequently met with aversion or anger outburst as they do their grief work, as most people refuse to face the reality that child-mortality is a fact of life that cannot be avoided.

As Witztum and Malkinson (2009) state in their study of traumatic grief and loss, society has a “conspiracy of silence” based on the need to remain in functional denial of childhood death (p.130). Adopting an avoidance strategy for dealing with bereaved parents allow others to remain in a state of perceived control over the health and well-being of themselves and their loved ones (Witztum & Malkinson, 2009). Other parents’ anxiety over facing the possibility of their own child’s death is simply too much to process, and bereaved families often end up socially outcast. This loss of social support is especially damaging as social support is a known factor in healing (Goodkin, 2006; Parkes, 2002). Remaining present and supportive as the
bereaved parent grieves provides the safe space he or she needs to do the hard work of integrating loss into daily functioning. As Bissler (2005) says in her study of effective healing techniques for bereaved parents, the bereaved parent’s “support systems help [them] to assimilate the loss”, but should be carefully chosen because not all are up to the task of being present under such trying circumstances (p. 129). The goal of therapeutic intervention should be compassionate and skilled care, because “effective psychosocial care that is mindful, humble, and nuanced has the capacity to abate human suffering” (Cacciatore & Flint, 2012, p. 63) and mindful attendance with compassion amid traumatic loss helps moderate long-term, negative outcomes for all involved in treatment (Rushton, Sellers, Heller, Spring, Dossey, & Halifax, 2009; Walsh, 2007).

Allowing Grief Responses

Grief demands to be felt. Allowing the parent to feel and express all of their personal grief reactions is best for positive outcomes over time (Cacciatore & Flint, 2012; Gear, 2014). Encouraging the normal and healthy expression of grief is important to the processing of the monumental loss they experienced. It is imperative not to suggest they ‘stop grieving’, ‘let go’, or ‘move on’. Instead, simply sit and allow grief to do its work (Worden, 2009). “Bereavement workers are increasingly coming to realize [that] for parents their grief is their link to the child, grief is what keeps them connected” (Mitchell, Stephenson, Cadell, & MacDonald, 2012, p. 428), therefore, the natural expression of grief should never be denied, as the implication would be that the connection to the child must be relinquished.

As all parents experience grief differently, it would be impossible to dictate how he or she ‘should’ be grieving (Bogensperger & Lueger-Schuster, 2014). “Considering the many factors influencing parental bereavement, substantial variability has been identified with respect
to parents’ responses to loss and their subsequent outcomes, both within overall functioning as well as regarding specific aspects of parents’ lives post-loss” (Barrera et al., 2009, p. 499). Allowing individual grief responses will provide the best possible outcomes and foster a healing therapeutic relationship (Gear, 2014). Clinicians should, therefore, “address this [grieving] process with an open mind, given the individuality of every loss experience” (Bogensperger & Lueger-Schuster, 2014, p. 8).

**Remembering and Redefining the Relationship**

Just as the greatest fear of a parent is the death of a child, the greatest fear of a bereaved parent is that the child will be forgotten. Honoring the life of the child is the best gift to offer a bereaved parent. Simply saying the child’s name, looking at photos, or sharing stories of the child’s life can change the course of the parent’s healing and grief process. In the same way that parents like to share about their children and their accomplishments, so do bereaved parents want to share about the child who died (Barrera et al., 2009). Remembering allows the parent to identify their child’s unique characteristics, to remain in an active parenting role to the child, to provide hope, a sense of peace, and reassurance amid the mired of grief reactions, and to better manage daily functioning (Sormanti & August, 1997).

Many families of deceased children report an ongoing after-death connection with their child (Sormanti & August, 1997), which may include dreams of the child as he or she would be in time presently and, visions or signs. Allowing the parents to share these connections, without reprimand or discouragement, is useful in creating a safe space for their treatment. As Sormanti and August (1997) found after questioning bereaved parents about spiritual connections with their children, “with very few exceptions, the parents who experienced continued connection to their dead child derived psychological benefits from the connection” (p. 468). Similarly stated
by Barrera et al. (2009), “Contrary to earlier views, parents’ ability to maintain a continued bond with their deceased child and integrate this memory into a different socially-shared reality is now considered central to parental bereavement and adjustment” (p. 499).

Empirical studies have shown that the spiritual/inner relationship with a beloved dead child may continue throughout the parent’s lifetime, contrary to a former belief that breaking bond with the deceased was necessary for healing, which has been categorically disproven by evidence-based studies (Witztum, & Malkinson, 2009). Therefore, “if death does not end a relationship, then the quality of the ongoing relationship one has with a lost loved one can be seen as highly significant to how a person copes with loss” (Balk, 2012, p. 960).

Bereaved families will often maintain the newly defined relationship with the deceased child with them throughout the remainder of their lives (Mitchell et al., 2012; Gear, 2014). “Deceased children are parented and nurtured, encouraged to interact with other death children, and attract the communication of people whom they never met in their lifetimes” (Mitchell et al., 2012, p. 428) via online memories, such as pages on Facebook or other online resources dedicated to this goal, or in person assemblages such as memorial walks, etc. They may also include their child in daily activities, display photographs/personal effects in their homes, and use his or her name in normal conversation. All these things, and others, are typical responses to parental bereavement, and should be seen as useful, not detrimental, to healing (Lichtenthal, Currier, Neimeyer, & Keesee, 2010).

**Adlerian Perspectives**

Adlerian concepts are useful in understanding grief and loss and supporting individuals, couples, and families who suffered the death of a child, but there is limited research on the Adlerian perspective of bereavement at this time. Despite this lack of research-based
information, it is possible to understand grief through the lens of Adlerian theory. This section examines those areas of Adlerian theory that apply to grief, bereavement, trauma, and coping with loss.

**Individual Psychology**

Adlerian Psychology is also known as Individual Psychology. Treating each individual holistically is useful in working with bereaved families, as grief experiences are very personal and individualized based on many life factors. Even when grieving the death of the same child, each person will react in a manner unique to his or her individual biological, psychological, and sociological make-up. Alfred Adler (Adler, 1927) wrote of understanding individuals beginning with their soul, based on their “Psychic Life”. Because the death of a child is a loss on a soul-level, this would be a useful tactic for exploring grief reactions in bereaved parents as individuals, or holistic beings. As he explains, “[T]he living organism responds according to the situation in which it finds itself” (1927, p. 18). Therefore, when considering grief responses, the soul-level response to the death of a child (i.e. the painful situation in which one finds him/herself) is agony, confusion, and the desire to move away from the condition of normal human reactions to loss. This movement is their goal directedness, Adler’s term for movement from an uncomfortable situation to one more serving of a person’s goal. Understanding the unique attributes and goals of the individual may guide the support of bereaved parents as all grief reactions are person-specific (i.e. individual).

**Lifestyle and Goal Directedness**

Every individual has an ever-present goal or set of goals that determines all of his or her behavior (Adler, 1927). The formation of these goals and the broader understanding of the world are his or her Lifestyle, and provide the foundation for all thinking and behavior, including the
formation of their goals. The Fictive Goal may always be in flux, yet it will be the unconscious guide for all behavior and longings. Understanding these goals will guide the understanding of all his or her behavior, yet these goals are often hard to uncover, and may be masked by short-term goals (or compulsions) that interfere with understanding the underlying ever-present goal. An individual’s movement through life and in nature will undoubtedly -- at times -- resemble unchangeable laws (p. 21), but should always be understood in the context of fluidity. “[I]f a man, for example, denies his relationships to society and fights them, or refuses to adapt himself to facts of life, then all these seeming laws are abrogated and a new law steps in which is determined by the new goal” (1927, p. 21).

In the context of loss then, each individual’s lifestyle and goals will determine his or her individual reaction to the loss (Hartshorne, 2003). Furthermore, as the rules of governing laws are either confirmed or offended instantaneously with the child’s death, so may the parent create new goals and movements in life. These new goals will be based on the new reality he or she finds him or herself in, especially when the former goals no longer meet his or her “wishes which promises both security and adaptation to life” (p. 24). The former Fictive Goal may be in conflict with actual circumstances, resulting in a complete change in self. For even as “upon these foundations [the fundamental factors which influence the soul] a super-structure is built”, after such a traumatic loss, “it may be modified, influenced, transformed” (Adler, 1927, p. 23).

Private Logic and Mistaken Beliefs

As very young babies, our goal-directed striving begins based on “those influences and those impressions which the environment gives to the child” (Adler, 1927, p. 23). “The fundamental factors which influence the soul life are fixed at the time when the child is still an infant” (p. 26), but can grow and develop as the environment does as well. Each individual will
develop his or her own private logic to explain the interworkings of life and society, based on the lifelong “necessity of solving the problems which constantly arise” (p. 26). This set of guiding principles plays into the primary goals, and directs the individual in decision making.

One such aspect of private logic may involve the natural order of life, i.e., birth, life, death, or parents dying before their children. When confronted with the harsh reality that death can and does occur at any stage of life, private logic is shaken, and must be re-defined. The parent takes the mistaken belief that love, care, attentive parenting, and other controllable functions can prevent child death, views it through the lens of natural law and reality, and re-forms their private logic of how life and death function. The private logic of superiority could also be present, where the individual believes “I do not deserve to have lost this individual. People as superior as I should not have this happen to them” (Hartshorne, 2003, p. 149), a common belief after the death of a child.

For all individuals, “man, as seen from the standpoint of nature, is an inferior organism [e.g. susceptible to death and loss]. This feeling of his inferiority and insecurity in constantly present in his consciousness [and] acts as an ever-present stimulus to the discovery of a better way and finer technique in adapting himself to nature” (Adler, 1927, p. 29). In the context of grief, the weight of inferiority based on the inability to ‘protect’ their child and themselves from death, leads to deep feelings of anger and regret, which lay waste to any former sense of superiority gained from previous movements in life. This damage will last for a long time, but eventually result in the need to begin striving for mastery over death and grief once again, in the form of healing, because, as Adler noted, “Every voluntary act begins with a feeling of inadequacy, whose resolution proceeds towards a condition of satisfaction, of repose, and totality
Therefore, the very feeling of inadequacy that arises from bereavement, will also play a role in healing.

**Social Interest and Life Tasks**

All individuals are a part of a larger society and all of “what we call justice and righteousness, and consider most valuable in the human character, is essentially nothing more than fulfillment of the conditions which arise in the social necessity of mankind” (Adler, 1927, p. 32). Connecting to this society, and fitting in to the social necessities and conditions is a need of all mankind. “Everyone must feel himself bound to his fellow man” (p. 33); it is a fundamental need to be socially connected. The *Gemeinschaftsgefühl,* or social feeling of an individual is his or her sense of connection to the society in which he or she resides, the community. As each individual strives for mastery over certain aspects of life, or ‘tasks’, individuals can join together to provide social feelings of connectedness, or social support.

Commonly, when a child dies, this connection to social support, and society as a whole, can dwindle, and the bereaved parents are left in isolation as they grieve. This may be by ‘force’, when the community leave the bereaved parent behind, or by choice, when the bereaved parent no longer feels a willingness to participate or belong in a world full of families whose child did not die. This lack of social support leaves most individuals feelings depressed and outcast (Bolton et al., 2013). As many studies have shown the importance of social support after loss (Bolton et al., 2013; Thienprayoon, Campbell, & Winick, 2015; Dyregrov, 2003), the lack thereof is vastly detrimental to the bereaved individual. Reconnecting to their social feeling, after time and work to integrate loss into their newly formed life goals is underway, will provide useful movement towards healing, and the social support needed to reinvest in life via the life tasks required by society where each individual must “be productive (work), get along
(friendship, and form bonds (love)” (Hartshorne, 2003, p. 147), all of which will be greatly impacted by the death of their child.

**Implications**

Based on the unique traits of this special population, any person attempting to interact therapeutically with bereaved parents should be specifically educated on the current methods of treatment and support for individuals, couples, and families after the death of a child. It is both reckless and imprudent to do otherwise, as the consequences of an uneducated attempt at grief counseling can be harmful for the bereaved parents and can lead to further stress. It may also irreparably damage any possible therapeutic relationship that might be established.

Instead, a trained grief counselor will understand the unique and nuanced elements of the lifelong grief resulting from the death of a child, and will be equipped to support these families in their deepest time of need. He or she will come alongside these families or individuals as they process the enormity of this loss, explore the ever changing terrain of new and overwhelming emotions, re-define their worldviews and interpersonal relationships, and rebuild a life without their child.

This counselor will let go of any and all pre-conceived notions of ‘timelines’ or ‘limits’ on grief. He or she will not impose any ‘stages’ or ‘levels’ that ‘should’ be achieved, but instead focus on supporting the bereaved parent right where he or she is at that point in time. This counselor will provide informed death education, attuned support, and useful healing techniques that focus on the unique needs of each individual seeking support (Cacciatore & Flint, 2012).

A skilled helper of bereaved families will recognize that while there are overlapping tendencies and predictable reactions in parental bereavement, grief reactions can also vary widely from person to person, based on a large variety of individual factors that are known to
influence grief outcomes (Rando, 1985; Goodkin, 2006; Keesee et al., 2008). Even two or more individuals reacting to the same child’s death may have differing experiences and reactions to the loss (Wijngaards de Maij et al., 2005).

This clinician will understand there is no set rules for how grief must be expressed, other than in a non-self-injurious manner. He or she will know that wishing to die is a common reaction among bereaved families, but that wish can be expressed as part of processing the loss without actual resolve to commit suicide (Alam et al., 2012). Any suicidal ideation should be explored for intent, just as in all other cases of high-risk populations (Tal Young et al., 2012).

This clinician will know that healing from the death of a child can be a lifelong task and will acknowledge there will be times of what can be misconstrued as “set-backs” along the way. These moments of extreme reaction should be seen as normal and allowed to happen in a safe environment without judgment or retaliation.

A grief therapist will know that a grief-related diagnosis should be used only in the most unique and rare cases, when there is truly a need to provide a psychological diagnosis. She or he will know that by far, the vast majority of grief cases – 80-90% (Tal Young et al., 2012, p. 179) – will not necessitate a diagnosis of Complicated Grief, or Prolonged Complicated Grief Disorder, or any other variation of this diagnosis that involves timely resolution of grief, because grief is a widely variable reaction that requires significantly more time than six months to even begin processing, let alone ‘resolve’ grief. Simultaneously, he or she will also be mindful when prescribing or suggesting medication as a tool for grief care, as grief needs to be felt to process and heal (Rando, 1985). Only in cases where grief is far beyond normal human reactions to loss should it even be considered, and then judiciously prescribed (Rando, 1985).
The effective clinician will allow bereaved families to remember their child in any manner that family finds meaningful (Lichtenthal et al., 2013). This may include talking openly about the child; speaking his or her name often; telling stories of his or her life; displaying memorial items in a shrine-type setting throughout their home; leaving up their child’s room, toys, awards, etc. for an undetermined time; touching, sleeping with, wearing, carrying their child’s things; participating in memorial walks or events; connecting online with other bereaved families; and any other activity that family feels useful to healing and remembering (Bissler, 2005; Gear, 2012).

Clinicians will never imply or state outright that a bereaved family needs to ‘let go’ or ‘move on’ or ‘stop being stuck’. He or she will instead remain supportive as the parents navigate this uncharted territory, despite the amount of time it takes to learn how to live again after this loss. Even when it may seem they are getting worse instead of better, the clinician will remain sympathetic, as he or she understands this a normal experience for many, if not all, bereaved families. At all times the helper should remember that it may take a minimum of 18 months for bereaved parents to begin to heal (Alam et al., 2012).

Similarly, this helper should never imply that the death of the child was ‘meant to be’, ‘God’s plan’, or any other form of statement meant to assign responsibility (Bogensperger & Lueger-Schuster, 2014). It is far better to always allow only the family to come to any conclusions they may have about ‘why’ this happened, or to accept the idea that it may simply be a senseless loss.

This clinician will also understand that the presence or absence of other living children does impact the outcomes of grief for bereaved families (Hunt & Greeff, 2012), and will use that knowledge to interact with the parents in a supportive way. She or he will never say ‘you need to
focus on your living children’, or imply they should ‘just have another baby’ as this is mostly seen as an attempt to undermine the importance of their child’s loss, and will not be a helpful technique for support. As most bereaved families with living children will describe, the lives of other children do not make up for the loss of the beloved child who died, for children are not interchangeable or replaceable.

Finally, clinicians will understand the value of the child who died to the bereaved family, and will make every effort to demonstrate that knowledge to the family through the use of the child’s name, remembering important aspects of his or her life and story, complimenting photos, engaging with memories, and never undermining the enormity of their death and loss (Rando, 1991).

**Future Research**

The death of a child is a tragedy that simply cannot be fully understood until it has been experienced personally. Therefore, it can be problematic for clinicians to accurately define, study, and analyze this experience in its entirety, unless that clinician has the unfortunate experience of living without his or her child after death. There simply are not the words to fully describe the pain and suffering a bereaved parent feels, or the always present longing that can be felt for the remainder of that parent’s life. With that being said however, clinicians have been making strides to understand -- in their limited capacity -- the reality of experiences, the special needs of this population, and create meaningful tools for supporting them.

As there is practically no research using Adlerian techniques to address grief, trauma, and healing after loss, future research is needed to understand how concepts such a Lifestyle, Encouragement, and Social Interest may impact bereavement and grief processing. Exploring
how Mistaken Beliefs may influence healing would also be a useful study. Social Interest as a healing technique may develop useful tools for clinicians and bereaved parents alike.

One aspect of grief and bereavement not fully explored is social expectations and normal grief reactions. Exploring how society has been educated on expected grief reactions, the process of bereavement, and the reality of living after loss of a meaningful person may indicate the problematic condition of societal ignorance on matters of normal grief reactions. Better social education would most likely improve the positive outcomes for the bereaved population.

Another possible area of research would be regarding the level of training clinicians receive concerning death, trauma, grief, bereavement, and healing. A possible hypothesis would be that higher levels of focused training on normal grief reactions would bring about more patient satisfaction, a stronger therapeutic connection, and more positive outcomes for both patient and clinician.

Finally, due the controversial nature of the diagnosis, a longitudinal study of the effects of a Complicated Grief diagnosis on grief outcomes would be beneficial in understanding why applying labels to the traumatically bereaved may be more damaging than useful, and how an open and supportive therapeutic environment without timelines or judgement will most likely produce the best possible outcomes.

Conclusion

Supporting a parent whose child died is challenging. Grief can be hard to understand and taxing to witness. Sincere efforts to understand the unique pain a bereaved parent is feeling, and doing the important work of supporting that parent as he or she re-learns to live again does make a difference. And for the parent learning to live without their beloved child, finding ways to honor and remember their child, while adjusting to life without them will be the hardest
challenge of their life, but it is possible to find meaning and healing without their child, all while bringing the precious memories of their life with them.
References


