

2003

## Group therapy for bereaved parents : sudden death of a child or adolescent

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### Recommended Citation

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### Abstract

This article reviews parental bereavement through sudden loss of a child by · homicidal, suicidal, or accidental death. It advocates for the Dual Process Model of grieving, and explores group therapy treatment for bereaved parents. This paper contends that parental loss of a child is more intense and traumatic than any other type of loss. Evidence is also provided to state that traumatic grievers benefit from group therapy as opposed to other types of grievers. Meaning reconstruction is established as a key element in the grief process. Overall, the article allows counselors to understand the complications involved in working with bereaved parents and provides a framework for group therapy.

GROUP THERAPY FOR BEREAVED PARENTS: SUDDEN DEATH OF A  
CHILD OR ADOLESCENT

A Research Paper

Presented to

The Department of Educational Leadership, Counseling,  
And Postsecondary Education  
University of Northern Iowa

In Partial Fulfillment  
of the Requirements for the Degree  
Master of Arts

By

Jessica L. Heidecker

May 2003

This Research Paper by: Jessica Heidecker

Entitled: GROUP THERAPY FOR BEREAVED PARENTS: SUDDEN LOSS OF A  
CHILD OR ADOLESCENT

has been approved as meeting the research paper requirements for the Degree of Master  
of Arts.

03/20/2003

Date Approved

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4.1.03

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This article reviews parental bereavement through sudden loss of a child by homicidal, suicidal, or accidental death. It advocates for the Dual Process Model of grieving, and explores group therapy treatment for bereaved parents. This paper contends that parental loss of a child is more intense and traumatic than any other type of loss. Evidence is also provided to state that traumatic griever benefit from group therapy as opposed to other types of griever. Meaning reconstruction is established as a key element in the grief process. Overall, the article allows counselors to understand the complications involved in working with bereaved parents and provides a framework for group therapy.

Running head: PARENTAL BEREAVEMENT

**Group Therapy for Bereaved Parents: Sudden  
Death Of A Child or Adolescent**

**By Jessica Heidecker**

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**May 2003**

## Group Therapy for Bereaved Parents: Sudden Death of A Child or Adolescent

Loss of a child is a far different experience and often far more detrimental to a parent's ability to cope than other kinds of loss. Not only is parental loss of a child distinct from other losses, different types of parental loss such as homicide, suicide, or accident are experienced differently from each other. Counselors must understand the uniqueness between the three types of parental loss, homicide, suicide, and accident, in order to determine the most appropriate approach in helping these individuals. The purpose of this research paper is for counselors to be aware of differences in loss of a child, to understand why some parents may have different reactions to loss, and encourage counselors to understand an appropriate grief model. Specifically this research paper advocates for the Dual Process Model of grieving and explicitly examines group therapy treatment for parent's whom are traumatized by the loss of their child or adolescent.

To extensively research parental bereavement, this author deems it imperative to illustrate specific cases and describe personal narratives of loss. For example, "For weeks after Mary died, I was still in somewhat of a daze... I kept thinking all of this was a bad dream... I think this was the body's way of not hitting us full force." "It was so painful to get up... you just couldn't understand, it was something you just couldn't understand... your whole body is in pain... not just your heart." These words seem limit the intensity of anguish experienced by

bereaved parents. The quotes are just a few excerpts from bereaved parents and their explanation of “At first (When your child is suddenly gone).” Ann K. Finkbeiner (1996) lost her own child and wrote the book *After the Death of a Child*, in which the excerpts are cited. The book includes stories of bereavement through the years, and in a sense, was a way for Ann to cope with her own loss. She wanted answers, researched, wrote, and concluded that recovery does not exist, at least not from her vantage points. Each bereavement experience is different yet counselors seek out a framework to guide them in working with such clientele. The narratives and examples throughout this paper will aide in helping counselors understand unique differences and dismiss the need for a “cookie-cutter” grief counseling set of stages.

Ann Finkbeiner’s conclusion that traditional recovery does not exist will be stressed and supported by this author by advocating for the dual-process model of bereavement (Stroebe & Schut, 1999) and by examining meaning reconstruction for parents who have lost a child suddenly. At the same time this paper will allow counselors to understand the general dynamics of sudden loss of a child and elaborate on group treatment deemed most appropriate through research, and often used in counseling bereaved parents.

### Types of Sudden Death

There are two things that a counselor must first understand. First, parental loss is different from other forms of grief and second there are different forms of



sudden parental bereavement. Fletcher (2002) studied bereaved individuals from past support groups and concluded that families who have lost a child have a more complex bereavement than individuals suffering from other losses. Although all forms of parental bereavement share many emotions, the parental grief has tremendous complications ranging from guilt to hostility. Moreover, the parental grief of a child or adolescent that dies from a homicide is far different from than loss from a suicide or accidental death. All three different experiences, homicide, suicide, and accident, have been examined and compared to each other in order to clarify how unique the experiences can be. Understanding different types of death force counselor's to examine the inimitability of each case that is presented to them. It also encourages counselor awareness and deters them from overlooking the complexity involved in parental bereavement and sudden death. The three types of sudden parental loss of a child that are examined include homicidal, suicidal, and accidental death.

### *Homicide*

According to Conrad (1998), the emotions of murdered-child grief take on more complex dimensions as opposed to other losses. Some of the emotions that are core to the grief process, yet are more complex due to the nature of the death (homicide) are shock, fear, anger, resentment, helplessness, and meaninglessness. Bereavement of a murdered child is not limited to these emotions; other emotions are also equivocally present such as betrayal, deprivation, despair, distrust,

anguish, disbelief, and rage. The research contends that these individuals experience intense emotions repeatedly as opposed to experiencing certain feelings in a sequential manner like stage models of grief suggest. For example, a bereaved parent may first experience intense anger or guilt initially, at some point experience acceptance in the grieving process, however may return to painful emotions such as guilt, perhaps guilt for accepting the loss.

Although most types of mourners experience shock after the death of their child, the shock is often complicated for parents when their child has been killed in a malicious act of murder. There are two reasons for such complications. First, the suddenness of the death alone intensifies shock. Second, shock is also convoluted by the parent's assumptions that the murderer believed that they had a "right" to take the child's life and that the murderer's rights outweighed the child's rights. The suddenness of the death coupled with the assumption and thought of "how dare they?" intensify shock for the parents of a murdered child and must not be overlooked by counselors as they work with such these parents (Conrad, 1998).

Fear is another emotion complicated by murdered-death compared to the fear experienced by other forms of grief. Conrad (1998) explains intense fantasies that follow the murder such as "killing the killer". One woman had such murderous fantasies after an unidentified male shot her nineteen-year-old daughter in the head. She came to realize that these thoughts were a natural by-

product of her rage in this grief process. They allowed her to vent her rage silently. She understood that if she had the chance to kill him, she would not follow through, because it would not bring her daughter back, it would hurt her family members even more, and it would have made her as depraved as the murderer.

These fantasies often leave the family members in fear that they are “no longer decent persons” or they are left “terrified by their evil thoughts” (Conrad, 1998, p. 40). Klass (1988), discussed how parents of murdered children are overwhelmed with anger and the need for revenge, which is often acted out in their thoughts. “The parent’s power to protect their child has been challenged and they wish to reassert that power by diminishing the power of the killer through an act of vengeance” (Klass, 1988 p. 126).

During any grief process anger is typically experienced (Becvar, 2001; Conrad, 1998; Drenovsky, 1994; Freeman & Ward, 1998). This anger is often directed at others such as in accidental deaths, however with murdered children there is also anger towards oneself as parent. Conrad (1998) explains that parents may blame themselves for not detecting the danger in advance. For example, a mother lost her two-year old daughter when the woman’s ex-husband murdered her. The cause of death was asphyxiation and the mother explained, “It took a long time to stop blaming myself or saying, What if...” Freeman and Ward (1998) states, “Usually the individual is confused by the intensity of the anger, seeing it

as inappropriate, but feels unable to defuse it” (p. 219). Hand in hand with anger, resentment also trails the parent of a murdered child. With the suddenness of such deaths, parents are left unable to say goodbye to their children. Resentment may also form against other bereaved parents that had the opportunity to say goodbye to their children. The sudden nature of the death deprived them of comforting their child in their last moments. These experiences need to be examined through the duration of counseling.

Helplessness and meaninglessness are also uniquely experienced for parents of murdered children. Helplessness is intensified by the unnaturalness and the suddenness of the child’s death. They have no time to protect their child. Moreover, the helplessness is exaggerated by the knowledge that their child’s life is taken away, while the murderer often still has the gift of life. Along with feeling helpless, meaninglessness is a powerful emotion experienced by these parents because their purpose in life as mentors and guides to their child has been utterly destroyed. These parent’s not only lose a loved companion, they also lose their mission in life to teach and advise their child (Conrad, 1998).

One woman’s seventeen-year-old child was killed from a shot in the back of the head. After the death of her child, she devoted her life to helping families of murder victims. This woman’s words illustrate the uniqueness of homicidal grief. She stated, “Based on my knowledge, I do know that the mere thought that

someone else made the choice to end our loved one's life makes grief by homicide very different from any other type of death" (Conrad, 1998, p. 43).

### *Suicide*

"Death by suicide leads to yet another situation in which the pain of the loss confounded by a mixture of emotions experienced in response to the circumstances of the death" (Becvar, 2001, p. 54). Along with core emotions of grief such as sadness, anger, and fear, parents that experience a child's suicide may specifically experience emotions such as puzzlement, resentment (toward the child), rejection, guilt, and shame (Becvar, 2001) (Bolton, 1986). Becvar (2001) notes that each suicide must be taken as a unique experience with unique emotions attached. For example, the suicide often leads to bewilderment or puzzled feelings because reasons for the death are undetermined. Suicide notes do not provide the answers that are sought during the aftermath of such a death. Puzzlement is also experienced with the question: "Why me?" The spiritual components to this answer are unique, which can aid or deter the grief process depending on personal beliefs.

"It must be my fault...I have failed my son...I should have been able to see the signs" (Bolton, 1986, p. 203). This is an example of the overwhelming guilt experienced after a child's suicide. "I felt personally rejected, which leads to self-pity...he preferred death to living with me" (Bolton, 1986, p. 203). Although the sense of failure as a parent is experienced by homicide, suicide and accidental

loss, the personal rejection associated with the suicide of a son or daughter is a distinctly separate experience. Drenovsky (1994) examined bereaved parents in support groups and concluded that the more than just the suddenness of a suicide creates anger in the parents. The study specified that these parents are also angered at the child for abandoning them (unable say goodbye or express their love), and for making such tragic mistake that cause their death.

Bolton (1986) explains that during treatment, she specifically clarifies the suicidal act as a statement more about the individual as opposed to a statement about the parents or anybody else. She explains how this clarification is used to alleviate the feelings of rejection associated with the death. Moreover, according to Drenovsky (1994), whom specifically researched anger and retribution of bereaved parents, suddenness of death such as suicide, homicide, or accident greatly increases the feelings of anger toward the lost child. The experience of rejection often leads to anger towards the lost child and complicates guilt.

A study done by Sequin, Lesage, and Kiely (1995), examined the comparison of suicide parental bereavement and accident parental bereavement. The study specifically focused on shame and how shame is more likely to be associated with the suicide bereaved parents. They found that parents that experienced suicide had more distress than those experiencing death from accident only in the beginning of grief. They also found that the parents with suicide deaths mentioned fewer persons as helpful compared to the parents with

accidental death. It was implied that the initial shame deters the family from social support and leads to personal vulnerability. The shame associated with the suicide is also noted in Becvar (2001) and Devries, Dalla Lana, and Falck (1994), stating that a difference between an accidental death and that of suicide is openness the public awareness due to the stigma attached to the death. In working with bereaved parents of suicide deaths, counselors must take this unique phenomenon into consideration by addressing the intense shame associated with a child's suicide.

#### *Accident*

Although accidental death is a unique and complex experience compared to other experiences, one distinguishing factor was not found compared the complexity of homicidal or suicidal deaths. All three forms experience intense emotions such as shock, anger, and resentment (toward the child, the perpetrator, or perhaps the person perceived as responsible for the accident). For example, one similarity often involves experiencing an environment such as an emergency room. According to Sanders (1986), the shock can be intensified by the way a parent learns about the death, whether it is suicide, accident, or homicide, and those working in an emergency room setting have an impact on the shock dynamic. It is vital that parents in these situations are informed of the death in a compassionate manner that does not imply any sort of responsibility and opens the door for support.

Nonetheless, there are more similarities examined. For example, the suddenness of an accidental death has profound “narcissistic injury” to a parent’s identity. Catherine Sanders, a psychologist and founder of the Loss and Bereavement Resource Center at the University of South Florida in Tampa, considers this type of death a “double edged sword” (Sanders, 1986, p. 182). Along with the death of a loved one, a parent’s identity is stripped suddenly. Therese Rando (1986) states, “The child has been an extension of the parent and has been invested with myriad symbolic meanings, along with hopes, dreams, needs, and wishes for immortality.” Thus, a parallel to loss of parental identity would be loss of meaning. There have been several research articles devoted to the reconstruction of meaning, which will be further addressed in the treatment section of this paper.

Overall, research has indicated that loss of a child unexpectedly has a profound impact on a parent. It is determined that emotions, parental identity, and meaninglessness are three crucial topics to address in counseling these individuals. Furthermore, the studies cited in Stroebe, Hannson, Stroebe, and Schut (2001), suggest evidence that this form of loss is more intense than any other form of loss including loss of a spouse, parent, or sibling. Higher levels of depression, more intense grief reactions, and longer lasting grief (compared to loss of a spouse, parent, or sibling) are all noted as poor outcomes. The research reviewed has several weaknesses such as lack of control groups (non-bereaved



groups) and the misuse of risk factors by assuming they are independent variables not subject to change.

It must also be noted that over a decade rests between some of the citations in this section, however the emotions experienced by parents and researched by experts continues to be the same over the years. In the latter portion of this paper, newer research will only be used in discussions of treatment due to the movement in grief counseling over the years. Now that the experience of sudden child loss has been explored, it is important for counselors to comprehend a recent theoretical model to explain the process of grief. An appropriate grief model, or frame of reference, is the foundation for grief counseling and allows counselors effectively grasp their unique, and often newly evolving, worldview. Without an effective model of the grief process, clients may be left feeling unheard or misunderstood.

### Etiology and The Grief Process

A review of sudden death research allows one to conclude that there are several components to consider in parental bereavement. In addition to the emotional components of parental loss, a counselor must consider a theory to explain the etiology of one's grieving path and examine the grieving process. Understanding etiology and the grief process are essential to gain a comprehensive understanding of the individual's goals for therapy and to determine the kind of services that would optimally help the each bereaved parent

or family. Using Bowlby's attachment theory to explain the nature of parental bereavement appears to compliment the findings related to the intensity of kinship losses because the parent/child relationship is specifically characterized by an attachment or bond (Stroebe et al, 2001; Parkes, 2002).

### *Theory of Attachment*

Collin Murray Parkes (2002) connects the aftermath of a loss with the type of attachment one has formed according to Bowlby's theory of attachment. Bowlby's renowned research on attachment has increased the field's comprehension of bonding, and the affects of bonding on later life. Bowlby formulated the concept of a "secure base" and Mary Ainsworth researched different forms of attachment that are developed. According the Parkes (2002), Ainsworth's three main types of insecure attachment are the anxious/ambivalent pattern, avoidant pattern, and disorganized/disoriented pattern. When one develops a "secure base" successfully starting from birth, it is concluded that a person is better able to cope while exploring and discovering life and the environment in which one lives.

To briefly explain, each insecure pattern of attachment derives from a particular form of parenting. For instance, anxious/ambivalent children had overprotective parents whom did not allow adhere to the child's need for autonomy. This child develops to be a clingy and anxious person. Avoidant children were neglected of closeness and maintain that distance from others while

developing. These are the ways each child has learned to survive, whereas disorganized/disoriented children were unable to learn one form of survival due to their parent's inconsistency between stress and depression. They develop into helpless individuals.

Parkes (2002) has attempted to "map out the attachment patterns of people who seek psychiatric help after bereavement" (p. 377). This research has concluded that those subjects whom perceived themselves to have been anxious/ambivalent children reacted to grief in a prolonged and clingy manner. The adults with avoidant patterns have are aggressive and assertive individuals, and after a death they have difficulty reaching out with their emotions or expressing their grief. The adults with the perceived disorganized/disoriented pattern react to the stress of grief by "turning in on themselves" (p. 378), perhaps harming themselves, or resorting to alcohol as a means to avoid. They initially react panicky and/or depressed due to their distrust in themselves or others. Bowlby's attachment theory related to the loss of a child through sudden death allows counselors to gain a better understanding of the path one may take in grieving (Parkes, 2002).

### *Task Model of Grief*

In the counseling field regarding grief, the movement has gone from a more rigid set of stages towards recovery to a flexible transformation of life and meaning that does not have a specific recovery or "back to normal" end. These

Rando (1986) disputes Worden's 1982 model, which includes four "tasks" of mourning. The first task is accepting the loss, the second is experiencing the painful emotions, the third involves adjusting to the environment and the fourth task includes reinvestment in new and/or other relationships. It is argued that these tasks do not fit the experience of parental bereavement in such a sequential manner.

She contends that the first task is difficult for parents due to the addition of sudden disappearance of the parent's sense of self and the violation of norms when a child dies before the parents. For some parents, this is not considered a task with an ending; it's more of an ongoing process in life. The second task is complicated and intense for parents. It has been already discussed that different types of loss are associated with different feelings. Although bereaved mothers and fathers do experience painful emotions, the cookie cutter view that this is a task with yet another task to do once completed allows societies stigma to remain to be "move on" and further aides in feeling socially isolated. Releasing the bereaved parent of the bereavement duties allows for acceptance and provides a supportive environment for whatever they are currently experiencing.

In examining the third task for parents, one cannot conclude that there is a "stage" one goes through to adjust to a new environment. The adjustment may be life long, watching other children the same age as their lost child graduate from school, marry, or perhaps have children. In reading loss narratives, it appears to

be ongoing, as opposed to redefining your role and resigning the roles that were held by the deceased to move on to the fourth task. Reinvestment, such as in the fourth task, may in fact occur for bereaved parents, however because of the sever of such an intimate relationship, the pressure of treating reinvestment like a task may impede the growth. The parental identity that was formed, is not replaced easily with other roles, moreover, if other children are involved the pressure to reinvest in those relationships may add to the guilt. In conclusion, these experiences suggested by Worden (1982), do have profound affect, however the concept of tasks or stages alludes to a mistaken belief about bereavement.

“Grief stages” implies a misconception of the grief process that “someday one will be back to the old self” when in fact a “new world view” never brings a person back to the prior frame of mind or self. In turn, many are left feeling alone and helpless. As briefly mentioned in the beginning of this paper, several authors, some whom have personal experience with parental loss, agree that grief has no ending; it is a part of the rest of one’s life (Becvar, 2001) (Conrad, 1998) (Finkbeiner, 1996). Becvar (2001) quotes, “grief never really ends, rather each of us who has entered the ‘valley of the shadow of death’ lives forever after, to one degree or another, in the presence of grief” (p. xii).

#### *Dual Process Model of Grief*

It is pertinent that the counseling field contests against the stigma associated with prolonged bereavement. The process that has been considered

grief stages in the past is now viewed differently. According to Parkes (2002), although the stages have been “misused”, the idea of stages exposed the concept that grief is a process. In harmony with the development of attachment, it is noted by Parkes (2002) that grieving individuals do through an aftermath process and past concepts such as “tasks of mourning” by Worden (1982) have set the stage for new views.

Stages implies a means to an end, however Stroebe and Schut (1999) designed a grief model called the Dual Process Model, which allows for what they call “oscillation between the loss oriented and restoration oriented.” Loss orientation pertains to focusing on the loss and longing for the lost person, whereas restoration orientation involves turning away from the loss and the thoughts (Stroebe and Schut, 1999; Stroebe et al, 2001).

Parkes (2002) relates his grief research to the Dual Process Model of bereavement created by Margaret Stroebe and Henk Schut (1999). The Dual Process Model concurs with the theory of attachment. For instance, both loss orientation and restoration orientation are a natural part of grieving however a person with an insecure attachment may become “stuck” in either loss orientation or restoration orientation. This model helps explain why some cannot stop grieving (anxious/ambivalent individuals) and why some avoid it (avoidant individuals). A study by Znoj and Keller (2002) concur with these findings by stating that avoidance of dealing with the painful emotions appears to lead to

psychological symptoms and other health problems. The study stressed that the grieving process has potential to create more psychological problems, or, on the contrary, improved regulation of emotion. It is implied by Parkes (2002) that individuals with a “secure base” are allowed to feel safe enough to either let go of the lost person and move to the restoration mode or to relinquish avoidance and face grief through loss orientation mode.

In considering the Dual Process Model, as opposed to the stages model, the back and forth fluctuation appears to fit grieving for these parents because it eliminates the idea that one must “get over it, or complete the tasks” of a complicated and devastating experience. Further evidence of this idea has been reiterated in the words of bereaved parents. For example, in the midst of restoration and worldview reconstruction, one parent noted, “Your whole mindset is that your kids are going to outlive you and then when something like this happens, you say, maybe I should have done this different and this wouldn’t have happened” (Finkbeiner, 1996, p. 140). The Dual Process Model of bereavement allots time for the emotions, and one to swim in memories (loss orientation). Furthermore, the dual model exemplifies that the moments of restoration or moving forward are also natural, which aides in alleviation of guilt along with emphasizing that it can return to the longing or yearning of loss orientation. Individuals enduring this time begin to recreate a new subjective worldview that includes the experience of such an immense loss.

It must be noted that the Dual Process Model does not ignore that tasks that have been emphasized by past research. The model incorporates the tasks that grievers attend to such as denial, and reinvestment in life. Stroebe et. al (1999; 2001), state that while experiencing loss orientation tasks such as grief work, intrusion of grief, breaking bonds, relocation, and denial or avoidance of restoration changes are experienced. Since one may oscillate to and from loss orientation, there are not specifics as when these tasks are attended to, or an order to attending to them. They also address tasks such as attending to life changes, doing new things, distractions or avoidance from grief, and building new roles, identities, and relationships. According to Stroebe and Schut (1999), "It will be evident that this is not a phasal model, we do not propose a sequence of stages, but rather a waxing and waning, an ongoing, flexibility over time" (p. 213). It is stressed that when bereavement first begins, the person predominantly experiences loss orientation, and over time experiences more restoration orientation or directs their attention to other stresses in life.

### Diagnosis

The research that has been reviewed indicates that shock from the sudden death of a child creates trauma, which influences and complicates the grief experience (more intense and longer lasting) (Sanders, 1986, p. 182; Stroebe et. al 2001; Murphy, Clark-Johnson, Lohan, & Tapper, 2002). According to Jacobs, Mazurc, and Prigerson (2000), these complications to grief call for a diagnosis



that that is separate from other disorders including Major Depressive Disorder, Panic Disorder, or Post-traumatic Stress Disorder. This research suggests that the diagnosis revolve specifically around trauma related to the death of a loved one where a significant attachment has formed. Researcher Holly Prigerson developed the term “Traumatic Grief” because the term “trauma” did not possess a negative connotation unlike “pathological grief” and it is not as vague compared to “unresolved or complicated grief.” Jacobs et. al (2000) contends, “Traumatic grief would be distinct from other disorders by virtue of unique diagnostic features rooted in the separation distress evoked by death” (p. 196).

In agreement, Parkes (2002) addresses the need for diagnostic criteria and contends that there is a stigma behind grief that delays such a category in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Parkes quotes, “By excluding grief from our diagnostic categories, we may collude with those who see all mental illnesses as permanent and shameful and, in doing so, we may perpetuate the prejudice” (p. 381). Furthermore, severe grief as an adjustment disorder is often not covered by health insurance, even though many bereaved individuals are unable to work due to the physical and psychological symptoms that inhibit the person. Allowing traumatic grief to be a part of the DSM would aide in providing evidence that this experience should be covered and these individuals protected medically and financially. If it were the norm to receive

medical treatment for severe grief, perhaps more would seek help and the grief process would less likely become “stuck” or “inhibited.”

The criteria for Traumatic grief, according to Jacobs et. al (2000), are as follows: Criterion A, (1) The person has experienced the death of a significant other (2) The response involves intrusive, distressing preoccupation with the deceased person (e.g. yearning, longing, or searching). Criterion B, in response to the death (1) Frequent efforts to avoid reminders of the deceased (2) purposelessness of feelings of futility about the future (3) Subjective sense of numbness, detachment, or absence of emotional responsiveness (4) feeling stunned, dazed, or shocked (5) Difficulty acknowledging the death (6) feeling that life is empty or meaningless (7) Difficulty imagining a fulfilling life with out the deceased (8) feeling that apart of oneself has died (9) Shattered Worldview (e.g. lost sense of security, trust, or control (10) Assumes symptoms or harmful behaviors of, or related to, the deceased person (11) Excessive irritability, bitterness, or anger related to the death.

These are noted for treatment purposes because much of the research suggested that treatment such as individual or group work only deemed beneficial with the grief with perceives as intense or traumatic (Neimeyer, 2000; Znoj & Keller, 2002). For example, Znoj et. al (2002), noted that they found no evidence to say that confiding in others was related to better emotional well-being. However, their study also noted that those whom appeared more traumatized

more often “expressed their feelings to close persons” (p. 560). The listed criteria would aid in selecting an appropriate treatment such as group therapy.

#### Treatment of Bereaved Parents with Sudden Loss

Neimeyer (2000) has found a consistent conclusion that grief therapy is appropriate for individuals whom are experiencing complicated or traumatic grief, and states that grief therapy may not be necessary for those whom are experiencing what is considered normal grief. This paper has established that the death of a child is far more complicated than nearly any other type of loss and trauma is often experienced. This concludes that group therapy for such individuals may often be beneficial.

The misconception and societal stigma that “one should be over it by now” only adds to the guilt and anger, especially in situations when the grief can be so complicated. An individual must choose to let go of such judgments, which is easier said than done. Counseling provides an avenue to be accepted where the person is at emotionally, whereas the individual may perceive society to draw lines and sets expectations.

Becvar (2001) contends, “Although we make efforts to help... what we do must be perceived as meaningful if it is to be helpful” (p. 57). Meaning reconstruction is noted in the treatment section due to the fact that the loss of a child often shatters a parent’s view of the world. Meaning reconstruction is a vital piece of the grief process and can be incorporated into group therapy. This author

views the entire grief process of oscillation between loss orientation and restoration orientation as the avenue for meaning reconstruction. This section explores the experience of group therapy and addresses meaning reconstruction as it pertains to loss. This illustration of group therapy for bereaved parents coupled with meaning reconstruction gives counselors an idea of how to proceed from beginning to end while working with these parents.

### *Group Work*

Often, grieving individuals, couples, or families join support groups for acceptance and relinquish from some of societies perceived expectations of them. This author deems it necessary to focus specifically on group therapy because so much of the research has been geared towards group therapy or self-help groups. It has previously been established that group work is beneficial statistically for complicated grieving, and there have been several narrative examples of individuals expressing the helpfulness of group therapy. For instance, in the research on grief group therapy by Murphy, Clark-Johnson, Cain, Das Gupta, Dimond, Lohan, and Baugher (1998), it was noted, “many parents commented, ‘the group helped me see things differently... we came here as strangers and now share things we wouldn’t tell anyone else’ (p.229).” Furthermore, Therese Rando (1986) contends that it is beneficial for mourners to share their grief with others.

Neimeyer (2000) argues that group selection is key. Individuals experiencing the immense loss of a child are all in different places with unique

struggles; some may be on the way to making sense of the loss, whereas some may be losing ground in the quest of meaning making. Moreover, individuals may be “stuck” as Parkes (2002) mentioned, perhaps depending on their type of attachment. These individuals may need to be screened for a specific bereavement group specific to prolonged or complicated grief. Jacobs and Prigerson (2000) concur from meta-analysis research, “the use of diagnostic criteria or a procedure for assessing high risk of clinical complications serves the purpose of identifying the bereaved population that will benefit most from intervention” (p. 489).

Other factors to assess include suicide assessment and the individual’s need for grieving. In these cases, individual counseling would be more appropriate than group therapy for the person and the group as a whole. Entering a group must be a mutual agreement between the therapist and the client. Research has found that gender differences may need to be considered, although it may not need to be a homogeneous group. It was identified that men benefited more from an emotion-focused group, whereas women benefited from a problem-focused group Murphy et. al (1998). It is also argued that women have more benefited from group therapy as opposed to men. Murphy et. al 1998) concludes, “Problem focused and emotion focused support appeared to normalize the traumatic experience for mothers” (p. 229). Factors such as socialization and true levels of distress may not have been noted until after the group, which may have impacted the results for fathers.

With group selection carefully executed, there are several components of group work that have been found beneficial to bereaved parents. First of all group therapy is a known environment to build group cohesion and allows sharing to occur in a safe and accepting environment. Cohesion occurs when individuals take risks to share, which coincides with the study that stated those whom appeared to be the most traumatized shared more (Zonj et. al2002), and research that has stated traumatic grieverers may be more suitable for counseling (Neimeyer, 2000). The tone of the group must be set for openness to “oscillation between yearning and moving forward”, and unconditional positive regard for where one feels “stuck.” Stroebe and Schut (1999) further evidence this by stating, “it is postulated that oscillation is necessary for optimal adjustment” (p. 216). Without such preparation and norm setting, group therapy could potentially be harmful.

These components will be reiterated as this author addresses the stages of group work and specifically examines the effects of a group process on a set of mourners according to Price, Dinas, Dunn, and Winterowd, (1995). Price et. al (1995), specifically examined the theoretical concepts behind group therapy (Yalom, 1995) and applies theory to the practice of group with members whom have lost a loved one.

In the initial stage of group, clarifying personal goals and expectations aide in helping the member find the group purposeful. If a therapist were to use the Dual Process Model, the tasks addressed in both loss orientation and

restoration modes would aide the individual in setting goals. The model would also allow members to decipher where they are at in the grieving process and distinguish which goal the member is attending to. To set expectations leaders must work avidly to set the appropriate tone and normalize the grieving process. During the study by Price et. al (1995), they found that members often felt alienated by individuals in their social circles once they became impatient or confused by the length and intensity of mourning. The initial stage helps normalize the grief process by forming a group for individual's all experiencing similar, yet unique, long, intense, and complicated type of mourning.

Meeting other grieverers alleviates alienation, however taking risks and disclosing one's personal story are the two key components to group cohesion. These authors contend that the initial stage for a grief and loss group is critical in that it establishes trust and group cohesion. Leaders must emphasize the importance of the group to become a safe haven for individual's to confide in others. Depth unfoldment occurs in the initial stage of the group. This exercise allows mourning group members to share their story about their loss. As in other therapeutic groups, finding one's identify is also critical the initial stage of group for mourners. According to Price et. al(1995), it was evident that individual's were assessing how much they had in common with others, or how different they were than others. Irvin Yalom's concept of universality was apparent during the initial stage, in this study, as evidenced by the sharing displayed in the group,

which is often “forbidden” for grieving in society or western culture (Price et al, 1995).

The next stage addressed by Price et. al(1995), is the transition stage, which is characterized by conflict, defensiveness, and resistance. Just as a child tests his or her parents to see if their home is safe, stable, and secure, members of this group attended to the same search for security. It appears the trust in a group may be given initially, however the testing behavior shows that a deeper level of trust must be earned. This study found that group members became more fluid in their roles during this time, as opposed to remaining the helper or the silent member. It is noted in this article that the flexibility in member’s roles aids in raising self-esteem. More suggestions by members were offered in this stage of the group. They note that avoidance of the loss is evidenced in this stage by intellectualizing the loss. This study appears to coincide with the Dual Process Model, as members learn to oscillate from loss orientation and restoration orientation together.

In the Price et. al(1995) study, the leaders facilitated oscillation by intervening or confronting when individuals habitually demonstrated storytelling (became stuck) or when members would attempt to give quick remedies. Education was also a key component during this stage, by discussing the importance of dealing with emotions. If one were to specifically gear a grief group towards the Dual Process Model, the leaders may also use this time to educate members about the grief process as explained by the model. The most



immense challenge during the transition stage for the Price et. al(1995) study was for the member's to move from telling stories to exploring more personal thoughts and feelings about the loss. This is a critical time in group work, specifically for griever's, because on one hand it has been geared towards alleviation of alienation, and on the other hand, the group is facilitating change. This author deems it imperative that leaders educate and frame the transition stage as a time to "go deeper" as opposed to "moving on". This author would also recommend that leaders emphasize oscillation, by stating that once members' explore their emotions at a deeper level, they may also return to loss orientation, and explain that this is normal for griever's.

The working stage was characterized by a shift from the leaders to the members attending to group and personal goals. The facilitators began pointing out similarities and differences, encouraging self-awareness, and offering support as opposed to educating and confronting. During this time it was noted that individual's disclosed other issues that existed before the loss that may have intensified their grieving. Another topic included discussion of family members. Many group members experienced difficulty with family because they were now more willing and able to discuss the loss, where their family members were not (Price et al, 1995).

This group experienced a specific challenge during this stage regarding the use of defense mechanisms. It is stated, "A leader's decision to provide an

interpretation of the consequences of a defense mechanism was made carefully and on an individual basis.... change was viewed as inappropriate until they had achieved a greater degree of stability in their day-to-day existence” (Price et al, 1995, p. 164). Subgrouping occurred however was not seen as a challenge for this group. Norms were set that losses could be discussed with certain member’s outside the group, however discussing other’s losses without that member present was not deemed appropriate. Overall, the working stage was a time for members to discuss how to function outside of the group. It was noted that the group did not enforce behavior changes. Changes were only suggested and there was freedom from coercion that these researchers found helpful for shy, silent, or culturally different members.

The last stage was integration and was characterized as a time for transfer of learning. It was a time for member’s to receive overall feedback, and address unfinished business. The research commented that the key components throughout the group were the cohesion, universality, altruism (Yalom, 1995), and role flexibility. Applying the Dual Process Model to this group could have perhaps enhanced the transition stage of the group.

#### *Meaning Reconstruction for Parents and Families*

The Dual Process Model allows for meaning reconstruction. For example, Braun and Berg (1994) discuss factors influencing meaning reconstruction and the experience of disorientation and adjustment, which can be related to loss and

restoration orientations of the Dual Process Model. This study found evidence to state that the core variable for meaning reconstruction was prior meaning structure. Prior meaning structure was defined by “the collection of beliefs, assumptions, values, and norms that characterized their reality or their knowledge of life prior to the child’s death” (p. 114). When the death impacts the prior meaning structure, disorientation occurs. This study found that women whose meaning structure included the belief that children should not die or do not die, had immense difficulty with the loss and much turmoil. This is similar to Parkes (2000) notion that one becomes stuck depending of their attachment type. In order for a parent to rebuild meaning in their life, one must experience reorientation. Braun et. al (1994), suggests that the belief that children do die must be included in a new meaning structure or worldview. Spirituality may play a role in this restructuring, such as the belief that it was God’s plan, or a higher power’s plan. The Dual Process Model considers these two experiences, bears in mind what tasks may be involved, and creates an avenue for exploration of all aspects, without setting forth expectations of the bereaved individual.

Braun (1994) identifies five beliefs and societal factors that influence meaning reconstruction and may need to be addressed in counseling. The first belief identified involves the centrality of the child’s life. As mentioned earlier, the importance of addressing parental identify is essential in the process of grief counseling. The child’s life may have been essential to the parent’s purpose and

meaning in life. Moreover, often children are the link to a family's vision of the future. Group work can especially be helpful in openness to different beliefs. These factors may be a common theme in a cohesive group and guilt may be addressed in looking towards the future without that child. The second belief identified in the study included the nature of life. The way in which one looks at life may be drastically changed, from viewing life as a gift or a celebration versus viewing life as something to endure. A parent's worldview may change dramatically and cause difficulty in the grief process.

Belief about personal control and external control are the third and fourth beliefs identified by Braun et. al (1994). Parents that include the belief that they have the power in affecting the outcomes may feel stuck in "I should have, or they would be alive right now if I would have." External control refers to the belief that a higher power has more control and determines one's course of life. The last belief that was identified in the study and proven to be a topic of merit for treatment of bereaved parents is the existence of order. Some mothers in the study differed in terms of how well they used their belief about the order of the world to explain their child's death. An example given in the study refers to one parent that has the internal control belief that he or she could have prevented the death and that "God" should have intervened. Whereas at other times mothers' speculations suggested that perhaps a higher power had a good reason. This fluctuation in thoughts and questioning beliefs is central to transforming or reconstructing one's

meaning in life. This study fits well with the dual-process model, and gives further evidence that viewing grief with this model in mind, allows for a non-judgmental and flexible treatment process.

Societal beliefs discovered by Braun et. al (1994) are that parenting is a planned emotional investment, that success in life can be achieved, should be sought after, and that life is basically good. The death of a child breaks societies beliefs and the notions regarding the way life should be. Discussing in a group, or other therapy setting, that society has played a part in beliefs may allow members to decide about what society says and if it does or does not fit for me or us (a couple).

Wheeler (2001), states that meaning reconstruction is a process. Reconstruction includes dealing with the initial response, current responses, and significance of the child's death. Initial responses in the process include inability to accept the death, emotional reactions, and preoccupation with the child. It is apparent that during meaning making the parent is more enmeshed in the loss orientation mode. Current responses include continued questioning, acceptance, and inability to accept the death. This shows that the fluctuation between both loss orientation and restoration orientation are begins. Factors associated with the significance of the death include the loss, the child, and connections with people, and positive gains. "For some parents keeping the memory of the child alive was a way of making meaning of the death. It is important that this focus on the

child is viewed as a way of making sense of the trauma in order to reinvest in the world, not an attempt to deny the reality of the death” (p. 63). Connections with people were found to be the most important focus that emerged from the Wheeler (2001) study. The participants of the study discussed slowing down to enjoy surviving children and the love and support they have received. Positive gains included “he (the lost child) taught me how to live and die... he has been my window to life... I realize that the quality not the quantity of life was important” (p. 59). The process of meaning making is essential to address due to the fact that it is so central to grief process.

### Conclusion

This extensive review of literature concludes that in order to make treatment beneficial for bereaved parents, one must examine the factors imminent to sudden death of a child such as the complex emotions involved, the differences and/or similarities between kinds of sudden death, and the impact on parental identity and life purpose. Moreover, it is evident that a counselor must have a well-established theory of development, an appropriate and flexible model of grieving, and an understanding of the criteria for diagnosis of traumatic grief. This builds a foundation for guiding treatment specifically for bereaved parents. It allows a counselor to effectively use a framework, while maintaining the inimitability of each client presented to him or her. Specifically using the Dual Process Model of bereavement as it creates a flexible back and forth flow from

yearning to moving forward. The model fits the narrative examples provided (that there is no end, but a there is a process experienced) and the oscillation feature of this model differentiates it from any other model, especially a stage model of grief.

The research cannot stress any more the importance of abandoning stages and emphasizing the recreation of meaning and purpose in the lives of these individuals through the Dual Process Model. As a member of the counseling profession, it is this author's duty to advocate for the Dual Process Model as a means to break social stigma and allow for personal growth of individuals, couples, and families. Utilizing these concepts, group therapy along with other forms of therapy can be proven beneficial, specifically for traumatic grievers. Counselors working with this population, must be aware that more control groups are needed to further study other models like the Dual Process Model and the effects of therapy. Ongoing research is imperative, along with lifelong learning about the grief process as research evolves.

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