1994

Therapeutic implications of parental bereavement

Tracey R. Bishop

Therapeutic implications of parental bereavement

Abstract

The loss of a loved one is a tragedy disproportionate from any other for many people. Most individuals experience the pain from losing someone very important to them during their lifetimes. Because of the large number of people it affects, the intensity of the loss experience, and the systematic variations with which its consequences are distributed across populations, bereavement has far-reaching implications (Stroebe, Stroebe, & Hansson, 1993). Due to this inevitable fact, many mental health care professionals have shown an increased interest in death and dying issues over the past 20 years (McClowry, Davies, May, Kulenkamp, & Martinson, 1987; Rando, 1986; Wright, 1992).

Therapeutic Implications of Parental Bereavement

A Research Paper

Presented to

The Department of Educational Administration

and Counseling

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

---

by

Tracey R. Bishop

December, 1994

This Research Paper by: Tracey R. Bishop

Entitled: THERAPEUTIC IMPLICATIONS OF PARENTAL BEREAVEMENT

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

9-29-94
Date Approved

Terry Kottman
Adviser of Research Paper

9/29/94
Date Approved

Jeffrey S. Ashby
Second Reader of Research Paper

9.30.94
Date Received

Michael D. Waggoner
Head, Department of Educational Administration and Counseling

The loss of a loved one is a tragedy disproportionate from any other for many people. Most individuals experience the pain from losing someone very important to them during their lifetimes. Because of the large number of people it affects, the intensity of the loss experience, and the systematic variations with which its consequences are distributed across populations, bereavement has far-reaching implications (Stroebe, Stroebe, & Hansson, 1993). Due to this inevitable fact, many mental health care professionals have shown an increased interest in death and dying issues over the past 20 years (McClowry, Davies, May, Kulenkamp, & Martinson, 1987; Rando, 1986; Wright, 1992).

Throughout the past 50 years, mental health professionals have questioned and searched for the standard duration of a person's grief response. Lindemann's (1944) study was among the earliest in bereavement research. He concluded that grief reactions should be completed within weeks of the death of a loved one. Up until the 1970s and early 80s, researchers proposed grief reactions should subside within a years time (Mawson, Marks, Ramm, & Stern, 1981; Ramsay, 1979).

Many people seem to be under the impression that it is inappropriate to grieve the loss of a loved one for any length of time, regardless of the relationship with the deceased. More recent research has led to the belief that it is normal for people to grieve beyond the one year anniversary date (Rando, 1986; Worden, 1991). There is some evidence that the second and third years may be even worse (Johnson, 1987) than the first year. Although research on grief has become more prevalent it is still ignored by much of the general public. Many grieving individuals and the people around them are still very confused and somewhat ignorant in regard to the grieving process.

Mental health professionals should be involved in grief issues for a variety of reasons. Persons may seek treatment when they are feeling stuck in their grieving experience, questioning the appropriateness of their response. They may also believe they will never be able to resume a normal, functional life. Individuals sometimes seek help for numerous physical and psychological ailments, not aware that grief or unresolved grief issues may be at the root of their condition.

Although bereavement is a universal experience, the process of grieving is uniquely individual. Factors that have been shown to predict bereavement outcome include the suddenness of the death; the nature of the loss and the quality of the relationship; preexisting personality variables and psychiatric history; the number and the relationship to secondary losses and life stressors; the quality of support available; and the personal experiences of attachment and loss as a child (Romanoff, 1993).

When focusing on the intensity and duration of grief, one type of loss which is considered the most painful and the most prolonged is parental bereavement (Johnson, 1987; Rando, 1993). Many people are unaware of the multiple implications the loss of a child has upon a parent. Individuals today are somewhat guarded from childhood death. Previous to the mid to late 20th century, it was not rare for children to die. Today, the death of a child is considered uncommon due to the medical advances of the modern world. Therefore, many bereaved parents do not receive the help they need to lead them toward a healthy resolution of their grief. Families and marriages might suffer from longterm negative affects due to the inability to achieve adequate resolution (Rando, 1985; Romanoff, 1993)

Bereaved parents have many unique and complicated issues which must be addressed in addition to the general grief symptoms. The specific issues mental

health professionals must consider when working with bereaved parents will be discussed throughout this paper. The author will address the unique factors involved in parental bereavement, the issues resulting from the various causes/types of death, recommended therapeutic techniques, and proposed directions for further research.

Unique Factors of Parental Bereavement

It is important for therapists to have knowledge of the general parental grief issues. In bereavement counseling, the therapist must be prepared to address marital issues as well as issues unique to mothers and fathers. Also, if the couple has other children, it is important for the therapist to point out how the loss of one child can complicate matters when parenting surviving children (McNeil, 1986; Rando, 1985; Romanoff, 1993; Wright, 1992).

General Parental Grief Issues

The emotional bonding between parents and child occurs prior to birth. A wide array of feelings are attached to the fantasized image of the child-to-be. The child can represent the ideals of society that the parent has internalized. Stroebe, Stroebe, and Hansson (1993) perceived children as having multiple meanings for parents. On the first level, children are physical extensions of the parents. Socially, genetically, and psychologically they are the repositories of their parents' beings. On the second level, they represent a reworked view of the past as they move dynamically toward the future.

Once the child is born, parents typically view themselves as being responsible for keeping their child out of harm's way. In no other role is there such a multitude of assumed and socially assigned responsibilities. Parents internalize these unrealistic expectations and compare themselves against impossible criterion.

When the death of a child occurs, regardless of the child's age, parents have lost their hopes, fantasies, expectations, and wishes for that child. They have lost a part of themselves, each other, their futures, and their family. Rando (1985) described parents who lose a child as being multiply victimized. They are victimized by the realistic loss of the child they love, by the loss of dreams and hopes they had invested in that child, and by the loss of their own self-esteem. The loss of a child leaves parents and other siblings in a position of being forced to cope with numerous grief experiences occurring concurrently.

Parents often feel cheated, betrayed, responsible, guilty, out of control, and inadequate (Edelstein, 1984). Survival guilt is often caused by the parents' feeling that they have let the child down by failing to carry out the basic roles of parenthood. The uncommon nature of the loss of a child also appears to aid in fostering this guilt (Rando, 1985). The strangeness of the event becomes a major stumbling block for the parents who cannot understand the reason for it happening and cannot take solace in the idea that the loss was inevitable. It is for these reasons that resolution is such a difficult task and why bereaved parents face many more obstacles than other bereaved persons (Rando, 1985).

The death of a child can represent an immense invalidation of fundamental assumptions about the laws of the universe. Predictability and rules of order are questioned, and parents experience a state of chaos. Rando (1986) described the reactions of parents to the loss of their child as "so different, uncontrollable, unexpected, and severe that a majority of parents believe they have actually lost touch with reality" (p.14).

All grief contains a sense that part of the self has been cut out. It appears that this sense is longer lasting in bereaved parents. Klass (1988) found that many

parents who described the death as a metaphor of amputation experienced a sense of deep narcissistic hurt and perceived their child as part of their drive for immortality. Although the majority of bereaved parents claim that the intensity of their grief decreases over time, the impact of their loss is such that parents resign themselves to never being the same again (McClowry, Davies, May, Kulenkamp, & Martinson, 1987). Parental bereavement is a permanent condition, an enduring change in the self (McClowry et al., 1987). A parent's sense of purpose is challenged, especially when an only child dies (Edelstein, 1984). His or her identity as a parent is drastically altered (Edelstein, 1984).

Parents are caught in a trap of double mourning (Klass, 1988). They mourn the child as he or she existed at the time of death. Simultaneously, they have an awareness of the developmental stages the child would have progressed through, such as entering high school, graduating from high school, graduating from college. Klass (1988) referred to this tendency as the "empty historical track" (p. 13).

Parents suffer from a loss of regulators in a stressful world (Klass, 1988). They are now bombarded by questions they never intended to answer. Parents will have to make decisions regarding how to celebrate the child's birthdays and holidays, what to do with the child's belongings, and how the answer the question "how many children do you have?" (Klass, 1988).

At a time when parents need support the most, they often find themselves isolated. Parents who have lost a child appear to experience more social stigma than other bereaved individuals (Romanoff, 1993). It is not uncommon for bereaved parents to experience feelings of frustration, abandonment, and helplessness in their experiences with other parents after the death of their child.

They are frequently avoided by other parents who are uncomfortable with the situation and are often unconsciously protecting their own internal beliefs about justice and predictability. Bereaved parents often find social invitations becoming almost nonexistent, which diminishes their social support network (Romanoff, 1993).

Effects on the Marital Relationship

The loss of a child can be difficult on the family as a whole, but the marital relationship may also suffer from its own complications (Wright, 1992). Tremendous stress is placed on a marriage after the loss of a child. The death of a child brings grief to both partners simultaneously. Each is confronted with an overwhelming sense of loss and multiple stressors. The person the marital partner would usually look to for support is unable to be supportive due to the fact that he or she is also consumed with grief.

Partners may run into problems when they assume that because they both suffered the same loss, they will experience similar grief (Wright, 1992). In fact, each parent will react differently. Fish (cited in Wright, 1992) indicated significant differences in intensity of grief between partners. He discovered that incongruity in mourning creates breaks in communication, thus adding additional strain on the marriage. Oftentimes, mothers and fathers grieve differently and therefore are out of synch with one another in their grief (Wright, 1992).

The differences in grieving styles and dissimilar expectations set each parent up for increased feelings of isolation and threat (Rando, 1985). Irrational demands may be made on one another, especially when one partner believes the other should be able to somehow make him or her feel better or take the pain away. Important issues are often left unaddressed because the loss of the child

predominates, and one partner may try to "protect" the other from additional pain. It is also common for individuals to displace feelings of blame and anger to those people who are closest to them, which in a marriage is often the spouse. Parents may remind one another of the deceased child and may serve as a painful stimulus. The chances for conflict are high (Rando, 1985).

The avoidance of conflict may encourage avoidance and detachment between partners when they need each other most (Rando, 1985). Johnson (1987) explained the detachment phase that marital partners may face. She described detachment as the process whereby people distance themselves from one another because of their own pain. Reasons for detachment include protecting self and others, being in too much pain to offer support, engaging in testing behavior, being in a state of initial shock which often precipitates withdrawal, expressing different grieving styles, and possessing instability in the marriage prior to the death.

Each partner must also deal with the grief of his or her spouse (Rando, 1985). Little opportunity exists to get away from the grief physically or psychologically. One can see the grief and pain in the face of their loved one, which may cause even more anguish. Partners often find it difficult to request a break from the other even when they are feeling respite may be necessary. This may cause an increase in exhaustion and in the guilt they are already bearing (Rando, 1985).

Partners' different opinions regarding the sexual relationship is another situation that can further the strain experienced by the couple (Lang & Gottlieb, 1993). It is not odd for the sexual relationship of marital partners to be compromised up to two years after the death of a child (Rando, 1986) Close intimacy and sexual contact may be comforting to one spouse, and it may have the opposite effect on the other spouse (Lang & Gottlieb, 1993). Partners not only feel incompetent

within the parental role, but also in the marital role due to the inability to fulfill previous expectations (Callan & Murray, 1989).

Many people are still under the impression that couples who lose a child are inevitably headed for divorce (Rando, 1986). Recent research has indicated that the increased strain put on a marriage by the death of a child may negatively affect the relationship, but if the couple has a strong, solid relationship upon which to build, they can work through this period and once again obtain a healthy, productive marriage (Rando, 1986; Schiff, 1977; Videka-Sherman & Lieberman, 1985). Schiff (1977) wrote that a major contributor to divorce after parental bereavement is that too much is expected of the mate by his or her partner and too little is given by the partner. She recommended that the marital partners receive counseling by a third party.

Parents may disagree on numerous decisions related to the loss and somehow need to consider each other's feelings and ideas and allow compromise (Rando, 1986). Marital partners must recognize that the grief experience will change each of them. They should not expect their mate to be exactly the same person as he or she was previously. A restructuring of the relationship and each person's roles may be necessary (Rando, 1986). Johnson (1987) indicated that sometime near the end of the first year of mourning, it is critical for parents to begin to reattach to one another. Couples who have lost a child need to reattach and make a joint decision to live again. If one of the partners fails to accept the decision to try and live again, complicated grief may develop.

Paternal Issues

Each parent has unique issues which must be addressed aside from the marital relationship itself. In regard to the father, the tasks of grief are usually

incompatible with traditional male roles (Stinson, Lasker, Lohmann, & Toedter, 1992). Many men are socialized not to show their feelings and certainly not in front of others. Fathers often pride themselves on the roles of protector, provider, and problem solver. When they lose a child, they may feel they have lost their competency in these areas. Fathers may feel ashamed at not being able to fulfill their roles as protector of the family unit, which may result in their feeling less able to be sexually intimate with their wives (Stinson et al., 1992).

In the case of crisis situations, many fathers acquire increased responsibility which may overburden them (Mandell, McNaulty, & Reece, 1980). Medical personnel and family members may view fathers as protectors and expect them to deal with many decisions and arrangements at a time when mothers are emotionally and physically incapacitated. Again due to socialization, men may see inquiring for help or admitting their need for help as failing or inadequate (Mandell et al., 1980).

The majority of studies indicate that women's anger tends to decrease over a two year period of time whereas men's increases (e.g. Mandell et al., 1980; Stinson et al., 1992). Men react to bereavement in a more angry, aggressive manner. Fathers tend to have fewer social supports and feel they are without anyone to discuss the loss and their feelings (Stinson et al., 1992).

Numerous studies suggest that mothers experience more intense grief reactions than fathers (Lang & Gottlieb, 1993; Romanoff 1993; Theut, Zaslow, Rabinovich, Bartko, & Morihisa, 1990). One can question whether this is the case or whether men grieve more privately in a less open manner, masking the extent of their grief.

Maternal Issues

Mothers also have unique issues that need to be addressed. Oftentimes, it is the woman who is the primary caregiver to the children, has more interaction with them, and is now exposed to more daily reminders of the deceased child (Edelstein, 1984; Schatz, 1986). Although it is not yet known if women grieve more intensely than men, research has indicated that mothers experience more of the feelings and reactions commonly described in the grief literature than do fathers (e.g. Lang & Gottlieb, 1993; Theut, Pedersen, Zaslow, Cain, Rabinovich, & Morihisa, 1989).

In a study by Edelstein (1984), the mothers claimed there were more people who were willing and able to provide comfort, support, and help with many tasks, which reduced their stress. When women turned to remaining children for emotional support and help, most turned to their daughters. Those daughters under ten years of age still needed care, which was gratifying to the mothers. More mature daughters were singled out as companions due to their similarities in grief reactions. Edelstein (1984) claimed other people responded more easily to the mother's loss than to the father's. This may also be due to the different grieving styles of men and women.

Parenting Remaining Children

Parents may be enveloped within their own issues and grief patterns, but they need to work as a team when it comes to raising the remaining children. When the child who died has surviving young siblings, an increased burden is placed on the parents (Rando, 1985). They must continue to function in the parental role, the role they are trying to grieve for and relinquish. It is difficult for many parents to try to relinquish and maintain the same role simultaneously (Rando, 1985).

Parents who are grieving the loss of a child may be so absorbed with their own grief that they cannot see or want to see grief symptoms in their remaining children (McNeil, 1986). Parents may find themselves focusing on the past and worshipping the child who died, often ignoring the relationships they have with the other children (Wright, 1992). Parental ability to respond to the other siblings' needs is often impaired. They are typically aware of their inadequate responsiveness, which can exacerbate feelings of guilt. The parents perceive themselves as not only failing to keep their dead child out of danger, but failing their surviving children as well (Wright, 1992).

It is not uncommon for parents to displace their anger to surviving children (Romanoff, 1993). The remaining children may serve as a painful reminder of the deceased child. Feelings of resentment may also emerge when the parent sees the other children resuming their lives and perceives them as grieving insufficiently or having adjusted too quickly (Romanoff, 1993).

Children may try to shelter their parents from additional pain. It is important that parents identify whether the remaining siblings are setting up unrealistic expectations for themselves by trying to protect and take the pain away from their parents, trying to be perfect, or trying the replace the deceased sibling (Rando, 1985). Grief education may be necessary for remaining children.

The surviving siblings may find themselves pressured to fill the void left by the child who died (Rando, 1985). Parents often subconsciously do this in an attempt to keep the dead child alive. Sometimes parents adopt a "replacement" child. Unfair burdens are placed on the new child, who is expected to live up to the image of the deceased child. Usually the child cannot attain such standards (Rando, 1985).

Fear for the safety of surviving family members is also common. Parents may rob remaining children of a normal life by becoming overprotective (Edelstein, 1986). This may deny the children of opportunities needed psychologically, socially, and physically. Parents' attempt to hold on to and protect their remaining children may in actuality push them away. The majority of mothers in a study conducted by Edelstein (1986) reported that their remaining children had become more precious and important to them. Parents should be encouraged to identify this need and be aware of its boundaries.

Issues Related to Unique Loss

Unique types of losses pose many specific issues which need to be considered when working with bereaved parents. The types of loss can include miscarriage, stillbirth, infant death, sudden death, death from an illness, death from a murder or suicide, and the death of an adult child. Although many of these bereavements have some common aspects, there are important, distinctive issues of which therapists should be aware.

Miscarriage

One of the most misunderstood deaths is that of perinatal death or miscarriage (Lietar, 1986). As stated previously, the emotional bonding between parents and child occurs before birth. Both parents begin to imagine the child at first news of the pregnancy. When a women miscarries, the parents only have an image to grieve. Even though the child has not yet been born or accomplished anything, the parents grieve the loss of the fantasies they have experienced during the pregnancy. The bereavement response will relate strongly to the dreams that the parents have had for the unborn child (Lietar, 1986).

Due to the loss being symbolic and intangible, the grief process may be more difficult. Parents who lose an unborn child may find that other people dismiss their pain. Grief is unrecognized when others do not perceive that intense grief reactions are appropriate, that the loss was not worthy of the grief they are experiencing. Because miscarriage is a common medical occurrence, many people forget the significance of the event (Lietar, 1986). Parents lack social support because many do not understand how painful the loss of a child who was never born can be. If the mother has not begun to show, many people may not have known she was pregnant. The father oftentimes does not hold concrete memories of the child, such as the feel of a kick, which further isolates the mother. Miscarriage is a major loss for most parents, and all the normal symptoms of grief can be expected (Lietar, 1986).

In situations when the death results from unexplained medical or genetic factors, parents put pressure on themselves to try and explain why their child died prematurely and defied the laws of nature (Stinson et al., 1992). Oftentimes parents are caught up in reflecting back to conception and questioning the things they did or did not do. In addition, the mothers may struggle with feelings of failure and worthlessness due to the fact they were unable to bring the baby to term (Stinson et al., 1992). Many couples find it beneficial to see the fetus in the case of miscarriage (Lietar, 1986). It can reinforce the reality of the death and initiate the grieving process.

Seibel and Graves (cited in Lietar, 1986) interviewed women who had experienced miscarriages. They found that the predominant concerns involved two questions: Why did the miscarriage happen? What caused the miscarriage? A quarter of the 93 respondents felt somehow responsible for the miscarriages;

blaming themselves for such things as bowling, having had sexual intercourse, and playing in general. Patients had often been misinformed, and they required more accurate and precise data about what had actually caused them to miscarry in order to dispel any unwarranted guilt.

Stillbirths

In contrast to miscarriage, in many stillbirth situations, the death is anticipated prior to the birth, resulting in anticipatory grief (Hutchins, 1986). The parents can find themselves in a state of limbo, neither life or the hard reality of death exists (Hutchins, 1986). Parents experiencing stillbirth or other perinatal death are often young and inexperienced in dealing with death and loss (Nichols, 1986). Caretakers and family members often overprotect the parents, but this only increases the chance for avoidance and denial (Nichols, 1986). Nichols (1986) encouraged others to provide a "gentled reality," (p. 151), a kind and gradual informative reality. It is important to explain to the parents the options, such as seeing the baby, photographing the baby, saving footprints, and having a funeral or memorial service in honor of the child.

Infant Death

Parents who lose a newborn may find that their grief can also be discounted, and they can suffer from many of the same misunderstandings as parents who have experienced miscarriages or stillbirths. When a child dies as an infant, parents are often told they are lucky they did not have longer with the child to become more attached, or they may be reminded that they have or can have other children. Few rituals of behavior are prescribed for such a rare occasion. People are not acquainted with the baby, therefore the reality of the death is again tested.

Callan and Murray (1989) reported that therapists should expect that at least 20% of parents could experience a marked deterioration in their health and well-being after the loss of a newborn. They also indicated that the acceptance of an infant's death by the parents may not occur in a time period shorter than two years. Nicole (cited in Harmon, Glicken, & Siegel, 1984) found that none of the mothers who saw or held their baby regretted it, and about half who did not see or hold their baby did have regrets. Lietar (1986) and Hutchins (1986) also found similar perceptions. The majority of studies have found that mothers whose infant died suddenly experienced more guilt, anger, meaninglessness, yearning, depersonalization stigma, and isolation than did mothers whose infants' death was anticipated (Lang & Gottlieb, 1993; Parkes & Weiss, 1983).

Sudden Death of Children and Adolescents

As in any childhood death, the question of preventability is often an integral topic in work with bereaved parents. When it is a case of sudden death, the question of preventability seems more pervasive. In the cases of children and adolescents, death is often sudden and the result of an accident. This type of death is more likely to produce traumatic effects and poor bereavement outcomes due to their unanticipated nature (Rando, 1986). Sudden deaths more often involve violence destruction, mutilation, and pain which can leave the survivors with an increased sense of helplessness and threat (Rando, 1986). This helplessness prompts extensive efforts by parents to find meaning in the death, determine who is at fault, and regain a sense of control (Rando, 1986). Parkes and Weiss (1983) described what they termed the "unexpected loss syndrome." It begins with a difficulty believing the loss really occurred and the inability to face the loss, as well as social withdrawal from others who could offer comfort and support.

The suddenness of the death can produce systemic shock, which can significantly diminish one's ability to cope (Parkes & Weiss, 1993). In most cases of bereavement, the shock phase is over in the first few weeks after a loss. In the case of sudden death, the shock phase lasts much longer, sometimes well into the second year of grief (Parkes & Weiss, 1983).

Sanders (1986) found that in comparison to parents who anticipated the death of their child, sudden death survivors reported more intense anger, frustration, and physical complaints during the first few years following the death. Sanders (1986) believed this could be attributed to the extended shock aspect, creating prolonged stress that further demoralized and debilitated parents. The manner in which parents are informed of the death can intensify the shock. Oftentimes in sudden death situations, parents are informed of the death by emergency room personnel who are not trained to work with the parents' shock and grief reactions.

One of the major tasks of mourning is relinquishing the attachment to the deceased and resolving the meaninglessness of the event (Rando, 1985; Sanders, 1986). In the case of a sudden death of a child, the overwhelming amount of shock makes this task difficult to accomplish. The guilt, rage, and confusion parents experience will also delay resolution (Sanders, 1986).

Death From Illness

Although medical technology has advanced considerably, medical doctors are still unable to prevent the death of many children due to illness. When parents are aware their child may be dying, unique questions and issues arise. Kupst (1986) found that parents deal with impending death in different ways. She was unable to find a common pattern or set of phases that holds true for the majority of families. Some parents keep fighting, searching for a cure, struggling to find alternative

treatment, or denying the child is dying. They frequently become angry at staff who fail to save their child.

Other parents may deal with the impending death by detaching themselves from the child. Kupst (1986) stated that while some distancing is normal and necessary for parents, it can be negative. The child may not receive the support he or she needs during this difficult time.

Parents may also come to accept the reality of the death and plan for it. Working with the child to plan for his or her death and the funeral can be helpful for both the child and the parent.

She found the majority of parents fall in between and often jump back and forth between trying to conquer death and accepting its inevitability. The majority of parents generally maintained hope until the end. Sometimes parents struggle with the perception of death as a relief from the discomfort and pain that the child may have suffered through treatment (Kupst, 1986).

McClowry et al. (1987) conducted a study examining the long-term responses of families following the death of a child due to cancer. Findings of this study indicated that many parents and siblings still experience pain and loss seven to nine years after the death of their child. Their analysis suggested that the death of a child creates an "empty space", a void, for surviving family members. Prevalent comments included "There's always one missing." and "It doesn't seem right yet."

McClowry et al. (1987) further examined this empty space phenomenon and found three predominant patterns of grieving in response to this feeling of emptiness. The first was termed "getting over it." Families described by this pattern did not continue to experience the empty space. They accepted the death matter-of-factly as either God's will or something people have to face. These

families had less vivid memories of the child and believed time brought cessation of the pain and the desire to go on with life.

The second pattern was termed "filling the emptiness." Family members attempted to fill the emptiness in one of two ways, either by keeping busy or by substituting other problems or situations. The families tried to fill the void by increasing their eating or drinking habits, by having more children, or becoming involved in a cause. The members of these families concentrated on current life, constantly searching for something to make them feel complete again. The empty space emerged when they were asked the number of children they had and when they celebrated holidays and anniversaries.

"Keeping the connection" was the third pattern of adjustment. Family members continued to be aware of the empty space. They were often involved in activities which might "fill the emptiness" for others, such as becoming involved in support groups for bereaved parents. These families members integrated the pain and loss into their lives, cherished collections, retained vivid memories, and shared stories of the deceased. The family continued to reserve a small part of themselves for the loss of a special relationship which they viewed as irreplaceable (McClowry et al., 1987).

According to McClowry et al. (1987), it appeared as if the pattern of grief was associated with the perceived quality of the relationships. Those who described the deceased person in terms of a particular relationship that could not be replaced experienced a continuing empty space. In contrast, the same people might describe the death of others as a loss but not with the intensity of the loss of those whose death became an "empty space." McClowry et al. (1987) emphasized that no pattern of grieving is suggested as superior to the others. However, therapists

may recognize the potential difficulty of family members in sharing their grief with each other when different patterns are used by individuals in the family (McClowry et al., 1987).

Suicide or Murder

As noted throughout this paper, unique issues which need to be addressed interplay with unique situations. This is also the case when the child dies from unconventional circumstances such as suicide or murder. It is not unusual for parents who have lost a child to suicide to experience exaggerated guilt and anger (Bolton, 1986). Much of this guilt may develop from the anger the parent feels towards the child. Guilt may also stem from the parents experiencing a conflicting sense of relief. Thoughts such as "he or she is no longer suffering" or "he or she is at peace now" tend to cause anxiety within the parents when at the same time they are angry at their child. Parents struggle to understand and rationalize what has just happened. They tend to look back often, believing they should have been able to see the signs of an impending suicide. An increased sense of failure, incompetency, and inadequacy often leads to a decrease in self-esteem in parents whose children have committed suicide. Parents may feel personally rejected, which can lead to self-pity (Bolton, 1986).

It is important for therapists to clarify that the suicidal act was probably more of a statement about the child than about anyone else (Worden, 1991). It may also be beneficial to discuss how a parent's grandiosity can lead him or her to believe he or she could have permanently stopped a child from committing suicide if the child was really determined to kill himself or herself (Worden, 1991).

Parents whose child dies from murder have all of the problems that other bereaved parents have, plus additional frustrations (Schmidt, 1986). In the case of

a murder, the child no longer "belongs to" the parents. The child and many of his or her possessions are the state's property, held as evidence. The body may not be released for burial for a number of years (Schmidt, 1986). Aside from the usual burdens the parents would normally have to work through, they now have to deal with lawyers, the courts, the media, and the public (Worden, 1991). Trials may last for years and their grief is often displayed in front of strangers. The opportunity to grieve in private is stripped from these parents. Therapists should be aware of the added frustrations the parents of murdered children must face in order to understand their prolonged grief process (Worden, 1991).

Adult Child

When people think of a child dying, they often picture a young child. This is not always true. Many adults who die are still considered children by their surviving parents. In the case of the death being that of an adult child, the parents are often ignored in favor of the spouse or children of the deceased adult (Wright, 1992). The parents have still lost their "child," which may feel just as unnatural to them as losing a school-age child. Helmrath and Steinitz (1978) concluded that parental grief, following the death of a fetus or a newborn infant, is less severe or prolonged an experience than the grief following the death of an older child. In contrast, others have found that regardless of a child's age at the time of death, parental bereavement can be long-lasting, severe, and complicated with reactions that shift over time (Rando, 1985; Wright, 1992).

Therapeutic Strategies And Techniques.

Bereaved parents often seek therapy when they perceive that there is a failure of the naturally occurring support systems or when the resources available are not sufficient for adequate coping (Alexy, 1982). The parent-child relationship does

not end with death. It continues in terms of internal representations or images (Worden, 1991). As the parent's life is reorganized in the absence of the deceased child, a new relationship must be structured (Rando, 1986). The relationship is based largely on recollection, memory, and past experience (Rando, 1986). Relinquishing the concrete loving of a living person and replacing it with the abstract loving of an absent child is the cognitive and intrapsychic process that parents must undertake (Rando, 1986). Worden (1991) described the central task of the therapist as helping bereaved parents find a way of continuing their relationship with the child through inner representations, while simultaneously focusing on their remaining relationships and going on with their lives.

It is important in counseling bereaved parents to minimize the risk of serious psychological, interpersonal, and psychological difficulties (Romanoff, 1993). The therapist can assist the parents by helping them cope with a changed world and find meaning and purpose in life without the child. Techniques that assist them to search for meaning include helping them establish new types of social networks and facilitating altruistic movements such as establishing memorial funds or participating in support or action groups. Helping them grieve for the loss of their child, and hopes and dreams they had for that child is also important (Romanoff, 1993).

The therapist must assist the bereaved parents in exploring their memory of their child's death and set the stage for the creation of positive memories of the child's life (Romanoff, 1993). Performing rituals can also aid in grieving. Planting a tree, passing on cherished belongings, visiting the cemetery, and other activities can aid in the realization that the child is dead. Romanoff (1993) recommended having the parents keep a journal of their activities,focusing on the thoughts and

feelings these activities produce. He has found that this strategy can further enhance parental coping.

Helping parents keep marital communication open and assisting them in identifying and verbalizing what each partner needs from the other can greatly enhance each person's support system (Rando, 1986). An explanation of the differences in grief patterns found between males and females should be introduced. The therapist needs to help parents recognize that they cannot underestimate the effect of grief on their relationship and inform them about the normal tendency to blame (Rando, 1986).

Therapists should try to normalize the parents' experiences. Often grief reactions to child loss are much more intense and sustained than other grief reactions. Therapists need to explain that there will be upsurges in grief at various milestones the child would have experienced and that these upsurges will be intermittent, and they are normal.

Emphasizing the need to remember to consider other surviving family members can be beneficial. Rando (1986) emphasized how important it is for parents to be aware that special considerations should be given to bereaved siblings. Parents should be encouraged to identify any unusual behaviors such as nightmares, illnesses, compulsive behavior, or any unexplained psychological symptoms. Maintaining close contact with the school should also be encouraged (Rando, 1986).

Therapists also need to demonstrate sensitivity to the bereaved parents' behavior, which at times can be ambivalent or paradoxical (Worden, 1991). Parents often attempt to escape reminders of the deceased child, while at the same time dwelling on the memories. They may insist that life is no longer living, at the

same time they are willing and able to take up responsibilities of home life and careers (Worden, 1991).

Therapy can be accomplished through a variety mediums: group, couple, individual, or family therapy. Group therapy is the most common mode of grief therapy and can serve as an important adjunct to individual or family therapy (Alexy, 1982). The individual comes to a group seeking "togetherness" and looking to receive confirmation of the manner in which he or she has been coping as a bereaved parent (Nahamani, Neeman, & Nir, 1989). The process of mutual acceptance among members allows for a sense of partnership to develop.

Often the act of attending the group together as a couple, and participating contributes to the sense of being a couple and brings them closer to one another (Nahamani et al., 1989). It also reinforces their motivation to return to subsequent sessions. The group leader needs to be aware of the competition that might emerge between the husband and wife. One partner may establish a monopoly on grief because he or she may believe that he or she had a unique bond with the deceased child. This may block out the other spouse from sharing in the sorrow. Both spouses will need to seek and discover a new equilibrium that will ensure them each the right to mourn (Nahamani et al., 1989).

A group offers the couple a milieu to explore the tensions and mutual hostilities and recriminations that have had no outlet previously due to the couple's fear of losing one another (Nahamani et al., 1989). The group can be a source of support for both spouses. The therapist and the other group members may be able to absorb part of the marital anger, allowing the conflict to subside and permitting greater individuation in the grief process with a freer flow of communication.

Parents can become more accessible to each other and their surviving children (Nahamani et al., 1989).

Not all bereaved parents who desire psychological counseling would respond well to a group format. Complications associated with the grieving process and difficulties related to the building of trust with others may inhibit parents from seeking and benefitting from group therapy. Also, if the parents continuously consume the majority of the group's time dealing with their own issues, individual or couple counseling may be preferred and needed.

Family therapy can be addressed from a systems perspective (Worden, 1991). Parents, children, and family are encouraged to talk openly about their reactions and feelings about the death. It is important for members to be aware that any change in the family will affect all of its members. Family therapy will encourage communication about the death when discussion of the deceased may otherwise be considered "off limits" (Worden, 1991).

Not only should therapists be aware the reactions of their clients, but they should also pay attention to their own responses. Transference and countertransference issues may cause the therapist to be reminded of his or her own losses or vulnerability to loss. The therapist can draw from his or her own experience with loss to sustain, not impair, empathy (Worden,1991).

Future Research

Grief research is becoming more prevalent, but there are still numerous issues that need to be researched more thoroughly . One area that needs to be addressed is the exploration of whether there is a psychological difference between losing a child as a couple versus losing a child as a single parent or even as divorced

parents. The majority of literature available speaks to the traditional two-parent families.

More research needs to be conducted on the topic of paternal bereavement and the male grief response. There are questions about whether men grieve less than women. There is a need for different models to explain the grief experience for mothers and for fathers (Lang & Gottlieb, 1993).

There is substantial research in the literature regarding the benefits of group therapy for grieving parents. Family therapy, couple therapy, and individual therapy are mentioned, but the research demonstrating the particular effectiveness of each of these treatment modalities is limited. In order to obtain a broad sense of grief therapy, the benefits of the other therapeutic strategies need to be addressed more completely

Conclusion

Although much more information is known about parental bereavement than in past years, many people are still unaware of the multiple effects the loss of a child can have on parents. Parents' internal representations of themselves and their child are challenged. They perceive themselves as failing at the roles of protector and parent. Therapists need to consider the various issues that impact bereaved parents. The marital relationship, distinct paternal and maternal issues, and the relationship with remaining children all have specific issues that should be addressed.

Parental grief is also much more complicated than other grief situations (Worden, 1991). Each special circumstance of loss entails its own unique issues. Miscarriage, along with stillbirth and newborn death, is still very misunderstood by

many individuals. The death is not any easier because the child was never born or the parents did not have a long period of time to bond with the child.

The question of preventability is almost always pervasive in childhood death, but it is even more intense when the child dies in a sudden manner (Sanders, 1986). In the case of the death being from an illness, parents often bounce back and forth on a pendulum from trying to prevent the child's death to accepting the reality of his or her death (Kupst, 1986).

When a child dies from murder or suicide, the parents involuntarily end up sharing their child with the world. The press and media infringe upon their privacy. The additional frustrations these parents must face may delay or prolong their grief for years (Bolton, 1986).

When the word "child" is used, it does not always refer to a school-aged child. A parent who loses a child at any age, even as an adult, can suffer from the same painful issues as other bereaved parents suffer from (Wright, 1992).

Parental grief is more intense and often longer in during than other types of grief (Rando, 1986). Rando (1986) recognized the complexity of parental grief and stated "whenever reasonably possible and warranted, professional intervention following the death of a child is advisable" (p. 88).

Research on grief and parental bereavement has made substantial gains in the past 20 years. There are areas that still need more research. Other types of parental loss not addressed in this paper include abortion, missing children, children who were given up for adoption, and the loss of multiple children.

Irvin D. Yalom (1989) best conceptualized parental grief in his text Love's Executioner. He stated:

> To lose a parent or a lifelong friend is often to lose the past: the person who died may be the only other living witness to golden events of long ago. But to lose a child is to lose the future: what is lost is no less than one's life project - what one lives for, how one projects oneself into the future, how one may hope we to transcend death (indeed, one's child becomes one's immortality object). Thus, in professional language, parental loss is "object lost" (the "object" being a figure who has played an instrumental role in the constitution of one's inner world); whereas child loss is "project loss" (the loss of one's central organizing life principle, providing not only the why but also the how of life). Small wonder that child loss is the hardest loss of all to bear, that many parents are still grieving five years later, that some never recover. (p. 132)

References

Alexy, W. D. (1982). Dimensions of psychological counseling that facilitate the grieving process of bereaved parents. Journal of Counseling and Development, 29, 498-507.

Bolton, I. (1986). Death of a child by suicide. In T. A. Rando (Ed.), Parental loss of a child (pp.201-212). Champaign, IL: Research Press.

Callan, V. J., & Murray, J. (1989). The role of therapists in helping couples cope with stillbirth and newborn death. Family Relations, 38, 248-253.

Edelstein, L. (1984). Maternal bereavement. New York: Praeger.

Harmon, R. J., Glicken, A. D., & Siegel, R. E. (1984). Neonatal loss in the intensive care nursery: Effects of maternal grieving and a program for intervention. Journal of the American Academy of Child Psychiatry, 23, 68-71.

Helmrath, T. & Steinitz, E. (1978). Death of an infant: Parental grieving and the failure of social support. Journal of Family Practice, 4, 785-790.

Hutchins, S.H. (1986). Stillbirth. In T. A. Rando (Ed.), Parental loss of a child (pp.129-144). Champaign, IL: Research Press.

Johnson, S. (1987). After a child dies: Counseling bereaved families. New York: Springer.

Klass, D. (1988). Parental grief: Solace and resolution. New York: Springer.

Kupst, M. J. (1986). Death of a child from a serious illness. In T. A. Rando (Ed.), Parental loss of a child (pp.191-211). Champaign, IL: Research Press.

Lang, A., & Gottlieb, L. (1993). Parental grief reactions and marital intimacy following infant death. Death Studies, 17, 233-255.

Lieter, E. F. (1986). Miscarriage. In T. A. Rando (Ed.), Parental loss of a child (pp.121-128). Champaign, IL: Research Press.

Lindmann, E. (1944). Symptomatology and management of acute grief. American Journal of Psychiatry, 101. 141-149.

Mandell, F., McNaulty, E., & Reece, R. (1980). Observations of paternal response to sudden unanticipated infant death. Pediatrics, 65, 221-225.

Mawson, D., Marks, I., Ramm, L., & Stern, R. (1981). Guided mourning for morbid grief: A controlled study. British Journal of Psychiatry, 138, 185-193.

McClowry, S. G., Davies, E. B., May, K. A., Kulenkamp, E. J., & Martinson, I. M. (1987). The empty space phenomenon: The process of grief in the bereaved family. Death Studies, 11, 361-374.

McNeil, J. N. (1986). Communicating with surviving children. In T. A. Rando (Ed.), Parental loss of a child (pp.451-458). Champaign, IL: Research Press.

Nahamani, N., Neeman, E., & Nir, C. (1989). Parental bereavement: The motivation to participate in support groups and its consequences. Social Work with Groups, 12, 89-99.

Nichols, J. A. (1986). Newborn death. In T. A. Rando (Ed.), Parental loss of a child (pp.145-158). Champaign, IL: Research Press.

Parkes, C. M., & Weiss, R. S. (1983). Recovery from bereavement. New York: Basic Books.

Ramsay, R. W. (1979). Bereavement: A behavioral treatment of pathological grief. In P. O. Sjoden, S. Bates, & W. S. Dorkens, III (Eds.) , Trends in behavior therapy (pp. 34-56). New York: Academic Press.

Rando, T. A. (1985). Bereaved parents: Particular difficulties, unique factors, and treatment issues. Social Work, 30, 19-23.

Rando, T. A. (1986). The unique issues and impact of the death of a child. In T. A. Rando (Ed.), Parental loss of a child (pp.5-43). Champaign, IL: Research Press.

Rando, T. A. (1993). Treatment of complicated mourning. Champaign, IL: Research Press.

Romanoff, B. D. (1993). When a child dies: Special considerations for providing mental health counseling for bereaved parents. Journal of Mental Health Counseling, 15, 384-393.

Sanders, C. M. (1986). Accidental death of a child. In T. A. Rando (Ed.), Parental loss of a child (pp.181-189). Champaign, IL: Research Press.

Schatz, B. D. (1986). Grief of mothers. In T. A. Rando (Ed.), Parental loss of a child (pp. 303-314). Champaign, IL: Research Press.

Schiff, H. S. (1977). The bereaved parent. New York: Crown.

Schmidt, J. D. (1986). Murder of a child. In T. A. Rando (Ed.), Parental loss of a child (pp.213-220). Champaign, IL: Research Press.

Stinson, K. M., Lasker, J. N., Lohmann, J., & Toedter, L. J. (1992). Parents' grief following pregnancy loss: A comparison of mothers and fathers. Family Relations, 41, 218-223.

Stroebe, M. S., Stroebe, W., & Hansson, R. O. (1993). Handbook of bereavement. New York: Cambridge.

Theut, S. K., Pedersen, F. A., Zaslow, M. J., Cain, R. L., Rabinovich, B. A., & Morihisa, J. M. (1989). Perinatal loss and parental bereavement. American Journal of Psychiatry, 146, 635-639.

Theut, S. K., Zaslow, M. J., Rabinovich, B. A., & Morihisa, J. M. (1990). Resolution of parental bereavment after a perinatal loss. Journal of American Academy of Child Adolescent Psychiatry, 29, 521- 638.

Videka-Sherman, L., & Lieberman, M. (1985). The effects of self-help and psychotherapy intervention on child loss: The limits of recovery. American Journal of Orthopsychiatry, 55, 70-82.

Worden, J. W. (1991). Grief counseling and grief therapy (2nd ed.). New York: Springer.

Wright, D. L. (1992). When parents grieve: An undiagnosable pain. Journal of Humanistic Education and Development, 30, 100-110.

Yalom, I. D. (1931). Love's executioner and other tales of psychotherapy. New York: Basic Books.