Family Resilience in the Wake of Loss: A Meaning-Oriented Contribution

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Mimi's daughter Tierney was diagnosed with Trisomy 18, a genetic disorder, just a few weeks after her birth. Statistically these babies rarely survive beyond a year. Along with her husband, Doug, and Tierney's 5 and 7 year-old brothers, Reilly and Keegan, Mimi was devastated.

Mimi was determined from the time of Tierney's diagnosis to make her child's life matter, to have significance for all who she touched, in the short time they had her. She explained to Reilly and Keegan that "90% of babies with Tierney's condition die before their first birthday," an expression that conveyed to their young minds that she would die before her birthday party—something they could not imagine. They therefore urged their mother to celebrate her birthday early, and the family began doing so each month, allowing the children generous input in suggesting how best to celebrate, decorating cakes, making goody bags, renting a bouncy castle for family friends to enjoy together. As the months added up, they began hopefully to plan the celebration of her living a full year, mindful of the fact that 90% of Trisomy families were denied that opportunity. With appreciation and empathy, the whole family and others in attendance wrote "letters to heaven" that they sent skyward on helium balloons to mark the occasion.

From a point shortly after Tierney's diagnosis, Mimi began to plan her daughter's funeral. Together with her sisters she selected appropriate music and songs, laughingly imagining having a concert rather than a conventional service. Working with a Catholic book on funeral planning, she encountered the idea of a pall, the covering over the casket, which would otherwise be as small and unadorned ad a Rubber Maid box. Together with her family, she conceived the idea of making a quilt for the occasion, with Reilly and Keegan joyfully contributing drawings on fabric of all of the important events of the short life of their tiny sister, who they imagined as having the "super powers" appropriate to the angel she would soon become: "Power Baby" fighting monsters, "Spider Baby" climbing tall

buildings with her special web, baby Tierney crying. Now, four years after her daughter's death, Mimi still cherishes and displays the quilt, imagining that she will be sewing it bit by bit for the rest of her life. As she says, "We were determined that it would be a beautiful thing that would cover the tragedy of losing her. My whole focus has been to see her as a beautiful thing, not a tragedy."[1]

As this case vignette illustrates, bereaved families often surprise us with their creative ways of dealing with a devastating loss. In relationship with one another and the broader community, family members can accommodate even the most dreadful experiences, endowing them with meaning while at the same time strengthening their collective resilience.

INTRODUCTION

For most people, the loss of a loved one through death is both painful and challenging. Losing someone with whom we have a relationship based on love sets in motion a series of bodily, emotional, cognitive, behavioral and relational effects that ripple through our world in the days, weeks, months—and for many—years that follow, with subtler effects for some that can be observed for a lifetime. *Grief*, as we use the term, is the label given to the multitude of biopsychosocial experiences that arise in the aftermath of the loss, which can be distinguished from *bereavement*, the relatively "objective" fact of having lost a significant person, and *mourning*, the culturally shaped practices by which such loss is expressed and processed (Stroebe, Stroebe, Hansson, & Schut, 2001). People obviously grieve in their own ways, within their own world of meanings and relationships. Different contexts, different family systems and different cultures give rise to richly varied ways of dealing with loss and ongoing life. At the same time, these diverse contexts impose their own assessment and valuation of ways of grieving (Paletti, 2008), in a sense "policing" grief to ensure that it stays within culturally acceptable bounds (Walter, 1999). While, for example, in some cultures

[1] Mimi's story and those of other parents who have lost children are featured in our colleague Todd Hochberg's video documentary, *Other Rituals: Parents' Stories of Meaning Making*, available at www.toddhochberg.com.

withdrawal and muted depression is considered an acceptable response to the death of a loved one, these behaviors may be construed as pathognomic of complicated grief in another (Rosenblatt, 2011). Similarly, while an intense expression of grief emotions or an overt continuation of the bond with the deceased (even to the point of sensory experiences of that person's presence) is tolerable in some families or couples, such behavior can be viewed with suspicion in others. Generally, a contemporary Western conceptualization of grief emphasizes confronting the loss and subsequently moving on with life in a functional way without prolonged and disturbing 'symptoms' (Harris, 2009).

Our goal in this chapter is to explore what is meant by *resilience* in the context of loss and grief, drawing on the predominantly Western literature to characterize this salutary response to loss and to consider its expression at both more individualistic and more systemic levels. Weaving clinical vignettes through our review, we conclude with several implications for therapists striving to respect and promote resilience within families, as well for researchers attempting to shed more light on adaptive processes when a member of a family or other small social system dies.

SIGNIFICANCE OF THE TOPIC

The concept of family resilience relative to loss has been explored in both the grief and the family therapy literatures, but with remarkably little cross-referencing of key concepts and findings. We hope to bridge these two fields by summarizing what emerges from a review of each, and making a modest contribution to their integration.

The concept of resilience in grief literature[2] is relatively new, and predominantly refers to an individual outcome without severe mental health or life adjustment problems after the loss of a loved one. For the majority of the 20th century, the bereavement literature has concentrated primarily on grief symptomatology, from Freud's (1917/1957) early writing on

[2] We searched the two main journals in the field of grief (*Death Studies* and *Omega: Journal of Death and Dying)* from 2000-2010 for themes of resilience, supplementing this strategy with our knowledge of the broader literature, both classic and recent.

"mourning and melancholia" onward. In this view, pathological grief became a clinical concern under one of two conditions: when survivors failed to "withdraw emotional energy from the one who died in order to invest it elsewhere," in theory continuing a form of "bondage" to the deceased, and alternatively, when the bereaved showed little by way of a grief reaction, giving rise to the suspicion that they were suffering from 'denied' or 'delayed' grief. A lack of empirical evidence to support this latter view ultimately led to the hypothesis that the absence of grief might not be an indication of pathology, but rather a sign of resilience (Bonanno, 2002). Hence, scholars in the field began to wonder why some bereaved were seemingly able to assimilate a significant loss in an ongoing healthy functioning, while others experienced severely disabling conditions after the loss of a partner, a child, or a parent. Subsequently, factors predicting positive outcomes were explored empirically, and bereavement interventions were developed based on the promotion of resilience for the bereaved individual (Brown, Sandler, Tein, Liu, & Haine, 2007; Sandler, Wolchik, & Ayers, 2008) or family (Kissane, Lichtenthal, & Zaider, 2007).

From a family therapy perspective[3], the theme of grief and bereavement is mainly approached from a family resilience viewpoint (Becvar, 2001; Boss, 2006; Greeff & Human, 2004; Shapiro, 1996; Walsh, 2006; Walsh & McGoldrick, 2004). In this literature the concept of family resilience is situated in ecological and developmental contexts, considering how relational resilience processes vary with unfolding challenges and evolving family structures across the life-cycle. In recent years there also has been growing attention to the strengthening of community in the aftermath of major disaster, such as the terrorist attacks in New York on 9/11/01 and Hurricane Katrina in 2005 (Bava, Coffey, Weingarten, & Becker, 2010; Landau, 2007; Landau, Mittal & Wieling, 2008; Saul & Bava, 2009; Walsh, 2007).

LITERATURE REVIEW

[3] We searched three main journals in the field of family therapy (*Family Process, Journal of Marital and Family Therapy,* and *Journal of Family Therapy*) from 2000-2010, for themes of resilience in relation to loss and grief.

Resilience and Family Resilience in Grief Literature

Traditionally, grief literature and research has concentrated on those bereaved individuals struggling with ongoing life after the loss of a loved one. For much of the 20th century this resulted in a nearly exclusive focus on grief symptomatology, and the refinement of the distinguishing features of what is now termed 'complicated grief'(Shear et al., 2011) or 'prolonged grief disorder' (Prigerson et al., 2009). Until recently, clinical theorists have warned of both overreactions and underreactions to loss, thereby pathologizing all deviations from what is considered to be a "normal" grief trajectory (Boss, 2006). From this perspective it is believed that individuals who grieve normally should acknowledge the loss of a significant relationship and intensively work through the painful feelings inherent in doing so (the *grief work* hypothesis, Freud, 1917/1957). The absence of such an intense and painful grieving process has long been considered indicative of psychopathology (e.g., Bowlby, 1980; Rando, 1993; Worden, 1991), and thus the need for grief therapy.

The last decade, however, has witnessed a multitude of studies and meta-analyses questioning the assumptions of the grief work hypothesis (Bonanno & Kaltman, 2001), as well as the effectiveness of grief therapy for most bereaved people (Currier, Holland, & Neimeyer, 2007; Currier, Neimeyer, & Berman, 2008; Neimeyer & Currier, 2009). These comprehensive reviews of controlled studies have demonstrated that most bereaved persons, including children and the elderly, adapt to loss without debilitating symptomatology, and without the need for specialized professional help to work through the grief. Similarly, Bonanno (2002, 2004) challenged the assumption that the absence of distress is a form of denial or grief inhibition, but instead might be indicative of resilience in the bereaved. He defines resilience as the capacity "to maintain relatively stable, healthy levels of psychological and physical functioning" following a highly stressful life event. Moreover, he contends that resilience is distinct from recovery, "as recovering individuals often experience

sub-threshold symptom levels, while resilient individuals, by contrast, may experience transient perturbations in normal functioning but generally exhibit a stable trajectory of healthy functioning across time" (Bonanno, 2004, p. 20). Ample research now demonstrates that the majority of bereaved people experience little to no major disruption in their psychological well-being and functioning (Bonanno, Moskowitz, Papa & Folkman, 2005; Bonanno, Wortman & Nesse, 2004). With regard to this finding, the Changing Lives of Older Couples (CLOC) study (Bonanno, Wortman & Nesse, 2004), a large prospective study of spousal loss, distinguished five grief trajectories after the loss of a spouse: common (or adaptive) grief, chronic grief, chronic depression, depressed improved, and a resilient pattern.

Interestingly, the resilient trajectory proved most frequent (45.6%), characterized by low levels of depression at pre-bereavement as well as post (from 6 months to 4 years post loss), and low levels of other grief symptoms (e.g., yearning). Rather than representing a dysfunctional form of detachment, denial or delay in the grieving process, a relatively stable low distress trajectory represented an adaptive pattern of coping with loss. Closely inspecting the prospective and longitudinal data from the CLOC study, Coleman and Neimeyer (2010) found that the resilient individuals appeared to be less likely to be thrown into a search for meaning relative to the death of the spouse. From a narrative perspective one could say that these individuals were able to integrate the loss into their existing self-narrative in a way that did not profoundly challenge the plot structure or thematic underpinnings of their previously viable life story (Neimeyer, 2006).

Besides the belief in a just world and an acceptance of death, other factors promoting resilience are often cited in the grief literature, such as the personality traits of hardiness (Bonanno, 2004; Mathews & Servaty-Seib, 2007), or dispositional resilience (Rossi, Bisconti, Bergeman, 2007). This personal resource is characterized by "being committed to find a meaningful purpose in life, the belief that one can influence one's surroundings and the

outcome of events, and the belief that one can learn and grow from both positive and negative life experiences" (Bonanno, 2004, p. 25). Moreover, factors such as self-enhancement (Bonanno, et al., 2002), repressive coping (Coifman, Bonanno, Ray, & Gross, 2007), social embeddedness, the flexible regulation of emotional expression (Mancini & Bonanno, 2006), and positive emotion and laughter (Bonanno, 2004) are considered important components of resilience in the aftermath of a significant loss. Finally, the experience of identity continuity is described as an important characteristic of the resilient individual (Bonanno, Papa, & O'Neill, 2002). Whereas for some bereaved the loss of a loved one might feel as if a piece of themselves is missing, as if there were no thread of continuity between their lives before and after the loss, the resilient bereaved seem to have the capacity to maintain continuity in the self.

Beyond simply surviving or coping with a loss, it has been argued that many of the bereaved experience some kind of growth or positive transformation as part of the grieving process (Tedeschi & Calhoun, 2008). This post traumatic growth following the struggle with grief refers to the emergence of new possibilities, an enhanced sense of personal strength, a greater appreciation of life, changes in relationships with others, and changes in existential and spiritual orientations. For example, in their study of bereaved parents, Lichtenthal, Currier, Neimeyer and Keesee (2010) found that despite their grievous loss, fully 79% of the parents reported some form of benefit in the experience, the most common of which included a greater capacity to help others, increased compassion for human suffering, and a reduced tendency to take life for granted. Moreover, Coleman and Neimeyer (2010) reported that those widowed persons able to "make sense" of their loss at 6 and 18 months after the death reported high levels of well-being, pride, and satisfaction as much as 4 years following their bereavement. For Bonanno this might reflect resilient people's capacity for adaptive experiences and positive emotion (Bonanno, Papa, & O'Neill, 2002), as opposed to merely

limiting symptomatology. Just how such growth relates to resilience remains unclear, however, as Balk (2008) has questioned how transformation can be possible for the resilient person whose assumptive world has not been challenged, such that new understandings were not demanded and daily functioning returned quickly to baseline.

A rare extension of the largely intrapersonal approach to resilience in grief literature is the contextual resilience framework of Sandler, Wolchik and Ayers (2008), who emphasize the central role of person-environment transactions in the process of adaptation. From this perspective, reorganization of both individual and social environmental systems is needed to enable positive satisfaction of basic needs and developmentally competent role performance for the parentally bereaved child. Researchers using this model have found individual level protective resources such as coping efficacy, appraisal of threat, self-esteem, and control beliefs, in addition to family level variables such as caregiver warmth and discipline, and caregiver mental health (Haine, Ayers, Sandler, Wolchik, & Weyer, 2003; Haine, Wolchik, Sandler, Millsap, & Ayers, 2006; Lin, Sandler, Ayers, Wolchik, & Luecken, 2004).

Although in this model the risk and protective factors occur at the individual, family, community, and cultural levels, the outcomes on which these authors focus are still individual (e.g., mental and physical health problems, substance abuse, grief, life satisfaction and growth for the bereaved child). Similarly, a study by Traylor and her colleagues (2003) shows that family characteristics such as communication and cohesion shortly after the death of a family member are central in the grief process of its members, with individual outcomes being marked by subsequent reductions in grief when families are communicative and connected. Occasional writings in the grief literature consider resilience at the level of family relationships and culture (Kissane & Bloch, 2003; Nadeau, 1998, 2007; Shapiro, 2001, 2008). Shapiro (2008), for example, challenges the exclusive focus on reduced distress as the outcome of interest in bereavement studies. She suggests expanding attention to the outcomes

of interest to include the bereaved themselves, which might be distinct for different bereaved family members. More than the level of functioning or the growth experienced by the individual, outcomes like marital satisfaction, sibling connection, family communication, mutual support, or shared meaning-making could be put forward as important outcomes of interest in their own right. For example, in her work on family meaning-making, Nadeau (2007) describes the importance for family grief and bereavement outcomes of the co-construction of meanings in a family around and after the death of a family member. As she concludes from her grounded theory study, "a family's ability to engage in meaning-making and the nature of the meanings that families co-construct are powerful determinants of how they will grieve and how well they will adapt to their loss" (Nadeau, 2007, p 13). Similarly, Kissane and Bloch (2003) underscore the importance of family communication, family cohesion, and conflict resolution for bereavement outcomes. In their family grief model, they formulate a typology of families based on their relational functioning. Two types of families are considered resilient in regard to coping with the impending loss of a family member: *supportive families*, characterized as highly cohesive, communicative, and free of conflict, and *conflict resolving families*, who experience transient conflict but are able to communicate and negotiate it together. Randomized controlled research suggests that neither of these families requires (or benefits from) professional intervention. In contrast, *sullen families* marked by poor communication, muted anger, and depression, and *intermediate families* characterized by mild reductions in communication and teamwork are quite responsive to professional therapy, using it to accommodate the loss of a family member with much less symptomatology. *Hostile families*, however, which are fractured by distance and conflict, are less responsive to family level interventions and instead are more likely to be helped in individual therapy (Kissane & Hooghe, 2011; Kissane, McKenzie, Bloch, Moskowitz, & O'Neill, 2006).

In summary, the concept of resilience in grief literature has grown against the background of the traditional assumption that mourning is best characterized in terms of grief symptomatology. As such, resilience is mostly defined as the relative absence of pathology in the years after the loss, or even as the opposite of what is called complicated grief. Unfortunately, relational outcomes are only minimally considered. In recent years empirical research mainly has been focused on distinguishing features of the resilient individual or protective factors in the individual-context interaction that promote resilience for the bereaved. Although it is not prominent in the grief literature, a few studies have begun to point to contextual factors, such as family characteristics, that are important for the ability of the grieving individual to adjust to a new life following the loss.

Grief from a Family Resilience Perspective in Family Therapy Literature

For many years, the theme of death attracted only minimal attention in the family therapy literature (Walsh & McGoldrick, 2004). However, since its inception, a family perspective on grief has contrasted with a pathology-based, individual centered approach in adopting an explicit emphasis on resilient systems. Most authors in this field assume that all families have the intrinsic potential to deal with loss in a resilient way, and hence work towards maintaining or strengthening this process (Bava, Coffey, Weingarten, Becker, 2010; Becvar, 2001; Boss, 2006; Greeff & Human, 2004; Kissane & Bloch, 2003; Landau, 2007; Landau, Mittal & Wieling, 2008; Saul & Bava, 2009; Shapiro, 1996; Walsh, 2007; Walsh & McGoldrick, 2004). Most prominent and influential is the work of Froma Walsh, who described a family and community resilience-oriented approach to recovery (2003, 2007). In this model she integrates her systemic approach to loss (Walsh & McGoldrick, 2004) with her framework for family resilience (Walsh, 2003). When families are challenged by the death of a family member, all family members are affected and the family as a whole is transformed. The loss alters the family structure, and changes family organization and patterns of

interaction. All members need to look for a new story that fits coherently into the family's life experience and belief system. Four family tasks should be accomplished for the long term adaptation of all family members and the family as a functional unit: (1) a shared acknowledgement of the reality of death, (2) a shared experience of loss and survivorship, (3) the reorganization of the family system, and (4) the reinvestment in other relationships and life pursuits (Walsh & McGoldrick, 2004). These tasks of family bereavement involve processes in three domains of family functioning: belief systems, organizational patterns, and communication/problem-solving processes (Walsh, 2007). Echoing themes in the more individualistic grief literature, Walsh contends that the loss of a loved one can shatter one's belief system, and that of the family. Through interaction with one another as well as others outside the system, families reconstruct their reality, including their sense of the loss, their suffering, and ongoing life. Families need to make meaning of the loss experience, and regain hope in future possibilities. For some bereaved families their spiritual or religious values and practices bring solace and purpose. In addition, the organization and interactional patterns of a family might be disrupted. Flexibility to adapt to the multitude of associated changes, as well as stability in ongoing daily life is needed. Moreover, for most bereaved the experience of connectedness with family members and other support resources is vital in times of grief. Finally, Walsh (2007) underscores the importance of open communication and problem solving processes for family resilience in dealing with loss. This includes clear, consistent information, emotional sharing and support, and collaborative problem solving following the loss experience. This model of family resilience to loss was also used by Boss (2006) in her work on ambiguous loss. Building and supporting family resilience in this tormenting situation of "an unclear loss that defies closure" (p. xvii), she pays attention to the belief systems of couples and families (e.g., to rethink power and control), their organizational patterns (e.g., to build community) and communication processes (e.g., to encourage

dialectical versus absolute ways of communication) (Boss, 2006, p. 59-67). As the family literature is by definition context sensitive, so too is its approach to grief and resilience, considering the specific contextual features in identifying what is important to a particular family in a particular culture, at a particular time. However, it is noteworthy that these sophisticated systemic models, unlike the more individualistic work in the grief and bereavement literature, are largely undocumented by empirical research.

CLINICAL IMPLICATIONS

Although clearly formulating different approaches to resilience in the aftermath of loss, the grief literature and the family therapy literature underscore similar key processes for the therapist directed toward the strengthening of (family) resilience. Here we make a modest contribution to the bridging of these disparate literatures by discussing three: (1) the reconstruction of meaning, or family meaning-making, (2) open communication, or emotional sharing, and (3) relational connectedness. We illustrate these key processes with stories of the bereaved, in and outside a therapy setting. Finally, we elaborate on the importance of trust in the inherent resilience of the bereaved individual, family, and community in guiding therapeutic decisions—including when *not* to intervene.

The Reconstruction of Meaning

A central process in grief resolution is the reconstruction of meaning, understood as a partly verbal, partly tacit process that unfolds in a social field (Neimeyer, 2001). Clinicians can facilitate this process by making room for the sharing of different meanings related to the dying process, the death, the person of the deceased, and the changed life of all family members. More specifically, it is important to help families create a safe space in which to explore and share meanings related to blame, shame, and guilt connected to the loss, as well as the equally important opportunities to affirm love, draw on unique and cultural meanings and rituals that conserve a sense of continuity during transition, and honor the significance of

their loved one in their joint lives. In transactions around the dying and following the death, family members seek partially communal, partially idiosyncratic significance in the loss and its implications for the future. The contexts for this social (re)negotiation of meaning can be as varied as discussing the meaning of dreams about the deceased and trying to make sense of the circumstances that led to the death. Alternatively, family members may attribute spiritual or philosophic meanings to apparent coincidences, such as hearing the loved one's favorite song on the radio on the anniversary of the death (c.f., Nadeau, 1998). Although much of this family meaning-making arises spontaneously without prompting by the therapist, it can nonetheless be woven into the dialogue of family therapy to foster patterns of resilient adaptation. At other times, explicit invitations to in-session or between-session tasks and rituals can promote adaptation, especially when families are struggling with the meaning of the death and the rupture of attachment with the deceased it occasioned.

One such therapeutic strategy is the *life imprint*, which involves the tracing of the durable legacy of the deceased in the lives of the living (Neimeyer, 2010; Neimeyer, van Dyke, & Pennebaker, 2009). Whether viewed in psychodynamic terms of the introjection of aspects of significant others into ourselves, in postmodern terms of the radical blurring of self and social system, or in simple behavioral terms of modeling, most schools of therapy recognize that our sense of who we are carries the imprint of our important attachment relationships. These can, of course, be perceived at many levels, ranging from our distinctive vocabulary of gestures and expressions, through our ways of speaking, telling a story or relating to others, on through to our central life pursuits, purposes and personalities. Inviting each family member to reflect on those imprints that their loved one conferred on them as a between-session assignment and then share these in the subsequent session can prove to be an emotionally powerful intervention, one that helps them recognize and consolidate the living legacy of the other, who in a very real sense now lives in and through them. Equally

important, recognizing the often different imprint left by the deceased on various family members also acknowledges the complexity and distinctness of each family relationship, opening discussion of the question of why, when family members have had the same loss, they do not necessarily have the same grief (Gilbert, 1996). Of course, it is important to recognize that not all imprints are positive, as survivors could also trace their tendency toward self-criticism or distrust of others to a demanding or emotionally unavailable parent, for example. Still, acknowledging such imprints can itself play a role in healing, as the therapist assists each family member in deciding which legacies to cherish and extend, and which to seek to release and transcend. In fact, it is not uncommon that negative relationships actually empower positive commitments, as when an adult child of an abandoning parent passionately commits to "being there" for his or her own children. In both these indirect ways and in the more direct importation of admirable qualities of the loved one into the self, using the life imprint method in the family setting provides a "counter-narrative" to the dominant story of loss, emphasizing what is retained as a resource for living, rather than relinquished as a result of the death (Hedtke & Winslade, 2003).

Pursuing the use of the life imprint in a joint therapeutic session, Cristina and her adult daughter Nuria each took a few minutes to write about the impact of Jose, the recently deceased husband and father of the family, on their sense of who they were as individuals. In subsequent sharing prompted by the therapist in the same session, Nuria looked on intently as Cristina described movingly how she now carried the confidence her partner had always had in her, as when he supported her desire to study for an advanced degree despite her own insecurity about her ability to do so, and how his undying love for her, even after they had lost an earlier child to stillbirth, instilled hope in her and let her embrace the decision to "try again." Cristina was then affirmed as Nuria, the product of this second attempt at building a family, related how the memory of her father's playful engagement with her through her

youth, and his dying expression of pride in her as she entered womanhood, now gave her conviction to live passionately and to pursue her own ambitions. Through a veil of tears, each woman then gazed into the eyes of the other and embraced, feeling Jose's presence as another set of arms wrapped around them both.

A second resource for collective meaning-making in the wake of loss is *ritual*, which can give impetus to the social reconstruction of meaning by providing symbolic and communal validation of the changed reality of the bereaved, as well as tangible expression to their ongoing sense of connection to the deceased. Such rituals can be as prescriptively precise as a Buddhist *sutra* or a Jewish *shiva*, or as improvisational as relating stories of the loved one around the Thanksgiving table or at a family reunion. Frequently, however, in the therapeutic arena the use of ritual follows the dictum that *such practices need to be sufficiently open to individual interpretation to make them meaningful, and sufficiently structured to make them feasible*. Therapists therefore can assist families by prompting them to discuss how they might symbolically honor the place of their loved one in their lives, or signal their collective transition, taking care to construct an appropriate form of participation of each in the ceremony or activity they develop. As Walsh and McGoldrick (2004) caution, children and the frail elderly are especially likely to be marginalized in the presence of loss in a misguided effort to protect them, so that taking care to include rather than exclude them is a particular therapeutic goal. Most importantly, therapists need to recognize and respect that the most effective rituals are those that are adapted or invented by the clients, rather than crafted by the clinician (Lewis & Hoy, 2011). This does not mean, however, that the therapist cannot play a role in fostering discussion of ritual opportunities, or in the case of disaster work, creating a "safe space" within which families can create and perform their own "acts of meaning" in relation to a collective loss (Kristensen & Franco, 2011).

Holly and Tom's baby Ceclia was born at home on Mother's Day, and then rushed to the hospital. Her under-developed lungs and kidneys could not sustain her, and she died 15 hours later in the arms of her parents, grandparents, and Tom and Holly's brothers and sisters, all of whom had a chance to meet her before her short life ended.

A practical man, Tom humbly went about his work to memorialize her. Cecelia's 4-year-old sister Grace was a strong impetus for him to do so, as he wanted her to have a loving memory of the little sister she had had all too briefly. As an amateur carpenter, Tom recalled the lumber he had cut a year before from a special black walnut tree that he helped a neighbor remove, a tree that he and his family had planted over 30 years before, and that he had cherished memories of playing in as a child. With the assistance of his lifelong friend, Tony, Tom carefully constructed a casket for his newborn daughter, lined with silk and furnished with a tiny pillow that Holly made to symbolically comfort her small body. Not being a man of words, Tom found that his hours of working quietly on his own or with Tony to plane, construct and varnish the miniature coffin gave him the time and space he needed to reflect, and to spend time out of doors in what was his preferred environment. Following the funeral service, he returned to his work on the casket, cutting it in half to accommodate the urn that his company made for him to hold and lay to rest his daughter's ashes following her cremation. The other half, he reasoned, could be fashioned into a keepsake box for her sister when she got a little older, decorated in a way that would be appropriate to its new function.

Holly completed the circle of remembrance by planting another black walnut exactly one year later in Cecelia's memory with the assistance of her daughter Grace. Both Tom and Holly hoped the tree was one that she would play in one day, just as Cecelia might have done if she had had a chance to do so. The tree, they imagined, would get bigger and stronger each year, just like their love for their family. And both hoped that through her participation

in the tree planting as in the funeral, they were also cultivating memories that Grace would take to heart, along with stories she might share one day with others (See note 2).

Open Communication and Emotional Sharing

It is generally assumed that the expression of one's emotional reactions to the loss is an important component of adaptive grieving (Harvey, 2000). 'Storying' our experiences is a way to create coherence and to reorder our sense of self and our worldview, both of which can be threatened by loss. Moreover, sharing grief experiences with family members in an open and honest way can be a key resource in adapting to loss, one that can contribute to stronger bonds and relational intimacy within the family. The possibility of emotionally connecting with significant others in grief can co-construct a shared reality and mutual support, as well as reinforce a sense of security, togetherness, and understanding of each other. Therefore, many family therapists underscore the importance of working with whole family systems in therapy, creating the opportunity for family members to connect in their grief, and enabling them to become more resourceful in facing future challenges. For Walsh (2006), therapists should "try to help family members to find ways to talk about the unspeakable" (pp. 190) and should "press reluctant members to take part" (p. 193).

Notwithstanding the value of sharing grief with family members, we argue for considering the complexity of communication in the context of bereavement (Hooghe, Neimeyer, & Rober, 2011). We see communication as a process between people over time, and want to explore the meanings of both talking and silence in a *dialectical*, *dialogical* and *dynamic* approach. While the bereaved sometimes feel the desire to share how they are feeling and to *dialogue* with others in this grief, at the same time they often feel restraint in doing so in order not to be a burden to others, to spare loved ones the pain, to manage their own emotions, or to respect the impossibility of expressing their devastation in words. This tension between openness and closedness is also experienced on a relational level, in the

communication between people. From a dialogical perspective, the story unfolds in the moment and all participants in the dialogue contribute to its unfolding (Bakhtin, 1986). Sometimes a bereaved family member initiates talking about the deceased, the death, or the grief, while the others are hesitant or not receptive at the time. The therapist is also part of this dialogue, often encouraging family members to share their grief, while sometimes honoring the need to create some breathing space in a 'grief-suffocating climate,' permitting some distance from the intensive raw pain experienced in the session. Moreover, communication is a *dynamic* process, so that every act of speech or silence must be understood in its context of time and space. Who is present in the therapy room, and who is not? What was discussed previously, and what is anticipated next? In clinical practice, rather than approaching grief communication as a necessary condition for all bereaved, we (Hooghe, 2009; Hooghe, et al., 2011) propose to explore the contextual factors, ambivalences, and relational tensions—in a word, the *dialectical* factors that shape the interaction—at a specific moment in the grieving process of the individuals and relationships involved. We therefore try to create a safe space and opportunity to explore with family members the possibility of sharing their grief experiences with others, or, as Fredman (1997) calls it, 'talking about talking,' while simultaneously acknowledging the difficulties of sharing and the good reasons family members might have to *not* share their experiences (Rober, van Eesbeek, & Elliott, 2006).

Marc and Sonja lost their only son Rik, when he was 13 years old. Since his death, two years ago now, they feel like they need to endure life, simply trying to get through every day. In their experience the best way to go on is to spend their days together, each remembering their child on his or her own. They feel a growing distance with most people in their social network because these former friends don't seem to realize and accept how their son is still a part of their lives. The first time they reluctantly came to therapy it was obvious that they very much doubted its usefulness. In this first session and parts of those that followed, the therapist

intensively explored the possible value of psychotherapy for them, and more specifically, how it would be to share their grief with each other and with the therapist. How could psychotherapy or talking about their son be helpful? One thing was certain: no amount of talking would bring their son back. So what could be the meanings of 'helping?' Exploring this further, Marc noticed that he was actually afraid that therapy would make him feel better, *seemingly creating a further distance from their deceased son. At the same time they felt very close to Rik in these sessions, being offered the time and space to remember him, to talk about him out loud. However, they both felt hesitant to verbalize how deeply wounded they felt inside, sometimes to the point that they doubted the value of living. Both feared that making this explicit might hurt the other, and make it more real for themselves. Being there together, listening to each other's immense pain, also felt frightening at times. To see the tears in each other's eyes, recognizing the pain, and knowing that there was so little they could do, was something they can only bear at times. The exploration and verbalization of these fears and hesitations to share their grief were important in creating a safer place for the therapy process, in which they also explored how they could "dose" their exposure to shared grief.*

In the context of grief, talking about the deceased can be a way of both remembering and a way of integrating this memory into everyday life. Riches and Dawson (1998, 2000) use the concept of '*conversational remembering,'* and propose that grief is, at least in part, a process through which the bereaved review and reorder significant events in the life of the deceased, in conversation with others, so as to produce a memory with which they can live. Although not the purpose of this approach, it is our experience that the opportunity to explore and share the meanings of talking and keeping silent about one's grief often creates the needed space for the bereaved family members to talk with each other, and connect in their grief process (Hooghe, 2009). In addition, the necessity of the spoken word in order to

connect with others in grief can be questioned and expanded to nonverbal ways in which emotions can be expressed and shared as the previous vignette about Tom and Holly suggests.

Relational Connectedness

People rarely grieve in a vacuum, but instead do so in a network of relationships, family structures, social networks, and culture. Although the value of social support for the bereaved is subject to debate in grief literature (Stroebe, Zech, Stroebe, & Abakoumkin, 2005), it is generally assumed that these interpersonal connections, and more specifically family hardiness and cohesion (Greeff & Human, 2004; Kissane & Bloch, 2003), are paramount in the grieving process. In therapeutic practice, we aim to reinforce supportive connections with family members, so that families become more resourceful in meeting future challenges. In this way the family is empowered in its capacity for self-repair and in fostering resilience in all its members (Walsh, 1996). Therefore as therapists we want to identify significant connections in the lives of the bereaved, as lifelines in their recovery process (Walsh, 2007). Who makes up the 'psychological family' of the bereaved (Boss, 2006)? What are the natural support resources needed for resilience? In our work with the bereaved we look for ways to help them optimize reliance on and reinforcement of human connection in its most natural context, the family (Kissane & Hooghe, 2011). In this fashion both existing and new support resources are identified and reinforced.

A bereaved mother, Mieke, came to therapy following the loss of her son, Pieter. For the first session her husband, Koen, and daughter, Veerle, were invited to come as well, but only her husband accepted the invitation. Veerle, Pieter's twin sister, was not yet ready to talk about her loss, as Mieke explained. Koen made it very clear from the beginning that he came along to please his wife but that he would only do so once. Exploring his reluctance, he explained how talking was not a good way for him to deal with his loss, as it was too painful. In addition, he was recently diagnosed with a brain tumor and would spend much of his time

the next few months in the hospital for chemotherapy. For Mieke it was important to hear that his reluctance had to do with its being too anguishing, rather than his being unaffected by the loss of their son.

In the following sessions we explored the possibility of inviting Mieke's sister, Greet, to accompany her. In the presence of her supportive sister, an atmosphere emerged in which to comfortably share stories related to the loss of Pieter, as well as their fears about Koen's pending death. With her sister, Mieke shared her loneliness, her fears, and even began to plan for Koen's funeral. The therapist discovered that the two sisters developed their own ritual while driving to therapy. While the actual journey took only 20 minutes, they allowed a full hour. Laughingly, they admitted that they had their "own secret spot, somewhere down the road" to talk together on the way. After each session, they regularly treated themselves to an ice cream as a reward for their hard and emotional work. In this way, they connected for more than three hours during each evening they came to therapy.

One week after the seventh session, Mieke called the therapist to say that Koen had died. The last days of his life had been "horribly painful, but also very connected and loving." At the funeral, Mieke expressed appreciation not only for the therapy, but especially for the wonderful connection with her sister, who had been beside her, often silently, in the last days of Koen's life. [4]

Working with the irreversibility of death and the raw pain of clients who have lost someone whom they loved deeply, therapists often feel powerless to lighten this kind of deep suffering. As this case illustrates, family members can be a rich support for each other not only in the sessions, but also, and even more importantly, in their shared world of everyday living.

TRUSTING RESILIENCE

[4] A more extensive discussion of this case also appeared in Kissane & Hooghe, 2011.

In the context of our qualitative research study on the sharing and not sharing of grief within the partner relationship after the loss of a child (Hooghe, Neimeyer, & Rober, 2011), we encountered a great deal of resilience in the bereaved couples we interviewed. Unlike the couples we see in our psychotherapy practice, most of these bereaved parents did not chose to pursue psychotherapy. Although they all acknowledged the pain of grief, they also stressed the importance of finding their own unique ways of dealing with it in the context of their natural support systems. For example, Gunter, one of the bereaved fathers, explained how it would not be a good thing for him to talk about his grief too much, or share his pain in a therapy context, *"I don't feel inhibited to talk about it, so I don't feel like I'm suppressing it. But I'm not searching for it either."* He added that even the interview could hold the risk of things surfacing, while he and his wife have been doing well in the considerable time since the loss:

> *At this point we have a good coping trajectory of many years, and I think we are doing okay together…. It could be that we are a little strange, but we can live with it for the rest of our lives, without having too much burden from it.*

A subtext of the foregoing material, from the research review through the description of therapeutic procedures to clinical and non-clinical vignettes, is that many of the bereaved adapt stoically, practically or creatively, to the hard reality of their loss, and do so without the intervention of professional therapists. And this is hardly surprising, given that human beings are "wired for attachment in a world of impermanence" (Neimeyer & Noppe-Brandon, 2011), and thus have evolved in a way that they are able to adapt capably to life's many unwelcome transitions. This fundamental adaptability underlies our capacity for resilience, even in the face of profound loss, as we revise our basic roles and goals in light of the changed life we now have. In doing so, we draw on both individual and communal resources, in effect

reaffirming or reconstructing a self- and family-narrative that has been challenged by bereavement.

As ample data illustrate, resilience among the bereaved is more the rule than the exception, with a solid majority of those persons who lose a loved one adapting to their changed lives without debilitating and prolonged symptomatology (Bonanno, 2004; Bonanno, Wortman & Nesse, 2004, etc.). As a corollary of this fundamental postulate, dozens of randomized controlled trials of grief therapy demonstrate that it makes little contribution to the adjustment of the bereaved when offered "universally" to all who have lost a loved one (Currier et al., 2008; Neimeyer & Currier, 2010). Somewhat more evidence supports the helpfulness of professional therapy provided "selectively" to those persons suffering high-risk bereavement, such as children losing a parent, parents losing a child, or those whose loved ones have died by violent means—suicide, homicide or fatal accident. However, the strongest case for the efficacy of grief therapy can be made when it is extended to "indicated" cases of complicated, prolonged and debilitating efforts to accommodate the death, in which case it yields clear and consistent contributions to client well-being (Currier et al., 2008; Neimeyer & Currier, 2009). As work proceeds to identify the shared features of these effective interventions (Shear, Boelen & Neimeyer, 2011), there is reason to hope that professional therapy can help provide the additional resources to those clients struggling with life-limiting loss required to help them achieve the hopeful adaptation that their more resilient counterparts demonstrate without clinical assistance.

RESEARCH IMPLICATIONS

As recent handbooks and research reviews demonstrate, a great deal of clinical relevance has been learned about grief and its vicissitudes in the last decade (Center for the Advancement of Health, 2004; Neimeyer, Harris, Winokuer, & Thornton, 2011; Stroebe, Hansson, Schut, & Stroebe, 2008). However, much of this research focuses on the

"pathology" of grief, with much less attention being paid to those processes by which individuals adapt constructively to loss. Moreover, as was evident in our own research review, the great majority of those studies that do shed light on resilience among the bereaved focus on individualistic factors in adaptation, rather than on the systemic factors that promote or sustain it. In its starkest expression this contributes to a literature marked by the "accumulative fragmentalism" of dozens of individual-focused studies in the bereavement literature on factors correlated with adaptation to loss, but in the absence of an over-arching theory, juxtaposed with grand and sweeping models of family resilience following loss, which are minimally grounded in research. Clearly any useful research agenda should seek to close this gap by positing and pursuing the study of processes of adaptation that span the self and system, and that investigate outcomes defined at relational as well as individual levels.

What might be some questions that could be addressed within this frame? Although the paucity of research done to date on systemic factors in bereavement leaves ample room for imaginative investigators, a few illustrations might be offered. For example, how might couples collaborate to support one another as well as surviving children in the aftermath of the death of a child? How does emotion regulation occur between people as well as within people as they contend with severe grief? How do meaning-making processes, whose role in predicting positive outcome is amply documented at individual levels, play out in the crucible of family communication? And what distinctive risks and resources exist for culturally distinctive groups as they strive to accommodate often violent loss against a backdrop of a history of racism on the one hand, and a supportive spirituality on the other? Some intriguing hypotheses about each of these and many other topics are suggested by thoughtful qualitative research done to date (Buckle & Fleming, 2010; Hooghe et al., 2011; Nadeau, 1998; Rosenblatt & Wallace, 2005), but much more remains to be done to craft clinically grounded and empirically informed models to assist therapists working alongside families facing loss.

CONCLUSION

Both our work as clinicians and our efforts as researchers confront us with the hard reality of death in human life, and with the equally real phenomenon of human resilience in its wake. At profoundly personal as well as intricately interpersonal levels, the clients with whom we sit share stories of devastation, and more often than not, gradual reconstruction of a livable life by dint of their own efforts, the support of their families, communities and cultural resources, and—gratifyingly—our own well-intended efforts to help. We hope that this chapter provides encouragement to other clinicians who find themselves facing the existential challenges of bereavement with their clients, as well as to researchers who seek to shed more light on the factors that foster and sometimes frustrate their adaptation in the aftermath of loss.

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