CHAPTER 1

Facing Death and Loss

The Human Predicament

In coming to accept death, we can more fully embrace life.
—Viktor Frankl, *Man's Search for Meaning*

Of all human experiences, death and loss pose the most painful and far-reaching challenges for loved ones. Unbearable, shattering, devastating, unspeakable are words commonly used to capture the impact of a tragic loss. Bereavement theory, research, and practice have focused primarily on individual grief after the loss of a significant dyadic bond. Yet the impact of a death ripples through entire relational networks, touching many lives with immediate and long-term ramifications. Couple and family bonds can be broken; hopes and dreams may be shattered. The submerged pain of overwhelming loss may surface years later in problematic behavior, relationships, or life pursuits, which bring people to therapy.

This book expands our lens to address grief and adaptation to loss in light of complex systemic processes in situations of complicated and traumatic loss. Applying a resilience-oriented framework, the approach presented here attends both to the experience of deep suffering and to the human capacity for adaptation and positive growth. With this approach, practitioners working with individuals, couples, families, and other relational systems can address risk factors for maladaptation and can facilitate relational processes and supportive resources to heal from grief and to live and love fully in the wake of loss.

OVERCOMING AVERSION TO ATTENDING TO DEATH AND LOSS

Mental health professionals work with many situations of extreme suffering, ranging from serious health and mental health conditions to addictions, violence, and sexual abuse; we treat widespread trauma effects in the ravages of war, community disasters, and global pandemics. Yet many practitioners are uneasy in approaching death and loss. Our own anxieties are aroused because we must all experience their impact. There is no safe boundary between professionals and our patients/clients: we, the helpers, are all vulnerable, facing the inevitability of our own mortality and the devastating loss of loved ones and others important in our lives.

Irving Yalom (2009) observed that living with awareness of death is like trying to stare directly at the sun—we can glance, but we quickly look away. We all have difficulty facing our anxiety. Highway traffic slows down to witness a crash site—then speeds up again, it could have been us. For some, the fear can lead to unhealthy rumination; for others, it can go underground, surfacing later and in other relationships. Some seek escape in overwork or affairs, in alcohol or drugs. Others defy (or invite) death in risk-taking behavior. Yet, as Yalom contends, we cannot live or love fully if we are frozen in fear or denial. Rather, by facing it and grasping our human condition, we can savor the preciousness of each moment and more fully live and gain compassion for ourselves and for all others.

DEATH AND LOSS IN SOCIOHISTORICAL CONTEXT

Families over the ages have had to cope with the precariousness of life and disruptions wrought by death. Before modern medicine, death frequently struck young and old alike—as tragically, it continues to do in marginalized and underresourced communities. Even when commonplace, each death is a profound loss for loved ones. Until 20th-century medical advances, the life expectancy in North America was just 47 years—an age now considered midlife. Parental death often disrupted family units, shifting members into varied and complex kinship networks. Before the advent of hospital and institutional care, people died at home, where all family members, including children, were involved in preparing for death. Modern technological society fostered the avoidance of grief processes as Western medicine, hospitals, and nursing homes removed the frail and dying from everyday life and community supports. Geographical distances and pressured work schedules in modern life increasingly hindered direct contact of family members at times of death and dying.

Across cultures and faiths worldwide, mourning beliefs and practices have facilitated both the integration of death and the transformation of survivors, who must carry on with life (see Chapter 3). Most traditions hold a worldview and rituals that facilitate acceptance of the inescapable fact of death, including it in the rhythm of life, the passage to a spiritual realm, and an abiding faith in a higher power. Most approach loss as an occasion for family and community cohesion and mutual support.

The dominant Anglo-American culture, in contrast, has fostered avoidance in facing death and has encouraged the bereaved to minimize the profound impact of loss (Becker, 1973). Western medicine has tended to view death as a failure of treatment. Workplace systems expect a rapid return to job responsibilities, and few offer paid bereavement leave. Our ethos of "the rugged individual" urges the bereaved to quickly gain "closure," "get over it," and move on with life. A dichotomous view prevails in masculine images: "staying strong versus falling apart." Reflecting this cultural aversion, the training and practice of mental and behavioral health professionals have been slow to recognize and address loss-related issues.

Yet, there has been a growing recognition of the importance of attending to anticipated loss with life-threatening conditions and to care for the dying and the bereaved (see Chapter 4). Developments in palliative and hospice care ease suffering and provide support and comfort to patients and families facing end-of-life challenges. Still, sudden, preventable, and untimely deaths are all too common in underresourced, racial/ethnic communities and other marginalized groups.

The internet and social media have expanded attention to widespread traumatic losses in catastrophic events worldwide, from major disasters to war and mass killings (see Chapter 11). We have been navigating perilous times through the COVID-19 pandemic, with heightened awareness of the precariousness of life and death and multiple losses in our volatile and uncertain global environment. The tragedy for each bereaved family can be obscured by statistics, particularly when others are eager to move on. The need is all the more urgent for therapists to attend to the bereaved and to support their positive adaptation going forward.

Amid the social, economic, and political upheavals of our times, many families are dealing with multiple losses, disruptions, and uncertainties. This volume focuses on loss through death; yet, the adaptational challenges and intervention approach described have broader applicability to other disruptive life experiences involving loss, such as migration, unemployment, illness/disability, family separation, divorce, foster care, and adoption (Harris, 2020). By attending to their grief and life disruptions and in strengthening their resilience, we can help those affected to deepen vital bonds and forge new strengths.

LOSS IN COUPLES, FAMILIES, AND OTHER RELATIONAL SYSTEMS

Our understanding of loss and our clinical approaches with those in distress must be attuned to our clients' relational lives and their social contexts. Couples and families today are increasingly diverse and complex, each weaving a web of intimate bonds and kinship ties within and across households and geographic locations and over an expanded life course (Walsh, 2012). Demographic trends reveal growing cultural diversity; varied family structures, role relations, gender identity, and sexual orientation, as well as socioeconomic and racial disparities in resources and life chances.

A broad view of family and other significant bonds is crucial to understand the meaning and significance of losses in immediate and extended relationships. Families may involve multigenerational and social networks, and they may be defined by blood, legal, and/or historical ties; by formal and informal kinship bonds; by residential patterns within and across households; and by past and/or future commitments. Bonds with cherished companion animals can bring profound grief with their loss (see Chapter 8). Many persons consider their closest friends or interpersonal networks as their "kindred spirits" or chosen families, as is common in lesbian, gay, bisexual, transgender, queer, and other gender or sexual variant (LGBTQI+) communities. The impact of loss can also reverberate throughout closely knit workplace, healthcare, and educational networks, faith congregations, and communities. Systemic responses in each situation can facilitate individual, relational, and group healing and resilience.

UNDERSTANDING LOSS IN SYSTEMIC PERSPECTIVE

Attention to bereavement in clinical theory, research, and practice has focused primarily on individual grief reactions to the loss of a significant dyadic bond. In the family, a parental death for a child is also a spousal loss for a surviving parent and the loss of a child for grandparents. Individual members who are not symptomatic or seeking help are often presumed not to need attention. Yet, the impact of a significant loss ripples across the relational field, touching all others and their bonds, even years later, and affecting those who may not have even known the deceased.

In my clinical experience, a husband may send his intensely grieving wife for counseling after the death of their child, while distancing from her sorrow and his own, not knowing how to be helpful or checking his

own grief to keep strong and function on his job. The wife, in contrast to her empathic therapist, may feel abandoned by her spouse, with mutual withdrawal and alienation. In another situation, a wife, overwhelmed emotionally by the sudden death of her beloved father, turns on her husband, raging at his every fault; she abruptly leaves him and moves away, leaving their confused and abandoned children in the wake. Two years later, he seeks therapy, still trying to make sense of the divorce and his personal faults, wanting to help his kids who are hurting and hesitant to trust a new intimate relationship.

Attachment theory has offered an understanding of the roots of grief in early-life dyadic bonds with a primary caregiver (Bowlby, 1982). Insecure early attachments can influence not only painful difficulties with the loss of that bond, but also problematic reactions to bereavement in other relationships in life, including prolonged or blocked grief, anxiety, and depression (Rubin, Malkinson, & Witzum, 2012). Byng-Hall (2004) expanded Bowlby's dyadic perspective to the relational system, stressing the importance of a secure family base and showing how complex dynamics affect family loss processes across the generations (see Chapter 10).

A systems orientation attends to the interactional processes and mutual influences throughout the relational network. Loss is a powerful nodal experience that shakes the foundation of family life. Individual distress stems not only from grief, but also from the realignment of the family structure and emotional field, affecting marital, sibling, and intergenerational relationships. Murray Bowen (1978) and others observed how death or threatened loss can disrupt a family's functional equilibrium. The intensity of the reaction is influenced by the significance of the lost member, by the circumstances of the death, and by relational dynamics and family functioning at the time of the loss, as will be addressed in the chapters throughout this volume.

Family cohesion can be shattered with a traumatic loss, each member reacting in their own ways and without relational support (see Chapter 9). One child may be withdrawn, depressed, or anxious, while another sibling may externalize distress in problematic behavior and yet another may seem to be unaffected or will act cheerfully to support an overwhelmed parent (see Chapter 6). Parents may deflect their grief by focusing on a symptomatic child, who is brought in for individual therapy, when the whole family is suffering and is needing help.

> Many months after the mother's death to cancer, Zoe, 19, away at college, was crying uncontrollably and unable to study; individual grief counseling was unhelpful. At home, her brother, Greg, age 12, was isolated in his room, immersed in video games. Her sister Denise, 16, kept

cheerfully attentive to their widowed father, who was preoccupied with his demanding job.

The father and daughters came for a family consultation session with me. (The son had refused to come.) Denise sat close to the father; Zoe sat across the room, near the door. I began by offering my condolences for their loss and asked them how our session might be helpful. The father looked over at Zoe, who replied, "I can't stop crying." I asked, "Have you all shared your tears with each other?" Zoe responded, "I feel like I have all the tears for everyone. My brother's checked out. My sister's acting like the little mother, taking care of our father—and Dad [turning to him]: You act like you don't even care that Mom died!" I asked, "Would it help if your dad could share his tears?" She nodded vigorously, "Yes, yes!" As Denise reached out to pat her father's arm, I asked her thoughts. "I worry that he loved my mother so much, he could fall apart or just disappear and we would lose him, too. So, I try to keep his spirits up." Turning to their father, I asked how this terrible loss has been for him. He replied, "It's all too much to bear, so I try to keep strong for my kids and just keep functioning." Acknowledging the pain and concerns of each of them, and noting the son's absence, I observed how hard it is to grieve such a huge loss alone and how beneficial their mutual support could be in their healing process. The father nodded, adding, "I didn't realize how much we all need each other to get through this—and how they need me to help them."

Beyond the grief reactions of the closest members, emotional shock waves can reverberate throughout the relational network, immediately or long after a death. Unbearable losses can fuel strong reactions in other relationships—from marital conflict, distancing, and divorce to precipitous replacement or extramarital affairs (Paul & Paul, 1986). In our separate early research and clinical practice, Monica McGoldrick and I observed serious complications of past traumatic losses throughout the family system and across generations (McGoldrick & Walsh, 1983; Walsh, 1983; Walsh & McGoldrick, 1991, 2004; see Chapter 10).

How the family handles the loss situation has far-reaching effects, as I have seen in my practice over the years.

Hope, a divorced woman in her 50s, came for individual therapy at the urging of her adult children, who complained, "You've got to stop overmothering us—we're grown adults with children of our own!" While generally in good health, Hope suffered for many years with fibromyalgia.

In the first session, Hope said she couldn't help worrying—she didn't know how to be a mother of adult children, since she had lost

her own mother to cancer when she was 7. As we explored that loss, she recalled feeling abandoned in the months before the death, as her father hovered over her mother and tried to shelter her from child care burdens. She recalled the last night, when relatives gathered behind closed doors in the parents' bedroom, where her mother lay dying. Hope dressed her younger brother and herself in their Sunday best, and they sat holding hands, waiting to be called in to say their good-byes, but no one came for them. In the chaotic days that followed, they weren't taken to the funeral, with well-intentioned relatives believing it would be too upsetting for them. As their father was too overwhelmed in his grief to care for them, two aunts each took in a sibling, separating them from mutual support, with anxious uncertainty when or if they would return home to their father.

On their return several weeks later, the father, isolated in his unbearable grief, drank heavily and came into her bed at night, sexually abusing her. Her secret torment continued until he remarried a year later. Listening with compassion to her story, I noted that Hope showed no anger in relating this abuse—the first time she had ever revealed it to anyone. She said she never blamed her father because she felt so sorry for his deep sadness and loneliness; it comforted him and eased her fear of losing her only surviving parent.

Years later, Hope married a man who was a heavy drinker. She endured his physical abuse for many years to keep her family intact for her children until they were grown. I asked about her brother. She said their close bond remained her lifeline over the years—they checked in with each other daily. It was only at that point in our sessions that she broke down sobbing, revealing that Jim had died a year ago in the crash of a small plane.

Legacies of loss find expression in far-ranging patterns of interaction and mutual influence among the survivors and across the generations. Therefore, it's important for therapists to assess the relational system and the family dynamics surrounding loss to understand the meaning and context of presenting difficulties. As in this case, some families fall apart after an unbearable loss, with surviving partners/parents unable to provide needed comfort, reassurance, and security in the aftermath. Anxieties with secondary losses of separation, unclear communication, and future uncertainty increase suffering. Sibling bonds can be vital lifelines through loss and disruption and for years to come. The recent tragic death of Hope's brother was a devastating loss of her primary bond and reactivated her childhood trauma, with reverberations in her relationships with her adult children. The biopsychosocial interconnections of painful loss also emerged in a flare-up of her fibromyalgia.

A systemic approach is a conceptual orientation to practice, whether working with individuals, couples, families, or communities. In addressing loss from a systemic perspective, we attend not only to individual grief but also to family processes and larger contextual influences that constrain or facilitate healing and resilience, as will be considered in the chapters that follow. The complex meanings of a particular loss event and individual responses to it are shaped by family belief systems and significant life experiences. A loss may also modify the family structure, requiring reorganization of roles and other relationships. A death in the family system involves multiple losses and reconfigurations in numerous relationships, in role functioning, and in the family unit:

- Loss of the person
- Loss of each member's unique bond
- Loss of functional roles
- Loss of the intact family unit
- Loss of hopes and dreams for all that might have been

The impact of loss is greater the more central the role the deceased had, such as primary breadwinner, caregiver, or matriarch. Loss of the love of one's life or an only child leaves a particular void. Grief in highly conflicted or estranged relationships may be unexpectedly strong and often more painful because it is too late to repair bonds. Widespread catastrophic events, such as disasters, epidemics, or war or political oppression, may involve multiple losses and displacement in kin and social networks, homes and communities, schools, jobs, and income security.

When significant losses have been unattended, symptoms are more likely to appear in a child, or spousal conflict may erupt, without connecting such reactions to the loss. Therefore, to better understand the meaning of symptoms and to facilitate healing, it is important to assess the relational configuration, the significance of painful losses, and the family's transactional processes surrounding the loss.

BEREAVEMENT IN SOCIAL AND DEVELOPMENTAL CONTEXTS

The meanings and ramifications of loss vary depending on the intersection of multiple variables, including the nature and circumstances of a death, the state of relationships, family functioning, sociocultural influences, and the phase of individual and family life-cycle passage at the time of loss, as will be addressed in the chapters that follow.

An ecosystemic orientation (Bateson, 1979) informs our work with

the dying and bereaved. We attend to interconnected biopsychosocial influences in adaptation to loss, with expanded attention to the social context. It may be important to address barriers in healthcare, financial, and other resources that constrain adaptation and to mobilize practical and emotional supports in extended kin and social networks, communities, educational and work settings, and other larger systems. Socioeconomic inequities and marginalization involving poverty, racism, sexism, heterosexism, and other forms of discrimination render disadvantaged groups at higher risk for fatal conditions, traumatic losses, and complications in adaptation (McDowell, Knudson-Martin, & Bermudez, 2019).

Like the social context, the temporal context holds a matrix of meanings, influencing present and future adaptations with loss. From a developmental systems perspective, death and loss are not simply discrete events. They involve many interwoven processes connecting the deceased and survivors and significant others over time—from the threat and approach of death, through the immediate disruption and aftermath for the bereaved, and on to long-term implications in life strivings and other relationships. The unbearable heaviness of remembering leads some to disconnect from themselves, their past, their loved ones, and new attachments. In clinical practice, clients may present individual or relational problems that stem from or reactivate past loss experiences, often out of their awareness of connection.

A family life-cycle perspective attends to the mutual influences within and across generations as they respond to loss and move forward over time (see Chapters 6 and 10). Current difficulties may be exacerbated by a pileup of stressors or previous adverse experiences. We consider past, present, and future connections, not in deterministic causal assumptions, but rather in exploring their possible relevance. Each loss ties in with all other losses and yet is unique in its meaning. The ability to accept and integrate loss as a natural and inevitable milestone in the life cycle is at the heart of healthy processes in human systems. Although loss is painful and disruptive, sharing grief with kin and community facilitates healing and the ability to reengage fully with life.

ADVANCES IN UNDERSTANDING GRIEF AND ADAPTATION TO LOSS

Contemporary approaches to bereavement, grounded in extensive research, have advanced from earlier griefwork models, which were heavily influenced by Anglo-American cultural norms and psychoanalytic theory. Based on assumptions about normal versus abnormal grief, they purported

a single, universal standard of normal grief, with other responses viewed as pathological. Clinical approaches have evolved from a simple "one-size-fits-all" griefwork model to appreciate the varied and complex mourning processes in family, social, and developmental contexts. Current best practices emphasize the following:

1. There are many varied ways to grieve and adapt to loss. There is no single "right" or "best" way for healthy bereavement. Epidemiological and cross-cultural studies have documented a wide variation in the timing, expression, and intensity of individual grief responses (Wortman & Silver, 2001). Sociocultural standards, religious teachings, family traditions, and personal differences influence a wide range of mourning approaches.

2. Grief processes do not follow an orderly progression or stage sequence, as proposed by Kübler-Ross and Kessler (2005). Common reactions of shock and disbelief, anger, bargaining, sorrow, and acceptance are better seen as facets of grief, which ebb and flow over time and can resurface with unexpected intensity. Sorrow and yearning for all that was lost are most common. Yet, popularized notions of passage through stages of grief have persisted in faulty linear expectations of progress and completion that too often compound the pain of loss (Stroebe, Schut, & Boerner, 2017).

3. Adaptation to loss does not mean resolution, as in some complete "once-and-for-all" getting over it. Significant losses may never be fully resolved, and grief may resurface years later or persist over a lifetime. Therefore, I prefer not to use the term unresolved loss to refer to troubling or unaddressed issues that may bring people to therapy. Mourning and recovery are gradual, fluid processes, usually lessening in intensity over the months and years following a loss. Yet various facets of grief are commonly aroused, particularly at anniversaries, birthdays, and milestones.

4. Adaptive coping involves a dynamic oscillation of attention between loss and restoration. In dual processes, the focus of the bereaved alternates: at times on grief and at other times on emerging life challenges (Stroebe & Schut, 2010). Beyond brief grief-focused counseling in early bereavement, therapeutic attention may be needed to address the practical, emotional, and relational challenges for survivors in reorienting their lives. Some may not seek therapy until many months after a death, when the immediate crush of responsibilities subsides and social support wanes.

5. Continuing bonds: Transformation of bonds. Death ends a life but not relationships. Past grief theory emphasized the importance of "letting go" and detachment from the deceased. Healthy mourning processes are now seen as a transformation of emotional connection from physical presence to continuing bonds (Klass, Silverman, & Nickman, 2014; Walsh & McGoldrick, 2004). These bonds are sustained through spiritual connections, memories, stories, photos, deeds, other relationships, and legacies passed on to future generations.

6. Grief is a healing process over time: We don't get over it; we move forward through it. We often speak of the recovery process as a journey, yet it is not a journey anyone chooses, and it does not have a final destination. The path forward has many twists and turns, with few guideposts along the way. Clinicians do well to slow down pressure by clients and well-intentioned others for rushed and rapid "closure" of painful emotions. Although loss is disruptive, we heal and grow stronger by going through it, not by getting over it.

7. We are fundamentally relational beings. Healing and resilience are best forged through relational connections and social support (Shapiro, 2008). By sharing grief and ways to honor the deceased with kin and community, we regain our spirit to reengage fully with life and other relationships going forward.

NORMALIZING AND CONTEXTUALIZING COMPLICATED GRIEF PROCESSES

Extensive research finds that most bereaved persons experience transient and moderate distress over the early weeks and months after a death. Over time, the vast majority gradually adapt, returning to baseline levels of functioning, and many forge positive growth through the painful experience.

A small percentage of bereaved individuals (10–20%) suffer complicated grief, with a range of mental, physical, functional, and/or interpersonal impairments (Stroebe, Schut, & van den Bout, 2013). Research has focused mainly on individuals who suffer profound and persistent psychological distress in the loss of a significant dyadic bond. Studies find a heightened risk for poor physical health, shortened life expectancy, and suicide. Grief symptoms, such as yearning for the lost person and rumination about the death, often continue to dominate life, with the future seeming empty and bleak, and the person feeling lost and alone.

Based on studies of complicated grief in older widows and others who lost a significant attachment, Prigerson and colleagues proposed a new diagnostic category, prolonged grief disorder (PGD), which includes a range of symptomatic criteria (Prigerson, Kakarala, Gang, & Maciejewski, 2021). In 2013, the American Psychiatric Association adopted PGD as a new psychiatric condition in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). PGD was also added to the *International Classification of Diseases* (ICD-11; World Health Organization, 2019; see Killikelly & Maercker, 2018). Both included grieving persons whose symptoms persisted longer than 6 months after a death. This provoked a backlash in a broader critique that mental health professionals were overdiagnosing and overmedicating patients (Kleinman, 2012), reviving a longstanding concern that grief not be treated as a disease (Engel, 1961).

In response, in 2022, the American Psychiatric Association revised its diagnostic criteria for PGD in DSM-5-TR. It now requires at least three of eight distressing mental and emotional symptoms for at least 12 months after the loss of a close attachment, with impairment in important areas of functioning (and distinct from major depressive disorder, posttraumatic stress disorder (PTSD), substance use, or other medical condition; Prigerson, Shear, & Reynolds, 2022). Prolonged grief disorder therapy (PGDT), a 16-week program of individual psychotherapy designed by M. K. Shear, focuses on symptoms concerning the lost bond, drawing on exposure techniques for victims of trauma for symptom reduction (Prigerson et al., 2022; Shear, 2015).

The diagnosis of PGD was intended to increase access to treatment for bereaved adults suffering a year after a loss (or at 6 months for youth) and unable to return to normal activities. However, the psychiatric classification of prolonged grief as a mental disorder poses several concerns for clinicians and for those needing help with bereavement. In the United States, the reimbursement system for psychotherapy is tied to managed care and the insurance industry, requiring a DSM diagnosis for coverage. With the DSM designation, clinicians can now bill insurance for treating people diagnosed with the condition. However, many who are in distress are reluctant to come for therapy with the stigma and shame of a psychiatric disorder. Having a diagnosis of mental disturbance on their permanent health records is also a serious concern. Yet, without the diagnosis, they may be denied coverage for loss-related issues. Clinicians sometimes use nonpathologizing diagnostic categories, such as reactive/adjustment disorder with anxiety or depression, but reimbursement may be denied if longer term therapy is needed.

A further concern is that the psychiatric diagnosis will lead to

overmedicating the bereaved without attending to their loss experience and adaptational challenges. While short-term psychotropic drugs may be helpful in regaining daily functioning or reducing risks of self-harm, it's vital for clinicians to assess and address complex relational and contextual influences that may contribute to suffering and constrain adaptation. For instance, withdrawal into isolation, rumination, and despair after painful losses and the high risk of suicide are strongly influenced by social stigma and a lack of family and social support as well as by financial duress.

It's also problematic to define a certain length of time as a prolonged grief disorder. Setting a time limit implies that normal grief should be subsiding by this point and that further distress is abnormal. In a society that minimizes bereavement processes, it further stigmatizes grieving people who are encouraged to "get over it" as quickly as possible. Although the DSM adds that the duration and severity of the bereavement reaction should clearly exceed an individual's social, cultural, or religious norms, the criteria are based on American research and norms. Across and within cultures, there is tremendous diversity in what are considered normal mourning processes, such as length of time and emotional and behavioral expression. Gender and generational norms differ, and responses vary with the unique situations of a death, the relationship and role functioning lost, and the ramifications for survivors. The sudden death of a child, the loss of the family breadwinner, the destruction of homes and communities, or violent deaths in a car crash, homicide, or suicide are likely to pose more lengthy and complicated bereavement processes—which are normal (i.e., expectable, common, and understandable in context) in unexpected, extreme, or abnormal situations.

In sum, loss situations and grief and adaptation processes are varied and complex. A diagnosis of mental disorder and an arbitrary time frame for normal versus disordered grief don't account for the many influences that may contribute to distress and overwhelm functioning. Professionals need to be wary of any expectation that intense suffering should subside within a specific time. Moreover, clinicians need to be particularly alert to later bereavement complications that only arise long after a significant loss, as we found in our research and clinical experience (see, e.g., Walsh & McGoldrick, 2004). With the emotional upheaval of an unbearable loss or the press of immediate practical demands, initial grief may be submerged, only to surface in intense distress at an anniversary of the loss, another milestone, or in other relationships or life pursuits. Some persons come to therapy years later, presenting other mental or physical health concerns or relational or career problems that are related to a painful past loss, often

not initially connecting their current difficulties to the earlier experience (see Chapter 10).

As Attig (2011) has cautioned, grieving is not about coming down with grief symptoms to be treated, and no one can grieve for us. More than painful reactions, the grieving response involves an active process in coping and relearning how to be and act in a world where loss transforms our lives. Loss forces us to relearn daily patterns and relationships with ourselves; with others, including the deceased; and with our faith; and to reexamine the meanings of our lives. Experiences with loss and grief are varied, complex, and richly textured. These life stories need to be understood for helping professionals to support clients' healing and resilience, soon after a loss or later in their life passage.

Understanding Traumatic Loss

The terms *trauma* and *traumatic* have become so widespread that they tend to be overgeneralized, often pathologizing normal or varied responses to sudden, extreme, or violent loss situations. Trauma literally means "wound, injury, or shock." A traumatic loss can refer to (1) an extreme and shocking death event, (2) an overwhelming experience, and/or (3) a debilitating personal reaction. Traumatic loss experiences can wound the mind, body, spirit, relationships with others, and future life pursuits. Trauma-informed individual approaches, combining cognitive-behavioral and exposure techniques, can be helpful in many cases (Perlman, Wortman, Feuer, Farber, & Rando, 2014).

Some loss events are so highly stressful that most people would find them traumatic, such as a violent death, murder, suicide, war, or widespread disaster. Yet there are considerable individual, relational, sociocultural, and contextual differences in impact. Too often, survivors are presumed to have PTSD, with faulty assumptions that most persons—adults or children—affected by the experience are likely to suffer profound and long-lasting damage.

Traumatic stress research has documented the human potential for recovery and resilience in a range of traumatic loss situations and social contexts. Studies of neurobiological and psychological processes show that acute stress symptoms are common in the immediate aftermath. Although some individuals are more vulnerable, no one is immune to suffering in extreme situations. Yet there is wide individual variation at the same level of risk: while up to a third experience long-term dysfunction, most distressed persons experience gradual recovery over time, and many forge remarkable resilience. Intense grief, suffering, and struggle to move

forward often yield new strengths, transformation, and growth (Tedeschi, Shakespeare-Finch, Kanako, & Calhoun, 2018; see Chapter 2).

Healing and Treatment in Clinical Practice

Healing and treatment are distinct approaches in clinical practice. Western science, medicine, and psychotherapy have tended toward an unbalanced focus on pathology, with treatments designed and administered by experts and focused on symptom reduction. In addressing life-threatening conditions, metaphors of war and combat are prominent: winning or losing the battle, with aggressive treatments seen as weapons to destroy disease and conquer death.

Helping professionals foster healing through a collaborative therapeutic relationship that strengthens resources within the person, the family, and the community. Integrated biopsychosocial healthcare (McDaniel, Doherty, & Hepworth, 2013) focuses on the whole person and their loved ones and attends to influences in the family and larger systems to address suffering and foster well-being. Understanding systemic processes with an unbearable loss can enable clinicians to enhance functioning for healing and resilience.

Although psychotherapists are considered specialists in the healing art, some are uncomfortable with the notion of healing, in connotations of the therapist as healer, with the power to cure or alleviate pain, much like faith healers. Yet, in predominant treatment approaches over the past 50 years, therapists nonetheless assumed a position of authority over patients by virtue of their special knowledge, expertise, and professional status. Most therapy models have focused on therapist techniques to alter individual or family dysfunction. Strength-based systems approaches emphasize a therapeutic partnership that fosters clients' inherent potential for healing and resilience.

This collaborative approach is at the core of systemic practice in working with the dying and the bereaved. Distinct from curing or problem resolution, healing is seen as a natural systemic process in response to injury or trauma. One who is terminally ill may not recover physically, but they can heal mentally, emotionally, and spiritually in facing the end of life. Sometimes people heal physically but don't heal emotionally, mentally, or spiritually. The bereaved may return to basic functioning but don't regain the spirit to thrive or to fully love again; wounded relationships may remain unhealed. Therapists can foster psychosocial-spiritual healing even when a death cannot be reversed. The literal meaning of healing is becoming whole—and adapting and compensating for losses.

WORKING WITH INDIVIDUALS, COUPLES, AND FAMILIES: A RESILIENCE-ORIENTED SYSTEMIC PERSPECTIVE

This volume broadens our perspective on the experience of loss to understand individual symptoms in context and to consider the profound impact of loss in relational networks. It presents a resilience-oriented systemic approach to address complex situations of loss. As loved ones face end-of-life challenges and bereavement processes, we will see how their grief and adaptation can be complicated by many interacting influences: by the lack of preparation and sudden, unanticipated, or untimely occurrence of a loss; by the extreme or traumatic circumstances of a death; by complex family dynamics and past traumatic losses; and by unresponsive social contexts.

Adaptation to loss can be complicated by many factors. Grieving processes are especially challenging with ambiguous losses, as in the uncertain fate of a loved one or in the heartbreaking losses with dementia. Moreover, grief is hampered when it is unacknowledged, minimized, or stigmatized by others (see Chapters 7 and 8). Losses can be unbearable when violent or traumatic circumstances surround a death (see Chapter 9). Powerful emotional reactions, transmitted through emotional connections in relational systems, may find expression in other bonds (see Chapter 10). Unattended or suppressed grief may be distorted and displaced, becoming problematic in other relationships and life endeavors; it may be reactivated years later and across generations when the pain from past loss is aroused. In collective trauma events, loss and suffering are widespread, as in major disasters and pandemics; war and displacement; recurrent community violence; and mass shootings (see Chapter 11).

A resilience-oriented systemic assessment considers the sudden, violent, or traumatic nature and circumstances of a death; the emotional, practical, and social resources of the bereaved; and the multiple stressors and future challenges posed by the loss for individual, relational, and family functioning and well-being. In clinical work from a resilience perspective, we normalize grief as a universal experience in response to loss to reassure clients that distress is common; to respect cultural differences; and to expect varied reactions of family members, adults, and children. We strive to understand the complexities of their loss situation and the varying impact on their lives ahead. We attend to intense, persistent, or later symptoms, and we validate the distress without pathologizing it. The bereaved don't "get over" complicated and traumatic experiences of loss, but therapists can help them gradually come to terms with and weave them into the fabric of their lives going forward.

In the chapters that follow, we'll see how the impact of complex and traumatic loss experiences ripples throughout relational systems, touching

all individuals and their bonds. Practice principles and case examples are offered to address pertinent issues, support grief processes, and strengthen capacities for resilience. The potential for healing and resilience depends greatly on the family response. Therefore, it's important for all mental health professionals, whether working with individuals, couples, or families, to understand and address the challenges and repercussions of complicated loss in relational networks. The family resilience framework described next, in Chapter 2, offers a useful guide to strengthen key relational processes that support healing and positive adaptation.

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