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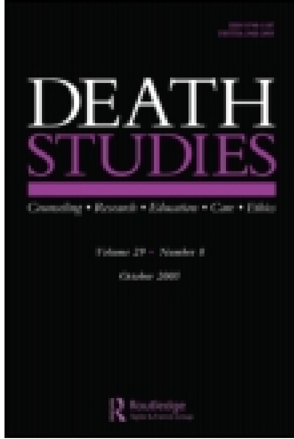

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ATTEND: Toward a Mindfulness-Based Bereavement Care Model

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ATTEND: TOWARD A MINDFULNESS-BASED BEREAVEMENT CARE MODEL

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Few, if any, mindfulness-based bereavement care models exist. The ATTEND (attunement, trust, touch, egalitarianism, nuance, and death education) model is an interdisciplinary paradigm for providers, including physicians, social workers, therapists, nursing staff, and others. Using a case example to enhance the breadth and depth of understanding, this article focuses on attunement as a means to moderate the negative effects of traumatic bereavement, support the framework for posttraumatic growth in the bereaved, improve psychological outcomes for providers, and set the stage for the other aspects of the ATTEND model.

> I recommend almost dying to everyone . . . you get a much clearer perspective on what's important and what isn't, the preciousness and beauty of life.
>
> —Carl Sagan (2006)

For decades researchers have attempted to define a model for the treatment of traumatic bereavement that fully supports not only the client, but also those working with the clients around their trauma material. The impact of traumatic deaths, such as those outlined by Walsh (2007), are far-reaching. Homicides, untimely deaths (such as the deaths of children or premature conjugal deaths), sudden deaths, or disenfranchised losses (Doka, 1989)

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such as suicide, stillbirth, and AIDS have profound impact on survivors. Traumatic death, particularly when it is one that "violates the natural order," forces the survivor to face unique challenges that resonate in both the biophysical and the psychosocial realms (Neimeyer, 2002). These highly interconnected psychological, physiological, and psychosocial facets of treatment prove to be quite complicated at times. Not only do survivors suffer such medical complications as high blood pressure (Prigerson et al., 1997; Prigerson & Jacobs, 2001), cancer (Prigerson et al., 1997), and cardiac events (Prigerson et al., 1997), but they are also susceptible to serious mental health outcomes (Horowitz & Siegel, 1997; Raphael & Martinek, 1997) including heightened risk of suicide (Ajdacic-Gross et al., 2008; Prigerson et al., 1997).

Although it is true that there is a proportion of individuals who are able to accommodate their loss and return to a level of functioning considered to be "normal" (Lindemann, 1944; Neria & Litz, 2003), there is a subset ranging from 10% to 20% of the bereaved who experience significant functional limitations from their traumatic loss (Neria & Litz, 2003). In the literature, loss has been typically explained through psychodynamic means, positing that when "normal resolution" is somehow interrupted and the necessary "grief work" is left undone (i.e., avoided), grief will become "chronic, enduring, and disabling" (Neria & Litz, 2003, p. 74).

Because of the intensity of this type of trauma, it is necessary for the clinician working with such clients to develop an awareness of the impact of the trauma on the client, on the clinician–client relationship, and on the clinician him- or herself outside the four walls of the office. Despite the need for relationship-centered, evidence-based practices for working with the bereaved, providers often find themselves in a quandary: Budget restrictions may oblige administrators to turn their attention away from relationship-based care, incentivizing policies that are "inexpensive and perforce, brief, superficial, and insubstantial" (Yalom, 2002, p. 4). Yet, poor psychosocial care has also been shown to increase litigation risk, thereby raising economic and social costs (Levinson, 1994). Mental health providers are also trained within the context of the "HMO reality" and, likewise, may be pressured by economic restrictions. This type of care often leads to pharmacologically based, laconic interventions, ones that are

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hyperstandardized (Cacciatore, 2010; Yalom, 2002). Yet, providers are obligated to act ethically in the patient's best interest, often with particular attention to vulnerable populations, such as the traumatically bereaved. Our modest goal in the present article is to sketch an overarching model for meeting these client needs while also recognizing their own, concentrating here on the most basic of its foundational features: mindful attunement to both self and other in the healing partnership.

Psychosocial Care and Suffering

Suffering, broadly defined, is an existential experience, and medical pedagogy has tended toward antithetical views: The first is to "respond to suffering with objectivity and detachment" to avoid becoming "overwhelmed and paralyzed by pain" and to ensure that medical decisions about patient care are made with objectivity (Coulehan, 2009, p. 592). Despite the fact that there is no empirical evidence to suggest that detachment improves medical performance and mitigates provider fatigue, these views remain widely accepted. The other view is that providers should "form bonds of compassionate solidarity with [patients]" (Coulehan, 2009, p. 593). Compassion, suffering with the other, is considered by some to be a "medical virtue" that can alleviate emotional angst (Coulehan, 2009; Reich, 1989).

Effective psychosocial care that is mindful, humble, and nuanced has the capacity to abate human suffering (Cacciatore, 2010) and "requires a degree of flexibility [and] fluidity" that entails a focus on (a) clinical research and experience, (b) patient concerns and well-being, and (c) best practice. This trilogy should construct and inform evidence-based practice (Porter-O'Grady, 2010, p. 3). Interestingly, there is a dearth of literature on mindfulness-based bereavement care (MBC). Yet, research suggests that a compassionate, mindful presence in the midst of the traumatic loss helps moderate long-term, negative psychiatric sequelae for both providers and clients (Rushton et al., 2009; Walsh, 2007).

Mindfulness-Based Interventions

The term *mindfulness* has its roots in the Pali word *sati*, meaning awareness, attention, and remembering. However, researchers

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and clinicians have struggled with an absolute definition of mindfulness because it is a "subtle, nonverbal experience" for both patient and provider (Germer, 2005, p. 6). Mindfulness skills are mastered in the therapeutic relationship through "practice by the clinician rather than the client" (Turner, 2009, p. 96). Although the current scientific literature is emergent, findings are promising. Mindfulness-based cognitive behavioral therapy and mindfulness-based stress reduction (MBSR) have been used successfully to treat anxiety (Kabat-Zinn, Massion, Kristeller, et al., 1992; Koszycki, Benger, Shlik, & Bradwejn, 2007; Lee et al., 2007; Weiss, Nordlie, & Siegel, 2005), depression and recurrent depression (Kenny & Williams, 2007; Teasdale et al., 2000), eating disorders (Kristeller, Baer, & Quillian-Wolever, 2006), chronic pain (Kabat-Zinn, 1982), insomnia (Heidenreich, Tuin, Pflug, Michal & Michalak, 2006), substance abuse (Bowen et al., 2006), and domestic violence (Silva, 2007). There are also many studies that demonstrate improvements in chronic health conditions such as cardiovascular disease. One randomized controlled trial found that MBSR reduced systolic and diastolic blood pressure and heart rate for hypertensive individuals (Manikonda et al., 2008). Yet, many mental health and medical providers may not be familiar with mindfulness-based approaches to physical, social, or psychological health, despite the fact that these skills "can be cultivated by anyone" (Germer, 2005, p. 5).

Mindfulness emphasizes a process by which one develops a deep awareness of self and other and responds nonjudgmentally in the present moment with full acceptance (Kabat-Zinn, 1990). This framework helps individuals "work with the universal vulnerabilities and challenges that are an inherent part of being human" (Crane, 2009, p. 3). Mindfulness training cultivates empathy in providers, increasing neuronal activity in brain regions associated with compassion (Morgan & Morgan, 2005; Shapiro, Schwartz, & Bonner, 1998) and decreasing rumination. Although mindfulness practices do not "diminish the enormity" of suffering, they do "provide a greater basket for tenderly holding and intimately knowing" pain. This process is more likely to lead to resilience and posttraumatic growth (Kabat-Zinn, 2005, p. 91; Siegel, 2010).

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ATTEND: A Mindfulness-Based Bereavement Care Model

I help them be with what is true. The healing comes from that.

—Robert Hall, MD

The ATTEND model is an MBC that fosters healing, rather than retraumatizing, provider reactions. This paradigm is practical and cost-effective, interdisciplinary, culturally competent, theoretically sound, pedagogically adaptive, and most importantly may offer the bereaved a unique means through which they may fully experience their grief, eventually reconstructing new meaning and experiencing a higher likelihood of posttraumatic growth (Cacciatore, 2010; Siegel, 2010).

The acronym, ATTEND, stands for (A)ttunement, (T)rust, (T)herapeutic touch, (E)galitarianism (N)uance, and (D)eath education. This model is tripartite in nature: That is, the primary focus is on providers and the "subtle and profound" contemplative practices that often elude reductive quantification (Crane, 2009). Then, providers integrate aspects of the model into the therapeutic relationship with the patient. This is fostered through attunement with the client. Finally, clients are encouraged, both implicitly and when appropriate explicitly, to practice mindfulness on their own. This article will introduce the ATTEND model briefly, then focus on attunement as the basis for MBC.

Attunement in patient care is achieved through an emphasis on mindfulness, responsiveness, empathy, and self-awareness. Attuned providers are more likely to embrace contemplative practices, such as intentional, deep awareness of their own emotional state, daily prayer or meditation, stress reduction activities, and altruism. These practices enhance the provider's ability to express empathy and compassion, even in the presence of painful emotions such as those following traumatic death. They also decrease the likelihood of provider avoidance and distraction. Although being an attuned provider does not "diminish the enormity" of suffering for patient or provider, it does create a greater capacity to hold and tolerate emotional pain (Fulton, 2005; Kabat-Zinn, 1990), and this often leads to resilience, posttraumatic growth, and greater affect tolerance (Crane, 2009; Kabat-Zinn, 1982).

Certainly, if providers are unable to bear their own emotional responses, it becomes increasingly difficult to tolerate others' expressions of suffering (Fulton, 2005). Attunement represents solidarity with patients and their families and a willingness to be fully present (Coulehan, 2009).

Trust in the therapeutic relationship is achieved through compassionate and mindful communication that is relationship-focused. Relational trust unfolds when a provider fosters emotional intimacy, "letting the patient know that he or she has actually been heard." This process creates a "positive feedback loop" confirming understanding through iteration (Coulehan, 2009, p. 598). Iteration of compassion is embodied through a mindful awareness of personal space (proxemics), compassionate facial expressions, touch and posture (kinesics), eye contact (oculesics), and voice intonation (Cacciatore, 2010; Fulton, 2005). Silence can convey a subtle yet profound presence when words are inadequate and seem "superfluous, inauthentic, and shallow" (Nouwen, 1981). For example, a physician sitting quietly next to the parent of a terminally ill child might use mindful speech that is soft, choosing words carefully, speaking slowly, and allowing therapeutic silence when appropriate.

Touch, a rather intimate gesture, is often viewed as anathema in medical care. Yet, there is no more appropriate time for intimacy than when a family is facing traumatic death. Under these circumstances, "touching should be considered an indispensable part of the doctor's art" (Montagu, 1986, p. 282) primarily because touch reduces distress and improves therapeutic intimacy and rapport. Providers should not expect intimate and healing relationships to occur in the absence of touch, as "relying exclusively on talking is an impossible endeavor" (Heuer, 2005, p. 108). Neutral touches, such as the top of the hand, the nearest shoulder, or upper, midback, are often appropriate, particularly when within the safety of a trusting relationship that is sensitive to cultural idiosyncrasies.

Egalitarianism refers to a humble relationship that balances power between provider and patient, resulting in shared, informed decisions about medical procedures, end-of-life care, and death rituals (Cacciatore, 2010). This style requires collaborative communication in which decisions are made mindfully and creatively, unencumbered by pressure or fear and where the family's desires

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take precedence. For example, a family may want to hold their dying child in the hospital garden. In the absence of an egalitarian relationship in which providers willingly share decision-making power, parents may be fearful and reluctant to express their desires, and thus, they may miss this important opportunity for creative ritualization.

Nuance refers to an awareness of unique individual and cultural differences rather than care that adheres to a rigid protocol. Bereavement teams in hospitals sometimes use standardized checklists in the delivery of care. Yet, these checklists are assumptive, often focusing on manualization rather than the nuances of each family and circumstance. Nuanced care eschews arrogance and assumptions. Mindfulness practices are universally appropriate because of their high degree of personalization and adaptability, recognizing those differences and tailoring psychosocial care to meet each individual, familial, and circumstantial need. This fosters a milieu in which culturally competent care and interpersonal resonance flourish (Cacciatore, 2011).

Death education takes two paths. The first is psychoeducation from the physician to the patient. When a patient dies, the family may have questions related to seeing the body or about the postmortem evaluation. This type of psychoeducation helps family members feel better prepared to deal with their losses. Physicians, nurses, and other providers should also consider thanatologically focused continuing education. It is particularly important to be prepared to deal with traumatic death in order to allay avoidance, stress behaviors, compassion fatigue, and poor work performance (Kabat-Zinn, 1982; Crane, 2009), and to remain wholly present with grieving family members.

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Attunement

At the foundation of the ATTEND model lies attunement, and it is this dimension of the work that we will now consider in some detail.

The Attuned Clinician

Working with the traumatically bereaved takes a toll on providers. According to Henri Nouwen (1981), it requires a degree of

compassion wherein "we go with others to the place where they are weak, vulnerable, lonely, and broken" (p. 24). Yet, most people seek "to do away with suffering by fleeing from it or finding a quick cure for it." Thus, "we ignore our greatest gift, which is our ability to enter into solidarity with those who suffer" (Nouwen, 1981, p. 24). Yet, it may be this very gift that may help insulate providers from the long-term effects of others' suffering.

Researchers are now studying topics such as *compassion fatigue, vicarious traumatization*, or *secondary traumatization*, documenting the risk for profound disruptions in worldview, frame of reference, sense of identity, and spirituality of all types of providers, from therapists and social workers, to physicians and nurses. The effects may be emotional and psychological, such as crying, outbursts, sadness, helplessness, or anxiety and, in some cases, indifference to avoid emotional pain. There may also be physical symptoms such as lethargy, tightening in the throat or chest, forgetfulness, intrusive thoughts, and nightmares (Dobkin, 2009; Halbesleben & Rathert, 2008; Rubel, 2003). Health care professionals who encounter death are particularly vulnerable to depression, anxiety, anger, helplessness (Coulehan, 2009; West, Tan, Habermann, Sloan, & Shanafelt, 2009), lethargy, intrusive thoughts, and nightmares. Unresolved provider stress has been shown to adversely affect patient satisfaction, compliance, and even recovery (Coulehan, 2005, p. 596). Administrators who "take proactive steps to reduce" stress for their providers will realize immense "benefits in terms of patient satisfaction and recovery" (Halbesleben & Rathert, 2008, p. 29).

One of the most empirically validated ways to cope with vicarious trauma is through MBSR. One 8-week randomized, controlled trial with medical students showed the promising effects of MBSR including a reduction of anxiety and depression and a concomitant increase of empathy when compared to a control group (Shapiro et al., 1998). Other studies have shown that MBSR reduces stress and burn-out in high-stress careers, overall improved life satisfaction, increases in self-compassion, decline in ruminative tendencies, and improved patient outcomes (Gilbert, 2005). In particular, experiential avoidance exacerbates and prolongs posttraumatic stress in providers, whereas "self compassion is associated with greater willingness to engage painful thoughts" and memories of trauma (Thompson & Waltz, 2006, p. 558).

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Of particular note is the fact that distress and fearfulness on the part of the provider may prompt another type of experiential avoidance—that of the provider avoiding particularly important conversations with the client out of their personal distress. For example, a therapist working with a bereaved mother may ask her to recount painful details of her child's death. This process may rouse an intense emotional reaction. An attuned clinician would pay careful attention to any internal sensations in the presence of such fierce emotion, ensuring that the response would not be an attempt to "do for," interrupting or distracting from the moment because of his or her own discomfort. The mindful clinician is "present with" rather than "doing for" (Segal, Teasdale & Williams, 2004) and is able to tolerate the expression and processing of painful, even traumatic, memories.

There are three broad categories that help enhance provider attunement. The first is a conscious awareness of the present moment through a systematic methodology of contemplative practices such as: (a) the 3-min breathing space or minimeditation (3MBS; 3 min focused on the sensations of deep, slow breaths; Turner, 2009); (b) meditation, prayer, or contemplative time; (c) body scan (or autogenics, a progressive awareness of the body and intentional relaxation); (d) Hatha yoga; (e) "eco-attunement" (Siegel, 2010) through barefoot nature walks; and (f) reading poetry. Most of these can be practiced during work or home hours and can have spiritual or secular meaning and effects. Turner's (2009) 3MBS exercise, for example, can be used effectively in-between patients as a strategy to prepare for the next person, or an abbreviated version can be used if 3 min are not available:

1. Take a few moments and feel the rise and fall of your breath before the next patient.
2. As you walk to the door, imagine that on the other side is a human being waiting.
3. This human being is suffering and believes you can help.
4. Approach this person with the intention to be mindful, present, and compassionate.

The second category of mindful attunement is to strive toward an attitude of "kindness, curiosity, and a willingness to be present with the unfolding" experience of each moment. This means

tolerating uncertainty and inviting a place where the unfixable and uncurable can be explored. Finally, the third broad category is an "embodied understanding of human vulnerability" that cultivates mindful tolerance for the expression of very painful emotions and thought patterns (Crane, 2009, p. 6). That is, human suffering is inevitable for everyone, and by "opening to our own suffering we can remain better open to the struggles of others" (Fulton, 2005, p. 81). Thus, providers should strive toward experiential approaching rather than experiential avoidance both for the self and the other. Rushton et al. (2009) found that this type of approach in end-of-life care helped providers to stabilize the mind. When coupled with contemplative practices on the part of the provider, they fostered a more comfortable approach to dying patients and their families.

Self-compassion has been shown to reduce self-criticism and ruminative tendencies and will improve a provider's ability to reflect and learn from an experience (Thompson & Waltz, 2008). The same mindfulness practices that improve psychosocial care for patients can be used to facilitate the provider's self-compassion, that is, attunement and self-awareness around loss. Mindful providers express deeper satisfaction with their work and suffer compassion fatigue less often, and they are happier in their professional lives (Epstein, 2003; Zoppy & Epstein, 2002), more willing to acknowledge and approach their own emotions. Some providers find a degree of resolution to their own grief by following up with the family, reviewing details of the incident, and sharing their feelings with coworkers or other providers. Others may benefit from journaling, psychotherapy, exercising, or learning a new hobby. This inventory of self-compassion is based on a review of the literature on mindfulness-based strategies:

1. Spend at least 15 min daily in meditation, prayer, or quiet time just being.
2. Allocate at least 20 min a day of exercise within your abilities.
3. Practice laughter. Every day, try to find humor in something, even if it seems insignificant. Smile. Smile at others, smile at yourself. Just smile.
4. Surround yourself with caring others—family, friends, and work colleagues. Seek the company of others who are compassionate and kind.

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5. Get 20 min of sunshine every day.
6. Observe and truly experience nature. Notice the sky when walking to your car. Listen to the sounds of birds. Pay attention to the trees, smell blossoming flowers, hear the buzzing bees, and watch ants as they work.
7. Experience gratitude daily for even the simple things in life that are easily taken for granted: good health, family, running water, your home, and food.
8. Think positive thoughts whenever you can. Notice any negative self-talk, and see if you can counter them with positive thoughts.
9. Show compassion, actively, toward others. Look for even small opportunities to help. Open doors, offer to aid someone carrying groceries, really listen to someone else's story. Actively, every day, seek to show kindness. And volunteer for a good cause at least 1 day per month.
10. Support your brain: Eat a healthy diet and eliminate junk and fast foods.
11. Express your love and affection for your mate, children, friends, and/or family. Take the time to say "please" and "thank you." Tell others how much they mean to you. Give and accept praise.
12. Give yourself permission to experience self-compassion and self-love. Practice forgiveness, especially to yourself, and be your own best friend.

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The Attuned Clinician–Client Relationship

Mindfulness strategies practiced daily may help improve providers' ability to turn toward the patient, becoming more aware of the patient's moment-by-moment emotional and practical needs in bereavement care. Additionally—and particularly important when working with traumatic death survivors—it may help providers become aware of any personal anxiety or discomfort as it arises. Affect exposure, tolerance, and the willingness to face painful feelings help reduce the power of those emotions, which can be psychologically threatening to many providers (Zetzel, 1970). As a result both the provider and the client may become "less possessed" by those emotions (Fulton, 2005). Affect tolerance may

also help a provider refrain from what Freud (1917/1957) termed *furor sanandi*, that is, the rage to cure.

Attunement in the relationship fosters important therapeutic moments for the patient where the providers can "stand fully and simply with the patient in the full flame of suffering" (Fulton, 2005, p. 65) without being paralyzed by very intense emotional distress (Brenner & Homonoff, 2004). Providers' own contemplative practices provide a social learning model for clients in the dyad, modeling the processing, thoughts and behaviors, and affective states relative to a loss. Attuned providers are also intentional in their communication, choosing words with care and asserting a full, supportive presence through nonverbal expressions and congruent facial and bodily gestures. Ultimately, attunement "helps us remain open to the other," creating the "essential condition of trust" (Siegel, 2010, p. 75) and equanimity. This may include therapy that extends beyond the traditional four walls of treatment, such as incorporating creative expression such as poetry, art, music, ecotherapy (counseling sessions held in nature), after-hours calls, and rituals.

The Attuned Client

Traumatic grief often produces a consistent pattern of experiential avoidance, a key aspect of complicated bereavement (Shear, 2010). Experiential avoidance is an unwillingness to be in contact with "private experiences" such as body sensations, emotions, thoughts, and memories and actually take steps to "alter the form or frequency of these events and the contexts that occasion them" (Hayes, Wilson, Strosahl, Gifford, & Follette, 1996, p. 1154) and can incite dissociation. Although experiential avoidance may, at times, be adaptive, overuse may incite a prolongation of the mourning process (Shear, 2010). When prolonged, the bereaved individual tends to interpret the experience as indicative of future outcomes rather than related to the tragedy that occurred in the past (Boelen, van den Bout, & van den Hout, 2010). Clients may hold fears that they are "going crazy" or that if they confront the gravity of their loss they will "die." The resulting avoidance behavior serves to interfere with the client's ability to integrate the gravity of the loss into their existing knowledge base (Boelen et al., 2010) and, therefore, find their new "normal." Helping the

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client to gently sit with and be supported through their experience is a critical component to this model. Over time, this mindset is modeled by the clinician in a gentle, safe environment. The client who is attuned with his or her grief is more likely to reach a place where of being with, surrending to, and doing with grief. These individuals are more likely to discover ways to integrate the lost loved one into their lives in a meaningful, future-oriented way with newly defined aspirations and perspectives on life.

Case Example

Andrea is a 26-year-old single woman who experienced the tragic death of her 9-month-old daughter, Maggie, nearly 2 years before seeking counseling. She was in the process of moving from her home following a protracted divorce when a large screen television slipped from her grip. Unknowingly, Maggie, her only child, followed her into the room, and was crawling underneath when the television dropped. Horrified, she lifted the television off her baby and frantically called paramedics. Maggie was removed from life support later that day and died in her arms. During the intake, she described herself as "very good at pretending it didn't happen" noting that she "blocks" and avoids painful memories related to her baby's traumatic death. She stated that she frequently changes the subject when someone talks about Maggie and that she took down all her photos and reminders of her in her home.

Andrea sought counseling from a provider who specializes in MBC because she felt that she was "dying inside ... and the pain is killing me." At intake, Andrea scored 2.09 on the Impact of Event–Revised (IES-R) scale to measure posttraumatic stress disorder (threshold for diagnosis is 1.55) and 2.16 on the Hopkins Symptoms Checklist (HSCL) measuring anxiety and depression (threshold for diagnosis is 1.75). Andrea's counselor at the agency uses the ATTEND model both personally and professionally. She practices meditation daily and engages in other contemplative practices including daily self-care and self-compassion strategies, volunteering and service, art and poetry, and social justice and activism.

The first few sessions were spent building trust in the relationship through attunement. Andrea expressed a strong desire to "talk

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about that day and stop running from it" and to "be able to look at [Maggie's] pictures again and put them back on the walls." The counselor listened intently as she recounted the traumatic circumstances surrounding Maggie's death over the course of several sessions. These descriptions, including the blunt force trauma to Maggie's head and the shame and guilt Andrea was suffering because she "killed" her daughter, incited feelings of dread in the counselor of which she was keenly aware. "I did it, I killed her, I did it," she would say repeatedly. Interestingly, she told the story in rather broad strokes, lacking detail, and her affective state seemed incongruent with the story. Andrea would visually dissociate during the telling, and she was remarkably phlegmatic. The counselor noticed this, as well as the absence of eye contact with the counselor. The counselor focused her attention on remaining fully present, empathic, and tender with the client and with her own emotional state, both inside and outside of session.

The counselor felt that trust was established after three to four sessions as Andrea began to tolerate and disclose more details related to Maggie's death. Slowly, Andrea's emotional expression became more congruent with the telling of the story. She became openly sorrowful, sometimes laying on the ground for long periods of time weeping. Her counselor would not interrupt but would sit on the floor next to her quietly, occasionally touching her on the back to assure her she was still there. One-by-one, Maggie's pictures were invited back into Andrea's life. Together, the team began to integrate some of the mindful bereavement practices: (a) becoming attuned to her grief by being with her suffering, (b) pausing and sitting quietly through it, (c) giving herself permission to weep and mourn for Maggie, (d) journaling and writing letters to Maggie, and (e) attending both intensive group and individual counseling sessions, which included reviewing videos and photos of Maggie from her birth to her death.

During the 10th session, Maggie and her counselor embarked on a "barefoot walkabout," hiking barefoot up a mountain trail, a technique practiced monthly by her counselor. The goal of the walkabout was to be in the present moment, paying attention to every step and accepting—metaphorically—unpleasant sensations along the path. She felt the walkabout "changed something" for her, though inexplicably. In the next few sessions, the relationship

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focused on surrendering to grief, even when painful images intruded, and learning to honor those. Andrea began to trust herself, realizing that the darkness, though very frightening and at times paralyzing, was something she could tolerate most days. She began learning to tell her story, repeatedly, rather than "hiding" her daughter's death and the intense shame and guilt she experienced as a result of her "own hands." She also attended a candle lighting and other memorial rituals held by a local non-profit organization for bereaved parents. During one surrendering session, Andrea wrote a letter of apology to Maggie for the act that took her life. She asked for her forgiveness. In a letter back to Andrea that "Maggie" wrote, forgiveness was granted because "Maggie" realized that Andrea "loved her enough to give her own life for her."

The next month, Andrea began serving others through random acts of kindness in her community to honor Maggie as well as to honor her grieving self. On one occasion, she went into a local bakery and anonymously purchased a birthday cake for a little girl who was the same age as Maggie. She described that as "powerful" and "emotional in both good and bad ways." She began baking treats every month for fellow support group members and volunteered for several events such as a Mother's Day walk. She became a community volunteer and a leader in her support group and began making memorial cards for other families in memory of her daughter.

About a year after Andrea entered counseling, her IES–R scored had dropped to 1.04, and her HSCL dropped to 1.68, both outcomes below the threshold for psychopathology. Andrea noticed that her priorities began to shift. She decided on a career change and registered for school, planning to become a counselor so she could "eventually help other parents who were hurting" in the aftermath of child death. And, she took on a more active role in supporting others' grief during group sessions, shifting the focus away from her own mourning to the more recently bereaved. Though the road remains long and arduous for Andrea, her chances of posttraumatic growth—and a life of transcendence—are greatly improved. In addition, her counselor has experienced the psychological benefit of witnessing her transformation, certainly an unintended consequence of attending to the suffering of another.

Potential Outcomes

Human suffering, particularly when it includes traumatic bereavement, ignites an existential crisis from which a wellspring of concerns emerges. These are often important concerns related to the ultimate struggle of spirituality, meaning, or purpose. The ATTEND model, when applied to the provider–patient relationship, is intended to reduce negative psychiatric sequelae for individuals and improve outcomes for families and communities. Additionally, mindfulness practices demonstrate strong effect sizes, suggesting they may improve life satisfaction, help manage stress, relieve extraordinary distress, and increase overall well-being for providers (Grossman, Niemann, Schmidt, & Walach, 2004). Education on mindful provider care has been shown to improve attitudes toward patients and increase emotional stability in both mental and medical health professionals (Krasner et al., 2009; Salyers et al., 2011) and decrease provider mood disturbances such as depression, fatigue, tension, and emotional exhaustion (Krasner et al., 2009).

Although there is as yet no empirical evidence for posttraumatic growth within the context of MBC, there is sufficient anecdotal data to warrant its exploration. For example, the type of metacognitive awareness fostered in mindfulness training has been associated with higher levels of self-esteem (Fennell, 2004). And self-esteem was the greatest predictor of posttraumatic growth in bereaved parents (Engelkemeyer & Marwit, 2008). These same variables and outcomes could, ostensibly, be applied to providers as well, intimating that mindfulness practice, overall, can help both patients and providers. In addition, good psychosocial support is associated with higher levels of self-esteem and lower levels of depressive symptoms (Brown, Andrews, Harris, Adler, & Bridge, 1986). Transcendence and posttraumatic growth address that which goes beyond the mundane of the material world and entails finding hope amidst the hopelessness of grief. For the spiritual, posttraumatic growth may be demonstrated by an enriched relationship with the Creator or a deepened connection to the Universe; it may also extend to meaning through a physical legacy that will withstand time such as a work of art, writing a book, or other type of enduring legacy in service to others (Corr, Nabe, & Corr, 2006; Frankl, 1946/1985). However, it is difficult to

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accomplish meaning reconstruction in the absence of approaching behaviors. And such meaning reconstruction, despite a person's individual spiritual orientation, may help a mourner reframe, integrate, and better cope with the loss (Neimeyer, 2002; Neimeyer & Sands, 2011). The bereaved need mindful providers willing to bear witness to their pain in the moment, nonjudgmentally, and with full acceptance of their emotional, social, and existential state. This may then model a state of mindfulness practices for the bereaved, increasing their own ability to be present with, tolerate, and grow beyond their own experiences of traumatic death.

Conclusion

The rigidity through which care of the traumatically bereaved is currently undertaken may not allow providers to be aware of and fully present with the nuances of each individual and his or her unique circumstances (Siegel, 2010). Mindfulness, by its very nature, eschews assumptions and embraces acceptance. This results in a higher-level of competency that arises with intrapersonal resonance (Siegel, 2010). Siegel (2010) cited the acronym COAL—curiosity, openness, acceptance, and a "healing form of love . . . and and compassionate concern"—as a means through which a provider can provide the kind of care that recognizes individual clients and their culture during suffering (p. 55). In other words, providers should engage in sincere inquiry with an open attitude that is nonjudgmental. In this way, both individual and cultural sensitivity is more likely.

The 19th-century Czechoslovakian-born poet, Rilke (1903/1984), spoke poignantly about being with suffering:

> if a sadness rises before you larger
> than any you've ever seen, if an
> anxiety like light and cloud shadows
> moves over your hands and
> everything that you do. You must
> realize that something has happened
> to you. Life has not forgotten
> you, it holds you in its hands
> and will not let you fall. Why do
> you want to shut out of your life
> any uneasiness, any miseries, or

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any depressions? For after all, you
do not know what work these conditions
are doing inside of you.

There is, indeed, a more sane and compassionate framework of bereavement care that may cultivate a therapeutic environment in which the bereaved can grow within and beyond their losses. It is also possible that this type of MBC, which arises from mindfulness practice, may enhance provider well-being both personally and professionally. Althogh further research should be done on MBC for the bereaved, the ATTEND model represents a paradigm shift in the care of the bereaved that offers hope to patients and providers suffering the inevitable and unavoidable experience of death that unites us all.

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