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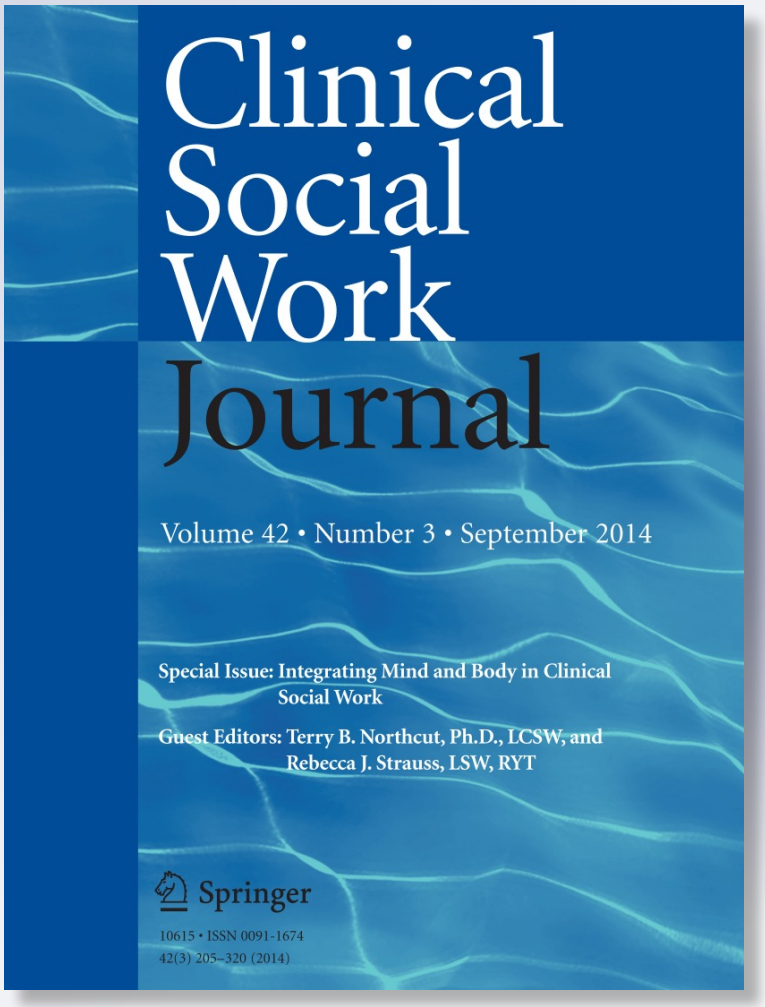
Clinical Social Work Journal

ISSN 0091-1674
Volume 42
Number 3

Clin Soc Work J (2014) 42:269-281
DOI 10.1007/s10615-013-0465-y



Springer

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ORIGINAL PAPER

Of the Soul and Suffering: Mindfulness-Based Interventions and Bereavement

Joanne Cacciatore · Kara Thieleman · James Osborn · Kelly Orlowski

Published online: 26 October 2013

Abstract There has been increased interest in, and evidence for, mindfulness-based interventions (MBIs) as integrative approaches for a wide variety of psychosocial issues. However, there is very little research on the use of MBIs in bereavement care and only one proposed model existing in the literature. This article presents an overview of the mindfulness-based literature and uses a case study of a bereaved parent to illustrate a mindfulness-based model of bereavement care that is consistent with social work values. Such a model may provide a future direction for care of the bereaved as well as interesting opportunities for further development and research.

Keywords Mindfulness · Grief · Bereavement · Trauma · Child death · Bereaved parents

Over the past two decades, there has been an accelerating level of academic and clinical interest in mindfulness and mindfulness-based interventions (MBIs) across a range of disciplines including social work, psychology, medicine, and neuroscience. This interest is reflected in the broader culture, with mindfulness programs making inroads into corporate training regimens (Chaskalson 2011), classrooms in educational systems (Gold et al. 2010; Napoli et al. 2005), soldier preparedness and resilience training (Stanley et al. 2011), and prison rehabilitation programs (Bowen et al. 2006; Himelstein et al. 2012; Samuelson et al. 2007), among other areas.

Mindfulness practices can be found in various spiritual traditions around the world, but are most strongly associated with Buddhism, where they are practiced in order to help attain freedom from suffering. Mindfulness practices in the West derive largely from *vipassana* (meaning "insight") meditation practices which emphasize simply paying attention to experiences in the present moment. The focus is on taking a step back from and simply noticing bodily sensations, emotions, and thoughts. Doing so creates a sense of spaciousness that allows a person to respond mindfully rather than react habitually to difficult experiences (Baer and Krietemeyer 2006). Unlike some forms of meditation, where the stated goal is to achieve bliss or to enhance devotion to a deity or to a belief structure, the explicit purpose of *vipassana* meditation is be attuned to one's experience of reality.

Despite its strong association with Buddhism, mindfulness practices are not limited to this tradition, and may instead be viewed as "an inherent human capacity" (Kabat-Zinn 2003, p. 146) that exists independent of spiritual traditions. The concept and practice of mindfulness are adaptable from their ancient roots in *vipassana* meditation. Within the behavioral sciences, a variety of treatment approaches have incorporated such mindfulness practices, attempting to retain the essential elements while breaking them down into skill sets that can be used in a Western context. The explicit use of formal mindfulness practices to develop attention and awareness in health settings first became popular during the 1990s. An early line of research began with the Stress Reduction and Relaxation Program, developed by Jon Kabat-Zinn at the

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University of Massachusetts Medical Center. This program was used to train chronic pain patients in a group setting to self-regulate and thereby reduce the intensity of pain using mindfulness meditation (Kabat-Zinn 1982). This approach has become standardized and is known as mindfulness-based stress reduction (MBSR). Much of the subsequent research on mindfulness built on this foundation or focused on evaluating the efficacy of MBSR (Mason and Hargreaves 2001). Perhaps some of the most widely utilized forms of therapy that incorporate mindfulness practices are mindfulness-based cognitive therapy, acceptance and commitment therapy, and dialectical behavioral therapy.

Defining Mindfulness

Within the Western context, researchers have offered various definitions of mindfulness. For example, Kabat-Zinn defines mindfulness as "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (2003, p. 145). Mindfulness can be viewed as "a coherent phenomenological description of the nature of mind, emotion, and suffering and its potential release, based on highly refined practices aimed at systematically training and cultivating various aspects of mind and heart via the faculty of mindful attention" (Kabat-Zinn 2003, p. 145). This phenomenological understanding and the accompanying practices may be incorporated into the development of mindfulness-based therapeutic interventions aimed at reducing suffering in both spiritual and secular traditions.

Bishop and colleagues have proposed an operational definition of mindfulness comprised of two components: "the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment," and "adopting a particular orientation toward one's experiences in the present moment, an orientation that is characterized by curiosity, openness, and acceptance" (2004, p. 232). Thus, mindfulness can be thought of as both a mental practice that is cultivated in order to develop a particular stance toward experience, as well as that stance toward experience itself. It is both an action in which one chooses to engage (e.g., paying attention, self-regulating, cultivating a certain view of life) as well as the fruit of such action in one's life (e.g., a special mode of perception or a different orientation toward one's experience). In mindfulness practice, experiences of both internal and external stimuli are simply noted as they arise (Baer 2003). Mindfulness practice asks the individual to focus on and turn toward unpleasant and painful sensations when they arise, rather than avoiding them (Kabat-Zinn 1982).

Mindfulness for Health/Mental Health Problems

The application of mindfulness, in the form of MBIs, is growing rapidly in Western societies. Along with this has emerged a body of empirical literature supporting the efficacy of MBIs in addressing a range of problems. For example, MBIs may be helpful for some forms of chronic pain (Kabat-Zinn 1982; Morone et al. 2008; Rosenzweig et al. 2010), anxiety disorders (Kim et al. 2009; Lee et al. 2007; Miller et al. 1995; Ossman et al. 2006; Piet et al. 2010), depression (Kuyken et al. 2008; Ma and Teasdale 2004; Teasdale et al. 2000), irritable bowel syndrome (Gaylord et al. 2011; Kearney et al. 2011; Zernicke et al. 2012), fibromyalgia (Grossman et al. 2007; Kaplan et al. 1993), binge eating (Kristeller and Hallett 1999; Safer et al. 2010), psychosis (Ashcroft et al. 2011; Bach and Hayes 2002; Chadwick et al. 2009) and substance abuse (Witkiewitz and Bowen 2010; Witkiewitz et al. 2005). MBIs are promising because they may be effective in populations unresponsive to other treatments, such as individuals with chronic depression (Kenny and Williams 2007).

MBIs have also been used to reduce psychological distress among medical students (Rosenzweig et al. 2003; Shapiro et al. 1998), nurses (Beddoe and Murphy 2004; Mackenzie et al. 2006), therapists in training (Shapiro et al. 2007), survivors of child abuse (Kimbrough et al. 2010), caregivers of children with chronic conditions (Minor et al. 2006), and cancer patients and survivors (Foley et al. 2010; Lengacher et al. 2009; Speca et al. 2000). Other studies have examined the potential of MBIs to improve overall well-being (Ando et al. 2011) and health-related quality of life (Roth and Robbins 2004), to reduce fatigue and decrease anxiety related to Chronic Fatigue Syndrome (Surawy et al. 2005), and to improve the quality of interpersonal relationships (Carson et al. 2004). Research has also sought to quantify the physiological impact of mindfulness, including alterations in brain and immune function (Davidson et al. 2003) and changes in endocrine function and blood pressure among cancer patients (Carlson et al. 2007).

Facing Death Mindfully

While MBIs have been applied to a range of psychosocial and medical problems, there has been very little research conducted on their use with individuals and families

experiencing bereavement. However, there are several studies in a related field conducted with individuals who have been diagnosed with potentially terminal illnesses such as cancer. One such study, a randomized controlled trial using an MBI, reduced mood disturbance and stress in cancer patients (Speca et al. 2000). The results were maintained 6 months after the conclusion of the original study (Carlson et al. 2001). Another study reported significant improvements in quality of life, stress symptoms, and sleep quality in early stage breast and prostate cancer patients, though there were no significant improvements in mood (Carlson et al. 2004).

Researchers have observed many sources of distress for individuals and their families grieving the loss of their health and well-being, including patients with cancer and chronic pain. These sources of distress include fearful anticipation of health decline, heightened awareness of mortality, decisions around pain management, emotional and physical suffering, choices about therapies, and life changes and adjustments (Carlson et al. 2001; Sagula and Rice 2004). Simultaneously, family members with a loved one facing impending death must also deal with existential issues such as trying to make sense of the loss of life. In this context, mindfulness practices may help individuals, as well as their families, navigate profound grief and shift their relationship to mourning processes to be more accepting and less unbearable (Bruce and Davies 2005; Carlson et al. 2001).

Mindfulness and Social Work Practice

There has recently been greater interest in integrating mindfulness into social work education and practice. Both social work and mindfulness practices seek to reduce suffering and increase overall well-being (Turner 2009). In addition, mindfulness on the part of the social worker can enhance the therapeutic relationship by increasing attunement and acceptance of both client and self (Turner 2009), while cultivating the cognitive processes needed for enhanced empathy (Gerdes et al. 2011). Social workers often encounter intense distress in the context of limited resources and adopting mindfulness practices may lead to a sense of equanimity and an increased ability to work effectively under such constraints (Turner 2009). For instance, the emphasis on attention to the present moment with a non-judgmental attitude aligns well with social work's person-in-environment framework and can heighten awareness of and sensitivity to contextual factors, including issues of power and oppression. There in an inherent power imbalance between a therapist and a client, as well as greater feelings of vulnerability experienced by a client. Mindfulness can assist the therapist in remaining alert to these factors and how they may affect treatment, leading to actions such as assuming a "not-knowing" position that support the values of self-determination and autonomy. Mindfulness practices may also reduce the potential for burnout, vicarious trauma, and compassion fatigue (Christopher and Maris 2010; Goodman and Schorling 2012; Thieleman and Cacciatore, in press), identified risks in the field of social work.

Mindfulness and Traumatic Bereavement

While a small number of mindfulness-based studies have focused on those with potential terminal illness, only a single small, uncontrolled study so far has targeted the bereaved specifically (Thieleman et al., in press). This study found reductions in traumatic stress, anxious, and depressive symptoms in individuals who had experienced traumatic bereavement and engaged in grief counseling using a mindfulness-based framework. Most participants had experienced the death of a child, considered to be one of the most traumatic of all death experiences and known to yield enduring and intense psychological distress for parents (Cacciatore et al., in press). However, some participants had experienced the death of other family members, such as siblings or parents.

In the United States, 50,000 children die of terminal illness each year, and many more die suddenly and unexpectedly (Arias et al. 2003). Babies are particularly vulnerable, with combined mortality rates of stillbirth and infant death nearing 60,000 deaths per year in the United States alone (National Center for Health Statistics 2011). Another 500,000 children are diagnosed with life threatening medical conditions (Arias et al. 2003; Himelstein et al. 2004). Children who are actively dying may be concerned about how their family members will cope with their deaths (Himelstein et al. 2004). Since bereavement in this population is so complex and difficult, it is imperative for medical and mental health professionals to be well-prepared and fully informed in order to deal with the tragedy of child death and to practice compassionate psychosocial interventions for both children and their parents. Parents who have experienced the child death are a unique population in many ways. The death of a child is out of order, untimely, and traumatic, even when the child's death is expected, as in terminal illness or congenital anomalies (Barr and Cacciatore 2007–2008; Cacciatore and Flint 2012; Rando 1985). Yet, because of its present moment orientation, focus on approaching rather than avoiding painful affective states, and ability to help increase tolerance for fluctuating feelings and thoughts, MBIs may be especially beneficial both for these families. One of

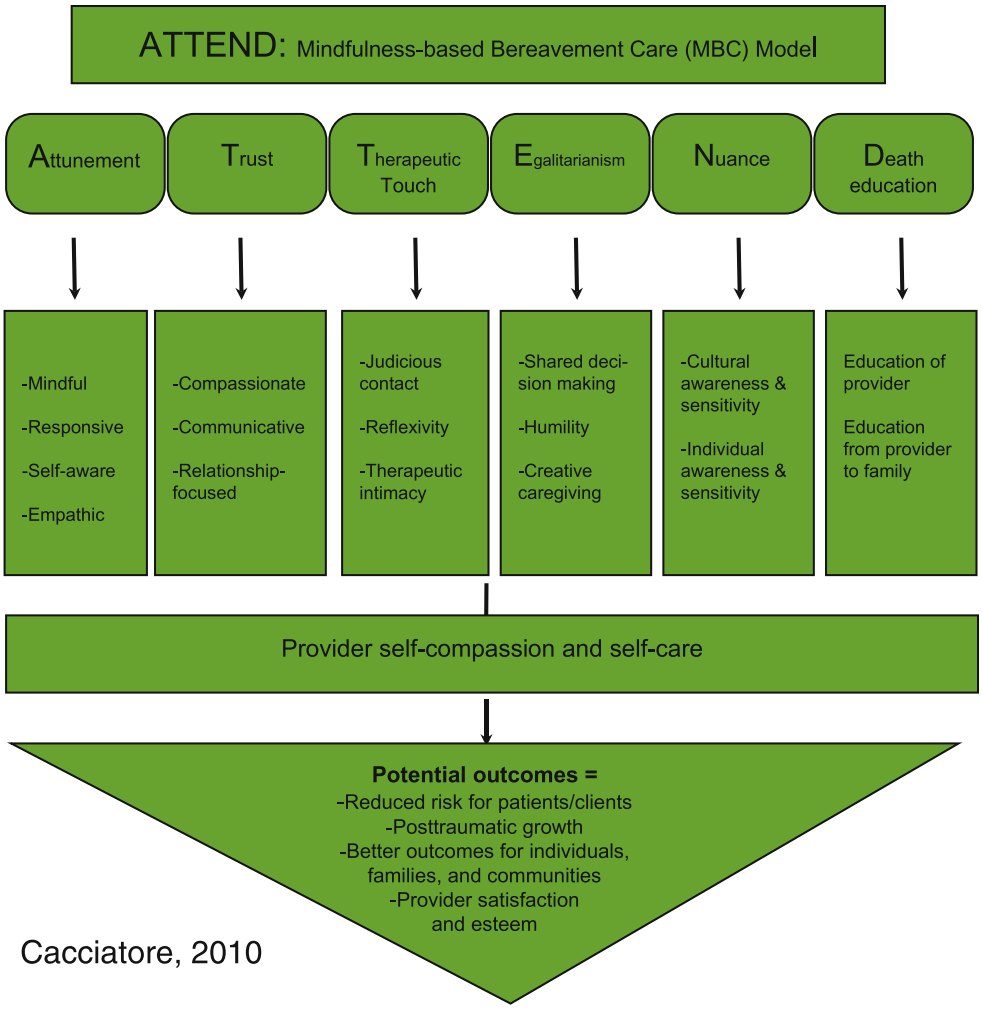

Fig. 1 ATTEND mindfulness-based bereavement care model

the strengths of a mindfulness-based model is its ability to call to attention the provider's own emotional responses, with the potential of increasing compassion and decreasing provider avoidance (Berceli and Napoli 2006) and burnout (Christopher and Maris 2010) in the face of intense suffering.

The ATTEND Model

The ATTEND model (attunement, trust, therapeutic touch, egalitarianism, nuance, and death education) is a mindfulness-based bereavement care model built upon the precept of self-care and compassion, integral for those who work in emotionally intense fields of social work (Cacciatore 2011; Cacciatore and Flint 2012) (Fig. 1). The model is tripartite in that the client, the relationship, and the clinician experience and benefit from the elements contained in the model (Fig. 2). For example, the social worker demonstrates attunement to the client through attention, awareness, and acceptance of the client's painful emotions. This encourages deepened emotional intimacy with the client, all while the social worker is paying attention to his or her own inner experiences. Trust is built through deep listening, empathic caring, and validation of the client. Some clients may need extra support outside the four walls of counseling, particularly the acutely and traumatically bereaved. This may mean sending a card on the anniversary of the death, sending a photograph of a sunrise, butterfly, or other totem that is connected to the child (or person) who died, or other small acts of remembrance that may assist in building trust.

Therapeutic touch is used, when appropriate, in a culturally sensitive manner. Touch may provide connection, comfort, and presence at times when the client becomes increasingly emotional. Yet, at certain times, it would be an interruption of process to touch a client during these

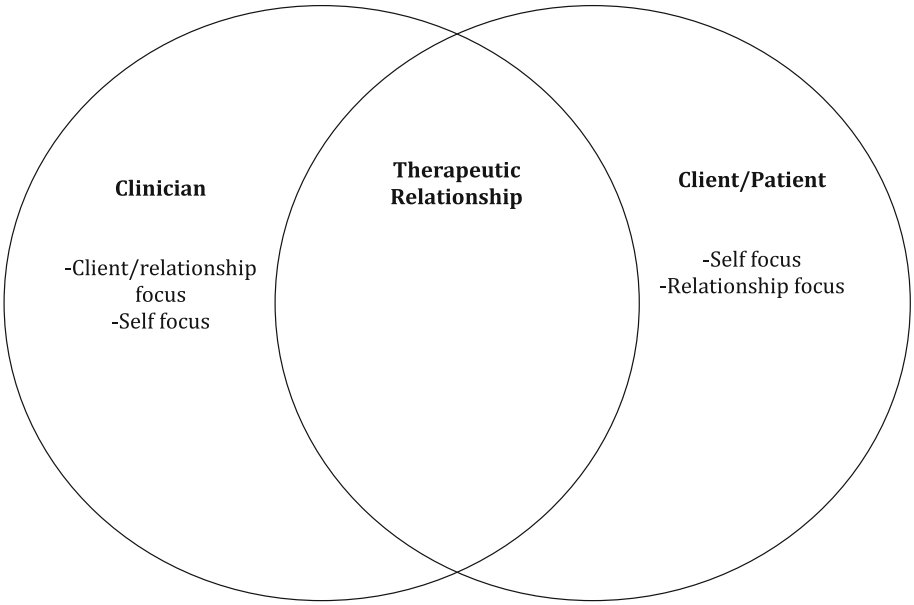

Fig. 2 Tripartite framework for ATTEND mindfulness-based care

periods. A more appropriate response might be to lean in toward the client and present a humble posture, such as unfolding the legs, setting aside any files or papers, or moving a chair closer to the client without touch. Deep awareness of a client's readiness for touch, then, comes from being fully present and having built a trusting and intimate relationship. In addition, some clients might not welcome touch due to their cultural background or perhaps due to past experiences of abuse or violence. In such cases, touch may be inappropriate or unwanted, and could be perceived as coercive. Thus, the clinician must be mindful of such factors around the use of touch. Nuanced caregiving may increase the likelihood that a social worker's decision to touch or not to touch is based on a client's situation, needs, and the appropriateness of doing so.

An egalitarian relationship is one that is balanced by a humble provider who honors the unanswerable questions, particularly as they arise in the case of traumatic death. Egalitarian relationships foster humble and creative caregiving, addressing each client's unique needs while maintaining role differentiation. Thus, one client may do well with a visual imagery exercise to help ease anxious feelings, while another client may respond to nature hikes or another ecopsychological intervention as a means to do the same. Egalitarian relationships allow clients the opportunity to guide the intervention based on their own needs and preferences with the gentle companionship of the clinician.

Nuanced counseling pays attention to the individual, familial, and ethnic culture as well as the unique circumstances of each client. In many ways, the social worker becomes a student of the client's culture. For instance, a traditional Native American family may experience a traumatic death differently than an acculturated one. In addition, circumstances of the child's death may influence a family's response to the traumatic loss. The death of a firstborn son may be symbolically unique for some families and the social worker should pay attention to such nuances, being respectful, open, and curious. Death education in this model represents the ways in which the social worker becomes educated in death studies and also how psychoeducation can be used as a means through which to empower clients on issues regarding death, dying, and grief when appropriate. Clients may take comfort from knowing that many other bereaved individuals have had similar grief experiences and difficulties.

These six main features of the ATTEND model are built on a foundation of provider self-care and compassion that includes mindfulness practice as a part of daily life. Mindfulness on the part of mental health clinicians has been associated with significantly improved client outcomes compared to the clients whose clinicians do not meditate (Grepmair et al. 2007). This suggests that the single, simple tool of provider mindfulness can have a powerful impact on client outcomes. The use of mindfulness practices is integrated throughout the ATTEND model. For example, in the context of bereavement counseling, mind–body awareness exercises, non-judgmental acceptance of emotions, awareness journaling, and meditation exercises are offered. Clinicians, whether social workers or other mental health professionals, exercise and model mindful awareness skills and non-judgmental

acceptance. Clinicians are encouraged to use a professional self-reflection sheet with prompts such as: "I was ATTUNED to my client this month in these ways…," "Their culture of one played a role in this way…," and "It felt…" (see "Appendix").

Like other approaches rooted in mindfulness, this model aims to strengthen emotional tolerance by increasing emotional and bodily awareness and helping clinicians and clients to pause and *respond* to internal states and external circumstances rather than *reacting* to them (Baer and Krietemeyer 2006). This is thought to lead to a reduction in distressing symptoms and improved coping and overall well-being (Cacciatore and Flint 2012). To date, this is the only mindfulness-based model of care focused on bereavement. An example of how this approach can be used with a client is provided in the following case study. The client described below entered counseling with one of the authors (JC), who has practiced meditation and mindfulness since 2007 as a means through which she is better able to practice and conduct research in the context of intense suffering related to infant and child death. The agency uses the ATTEND model to train its counselors and volunteers, however clients are not required to participate in mindfulness practices if they are not comfortable with such treatment approaches.

A Case Study[1]

Chuck is a 34-year old African American single father of four who presented at a local mental health agency "*unable to live anymore*" after the sudden death of his teenage child. His son, Marcus, aged 13, died abruptly of a heart anomaly after complaining to Chuck of feeling tired and unwell. Chuck's three surviving children were home at the time Marcus collapsed. Chuck did not seek counseling services until 14 months after his son's death, though he had been under the care of a psychiatrist for medication management for the preceding 13 months and had been diagnosed with major depressive disorder (MDD), anxiety disorder not otherwise specified, and posttraumatic stress disorder. Upon intake at the counseling agency, he was taking alprazolam (anxiolytic), venlafaxine (antidepressant), and zolpidem (sleep aid). His symptoms at intake exceeded the clinical threshold for likely Posttraumatic Stress Disorder, particularly the avoidance subscale, as measured by the impact of event scale-revised (IES-R), as well as the clinical threshold for anxiety and depressive symptoms as measured by the Hopkins Symptoms Checklist-25 (HSCL-25). The social worker practiced mindfulness in order to help Chuck feel safe and to build the therapeutic relationship. Together they formulated goals for treatment based on the tripartite aspects of the ATTEND model: (1) contemplative practices on the part of the counselor which included meditation, mindful walking and eating, attention to nature, 3-min breathing space exercise (attention to bodily sensations, emotions, and thoughts) (Baer and Krietemeyer 2006), and other intentional self-care strategies; (2) client commitment, if and when ready, to mindfulness practice that might include a gradual progression from a few minutes of "quiet time" every morning to longer daily meditation periods; and (3) MBIs that extended beyond the four-walls and between sessions. Various aspects of these three elements will be discussed.

In the first counseling session Chuck vaguely and unemotionally outlined the circumstances of his son's death to his counselor, a social worker at a local bereavement agency. He described changes in sleep patterns, down to an average of 4 h per night, and frequent nocturnal disruptions that included vivid and terrifying nightmares in which he was unable to save his son. The primary affective focus was anger and he noted that he felt cresting rage that made it difficult for him to engage socially or at his place of employment. He engaged in passive suicidal thoughts such as, "*I don't want to wake up,*" but he also said at various times throughout the initial intake that he would not actually harm himself or anyone else. He reported high conflict in his family of origin, remnants from a difficult, sometimes abusive, childhood. In particular, he often experienced conflicted and vacillating emotional states toward his mother.

During this first session, the social worker paid close attention to herself and to the client (attunement). She felt fully present and engaged, noticing her own deep feelings of sadness and loss as he recounted his story with relative emotional detachment. She continued to listen deeply, remembered details of his story, used his child's name throughout the session, and expressed her own feelings of sympathy to which the client responded gratefully (trust). The social worker noticed that Chuck avoided sharing some of the details of his son's death as well as expressions of difficult emotions. They scheduled another appointment, and she followed up with a greeting card thanking the client for sharing his son with her.

Chuck continued with intensive weekly counseling sessions, lasting 1–2 h and relatively unstructured, which incorporated mindfulness-based counseling techniques. Because of the highly distressing nature of the client's circumstances, his social worker allowed the client to guide each session. Some days, he would want to stay the

[1] Names and non-substantive demographic variables have been slightly changed to ensure anonymity. Client provided permission to use his case study.

entire 2 h that the social worker had scheduled for him, often practicing some of the mindfulness exercises. Other days, particularly those that were emotionally intense from the beginning, he wanted them to be briefer. The social worker was attuned to Chuck's presenting emotional state during each session and by remaining fully present with him she was able to be empathic and responsive. She continued to work toward increasing trust through compassionate, non-verbal and verbal communication and engaged in therapeutic touch when appropriate. For example, during the fourth session Chuck started to become emotional and indicated he could not speak. The social worker reached over and touched his hand lightly, saying, "*Take your time, I'm here.*" Then, she waited quietly for him to continue.

The social worker maintained an egalitarian relationship while maintaining her role as counselor. She consistently reminded Chuck that they were working together as a team and that he was not alone. Chuck also completed a genogram between his eighth and ninth session to help them both better understand his family dynamics. This exercise was particularly useful for Chuck and he reported that he started to notice his own emotional reactions to each family member as he completed the genogram. His social worker asked him to record his reactions during the process of creating the genogram, focusing on process experiences as well as content. Chuck had strong ties to his African American community and his church, and though he stopped attending church after the death of his son, he recommenced about 2 months into counseling of his own volition. As his faith became increasingly important to him, the social worker remained sensitive to cultural and ethnic nuances, often asking about his spiritual views and the ongoing discussions he was having with his pastor. Frequently, the social worker would engage Chuck in psychoeducation, providing relevant information to normalize his feelings of grief and exploring new information based on his questions.

The social worker engaged Chuck in narrative therapy in which he told and retold the events leading to his son's death, featuring different aspects of his story that felt prominent at that moment in time. In addition, he also began to progressively learn *vipassana*-based meditative practices, after expressing an interest in them. When he was ready, he eventually committed to 15–30 min meditation periods per day. To manage "*uncontrollable panic attacks,*" his social worker taught him to engage in one or more of these techniques: (1) 3-min breathing space, (2) three slow, deep breaths, (3) autogenics or progressive muscle relaxation, and (4) relaxation music. During the first 3 months, narrative sessions focused on approaching painful memories regarding his son's death and the emotions attached to those memories. Once trust was established in the relationship, the client often wept during sessions and the social worker used a therapeutic, but silent, presence, consistently mindful of her own emotional responses to his expressions of suffering.

During the next few months, the client and social worker began co-creating other self-care strategies which the client reported met his needs and desires. These included 15 min of sunshine per day, journaling and identifying adjectives to describe his affective state, and engaging in active ritual such as lighting a candle for his son at dinner. This ritual was something that Chuck found especially meaningful and he and his surviving children continued this practice throughout his time in counseling. In addition, eco-practices such as walking very slowly and silently in nature and the cultivation of self-compassion through acts such as forgiving his perceived weakness and fragility when he felt vulnerable and tearful were implemented.

Over time, Chuck expressed a greater ability to tolerate his emerging painful emotions, both in session and at home. Six months into treatment he decided to write his life story in a book. He experienced this as "*surprisingly healing*." Other mindfulness interventions based on the Tibetan practice of tonglen were implemented when Chuck was ready. Tonglen is a practice focused on breathing in the suffering of others, and breathing out well-being directed toward them. This practice is thought to increase the capacity for compassion for self and others by situating one's own suffering within a larger context (Schuyler 2010). This idea was modified from a sitting meditation practice to a series of acts of service and volunteerism inviting Chuck to observe the struggles of others and to act on feelings of compassion by helping strangers in need, volunteering for charity events, and attending a bereaved parent group to offer support to others who had experienced a similar tragedy. Through these practices, he found that he was able to participate in group discussions and share deep emotional connections with others.

As Chuck was becoming simultaneously more aware of his emotions and bodily sensations, he was better able to recognize and respond to anger as it arose. In one session, he expressed his surprise when realizing that he became "*most angry*" when he felt "*hurt or offended*" by someone he loved. The social worker was then able to help Chuck learn to put his hurt feelings into words. In one instance, rather than reacting to feelings of disappointment and sadness, he was able to tell his mother that he felt hurt because she didn't call him on the anniversary morning of his son's death. This then opened the door for his mother to

apologize, communicating her own "*fear, sadness, and anxiety*" about the death of her grandson.

Chuck was given the IES-R for measuring trauma responses and the HSCL-25 for measuring depression and anxiety at intake at the agency. The IES-R is not designed to be a diagnostic instrument; however, scores of 1.5 and above are generally accepted to indicate significant trauma symptoms (Creamer et al. 2003). The IES-R has shown high test–retest reliability ($\alpha = .89$–$.94$), good predictive validity, and high internal consistency ($\alpha = .96$) (Creamer et al. 2003). The instrument consists of 22 items regarding subjective distress related to a traumatic experience (e.g., "I felt as if it hadn't happened or wasn't real," "I felt watchful or on-guard"), in this case the death of Chuck's son. For each item, the respondent chooses from a five-point Likert-type scale (0 = not at all; 4 = extremely). The total score is divided by the number of items to calculate the mean score. Tests were re-administered every 3–4 months and were as follows: time one (intake): 3.09, time two: 2.30, time three: 2.20.

The HSCL-25 is a widely used self-report scale that measures anxious and depressive symptoms (e.g., "Spell of terror or panic," "Feeling low in energy, slowed down"). It is scored on a four-point Likert-type scale (1 = not at all; 4 = extremely). Scores are totaled and divided by the number of items to arrive at a mean score. The HSCL-25 has been shown to be adequate as a screening instrument for psychiatric disorders (Veijola et al. 2003). Various cut-off points have been identified as indicating significant symptoms, ranging from 1.55 to 1.75 (Veijola et al. 2003). Chuck's HSCL-25 scores were as follows: time one (intake): 3.48, time two: 2.72, time three: 2.42.

By the time he took the second set of measures, Chuck felt increasing confidence in his ability to tolerate his painful emotions. After several months of gradually decreasing the dosages of his psychotropic medications, he was able to discontinue them entirely. While scores on both instruments significantly declined, they remained above the threshold for likely psychopathology. However, in the context of a traumatic loss such as the death of a child such signs of continuing distress may not be uncommon (Cacciatore et al., in press). Chuck was in treatment for 20 months and consistently reported relief from night terrors and flashbacks and an increased tolerance for painful memories, emotions, and yearnings for his son. He ceased to experience thoughts of self-harm, though he still, understandably, had episodes of deep grief. Chuck also reported he was better able to parent his three surviving children, that he enjoyed them more fully, that he could "*pay more attention*" to them, and that he did not "*feel as much guilt*" about his son's death. He reported he was better able to engage socially, feeling comfortable interacting with family, friends, and even strangers. He also experienced a significant decline in maladaptive symptoms such as hyperarousal, intrusive thoughts, and experiential avoidance, particularly as they related to the death of his son, Marcus.

Discussion

This case study provides one example of how mindfulness-based bereavement care may be beneficial for parents who have experienced the death of a child. Child loss is anecdotally and empirically recognized as an extremely challenging bereavement experience for families as well as clinicians (Callahan and Dittloff 2007; Kaunonen et al. 2000; Rando 1985; Sanders 1979–1980). Time alone does not seem to heal grieving parents, and what happens in the aftermath of a child's death with regard to clinical and social support, familial communication, and an ability to express emotions has an impact.

For example, one study found that grieving mothers diagnosed with MDD years after the death of a child had several differentiating factors when compared to resilient mothers (de Tychey and Dollander 2007). In the case of mothers diagnosed with MDD, "(h)alf of them felt there was too great an emotional distance between themselves and their therapist" (p. 23). They experienced deep existential loneliness and isolation, even amid family and friends. Also, they were unable to elaborate on their feelings of guilt for the child's death, an affective state that mothers in both groups expressed. However, mothers diagnosed with MDD had no safe place to integrate those feelings. Finally, mothers in the resilience group received immediate psychotherapeutic intervention "whereas the mothers suffering from chronic depression were first treated with medication alone" (de Tychey and Dollander 2007, p. 30).

As evidenced by the case example above, the ATTEND model promotes deep connections with suffering clients, and, in line with the aims of other MBIs, helps clients increase their tolerance for painful affective states. Additional goals this model shares with other MBIs are to increase the ability to respond to experiences rather than habitually react, to decrease distressing symptoms, and to improve overall well-being. The ATTEND model components of attunement, trust, therapeutic touch (when appropriate), egalitarianism, nuance, and death education serve to achieve deep intimacy in the therapeutic relationship. These elements, when practiced mindfully by

the clinician, can help bring about the positive changes noted in this case example. Mindful caregiving can help clients feel safe and experience mutual trust, particularly when other sources of social support are limited (de Tychey and Dollander 2007, p. 30). Such an approach, along with specialized training in traumatic death, can help clinicians understand their bereaved clients' lived experiences more empathically.

The client described above reported and demonstrated greater willingness to approach painful emotions and memories associated with his son's death, instead of avoiding them. This benefit also extended to other aspects of his life, such as his difficult relationships with extended family members, where he showed greater willingness to engage in dialogue. He also showed an overall decrease in trauma, anxious, and depressive symptoms and was able to cope more effectively with any persistent symptoms. His anger became manageable and posed less interference with his social life. He began taking greater responsibility for his health and for self-care activities and reported more effective parenting. He reported a decrease in the most distressing symptoms that led him to seek counseling, such as nightmares, anger, anxiety, and passive thoughts of self-harm.

Within the mindfulness literature, the ATTEND model is the only approach created for use specifically within the context of traumatic bereavement. One way in which it differs from interventions such as MBCT and MBSR is that it does not use a standardized format. Instead, it is reflexive and can be adapted to each client's unique circumstances and needs while at the same time providing a consistent framework for grief counseling. This allows for greater attention to cultural differences and for the integration of clients' unique spiritual practices and beliefs. While such a format may make it more difficult to test specific components of the model, other unstandardized approaches such as acceptance and commitment therapy have nevertheless been evaluated and shown to be effective (Forman et al. 2007). Additionally, such flexibility allows for adaptation for use in other related populations, such as the terminally ill. If further testing supports its efficacy, mindfulness-based bereavement care could be extended for use in obstetrical, neonatal, and pediatric units, as well as emergency departments and hospices, as a holistic model for psychosocial caregiving (Cacciatore 2011; Cacciatore and Flint 2012). Finally, this strategy also emphasizes the importance of mindfulness practice on the part of the social worker both as a self-care measure and as a way to improve client outcomes. In a sense, the social worker's mindfulness serves as a catalyst for client change.

Conclusion

Though there is a growing body of support for MBIs for many problems, empirical research on mindfulness and bereavement is severely limited, especially for families facing infant and child death. Like other MBIs that have been shown to improve psychological well-being in those who provide patient care (e.g., Rosenzweig et al. 2003; Shapiro et al. 1998; Shapiro et al. 2007), mindfulness-based bereavement care may reduce the risk for compassion fatigue and other negative consequences of working with the traumatically bereaved (Cacciatore 2011).

As an emergent field, more studies are needed that examine a variety of factors, for instance the influence of the social network and the physical, emotional, and spiritual processes that play a role after traumatic bereavement. This preliminary case study illustrates one mindfulness-based strategy that may be effective for clinicians working with the bereaved. It is notable that the client in this case study sought counseling 14 months after the death of his son, making it unlikely that his improvement can be accounted for by the passing of time alone. However, this does not guarantee that this client improved as a result of mindfulness practice and this case study is not intended to show that this approach is effective for all clients. More rigorous testing is needed to determine how favorably this approach compares to other bereavement-related interventions and if there are other populations that may benefit from it.

Further studies should include rigorous designs and methodologies in addition to effective measurement tools (Kane et al. 2004). For instance, a measure of grief intensity was lacking in this case study and could be added to future studies to obtain a clearer picture of how this model affects grief. In addition, most studies with bereaved parents are conducted with mothers and the unique experiences and needs of fathers are not well represented in the literature (Macdonald et al. 2010). Despite these limitations, mindfulness-based practices align well with social work values and may hold promise for helping those suffering from profound, irreversible losses.

Appendix: ATTEND Model Self Reflection Sheet

I was ATTUNED to my client this month in these ways: _____

_____

_____

_____

_____

_____

I built TRUST by doing these things _____

_____

_____

_____

_____

I knew it was TRUST because _____

_____

_____

I felt like this about therapeutic TOUCH _____

_____

_____

_____

_____

I helped to make the relationship EGALITARIAN by _____

_____

_____

_____

It felt _____

_____

_____

I paid attention to nuance when I _____

_____

_____

_____

_____

Their culture of one played a role in this way

_____

_____

_____

_____

I learned this about DEATH during my interaction with this family

_____

_____

_____

I was able to teach or learn with them _____

_____

_____

_____

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