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ORIGINAL ARTICLE

Cognitive Behavior Couple Therapy-REBT Model for Traumatic Bereavement

Ruth Malkinson · Therese Brask-Rustad

Abstract Following the loss of a child, couple counseling focuses on their grief process as well as the impact of the loss on the marital relationship. Individual differences in reacting to and coping with the loss, different patterns of grieving, and differences in attitudes about relationship issues may cause further distress and increase marital conflicts and adaptation to the loss. When bereavement occurs under traumatic circumstances, the conflicts may be further complicated and involve problems in daily functioning related to distorted cognitions and attributions connected with traumatic bereavement. In this paper, cognitive grief therapy using the ABC model of REBT with a couple who lost a child under traumatic circumstances will be described.

Unless we have directly experienced it, we can only imagine that the loss of a child must be one of the most difficult challenges a couple could experience. The couple is not only faced with dealing with the loss of their child, but also the loss of dreams for his or her future and their family unit as such, while at the same time struggling to keep the marital unit intact and functional. If there are other children in the family who are affected by this loss, parents have to figure out ways to deal with their own grief as well as that of their other children.

One of the factors that plays a key role with regard to how well couples rebound after the death of a child relates to their cognitions, a concept that is central to cognitive and rational emotive behavior therapy. In this article, the authors will

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discuss ways to facilitate the grief process with a couple after the traumatic death of their child, demonstrating how to integrate grief therapy principles with the REBT framework.

Traumatic Bereavement

The term traumatic bereavement, or traumatic grief, implies that the bereaved's experience includes both the impact of circumstances of the event and images of the deceased in a manner that might disrupt an adaptive course of the process. In other words, traumatic bereavement refers to elements of loss of coherence, loss of capability, and loss of continuity in a relationship with the deceased. Additionally, in traumatic bereavement there is an oscillation between intrusion-avoidance of the event, and intrusion-avoidance of the deceased (Horowitz 2003; Rubin et al. 2003; Malkinson 2007) However, whether a loss is considered traumatic or not will depend on a variety of variables concerning the circumstances of the loss (whether the loss happened under "terrible circumstances both seen and not seen" (Rubin et al. 2003, p.668), and the symptoms of trauma experienced following the loss. Importantly, from the continuing bonds perspective, the function of bereavement is to reconstruct inner relationships with the deceased and search for a new meaning to life without the deceased (Klass et al. 1996; Rubin 1999). Factors relating to the relationship with the deceased are crucial in determining whether the loss will be assessed as traumatic or not. In traumatic bereavement, both dimensions of life tasks and the relationship with the deceased are affected and need to be assessed and considered as part of the intervention. Such an integrated view of loss and trauma provides an additional lens from which to assess complications in the process and outcome and the approach to therapeutic intervention (Malkinson 2007; Rubin et al. 2012,in press).

Parental Grief and Gender Differences in Traumatic Bereavement

The death of a child of any age is traumatic; a profound, difficult, and painful experience. While bereavement is stressful whenever it occurs, studies continue to provide evidence that the greatest stress, and often the most enduring one, occurs for parents who experience the death of a child; (Rubin 1999; Rubin and Malkinson 2001; Malkinson and Bar-Tur 2004–2005). The process of conceiving, giving birth, and raising offspring is shared by virtually all living animals. The human experience of this process, however, adds many elements of psychological, social, and meaning. At various stages in the life cycle, men and women relate to child-conceiving and child-rearing roles as central to their existence. Of the bonds formed within the family, the parent–child bond is not only particularly strong, but is also integral to the identity of many parents and children. Much has been written about the significance of the parent–child attachment bond as a major organizer of the individual parent's positive sense of self and significant relationships with others. Children also assume great symbolic importance in terms of parental generativity and hopes for the future. All parents have dreams about their children's future, and

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when a child dies the dreams may die too. This death of future seems integral to the intensity of many parental responses. Parents assert that their grief continues throughout their lives, often saying "It gets different, it doesn't get better". Words such as "closure" can be deeply offensive.

Three central themes in the parental experience when a child dies include, (1) the loss of a sense of personal competence and power, (2) the loss of a part of the self, and (3) the loss of a valued other person whose unique character was part of the family system. While guilt and self-blame are common in bereavement, they are especially pronounced following the death of a child. The parental role as caregiver, protector, and mentor for their child is severely threatened by untimely death (Rosenblatt 2005).

Although grief is an intra-personal process involving an inner relationship with a deceased child, it exists within a context of relationships with living family members. Concurrently, grief is both an intra- and inter-relationship. Family members experience grief in individual, unique ways that are affected by the special interactions, intimacy, and history that they shared with the deceased (Rubin and Malkinson 2001). The death of a child imposes an additional stress on the marital relationship and oftentimes it is a reason for marital therapy. One of the identified risk factors is associated with the untimely event that shatters the family life cycle which was believed to be the cause for increasing the likelihood of divorce, although this assumption was not supported empirically (Rosenblatt 2005; NFO Research 1999; Schwab (1998) argued that marital distress and communication problems should not be equated with marital breakdown. Bereaved parents might feel considerable distance and irritation with one another for some time before regaining the same or even greater level of intimacy than they shared before the child died.

Parents seem to grieve differently. Differences may be related to the role each one has in the family as well as gender, cultural and personality differences (Martin and Doka 2000). Martin and Doka found that fathers, at least in the initial phase of bereavement, are more likely to put their energies into practical issues, supporting their partners, controlling their own emotions, rationalizing the loss in terms of its wider implications for the family, and finding ways to divert their grief into practical activities. Mothers, on the other hand, are more likely to connect directly to their raw feelings, responding to the death through the experience and expression of strong emotion. It is accepted that the mother's role is generally far closer to the child, not only emotionally, but also practically. This may explain the gender differences in strength and duration of grief. Cultural roles and expectations which explain the different reactions of mothers-women and fathers-men should also be considered (Martin and Doka 2000; Malkinson and Bar-Tur 2004–2005).

Cognitions and Emotions in Traumatic Bereavement

Central to CBT-REBT in traumatic bereavement is how the person perceives and appraises the traumatic loss, as well as emotions, physiological, and behavioral responses. Moreover, cognitions are central to understanding emotional disturbance

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and indicate the choice a person has in interpreting a "choiceless" event such as loss (Attig 1996, p. 10).

Research studies indicate that individual differences in the appraisal of a traumatic event and/or its sequelae will determine the outcome and explain individual differences. (Ehlers and Clark 2000; Bowlen and de Keijser 2007). It is not the mere occurrence of the traumatic event that affects the consequences, but a number of variables such as the perceived relationship with the deceased, the circumstances of the loss, earlier experiences with loss, coping style, availability of support, gender, and the socio-cultural context within which the loss occurs (Malkinson 2007). Traumatic bereavement shatters the individual's world assumptions (Janoff-Bulman 1992), and the human tendency to think irrationally increases (Ellis and Dryden 1997). The major tenet in cognitive grief therapy is the distinction between the adaptive and maladaptive course of grief, and the belief that this irrational thinking can be modified by applying a variety of cognitive, emotional and behavioral techniques aimed at assisting clients to adapt to the new reality and reorganize the inner relationship with the deceased (Malkinson 2007).

Thus in cognitive grief therapy, a distinction is made between "rational" adaptive thinking which results in appropriate emotional consequences of sadness and "irrational" maladaptive thinking which results in prolonged distress and depression. Grief therapy is a multifaceted process of assisting the bereaved to cope with the stress that follows the loss and to cognitively construct a more balanced or rational inner relationship with the deceased (Neimeyer 2006). The following chart illustrates the differences between rational and irrational thinking as it impacts emotions:

Functional healthy evaluations and adaptive emotional consequences	Dysfunctional unhealthy evaluations and maladaptive emotional consequences
Sadness: Life has changed forever	Depression: My life is worthless
Anger: It is a pity that he didn't think about the outcomes	Rage: I will never forgive him for doing it to me.
Yearning and Pain: I miss her and feel painful to think that I will never see her again	Anxiety: It's too painful, I don't want to think about it, I can't stand the pain
Remorse: I couldn't help it, I will miss her	Guilt: It's my fault. I wish I was dead

The issue of pain tolerance is central in the grief process. Although it is not an emotion, its evaluation by the bereaved can be healthy and adaptive ("It's painful to think that he will not be the musician he wanted to be") or unhealthy and maladaptive ("I can't even think about the fact that he will never be the musician he wanted to be. It's too painful"). There are evaluations that the pain will be too overpowering and result in avoidance of pain ("I don't want to think of my daughter as dead, its too painful" or evaluations that over experiencing the pain must be endured because one deserves it (a way of punishment) or that one must hold on to the pain because it is the only way to remember the deceased ("the pain is the only

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way not to forget my son"). These two forms of frustration tolerance are labeled as low frustration tolerance as opposed to (excessive frustration tolerance) (Malkinson 1996).

Case Study: Applying CBT-REBT to Help Couples Adapt to Loss

In individual grief therapy the relationship with the deceased is the focus of therapy and the relationship with other living family members is treated indirectly as one of the components of reorganizing one's life. In couple therapy both types of relationships are attended to and need to be assessed. Moreover, couple grief therapy is initiated as a result of the shattered relationship with both the dead and the living. Therapy is aimed at strengthening attachments with the deceased as well as between the spouses. While attachment with the deceased is being cognitively and emotionally relocated inward, those with the living spouse need to be reorganized interpersonally. Also, the loss of a child affects the ability of each partner to provide support for each other. Similar to individual grief therapy, couple cognitive grief therapy is aimed at identifying what cognitive distortions block an open and free sharing between the couple and changing their beliefs into more rational ones so as to facilitate a more adaptive process. The following case describes how a couple coming to a family counseling clinic suffered from severe and destructive marital conflicts which, as therapy progressed, seemed to be connected to the death of their daughter.

The couple contacted the clinic on their doctor's advice about a year after losing their young daughter who had been born with a congenital heart dysfunction. In the initial sessions, they stated that they were having frequent and bitter arguments and were considering divorce. The couple did not see the death of their child as the possible source for the conflict, but rather felt that their conflicts were about daily chores and activities. As therapy progressed, it became evident that chores and activities were symptoms of a bigger problem relating to the loss of their child which was still exceptionally painful and difficult for the couple to address. Therapy lasted for about a year with sessions every 2 to 4 weeks.

The couple's grieving was further complicated by the disagreement about how to talk about their loss, what the loss meant to each of them, and how they should cope with everyday activities. For the wife, her daughter had been central to her existence. Her daughter's illness increased her feelings of being needed as a mother and allowed her to give all her love and affection to her child. She shared that the bond between herself and the child was different from the bond between the husband and the child. The husband did not agree with his wife's assessment, stating that he had loved his daughter just as much as his wife did and that their bond was just as deep. Obviously the differences in how they both perceived their relationship to the child caused conflict and distress. The circumstances around the death were extremely distressing, and even though they had known that their child was seriously ill and might die, they were not prepared for the sudden death. The wife felt totally helpless when she realized there was nothing she or anyone else could do to save the child. The husband was extremely sad that their daughter was deceased,

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but was more accepting of this reality. The difference in how they experienced the loss was a constant source of conflict, and the wife kept blaming her husband for not sharing her emotions and reactions. The wife also believed that her husband would protect her and the child, and the traumatic loss challenged her assumptions about his strength and capability. She also expressed a deep resentment and disillusion, admitting that she blamed him for what had happened even if she knew it was not really his fault. She said she was terrified that she might start to forget her daughter and that she couldn't let go of the pain because by suffering, she could hold on to her child and not forget her. In this way she forced herself to over experience the grief as a way to remain loyal to the memory of her daughter. For her to accept the loss and to think of life without her child seemed like betrayal. On the other hand, her husband tried to focus on everyday activities as well as the future, an attitude that caused the conflicts to escalate because the wife blamed her husband for not caring the way she did and for letting her down.

As this case illustrates, the gender differences in how grief was expressed increased the marital stress. The wife's emotional response to the death was overwhelming. She was disturbed by the intensity of these reactions and feared that she was going crazy. She experienced strong physiological symptoms-sleep problems, hyperventilation, and heart palpitations, and was exhausted as a result of the physical stress and lack of sleep. She avoided any situations that reminded her of her child. The husband's response to the loss was more restrained and his way of accepting the loss was to find ways to resume his routine and let life go on, which his wife interpreted as experiencing "less grief", which in her mind meant that he did not love their daughter as much as she did.

In therapy, it was important to focus on the differences in the way each experienced the grief by legitimizing and normalizing the differences. Disputation is done gently and not in a vigorous manner because for the parents the loss of a child is in and by itself irrational. Using Socratic or circular questions (Malkinson 1996, 2007), the therapist asked the husband: "What would you have said to your best friend who had just lost his daughter and he was grieving a lot? Would you think he would be weak? Of course not–grief is a human and normal response to a tragic event". To the wife: "It seems that think that returning back to the usual routine is a sign of your husband not loving your daughter. Could you think of additional ways to express love?"

In applying REBT-CBT to grief during the acute or complicated grief stage, "logical" disputation is not useful, but instead, legitimizing and normalizing is used: losing a child is in and by itself not logical (Malkinson 1996, 2007). In addition, the therapy needed to focus on their relationship with the deceased child and the couple relationship itself. The husband and wife both thought that the worst pain of grieving should have been over by that time and were worried about the possibility that it would never subside. They wondered if something was wrong with them and their relationship. Therapy focused on their dysfunctional beliefs by providing information and normalizing their differences: that they should have been able to put the loss behind them and continue on with life by this time, as well as the wife's belief that her husband should have protected her from this loss. Furthermore,

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it was important to address the wife's belief that not hurting might mean she would forget about the child, which was causing her significant anxiety.

The objective of therapy was to normalize their reactions, but also to help them see that the goal of therapy was not to break the bond with their child, but to create a new internal psychological bond with their deceased daughter. In one of the sessions, the wife stated, "It shouldn't hurt so much! I feel that my friends and colleagues are getting fed up with me, and it has been more than a year now. But I feel I will never get over it! I guess I am a weak person because I can't move on, but therapy doesn't seem to be working—the pain is still there. But I am also scared that if the pain goes away, I may forget about her. It isn't right that I should be happy that she is dead."

The therapist replied by saying, "It seems to me that you may be a little hard on yourself by thinking that there is a time-line for grief". The therapist provided information and normalized the difference between fear of forgetting ("I must not forget my child") to concern ("I know that memories about my child will fade and I will do all I can do to preserve them"). The therapist also pointed out that there seemed to be a dilemma in that on the one hand her client blamed herself for continuing to feel such hurt, yet feared that letting go of the pain would mean that she had to get go of her memories of her child. The therapist pointed out that it is quite normal for parents who have lost a child to mourn a year or much longer and challenged the client to think about the logic of forgetting about her daughter even if she was deceased, helping her to realize that even if her daughter is not around anymore, she will always be in her heart.

The wife reacted well to this, relieved that she wasn't "abnormal" because she continued to feel pain. However, she still didn't understand how her husband could just go on as if nothing had happened. The therapist asked the husband to react to this, which he did by telling his wife that he believed that life had to go on and that that he was afraid that if he grieved too much he would be weak. The therapist explained the difference between adaptive and maladaptive grief (Belief-Emotional Consequence) and explored alternative appraisals to signify the difference between grief and weakness. The husband responded by saying that men shouldn't cry; that he had been taught that it was best not to show his feelings, and he was reacting the way other men in his family did when difficult things occurred. The therapist commented that though that was the family's way to react to adverse events, there is a difference between rational and irrational thinking. The therapist continued to work with him to help him understand the difference between the irrational demand and a rational belief. He gradually accepted that he wouldn't be a weak person if he showed pain over the loss of his daughter.

Marital Conflict Following Traumatic Bereavement

Compton and Follette (1998) referred to trauma literature that suggests that couples affected by trauma show marked levels of reduced emotional engagement and intimate behavior. They may also demonstrate avoidant behavior such as unwillingness to relate to painful thoughts, feelings, and memories connected to the trauma. Such avoidant behavior can result in reduced experienced support within

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the relationship and reduced opportunities for the working through of the painful experience together.

The couple in this case study struggled with dealing with the differences between their ways of expressing their grief, as well as being supportive towards each other. It was important to help the couple modify the belief that they should react in the same way, and instead make room for such differences and try to increase their ability to be more sensitive to each other's needs.

In one session, the therapist said to the couple that they seemed to have different ideas about the nature of their individual relationship with their daughter. She indicated that while there may be differences, does that mean that one of them loved their daughter more than the other, or could it be could it be that each of them expressed their love in different ways. Furthermore, she asked them if it was conceivable that they might also react to and express their pain differently. The therapist asked, "Do you think it is possible that we have two stories here, a little different, but both are true? When you watch movies or observe how others express love or react to pain, does everyone do it the same?" The husband acknowledged that this might be the case, adding that he loved his daughter but when he gets upset, he goes to the gym, needing to be on his own. He also expressed that he felt his wife's disapproval for his way of handling things but that he just would rather withdraw than deal with the conflict because he thought it would just make matters worse. His wife responded to this, saying that she felt hurt and anxious when he withdrew.

At this point the therapist introduced the connection between beliefs and feelings, sharing with the couple that the event, which was the death of their daughter, resulted in grief for both of them, but that they expressed it differently. Instead of accepting this difference, the wife thought her husband should grieve in the same way she did, and when he didn't, she felt hurt and anxious, which he interpreted as disapproval, which then made him feel worse.

The therapist worked hard to help them identify and dispute their irrational beliefs related to how they expressed their grief, and eventually they concluded that they would try to accept their differences without making judgments about who loved their daughter more. The therapist suggested a homework assignment which involved looking at photos of their daughter and just accepting that they might react differently but that one way wasn't better than the other and that they shouldn't try to change the way each one responded.

In the following sessions, the therapist continued to help them deal with their irrational beliefs, as well as provide information about the grieving process and normalizing and legitimizing their different experiences. In particular the therapist shared information about gender differences (Malkinson 2007; Baucom et al. 2002; Schwab 1996).

In addition, it was also important to focus on the other aspects of their relationship. The couple expressed concern that their marriage was in serious trouble, and that they both felt they were drifting apart. Intimacy was reduced, and they felt more and more that they were going their separate ways. They had very different ideas about how everyday chores and activities could best be planned, and how important they were, which also lead to conflict. The therapist addressed these issues to try and reduce the conflict.

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For example, the husband shared that he wanted to be there for his wife, but when he tried to make things easier for her by doing some chores, she got angry because to her, chores weren't important…how could either one of them focus on chores when their daughter had died? Who cared if the chores were done? The therapist pointed out that when the husband tried talking about or doing practical things, the wife thought he was being insensitive and indifferent to her pain. Instead of being appreciative for what he had attempted to do, she felt angry. The therapist helped her articulate her should: he should know better; he shouldn't care about these minor things when the big picture is that we lost our daughter. He shouldn't be over it and moving on…not when I'm not ready.

The therapist referred back to the information she had shared about gender differences, asking the wife, "Do you suppose it is possible that your husband can still be grieving but that it helps him to 'do something' instead of focusing on his feelings as you do? Is it possible that his offering to help with chores is a way of him showing some sensitivity to you, which might indicate that he does care?" The wife acknowledged that this could be possible and the couple was able to talk about each other's viewpoints more openly.

In CBT-REBT a key element is helping clients see the connection between an event that may serve as a trigger, and how irrational evaluations may cause emotional and/or behavioral consequences that often in turn lead to increased distress or conflict. Through the discussion the couple found a way to see the pattern in some of their conflicts, and how this was related to different assumptions about how they should deal with the grief.

Cognitions and Interpersonal Interaction

Emotional disturbances in the aftermath of a traumatic experience may involve distressing emotions including anger, anxiety, shame, guilt and depression. These emotions may in turn influence cognitions and appraisals in a reciprocal fashion and result in more conflict-ridden interactions with others because one might construe what happens in a more negative fashion, thus causing more interpersonal conflicts.

In cognitive therapy cognitions are seen not merely as by products of emotional disturbance. CBT-REBT in fact stresses the interactions between cognitions and emotions, and the emotional consequences of irrational or distorted thinking (Ellis 1991;Beck 1976). Emotions are seen as the consequences of evaluations of the adverse event which are either functional or dysfunctional. Because of the potential traumatic nature of a death, emotions may be seen as more dominant than cognitions particularly in the acute phase (Malkinson 1996). This may lead to greater emphasis on the emotions connected to the death because they are also more overt as opposed to cognitions which are more covert. This in no way should be taken to signify that cognitions are of less consequence. A traumatic death may shatter the bereaved's core assumptions about the world, the self and the future, and grief may be said to be the process whereby the person has to reorganize what has been shattered as well as reorganize inner relationships with the deceased (Malkinson and Rubin 2007;

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Rubin, et al. 2011/in press). In therapy this means that one also has to help the individual explore cognitions related to the traumatic bereavement that may cause additional emotional distress and help construe new meaning to life after the bereavement in order to help the person move on. In the case example both the wife and the husband expressed great differences in their ideas about their future as well as cognitions related to identity as individuals and as parents.

For example, in one of the sessions the wife said: "What am I now? I used to be a mother, but now that my daughter is dead, I feel very confused if someone asks me if I have children. The other day I was looking at the photographs on my wall, and there was my daughter and my mother. Even if my mother is long dead, I still feel like a daughter, but to be a mother without a child just doesn't feel normal! Even if I have a job, I don't have a career, and all I wanted was to be a mother. He (points at the husband) says we should try again, but it feels like a betrayal to my daughter!"

The therapist responded: "You feel it would be a betrayal if you loved a new child? If your daughter had lived today, would you still feel you would have betrayed her if you had more children?"

"But this is not how it was meant to be—it is so unfair! I want more children, but I am so afraid it would be a betrayal. But maybe it isn't really—it is just too hard because our first child has died. I feel as if there is no future for me, and there is no point in this marriage without children. What will I do with my life? What is the point of anything now?"

The husband replied:"I hate it when she says this, it feels like I am of no importance! It makes me so sad and angry! But maybe it is different for her—maybe it is different for mothers in a way? I always felt I have kind of two legs—a family leg, but also a professional leg. But it makes me really sad when I think that when we get old, there is no one we leave behind—it ends with us. I sometimes think about having another child, and this is also something we quarrel about. But I also feel guilty about that. And yet I am so afraid it will never get better."

Therapy focused on how the couple was stuck: if they moved on, would they be betraying their daughter? The therapist addressed the wife's guilt in particular by asking her, "If your daughter could talk to you right now, what do you think she would be saying? Do you think she would want you and her father to fight? Do you think she would say that you should never have another child because it might make you forget her? What do you think?" This was a very dramatic moment for the wife, who through her tears said that she thought her daughter would want them to move on. From that moment on, the couple seemed to be better able to accept their differences and at the same time, begin addressing with the therapist more adaptive ways to deal with their loss as well as how to move on as a couple.

This case study illustrates how the initial focus was on their individual distressing cognitions and symptoms of traumatic bereavement, but then moved to the relationship. Therapy oscillated between focusing on their relationship as a result of the loss of their daughter, their inner relationship with the dead child, and on their conflicts about how to deal with each other following the loss.

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Conclusion

For parents, death of a child can be one of the most traumatic events they experience in their life time. This chapter highlighted some of the therapeutic challenges and dilemmas in couple therapy following the death of a child, an event over which the couple in the case study had no control. Three major issues are relevant to couple grief therapy: The individual response to loss, the impact of the loss on the marital relationship and the reorganizing inner relationship with the deceased child. Therapy focused on normalizing the grief process and the individual differences in grieving, easing distressing symptoms, and enhancing communication skills.

The goal of the therapist in applying CBT-REBT is to facilitate an adaptive grief process, which does not mean absolving all pain and yearning for the dead child, but to promote a more adaptive process of grief and assist the couple to become a source of support for each other as they experience grief as a way to also increase a more intimate relationship. Teaching them how their irrational beliefs caused their feelings and resulted in counter-productive behaviors for the couple relationship became the avenue for facilitating the grief process and its impact on the couple relationship.

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