



Emotion Processing in Child Bereavement: Development and Validation of a Counseling Model Based on Resilience and Self-Compassion

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ABSTRACT

The present study aimed to develop and validate a counseling model for processing emotions associated with resilience and self-compassion among mothers who had experienced the death of a child. The model was designed on the basis of a qualitative analysis of the lived experiences of 30 bereaved mothers in Isfahan and was organized into nine weekly 90-minute sessions comprising an interconnected set of components addressing the emotional, cognitive, somatic, meaning-related, identity-related, and interpersonal dimensions of grief. The model is structured around four stages—activation, symbolization, meaning-making, and integration—and incorporates 11 key components, including establishing emotional safety, controlled emotional activation, working with trauma-related experiences, identity reconstruction, strengthening the continuing bond with the deceased child, social support, and planning for exposure to future triggers. The Delphi method was used to evaluate the validity of the model, and experts confirmed the necessity, appropriateness, and coherence of its components across three consecutive rounds. The findings indicated that the model had satisfactory content validity and was consistent with the lived experiences of bereaved mothers as well as with theoretical and therapeutic principles in the field of grief. Accordingly, the developed counseling model may be used as a valid, structured, and feasible intervention to assist mothers who have experienced the death of a child in processing emotions, reconstructing meaning, and strengthening resilience.

Keywords: emotion processing, resilience, self-compassion, child bereavement.

1. Introduction

The death of a child is widely regarded as one of the most devastating forms of bereavement because it violates deeply rooted expectations regarding the natural sequence of life, parenthood, continuity, and the future. Unlike many other losses, child bereavement may simultaneously disrupt attachment, identity, family roles, assumptions about safety, and the parent's broader system of meaning. Parents who lose a child frequently experience intense sadness, yearning, disbelief, anger, guilt, intrusive memories, somatic distress, and difficulty re-engaging with daily life. These reactions may fluctuate over time and can be reactivated by reminders, anniversaries, social encounters, or developmental milestones that the deceased child would otherwise have reached. Although grief itself is not inherently pathological, bereaved parents constitute a population at elevated risk for severe and persistent psychological difficulties, including depression, trauma-related symptoms, prolonged grief, social withdrawal, and impaired functioning (1-3).

Parental grief is particularly complex because the deceased child often occupied a central place in the parent's emotional, relational, and existential world. The loss therefore involves not only separation from a loved person but also disruption of future-oriented hopes, parental responsibilities, family narratives, and anticipated life trajectories. Longitudinal evidence suggests that the death of a child may be associated with enduring depressive symptoms among parents and that patterns of adaptation may differ across individuals and social contexts (3, 4). Research on parents who lose children following serious or life-limiting conditions has likewise demonstrated substantial consequences for parental well-being and quality of life, indicating that bereavement can affect emotional, physical, and social functioning long after the death itself (5). When the death is unexpected, violent, traumatic, or perceived as preventable, the grief process may become further complicated by shock, intrusive imagery, self-blame, helplessness, and trauma-related arousal (2, 6).

The interpersonal consequences of child bereavement are also substantial. Bereaved parents may encounter difficulties in family communication, changes in marital and social relationships, withdrawal from previously meaningful interactions, and the experience of being misunderstood by others. A recent scoping review of parental grief following

unexpected child death indicated that social networks may undergo marked changes after the loss, while peer and self-help groups can provide opportunities for validation, shared understanding, and connection with others who have experienced similar bereavement (7). At the same time, social interactions may become sources of additional distress when relatives, acquaintances, or community members pressure bereaved parents to "move on," minimize the loss, avoid discussion of the deceased child, or offer culturally inappropriate reassurance. Cultural norms also shape how grief is understood, expressed, and socially acknowledged, meaning that responses considered supportive in one context may be experienced as invalidating in another (8, 9). Accordingly, grief interventions require sensitivity to both individual emotional processes and the relational and cultural environments within which mourning occurs.

Contemporary grief theory has increasingly moved away from rigid stage-based models toward dynamic frameworks that recognize substantial variability in bereavement trajectories. The assumption that grieving individuals must progress through a fixed sequence of emotional stages has been criticized because empirical evidence does not support a universal, linear progression and because such assumptions may inadvertently pathologize normal individual differences in grieving (10). Current perspectives emphasize oscillation, adaptation, continuing bonds, emotional processing, meaning reconstruction, and the interaction between individual vulnerability and contextual resources. Emotional expression may be helpful for some bereaved individuals, but its effects depend on the function, timing, context, and degree of emotional engagement rather than on the mere presence or absence of expression (11). Thus, effective grief intervention requires a flexible framework capable of helping individuals access, differentiate, tolerate, regulate, and integrate painful emotions rather than simply encouraging catharsis or suppression.

Emotion processing is particularly important in this regard because grief involves repeated confrontation with affectively charged memories, bodily sensations, meanings, and attachment-related cues. From an emotion-focused perspective, adaptive change occurs when individuals are able to activate emotionally salient experiences, identify and symbolize them, differentiate primary from secondary

emotional responses, access unmet needs, and transform maladaptive emotional patterns through new emotional experiences (12, 13). Evidence regarding grief-focused psychotherapy also suggests that emotional processing is an important mechanism through which intervention may reduce distress and improve adaptation (14). Emotion-focused approaches are therefore especially relevant for bereaved parents who may simultaneously experience grief, guilt, anger, fear, shame, numbness, yearning, and self-criticism. Research on emotion-focused group interventions in other populations has also demonstrated that work with affective experience can improve emotional control and reduce painful self-conscious emotions, supporting the broader clinical relevance of structured emotional processing (15).

The emotional processes associated with bereavement are also closely intertwined with trauma-related responses. Sudden or distressing child death may create highly conditioned reactions to environmental reminders, sensory cues, locations, objects, or situations associated with the death. Trauma-informed approaches emphasize the importance of safety, stabilization, tolerable emotional activation, grounding, and gradual engagement with distressing internal and external cues (6). Body-oriented research has similarly highlighted the relevance of somatic processes in trauma-related distress, suggesting that attention to bodily sensations, arousal, and regulation may be valuable where emotional experiences are strongly embodied (16). Developmental models of posttraumatic stress further indicate that trauma-related symptoms may show both continuity and change over time and are influenced by subsequent experiences, coping processes, and environmental conditions (17). These findings are clinically relevant to child bereavement because mothers may experience grief not merely as cognitive sadness but also as intense physiological activation, breathlessness, numbness, fatigue, pain, agitation, and panic-like reactions.

For a subgroup of bereaved individuals, grief-related responses persist with sufficient intensity and duration to produce marked impairment and may meet criteria for prolonged grief disorder. Prolonged grief is increasingly conceptualized as involving persistent separation distress, difficulty integrating the reality of the death, emotional pain, identity disruption, meaninglessness, and impaired re-

engagement with life (18, 19). Bereaved parents appear to be particularly vulnerable to such difficulties because of the centrality of the parent-child bond and the perceived unnaturalness of the loss (1). Neurobiological research has also begun to explore how attachment, reward, stress, and memory systems may contribute to persistent grief responses, indicating that prolonged grief cannot be reduced to ordinary sadness alone (18). At the same time, culturally responsive assessment is essential because grief manifestations and interpretations may vary across cultural environments, and diagnostic frameworks should not treat culturally meaningful expressions of mourning as inherently pathological (9).

Meaning reconstruction constitutes another central process in adaptation to bereavement. The death of a child may challenge fundamental beliefs about fairness, predictability, spirituality, parenthood, identity, and the expected structure of life. Bereaved individuals may therefore struggle not only with emotional pain but also with the task of reconstructing a coherent life narrative after an event that appears incomprehensible or unjust. Constructivist perspectives conceptualize complicated grief partly as a crisis in meaning in which previously held assumptions are no longer sufficient to assimilate the loss (20). Empirical studies have shown that disruptions in meaning and negative appraisals are associated with prolonged grief, while meaning-making and meaning reconstruction are important components of adaptive bereavement adjustment (21, 22). Narrative reconstruction in grief therapy provides one pathway through which bereaved individuals can reorganize the story of the loss, integrate continuing attachment, and construct a future identity that acknowledges rather than erases the deceased child (23).

The concept of continuing bonds is particularly relevant to parental bereavement. Contemporary grief theory no longer assumes that psychological recovery requires emotional detachment from the deceased. Instead, adaptive mourning may involve transforming the relationship from a physical to a symbolic, internalized, spiritual, or memory-based connection (24). Continuing bonds can take forms such as speaking to the deceased, preserving meaningful possessions, engaging in memorial practices, performing activities associated with the child, visiting the grave, or

maintaining contact with people connected to the deceased. Symbolic rituals can help individuals maintain a meaningful connection while accommodating the reality of physical absence (25). For bereaved mothers, such practices may support both attachment continuity and meaning reconstruction, provided that they facilitate adaptation rather than reinforce rigid avoidance of the reality of the loss.

A further important construct in grief adaptation is resilience. Resilience does not imply the absence of suffering, emotional pain, or temporary impairment. Rather, it refers to the capacity to maintain, regain, or reconstruct adaptive functioning while confronting severe adversity (26). In bereavement, resilience may involve tolerating intense emotional states, drawing on interpersonal and spiritual resources, maintaining valued roles, developing flexible coping strategies, and gradually reconnecting with meaningful aspects of life. Because parents who lose a child often face recurrent waves of grief rather than a single discrete stress response, resilience should be understood as a dynamic process that can be strengthened over time. This perspective is especially important because framing bereaved mothers only in terms of vulnerability may neglect their existing strengths, relational resources, values, and capacities for adaptation.

Self-compassion may represent one of the psychological resources through which resilience and emotion regulation are strengthened. Self-compassion involves responding to personal suffering with kindness rather than harsh self-criticism, recognizing suffering as part of the human condition rather than as a source of isolating defectiveness, and maintaining mindful awareness of painful experience without becoming overwhelmed by it (27). These components are highly relevant to bereavement, particularly when mothers experience guilt, self-blame, perceived parental failure, or shame about their emotional reactions. Research in trauma populations has suggested that self-compassion may facilitate recovery partly through more adaptive emotion regulation (28). Among bereaved individuals, self-compassion has also been associated with grief-related adaptation and posttraumatic growth, suggesting that a more compassionate relationship with one's own suffering may reduce the burden of prolonged grief while supporting constructive psychological change (29).

Emerging intervention research further supports the relevance of self-compassion for bereavement care. A recent process evaluation of an online self-compassion-based group psychotherapy program for bereavement-related grief found that participants could engage with compassion-oriented practices as part of their grief process, highlighting the feasibility of incorporating self-compassion into structured interventions (30). Self-compassion may be particularly valuable for mothers who interpret moments of pleasure, rest, self-care, or re-engagement with life as betrayal of the deceased child. By helping individuals differentiate continued love from continued self-punishment, compassion-based work may permit self-care without demanding detachment from the child. This approach is also consistent with clinical perspectives that emphasize spiritual and existential dimensions of healing in prolonged grief, particularly when the bereavement challenges assumptions about death, justice, transcendence, or continued connection (31).

Clinical preparation for grief-related triggers is another important intervention component. Anniversaries, birthdays, holidays, familiar locations, family gatherings, photographs, clothing, media, and other reminders may reactivate distress even after periods of relative stability. Rather than interpreting such reactions as treatment failure or regression, grief interventions can help clients anticipate predictable triggers, recognize associated emotional and somatic responses, and develop coping plans that preserve both emotional openness and safety (32). Such preparation is particularly relevant for parents because the lost child's developmental milestones may generate repeated reminders across the lifespan. Integrating trigger planning into treatment can therefore support a more realistic and sustainable model of adaptation than attempting to eliminate grief responses altogether.

Self-care is similarly essential because bereaved parents may neglect sleep, nutrition, physical health, relationships, and daily functioning while coping with intense emotional pain. Longitudinal research has demonstrated meaningful associations between self-care and emotional exhaustion among bereaved parents, suggesting that impaired self-care may contribute to sustained psychological burden (33). Yet self-care in parental grief may be complicated by guilt, reduced motivation, identity disruption, or the belief that

attending to one's own needs diminishes loyalty to the deceased child. Consequently, counseling interventions should address self-care not as a superficial behavioral recommendation but as part of identity reconstruction, emotion regulation, and compassionate adaptation.

Taken together, the literature indicates that child bereavement is a multidimensional experience involving emotional activation, trauma-related responses, bodily distress, interpersonal changes, disrupted self-care, identity disturbance, guilt, continuing bonds, existential meaning, and culturally embedded forms of mourning. Existing evidence supports the therapeutic relevance of emotion-focused work, trauma-informed stabilization, narrative and meaning reconstruction, continuing bonds, resilience enhancement, self-compassion, social support, and preparation for grief triggers (12, 14, 23, 24, 26). However, these components are often examined separately, whereas the lived experience of bereaved mothers suggests that they are dynamically interconnected. Moreover, the diversity of parental grief across social and cultural settings underscores the need for counseling models that are grounded in the lived experiences of the target population rather than imported as predetermined sequences of grief reactions (8, 9). A contextually grounded model that integrates emotional processing with resilience and self-compassion may therefore provide a more coherent framework for addressing the complex psychological needs of mothers following the death of a child.

Accordingly, the present study aimed to develop and validate a counseling model for processing emotions associated with resilience and self-compassion among mothers who had experienced the death of a child.

2. Methods and Materials

The present study aimed to develop and validate a counseling model for processing emotions associated with resilience and self-compassion among mothers who had experienced the death of a child and employed an exploratory sequential mixed-methods design. This approach consisted of two principal phases: a qualitative phase for model development and a Delphi phase for model validation. The stages of the study are described below.

In the first phase, thematic analysis was used to identify the main components of emotion processing, resilience, and

self-compassion among bereaved mothers. Participants were mothers who had experienced the death of a child. Participants were selected purposively according to predetermined inclusion criteria. Inclusion criteria were permanent residence in Isfahan during the previous 10 years, loss of a child within the preceding 1–2 months, maternal age between 20 and 50 years, and a deceased child aged 18 years or younger. Exclusion criteria included legal divorce, death of the husband, marital separation, experiencing multiple bereavements during the previous year, use of any illicit substances, and use of any psychiatric medication. Following collection of the initial data, sampling continued until data saturation was achieved, resulting in a final sample of 30 participants. Data repetition began during the 24th interview and continued in the 25th interview. Five additional interviews were subsequently conducted to ensure data saturation. At this point, no new themes emerged from the additional interviews, and interview data collection was terminated.

Data were collected through in-depth semi-structured interviews, which enabled the researcher to follow predetermined areas of inquiry while also allowing participants to provide unrestricted narratives and personal details. Interviews were conducted in a quiet setting, without the presence of unrelated individuals, and with attention to participants' comfort. Each interview lasted between 60 and 90 minutes, and the sessions were audio-recorded after written informed consent had been obtained. Interview questions focused on emotional experiences, ways of coping with the loss, internal and external resources for adaptation, and the mothers' therapeutic needs. Following audio recording and transcription, the data were manually coded using the six-phase thematic analysis procedure proposed by Braun and Clarke (2006). The extracted main themes included intense unpleasant emotions, shock and disbelief, persistent emotional arousal, somatic experience of emotion, responses to cues, emotional reactivation on meaningful occasions, self-soothing strategies, constructive and maladaptive emotional behaviors, and emotional adaptability. These themes formed the basis for development of the counseling model.

To establish the rigor and trustworthiness of the obtained data, three criteria were considered: credibility, dependability/consistency, and confirmability. Credibility

was ensured by sharing the findings with participants and conducting member checking. To ensure dependability, efforts were made to reach agreement among the researcher, dissertation supervisor, and advisor regarding the accuracy of interpretations, and the research process was conducted collaboratively and in consultation with experts. With respect to confirmability, the researcher attempted to minimize the influence of prior assumptions during the data-collection process. In addition to minimizing researcher bias, the concepts generated by the researcher needed to be readily traceable to the original data. Accordingly, all data were personally traced by the researcher in written form, and all concepts and themes identified by the researcher were linked to specific segments of the data. Moreover, the codes and categories were reviewed and evaluated by researchers outside the research team who were familiar with qualitative research methodology.

Based on the extracted themes and a review of books and articles related to emotion processing, the emotion-processing counseling model was developed. The model consisted of a series of structured sessions, with each session including specific objectives, therapeutic content, techniques, and homework assignments.

The Delphi method was used to validate the developed model. This method enables the systematic collection of expert opinions and the achievement of scientific consensus regarding the components of a model. The Delphi questionnaire contained a list of the model components, session objectives, techniques, and session sequence. Experts evaluated each component according to the criteria of necessity, appropriateness, clinical utility, clarity, and

feasibility. The Delphi process was conducted in three rounds, and components receiving low scores or less than 70% agreement were revised. In the third round, consensus exceeded 80%, and the final model was approved.

At this stage, six experts, including clinical psychologists, family counselors, grief therapists, and university faculty members with clinical and research experience in grief and emotion-focused therapies, participated in the study. Experts were purposively selected according to the following criteria: at least five years of clinical experience in grief or emotion-focused interventions, publication of at least one relevant scientific article, familiarity with Acceptance and Commitment Therapy (ACT), Emotion-Focused Therapy (EFT), or compassion-based therapies, and willingness to participate in multiple Delphi rounds. The mean age of the experts was 51.33 years ($SD = 7.401$), and their mean professional experience was 17.08 years ($SD = 3.174$).

Delphi data were analyzed using the mean, standard deviation, and percentage agreement. The Delphi agreement coefficient was used to determine the degree of consensus among the experts.

3. Findings and Results

As shown in Table 1, the qualitative phase was conducted to identify the lived experiences of emotional difficulties among mothers who had experienced the death of a child. Thematic analysis of the semi-structured interviews resulted in the identification of 381 initial concepts, 33 subthemes, eight main themes, and two core themes.

Table 1

Summary of Themes Related to Emotion-Processing Difficulties Extracted From Interviews With Mothers Who Had Experienced the Death of a Child

Core Theme	Main Theme	Subtheme	Open Codes
Activation and experience of emotions	Intense unpleasant emotions	Emotional distress	Experiencing severe bodily pain; intense yearning and crying; having nightmares; feelings of isolation and misery; psychological and physical pain arising from the sense of having lost one's entire life investment; recollections of self-hitting and fainting; severe distress associated with loneliness and yearning; waiting for the child to return
Activation and experience of emotions	Intense unpleasant emotions	Shock and disbelief	Feeling as though one is going insane; wondering whether the loss represents divine punishment for sins; confusion regarding one's own emotional state and forgetting the first days of bereavement; silence and confusion about why God chose to take the child despite the presence of young children; feelings of shock and disbelief

Activation and experience of emotions	Intense unpleasant emotions	Persistent emotional arousal	Emotional distress worsening over time and feeling as though one's life is being taken away; increasing distress associated with prolonged separation from the child; sudden attacks of sadness and yearning at work; continuously experiencing emotions at peak intensity; only limited and occasional reduction in emotional intensity through reliance on God
Activation and experience of emotions	Intense unpleasant emotions	Somatic experience of emotion	Fatigue and restlessness; feeling exhausted and lifeless; feeling paralyzed; experiencing internal tension and silence; panic-like episodes accompanied by blurred vision and numbness of the hands and feet; shoulder pain and a sense of carrying a heavy burden; sensation of small stones or the child's grief resting at the back of the neck
Activation and experience of emotions	Emotional responses to cues	Recurrent trauma reactivation by environmental triggers	Becoming distressed when seeing a hospital; self-hitting and crying when hearing loud voices because the child died during a conflict; distress and a sensation of suffocation when seeing meat because of the child's occupation; returning to the feeling of being nothing more than a piece of flesh when seeing water and imagining the child drowning
Activation and experience of emotions	Emotional responses to cues	Emotional reactivation on meaningful occasions	Fainting when remembering the child on special days such as birthdays and Mother's Day; experiencing the worst possible emotional state on dates meaningful to the deceased child; returning to the emotional state of the earliest days of grief on special occasions such as birthdays and Labor Day; wishing to die on the child's birthday; recalling memories of the child's earlier life on the child's birthday
Activation and experience of emotions	Emotional responses to cues	Emotional reactivation through attachment cues	Becoming distressed when seeing a motorcycle; heartache when watching television and remembering watching movies together; feeling as though one is burning when seeing the deceased child's children at family gatherings without their father; heartache when passing the child's shop and recalling the child's aspirations; inability to visit the child's home after the death; intense emotions when seeing the child's friends
Activation and experience of emotions	Self-soothing strategies in response to emotion	Non-suppression of internal emotional experiences	Allowing internal feelings to surface; allowing emotions to be present and engaging with them; suddenly crying in front of others in some situations; permitting emotions to arise and be felt; being honest with oneself, becoming tearful, and crying; living with internal emotions as realities of life; allowing emotions to be present, making contact with them, and subsequently expressing them to prevent a sense of going insane
Activation and experience of emotions	Self-soothing strategies in response to emotion	Active/passive responses to emotion	Writing; praying to see the child again; talking to oneself; expressing emotions through prayer and crying during religious worship; prayer and supplication; talking with young grandchildren and crying because of intense loneliness; intense crying and anger toward prayer because the child died while traveling on a pilgrimage; praying to God for one's own death; praying on the balcony where the child used to talk to the stars
Activation and experience of emotions	Self-soothing strategies in response to emotion	Constructive/maladaptive emotional behavior toward oneself	Sitting and talking to oneself while crying; crying and shouting when in pain; remaining silent and crying when in pain; listening to music and obtaining emotional release; crying, self-hitting, and experiencing stress; excessive crying and dizziness after visiting the child's grave at unexpected times; performing prayer and dedicating its spiritual merit to the deceased son in painful circumstances; attempting to show affection and care toward the other children and spouse after painful emotional experiences
Activation and experience of emotions	Self-soothing strategies in response to emotion	Temporary emotional control because of others	Ability to maintain an outward appearance despite internal distress when necessary; feeling better in the presence of grandchildren; appearing strong in response to the grief of the spouse and children; maintaining composure because of awareness of one's loneliness in coping with problems and a desire not to upset others
Activation and experience of emotions	Self-soothing strategies in response to emotion	Emotional adaptability under difficult conditions	Remaining silent and crying under stress; coping with frustration through confidence in seeing the child again; allowing stressful situations to pass naturally; reciting religious phrases, praying, and walking in stressful situations; feeling compelled to adapt to stressful circumstances and perform difficult tasks for the sake of the family
Activation and experience of emotions	Self-soothing strategies in response to emotion	Concealed grief under obligatory and anxiety-provoking circumstances	Tolerating intense pressure so as not to negatively affect others; avoiding emotions for the sake of daughters; avoiding grief through silence or keeping busy because of a spouse's illness; avoiding grief when necessary; expressing emotions when alone or with others, except when grandchildren are present
Activation and experience of emotions	Effects of relational contexts	Sharing emotions with others	Expressing emotions by talking with a daughter; talking with supportive people; talking with people perceived as emotionally safe; talking and crying with other bereaved individuals; talking with friends; talking with the spouse as the principal empathic companion; talking with colleagues; remaining silent while wishing to talk with grandchildren
Activation and experience of emotions	Effects of relational contexts	Receiving external emotional safety	Feeling calmer in the presence of a daughter; obtaining a sense of safety from children and spouse; experiencing a sister as a supportive companion during bereavement; feeling safe in the presence of supportive people

Activation and experience of emotions	Effects of relational contexts	Constructive external support	Support from children during bereavement; support from friends during bereavement; family support throughout the grief process; assistance from a sister and daughter; support from the spouse and others characterized by empathic acceptance
Activation and experience of emotions	Effects of relational contexts	Avoidance of non-empathic relationships	Preferring solitude when one's own family or the spouse's family causes difficulties because of lack of understanding; preferring the absence of inauthentic or superficial individuals; preferring to remain with family rather than hearing upsetting comments from others
Activation and experience of emotions	Effects of relational contexts	Need for sustained understanding and empathy	Defining support as understanding and accompanying the mother despite her irritability; support being authentic and sustained until emotional recovery occurs; presence of companionship without expectations or criticism; defining support as deeply understanding the mother's inner pain
Processing painful experiences	Identification of personal strengths	Relationships as a life strength	Care provided by a daughter as a source of strength; the supportive presence of healthy and emotionally safe individuals as a strength; understanding and care from the spouse as a strength during bereavement; the importance of a daughter and spouse in life as a source of support
Processing painful experiences	Identification of personal strengths	Personal meanings	Maintaining an outward appearance; fantasizing as a personal strength; feeling less alone in the presence of family and grandchildren; having independence; striving to preserve one's life and emotional functioning
Processing painful experiences	Identification of personal strengths	Experiencing comfort through touching keepsakes	Wrapping the child's blanket around the shoulders and becoming calmer; feeling safe by wrapping the child's clothes around the neck; feeling safe by wrapping the child's sports clothing around the abdomen
Processing painful experiences	Identification of personal strengths	Religious beliefs	Becoming calmer through belief in reunion in the afterlife; strength derived from faith in God and the Day of Judgment; religion facilitating endurance of hardship and helping prevent self-harm
Processing painful experiences	Barriers to emotion processing	External pressures disrupting loss management	Circumstances worsening because of the spouse's expectations and problematic behavior; difficulty arising from the spouse's expectations; expectations from the spouse's family that the mother should rapidly move beyond grief; circumstances becoming more difficult because of pressure from others; situational pressures and others' expectations intensifying pain
Processing painful experiences	Barriers to emotion processing	Effects of difficult life circumstances on loss-related emotions	The inherent difficulty of adapting to the child's absence; difficulty moving forward because of environmental cues and memories; difficulty of burying the man of the household; physical weakening after experiencing the child's death; becoming overwhelmed by concern about an orphaned grandchild; the mother's own physical illnesses
Processing painful experiences	Barriers to emotion processing	Preoccupation with nighttime thoughts	Insomnia and rumination; falling from the hope that the child might still be alive into the painful reality during sleepless nights; repeated nighttime insomnia and staring at the wall
Processing painful experiences	Barriers to emotion processing	Belief in professionals' inability to provide emotional relief	Believing that only oneself can provide help and having no expectations of professionals; believing that anyone who has not personally experienced bereavement cannot understand a grieving mother; having no expectation that others can help provide comfort; perceiving support groups as unable to provide complete relief although they may facilitate some calming
Processing painful experiences	Failure to redefine identity	Lack of self-care following grief	Grief preventing enjoyment even amid ordinary life difficulties; memories and the child's absence preventing prioritization of physical and mental health; grief and life circumstances impeding self-care through difficulty letting go and continuing with life; grief preventing self-care through happiness and attention to one's physical and psychological well-being
Processing painful experiences	Failure to redefine identity	Identity disruption after loss	Lack of desire to perform activities and completing only essential tasks while exhausted; experiencing oneself as an unmotivated mother and merely carrying the title of spouse while attempting to cope; experiencing hardship while attempting to care for spouse and children; retiring because of loss of motivation to continue working
Processing painful experiences	Failure to redefine identity	Disruption of daily life	Grief affecting every aspect of daily life; decline in the quality of everyday functioning; difficulties with routine activities because others do not accommodate the mother's condition; negative effects of grief on daily functioning and perceived benefit from planning and reading
Processing painful experiences	Need to reconstruct and strengthen meaning	Grief as loyalty	Revisiting memories of the child; engaging in activities valued by the child, such as treating others kindly; maintaining relationships with the deceased child's friends; talking to the child's image through memories; visiting the grave; talking with the child's friends and preparing food for them in remembrance of the child; maintaining relationships with grandchildren and daughters-in-law
Processing painful experiences	Need to reconstruct and strengthen meaning	Guilt about failure to prevent the death	Anger at still being alive after the child; anger toward oneself, a son-in-law, and a grandchild and blame related to the circumstances of the death; self-blame for not preventing the child from leaving home; blaming oneself for not insisting that the child remain home; self-blame associated with believing that more advice should have been given or that the mother should have accompanied the child on the trip; anger toward oneself for transmitting a cardiac condition to the child

Processing painful experiences	Need to reconstruct and strengthen meaning	Confronting a crisis of meaning	Viewing life as empty; feeling unmotivated and perceiving life as meaningless; losing meaning in all aspects of life; aspirations and plans becoming meaningless; losing the meaning of life after having to bury one's child
Processing painful experiences	Need to reconstruct and strengthen meaning	Weakening or loss of relationships	A sense of being a "walking dead person" affecting previously positive relationships; desire for solitude and withdrawal from others; removing numerous people from one's life; becoming emotionally cold and detached in relationships; irritability and restricting social interaction; weakening and deterioration of relationships

1. Intense Unpleasant Emotions

The first main theme was **intense unpleasant emotions**, comprising the subthemes of emotional distress, shock and disbelief, persistent emotional arousal, and somatic experience of emotion.

In relation to this main theme, mothers who had experienced the death of a child described profoundly dysregulated emotional experiences during bereavement. These experiences were manifested as psychological and physical pain, nightmares, intense yearning, a sense of having lost the most valuable part of life, and a feeling of pain accumulating in the throat and body. Participant 1 stated: "I didn't feel well. My whole body hurt. I couldn't get my voice out. My whole existence had become longing, crying, and screaming, and I had a lot of bad dreams." Participant 5 stated: "Physical and emotional pain, silence... it was as if I had lost the greatest asset of my life." Participant 7 reported: "There are many things and events I don't remember at all. I only remember hitting myself so much and feeling death every moment. I would faint and then come back. You don't know how awful it was—grief, loneliness, longing, waiting... because I was still waiting for my child to come back." Participant 10 similarly stated: "I was suffocating. I remember hitting myself so hard from grief that my lip split and my whole body was black and bruised. I had so much grief that I couldn't say anything anymore. It felt as if all the grief in the world had gathered in my throat and body." Participant 13 described anger toward life and its perceived futility: "On the third day, my husband brought me a glass of water. I threw the glass against the wall. That was the day I understood what anger was—real anger. Not anger at someone, but anger that even breathing seemed pointless." Participant 15 similarly stated: "Only nausea. Nausea from everything, even from the mirror showing me my own face."

The mothers indicated that receiving news of their child's death produced profound shock and disbelief, accompanied by feelings of going insane, suffocating, repeatedly dying

and coming back to life, and feeling as though they were dying along with the child. Participant 3 stated: "It was as if they had thrown me to the bottom of the sea and I didn't understand what was happening to me. I don't know how to swim, and I'm suffocating and dying." Participant 4 stated: "I had gone crazy. I couldn't understand what was happening. It was as if I wasn't even in this world." She continued: "It was as if they had thrown me to the bottom of the sea and I didn't understand what was happening to me. I don't know how to swim, and I'm suffocating and dying." Participant 6 stated: "I didn't even know how I felt. I only wanted to know, 'Why me? Was I really such a bad servant of God?'" Participant 8 said: "Because of the pain and loneliness, I had just become silent. I was confused. I said, 'How could God take my young child away? Why this child?'" Participant 12 similarly stated: "I felt as if a bomb was sitting inside my chest, but it would neither explode nor empty itself. At night, I would silently lie in his bed and breathe in his scent until I fell asleep."

For these mothers, emotions remained highly activated as bereavement continued. Throughout the day, they experienced the sensation of life leaving the body, the pain associated with prolonged separation, sudden episodes of sadness, and intense yearning. Participant 2 stated: "It is always at its peak. The more time passes, it doesn't get better; it gets worse. It's like you haven't seen someone for a very long time and it becomes so difficult." Participant 8 described the intensity of her pain: "Oh, they have never changed. I am still burning." Participant 9 stated: "After one week, my emotions and feelings reached their peak. Only then did I come out of the shock and realize what had happened to me. I began having panic attacks. I did not talk to anyone and became severely depressed and anxious." Participant 11 similarly stated: "I buried my young son. I am always at the peak. Whenever I see my son's photograph—and I see it all the time—my condition changes completely." Participant 20 described the persistence of grief throughout life after bereavement: "I became alone. One night, I went

into the yard and looked at the sky. That night, I had a severe panic attack and thought I was having a heart attack. I took myself to the hospital. The second peak came the first time one of my patients at the center resembled my son—the same stutter, the same mannerisms. I cried in the hallway, went to the bathroom, washed my face, and returned. That day I understood that I would never get rid of this grief; I would only learn how to live with it.”

Some mothers indicated that their painful emotions manifested physically in their bodies. Participants 1, 3, 4, 5, 8, 10, and 11 made similar statements: “When my emotions become intense, I become extremely tired and restless.” Participant 9 described the effects of panic-like episodes: “When these emotions come over me, I have an attack. My breathing slows down, everything becomes dark and blurred before my eyes, and my hands and feet become numb.” Participant 16 described abdominal pain: “I feel everything in my stomach. A tight knot, just below my rib cage. When I miss him intensely, that knot starts turning and pressing.” Participant 25 described experiencing anxiety through trembling of the hands: “My hands. They always shake. The doctor says it’s anxiety. When I’m doing janitorial work, the broom shakes in my hand.”

2. Emotional Responses to Cues

The second main theme was **emotional responses to cues**, which was divided into three subthemes: recurrent trauma reactivation by environmental triggers, emotional reactivation on meaningful occasions, and emotional reactivation through attachment cues.

Regarding triggers that reminded them of memories of their child and the circumstances of the child's death, the mothers stated that they were repeatedly taken back to the trauma of the death and experienced painful emotions. Participant 3, whose child had died during a conflict, stated: “For example, if someone speaks loudly, I become completely agitated. I hate fighting now. I want to hit myself until I die, and then I sit down and cry for a long time because of the miserable state I’m in.” Participant 4, referring to her child's occupation, stated: “My son had a butcher shop. Can you believe that even when I see meat, I feel terrible? I’m suffocating. I can’t take it. The world collapses on me.” Participant 7 described what occurred when she sat in a car and remembered her child's death: “Whenever I get into a car, I think, ‘What did my child feel when he went under the

truck? What did he experience?’ Then I feel terrible.” Participant 14, referring to the date on which her child's illness had been diagnosed, stated: “April 4, the day my son was diagnosed. Every year on that day, I eat nothing from morning until night; I can’t. I sit in front of his pictures and just stare at them. At 3:00 p.m., the time the doctor gave us the results, I get up, go to the bathroom, and stand under a cold shower for an hour. It’s as if I want to wake myself from a dream. But I don’t wake up.” Participant 18 described seeing the pedestrian bridge that reminded her of her child's suicide: “The pedestrian bridge near our house. Every time I cross that bridge, my legs turn cold. Once I stood at the bottom of the bridge and looked down. I thought, ‘It’s so high; it must have hurt so much.’”

Another category of triggers that exposed mothers to painful grief-related emotions involved meaningful occasions, such as Mother's Day and birthdays. The mothers also reported wishing for their own death on such occasions and experiencing grief with an intensity similar to that of the earliest days following the loss. Participant 1 stated: “If there is a special occasion, such as the day before his birthday or Mother's Day, my whole body feels as if it is on fire, and I become so restless that I faint.” Participants 2 and 4 made similar statements: “At special moments connected with my child, I am in the worst possible condition a human being can be in.” Participant 6 stated: “His birthday, Men's Day, Labor Day because he was a worker, and every other special occasion take me back to the first days. In fact, my feelings are still like those first days. They haven’t improved; they’ve become even worse. Losing someone is really very bitter.” Participant 10 stated: “I have memories of her from every second and moment of my life. On Teachers' Day—because my daughter was a teacher—and on Mother's Day, she used to do so many things for me. Whenever her birthday or Teachers' Day comes, my whole body freezes. I go crazy. I don’t know where to go or what to do. I want the earth to open up and swallow me so I can die and no longer exist. At that moment, I only ask God to end my life. ‘God, why don’t you hear me? Are You even there?’” Participant 17 stated: “I bring the unfinished carpet into the yard, the carpet we wove together. I sit on it and touch those same threads.”

In addition to circumstances that reproduced the trauma associated with the child's death, mothers described cues that reminded them of their attachment to the deceased child.

They narrated memories such as spending time with the child, seeing the child's clothes, and remembering the child's aspirations, all accompanied by painful emotions. Participant 6 stated: "Even when I want to watch television, I can't. My heart hurts. We always watched together and commented on the movies. This is only the smallest description of how I feel." Participant 11 similarly stated: "When I see his friends, the videos of him, or his clothes that are still here, all of these create extremely intense feelings in me. At those moments, the whole world collapses on me and everything feels meaningless. I even say, 'I wish I had killed myself.'" Participant 8 stated: "When I pass the shop that he had opened with so many hopes and dreams, my heart hurts because not even a month passed before he died and he never really got to work there." Participant 15 stated: "The bus stop opposite my daughter's university. Every time I pass it, my legs become heavy. I stop and look at the bench where she used to explain my textbooks to me, laughing and saying, 'Mom, this is easy; use your brain.' In those moments, my body begins shaking—not from cold, but from something deeper." Participant 23 stated: "The brick kiln. He worked there. Every time I pass the road leading to the kiln, I break into a cold sweat." Some mothers also described emotional activation when seeing their grandchildren without their father and their inability to return to the deceased child's home. Participant 8 stated: "When I see his children with their aunts and uncles while their father is not there, I burn inside. At that moment, I just want to be alone and cry for myself." Participant 9 stated: "I can no longer go to my son's house. I have not gone there since he died because I knew that if I went, I would feel terrible and have another attack."

3. Self-Soothing Strategies in Response to Emotion

Self-soothing strategies in response to emotion constituted the third main theme and included the subthemes of non-suppression of internal emotional experiences, active/passive responses to emotion, constructive/maladaptive emotional behavior toward oneself, temporary emotional control because of other attachment figures, emotional adaptability under difficult conditions, and concealed grief under obligatory and anxiety-provoking circumstances.

Child bereavement was accompanied by internal feelings and emotions that, according to the mothers' narratives, were often confronted without suppression. The mothers had

accepted the presence of these emotions as part of certain realities of life. Participants 1, 5, and 10 made similar statements: "I let what I'm feeling come up inside me and I connect with my emotions." Participant 6 stated: "I'm honest with myself. Sometimes I get a lump in my throat and cry. I only hold back to some extent because of the people around me." Participant 7 stated: "If I suppress them, I'll go crazy, so I connect with them and let them be there. When I express them, I actually feel lighter, although it's temporary. But if I'm forced to suppress them somewhere, I feel much worse afterward." Participant 8 stated: "No, I don't want to distance myself from anything in my life." Participant 10 stated: "Even though I'm not educated, sometimes I understand when my heart is restless and I know how I'm feeling. Sometimes I suppress it because I don't have the opportunity to express it, maybe because of other people. But if I have the opportunity, I definitely let those feelings be there. If they aren't, I actually feel worse. I can spend hours immersed in myself and what I'm feeling." Participant 12 stated: "I allow feelings and emotions to come. I neither invite them nor push them away. When the crying is over, I get up and drink a glass of water. I've only recently realized that no emotion lasts forever. If you don't stop it, it leaves by itself. But if you suppress it, it makes a home inside your body." Participant 23 similarly stated: "I let my emotions be there. I cry. I tell my anger, 'Come on, we're fighting for justice.' I turn anger into energy."

According to the mothers, they used different strategies to respond to the emotions they experienced. Some of these responses were active, such as writing, crying, praying, and engaging in religious supplication, which made the emotions easier to tolerate and process. Participants 2 and 5 stated: "To process my emotions, I write them down." Participant 6 stated: "When I experience these emotions, I cry so I can feel better." Participant 6 also described talking to her young grandchild: "Sometimes I talk to my little grandchild, even though the child doesn't understand anything, and I hold the child." Participant 22 described reading the child's favorite books during periods of intense emotion: "She loved books, especially Forough's poetry. At these moments, I go to her bookshelf and read her favorite books." Participants 9 and 11 similarly described releasing painful emotions through prayer and supplication: "I usually express the emotions and grief inside me through crying and prayer while I am

praying. I become much calmer when I mourn during prayer.” Some strategies were passive and involved anger, which made the pain more difficult to tolerate and process. Participant 1 stated: “I become silent and irritable.” Participant 7 stated: “I don’t pray at all because, after all, my son was a pilgrim to Imam Reza and this still happened to him. I know it sounds irreligious, but I’m being honest.” Participant 10 stated: “When I do pray, I pray that God will let me die sooner.” Participant 26 described another experience involving waiting and praying for the child to return from the river: “I pray too, but not in the ordinary way. I ask God to bring him back, even if only in a dream.”

The mothers' subsequent accounts also indicated that they engaged in various emotional behaviors toward themselves during bereavement, some of which could provide comfort and represent constructive and effective strategies for dealing with pain. Participant 3 described talking to herself while crying: “I sit in a corner, cry, and talk to myself.” Participant 5 described remaining silent and crying: “I stay silent and cry.” Participant 6 described using music to facilitate emotional release: “I sit in a corner, listen to music, and cry so that I can improve my state and release what is inside me.” Participant 9 described compensatory, feasible behaviors: “When I feel bad, I perform a few units of prayer and dedicate them to my son's soul, and I feel better. After I calm down, I try to care more for my husband and children and show them affection.” Participants 15 and 27 similarly described engaging in deep yet positive acts for themselves during solitary moments. Participant 15 stated: “I do something very simple but meaningful: I make myself tea with honey and cinnamon. I sit down and drink every sip slowly.” Participant 27 stated: “I do something good for myself. I buy a book or watch a movie.” Participant 24 stated: “I take refuge in the mountains. I go to Tochal.” Some reactive behaviors, however, were maladaptive and exposed the mothers to greater physical and psychological harm. Participants 4 and 10 described excessive crying and shouting: “I cry and scream. I know these behaviors make me ill and I get severe headaches.” Participant 7 described harming herself: “Well, naturally, I hurt myself through crying, screaming, and stressing myself.” Participant 8 similarly described self-harming patterns: “Of course I treat myself badly. I cry so much that my blood pressure rises, or I go to my son's grave at all hours. Many times I’ve become

dizzy and fallen.” Participant 22 described developing a compulsive organizational routine: “I arranged all the books in the house alphabetically according to the letters in my daughter's name. Every morning, I dust them and rearrange them.”

The mothers stated that they sometimes controlled their emotions because of other attachment figures, including grandchildren, other children, and spouses, in order to avoid causing them distress and to remain present for them. Mothers with grandchildren also reported generally feeling better in their presence. Participants 1 and 8 stated: “When the house is busy and my grandchildren are around, I feel calmer.” Participant 2 described maintaining an outward appearance of well-being in front of her spouse and children: “When I see my husband and children grieving, I can show myself as much stronger and cope better. The only difference is that I’m maintaining an appearance. I tell them, ‘I’m fine, don’t worry and don’t make yourselves upset,’ but all of it is a mask.” Participant 6 similarly stated: “I’m still a mother and grandmother. I don’t know, maybe being a source of hope for some people gives me something to lean on.” Participant 3 described recognizing her own loneliness and trying not to upset others: “When I realize that no one can really do anything for you, I pull myself together, even if only briefly, and make myself appear calm, especially when I’m in a group where my grief might upset other people. I try to deal with my grief better.” Participant 11, referring to protecting her other daughter, stated: “I control myself in front of her only because of my daughter, because she has become very vulnerable.”

Another factor that the mothers described as temporarily helping them preserve emotional stability during difficult and stressful periods of bereavement was their own personal capacity to adapt to these circumstances. They developed strategies for coping with stress and frustration that enabled them to move through these experiences with less anxiety. Some mothers referred to hope of seeing the child again and doing whatever was possible when under stress. Participant 1 stated: “Just being certain that I’ll see my son again helped me cope with my frustrations, even when it was difficult.” Participants 3 and 4 similarly described allowing stressful circumstances to pass naturally: “Sometimes when I really can’t do anything and nothing works, I become quiet and just let time pass.” Participant 6 stated: “Generally, I’m someone

who keeps things inside and doesn't let anyone know. I can't say that I get up again easily after disappointment, but I continue with my ordinary routine." Participant 11 stated: "I do everything that is within my power. I put in all my effort. That is my only way of adapting." Participant 15 stated: "I take a deep breath and tell myself for three minutes, 'Just one more hour, just one more hour.' My way of adapting is dividing time into very small pieces. I don't tell myself, 'Get through today.' I tell myself, 'Get through the next ten minutes.'" Participant 28 described the compulsory nature of continuing with life: "Now, after the bereavement, I see a strong person in myself. Every time I don't want to go to work, I tell myself, 'I work in order to survive.'" Other mothers placed their hope in the presence of family during stressful circumstances. Participant 5 stated: "I have to adapt because I'm not alone and I have other children. Only my children and my husband are with me and help me tolerate things a little and keep going." Participant 9 described how her grandson's resemblance to her son was comforting during difficult circumstances: "My grandson is my connection to this life. When I become extremely restless and miss my son, I tell my daughter-in-law to bring my grandson so I can see him. My grandson is a boy and looks very much like his father. When I hold him, I feel as if he is my son and I become calm." Participant 22 described remembering the strength she had shown while raising her children: "Every time, I think, 'I have fought throughout life.' I remember that under all kinds of difficult circumstances, I raised my daughters and my son and gave them hope. Every day I told them tomorrow would be better. I don't know whether it will be better or not, but I have to say it."

In addition to controlling their emotions for the sake of other family members or drawing on personal strengths, the mothers described obligatory and anxiety-provoking circumstances that required them to conceal their grief. Such situations imposed considerable pressure, yet they preferred to carry the grief internally. These circumstances included a spouse's illness, the presence of grandchildren, or situations that were themselves anxiety provoking, such as reminders of the child or fear of the future. Participant 3 stated: "Sometimes I avoid my emotions because of my daughter." Participant 4 stated: "Sometimes when grief fills my whole being, I avoid it because of my husband's illness. I withdraw

more into myself or keep myself busy with housework." Participant 9 stated: "I avoid anything that reminds me of the past and of my son's memories." Participant 11 stated: "Fear of the future and loneliness, fear about my daughter's condition, and hopelessness—these are things I have to keep away from because of my life."

4. Effects of Relational Contexts

The fourth main theme was **effects of relational contexts**, which was divided into five subthemes: sharing emotions with others, receiving external emotional safety, constructive external support, avoidance of non-empathic relationships, and need for sustained understanding and empathy.

The narratives of mothers who had experienced the death of a child indicated that, when emotions intensified, relationships could provide companionship and comfort. The mothers discharged their emotions by talking and sharing their distress with family members, friends, and other bereaved individuals. Participants 2 and 7 stated: "I talk with the supportive people around me." Participant 4 stated: "Sometimes I talk with people who are grieving, regardless of whom they have lost. I talk and cry with them so I can calm down." Participant 5 described talking to friends and her spouse: "If I can, I talk with my friends, and if I can, I talk with my main empathic companion, my husband. Interestingly, both of us become a source of comfort for each other." Participant 6 stated: "I also talk with my colleagues and friends. I know it makes them sad, but I have no other choice." Participant 14 described participating in a group for bereaved mothers: "I joined a Telegram group for bereaved mothers, not only to talk, but because I know that if I can't sleep at 3:00 a.m., at least someone will be online." Participant 24 similarly stated: "I'm on the committee for victims' families. We meet every week. We cry and follow up on things. We have become a family together."

The presence of certain close individuals also compensated, to some extent, for the insecurity created by the child's absence and provided reassurance. Most mothers obtained this sense of safety and reassurance from their families. Participants 1, 8, and 29 identified their daughters as sources of comfort and companionship. Participant 1 stated: "The only thing that gives me a sense of safety is my daughter." Participant 8 stated: "Among my other children,

I have one daughter who is extremely concerned and caring. She is always with me wherever I go and has sacrificed a lot for me.” Participant 29 stated: “My daughters brought me comfort and supported me. They sleep beside me every night.” Participant 21 stated: “My 17-year-old son has become a man and takes very good care of me. One day when I was weak, he said, ‘Mom, shall I bring some bread?’ I said, ‘Yes.’ He went shopping, came back, placed the bread in front of me, and quietly ate with me.” Participant 3 described her sister's companionship: “The only really good companion I’ve had is my sister. She has always looked after me in every way. I experienced the greatest failure of my life, and I still haven’t been able to pull myself together.” Participants 2, 9, and 10 similarly described feelings of safety and reassurance provided by their children and spouses. Participant 9 stated: “During the difficult days I went through, my husband and my other children provided a great deal of help and reassurance.” Participant 7 likewise stated: “The people around me and those who are dear to me have helped me so much that I have been able to continue this far. Even agreeing to participate in your sessions happened because of them. The person who has supported me most is the son who lives with me. My grandchildren have also helped me a lot.”

Another aspect of the mothers' social context that was helpful involved support from others, particularly family members, expressed through empathic and understanding behavior throughout bereavement. Participant 1 described support from her children and friends: “My children, even those who are currently not speaking to me, and my friends provide helpful support—the kind of support where they understand you and stay with you despite all your irritability.” Participants 2, 4, and 6 made similar statements regarding family support: “My own family, especially my maternal family, provided the greatest support.” Participant 7 described support from her family, including her children and sons-in-law: “Bless my sons, daughters, and sons-in-law. They supported me greatly in every respect. They filled many empty places in my life.” Participant 8 similarly stated: “My other children, grandchildren, and daughter-in-law gave me the greatest hope, care, and helpful support.” Participant 10 noted: “My children and husband supported me a great deal, but no one supported them.” Participant 12 described support received from a neighbor: “The greatest

support came from the neighbor across from me, a 60-year-old woman. Not a counselor, not a therapy group, and not my relatives. She never said, ‘How are you?’ or ‘Be strong.’ Every morning, she left a container of soup or stew in front of the door. If I didn’t open the door, she simply went back. That food was a symbol to me. It meant there was someone who understood that even getting up to cook was difficult for me.”

In contrast to these forms of support, mothers reported having experienced the presence of individuals whose involvement was not constructive. Because empathy from others was particularly important for tolerating grief-related emotions, the mothers preferred to avoid relationships that did not provide empathic support. Participant 4 stated: “There are many people like that, including people in both my own family and my husband's family. Every family has people who don’t understand and only create problems. I prefer to be alone and somewhere those people are not present.” Participant 5 stated: “Yes, definitely. There are people who are better off not being there because their words and behavior aren’t genuine; they’re only superficial. I prefer being with a small number of emotionally safe people.” Participant 6 stated: “Some comments break your heart, but there is already so much grief and mourning that I don’t really care about those comments anymore. I would rather be with my family than with those people—no one else.” Participant 10 stated: “I would rather nothing replace him. What is the point if someone only wears away at your soul? I dislike people who pretend to be supportive just to maintain appearances.” Participant 14 stated: “Comparisons. ‘So-and-so lost three sons, but she’s patient.’ If I’m not patient, does that mean I’m a bad mother? Instead of all that, I wish someone would simply say, ‘I don’t know what to say, but can I come sit beside you?’ That’s all. Or bring me a glass of water without saying anything. Silent action is better than a thousand eloquent sentences.”

Mothers who had experienced the death of a child identified sustained, empathic support in the face of their emotions as one of their most fundamental needs. Participant 2 stated: “Helpful support, in my opinion, has to be genuine, nonjudgmental, full of companionship and empathy, and continue at least until the person becomes calmer.” Participant 3 stated: “Helpful support doesn’t have a particular form. Simply knowing that people are beside you

without expectations or blame means useful support, whether in happiness or grief.” Participant 4 stated: “Helpful support means that someone understands you with their whole being, understands what is happening inside your heart at that moment, and is able to accompany you instead of just coming and going out of obligation.” Participant 11 stated: “Helpful support means understanding what stage I am currently in and what is happening to me. People should always care for one another, not only temporarily for the sake of appearances.” Participant 26 similarly stated: “My sister calls every day and asks, ‘Sister, did you eat lunch?’ Helpful support is exactly that—helping someone continue with daily activities.”

5. Identification of Personal Strengths

The fifth main theme was **identification of personal strengths**, including the subthemes of relationships as a life strength, personal meanings, experiencing comfort through touching keepsakes, and religious beliefs.

Regarding the capacity to process the painful experiences arising from the loss of a child, mothers described identifying strengths that helped them temporarily process certain emotions. One of these strengths involved their relationships. Participant 1 stated: “Other than my children, I don’t have any strength. I think they are my greatest source of strength. I wake up because of them and do the things I need to do every day. I don’t do them well, but it’s better than nothing.” Participant 2 stated: “My husband is my source of strength and my safe place.” Participant 7 similarly stated: “I’m very weak myself, but my first source of strength is my grandchild, and I’m grateful to my son’s wife for allowing me to see my grandchild and for maintaining a relationship with us. After my grandchild come my sons and daughters. Whenever I look at them, I tell myself, ‘It’s good that they are here so I can continue this life.’” Participant 13 described the presence of her husband and their shared silence: “My husband’s presence. But not talking to him—sitting silently beside him. At night, we sit down, turn on the television without sound, and look at the screen. We don’t say anything. One hour. Then we go to sleep. That shared silence was better than a thousand sentences from a psychologist.”

Another source of strength under conditions of suffering involved personal meanings that helped the mothers tolerate and process painful experiences and the emotions associated

with them. Participant 3 described existential loneliness: “When I realize that no one can really help you, I pull myself together, even if only briefly, and make myself appear calm, especially when I’m in a group where my grief might upset other people. I try to deal with my grief better.” Participant 4 stated: “Maybe fantasizing is my only strength.” Participant 5 stated: “I think my independence is my strength and helps me cope with difficulties.” Participant 6 described the nature of life: “We are condemned to live, and that itself makes it possible to continue. You can rely on that belief.” Participant 7 found meaning in her children and stated: “After my grandchild, there are my sons and daughters. Whenever I look at them, I tell myself, ‘It’s good that they are here so I can continue this life.’” Participant 10 described her own endurance: “The fact that I’m still continuing is an accomplishment in itself, especially for someone like me who lost my whole life. There was a time when I never imagined I could cook, receive guests, or go outside again, but now I do all of these things. Sometimes I tell myself how resilient I am.” Participant 11 described understanding and caring for her daughter as she grieved her brother: “My only reason and companion is my daughter. I see how she is burning in grief for her brother. My child is going through adolescence, and I have to take great care of her.” Participant 16 described her patience and its role in preserving her life: “One day I emptied his entire wardrobe. I separated the clothes and matched the left socks with the right ones. Whenever a sock had a hole, I brought a needle and thread and carefully repaired it. Not because I wanted anyone to wear it, but because I needed to sit there and think only about sewing, rather than the emptiness he had left. One day, I sat for eight hours repairing stains on Arash’s jeans. My husband said, ‘This is a sign of obsessive illness.’ Maybe he was right, but that obsession kept me alive on the days when I wanted to throw myself off the roof. I was able to wait—wait for morning to come so I could water the sour cherry sapling again.” Participant 30 stated: “I see in myself the ability to talk about death. People are afraid of cancer, but I say, ‘My child fought cancer for four years. My child was a hero.’”

A third source of strength involved keepsakes that held special meaning for the mothers and whose tactile qualities could reduce anxiety and bodily pain. Participant 4 stated: “The thing that makes my body feel safe is my son’s old blanket, from when he was a child. At night, I wrap it around

my shoulders. His own smell has faded so much that it no longer smells like washing powder; it smells like safety.” Participant 9 stated: “The only thing that gives my body a sense of safety is his sleeping clothes. At night, I wrap them around my shoulders and put them under my face.” Participant 28 stated: “The thing that gives my body comfort is my daughter's headscarf, the one she wore the last time. It still smells like her perfume.”

Another source of strength under difficult and painful life circumstances, according to the mothers, consisted of religious beliefs. Participant 1 stated: “I haven't moved beyond it, but I have very strong faith in God. I believe in the Day of Judgment.” Participant 4 described the influence of her religious beliefs on continuing to live: “Religion has had a strong influence, but mainly because it helps me get through the hardship. Maybe if I didn't have religion, I would have harmed myself by now.” Participant 9 similarly stated: “Because of the strong relationship I have with God, I have been able to endure this bereavement.”

6. Barriers to Emotion Processing

The sixth main theme was **barriers to emotion processing**, which included external pressures disrupting loss management, the effects of difficult life circumstances on loss-related emotions, preoccupation with nighttime thoughts, and the belief that professionals are unable to provide emotional relief.

Regarding difficulties in emotion processing, mothers who had experienced the death of a child reported that several barriers interfered with the processing of grief-related emotions. They described expectations and behaviors from spouses and others that appeared unreasonable given the mothers' circumstances and further intensified their emotional disturbance. Participant 1 stated: “It's difficult. The expectations my husband has of me and his bad behavior make the situation even worse for me.” Participant 3 stated: “My husband and his expectations, and the situational behaviors of his family—they don't understand. I buried my beautiful young child, and they expect me to come to terms with it and return to how I was before.” Participant 7 stated: “Those inappropriate expectations are terrible. People expect things from someone who has lost a child, such as ‘Be patient,’ ‘God gave the child and now He has taken the child back,’ ‘You shouldn't still be like you were at first,’ or ‘You're grieving too much,’ and things like that.” Participant

16 described anxiety associated with the expectations and responses of others: “A lot of relatives gathered together. They brought a cleric and recited the Qur'an. I watched from the kitchen. I couldn't go into the gathering. Everyone wanted to tell me, ‘Be patient,’ or ‘Have another child.’ I still get stomach pain when I remember that day.”

The mothers also described aspects of difficult life circumstances that interfered with processing grief-related emotions, including the loss itself, physical weakness, family problems, and financial difficulties. Participant 1 stated: “The fact that my son isn't here is the hardest situation in itself. It is extremely difficult.” Participant 6 stated: “I don't really cope at all because coping is difficult. I allow myself to grieve, even excessively. I didn't bury just anyone; he was my only companion, the man of my household.” Participant 9 stated: “I'm already old and no longer have my previous health or energy. After this bereavement, I became physically weaker. Another thing is that I'm extremely worried about my grandchild's future. Even though the child has a good mother who does everything for him, the sorrow of my grandchild being fatherless has completely exhausted me.” Participant 11 stated: “My husband's illness has been added to all of this, along with a great financial burden.” Participant 19 stated: “My friends don't invite me because they don't know how to behave around me. I don't ask them either because I'm embarrassed. This isolation makes the wound deeper.”

Mothers identified nighttime insomnia and rumination as another barrier, because these experiences subsequently contributed to psychological and physical difficulties during the day. Participant 3 stated: “The days after nights when I can't sleep become the darkest days of my life. My mind keeps repeating, ‘I wish I had waited longer before letting him go cycling. I wish I had called him and told him to come back.’” Participant 5 stated: “Some nights I can't sleep and I imagine that he is still alive. Then in the morning, I remember that he isn't. That fall from hope back into reality is worse than the grief itself.” Participant 17 stated: “The insomnia is terrible. At night, if I stay awake too late, terrible thoughts come to me: my child is in the fire, screaming, and I can't reach him. In the morning, I no longer have the energy to do anything, and my headaches begin.”

Mothers who had experienced the death of a child also believed that even professional assistance could not

substantially facilitate processing of the painful emotions associated with loss or relieve their suffering. This belief constituted a barrier to seeking or regularly continuing professional support. Participant 4 stated: “No one can understand my pain unless they have experienced that same pain themselves.” Participant 6 stated: “No, I don’t expect anything from anyone. I don’t expect anyone to be able to do something to calm me down.” Participant 10 stated: “No individual and no organization can do anything for me.” Participant 17 similarly stated: “Counselors think an uneducated rural mother doesn’t even understand what losing a child means. I don’t know; maybe they can’t help me, especially given the society and culture I live in. A counselor can’t understand my situation.”

7. Failure to Redefine Identity

The seventh main theme was **failure to redefine identity**, comprising the subthemes of lack of self-care following grief, identity disruption after loss, and disruption of daily life.

The narratives of all mothers indicated that after losing their children, they had been unable to redefine themselves as individuals with identities extending beyond that of a bereaved mother. Consequently, intense grief was associated with low levels of self-care, including difficulty continuing ordinary life, lack of positive affect, and limited attention to physical and psychological well-being. Participant 2 stated: “My first priority should be myself and my physical and mental health, but the memories don’t allow it.” Participant 3 stated: “Self-care means that if someone or something hurts you, you can let it go and continue your ordinary life. Self-care means having peace for your own sake. My biggest obstacle is the life I am living, and now the grief for my child has been added to it.” Participant 6 stated: “Self-care means acceptance. It means living life properly, resting, and being happy despite all the grief. What do you think could prevent that other than grief, loss, and longing? Unfortunately, I have the greatest possible obstacle.” Participant 8 stated: “It means being able to remain strong at the height of hardship and continue your ordinary life instead of destroying yourself over something that will never change. My biggest obstacle is the loss of my child. I used to be a very strong person, but this bereavement completely broke me.” Participant 19 stated: “I feel obligated to suffer because I

think that if I take care of myself, it would be a betrayal of my child.”

Performing other roles had also become difficult. Participant 1 stated: “Nothing has really changed in terms of my roles; I simply have no motivation and don’t want to do anything. I only do certain essential things, and even those are very difficult. I have barely been able to adapt.” Participant 4 stated: “No, I am still a mother, but an unmotivated and ill mother. I am still a wife, but I merely carry the title of wife and can’t do anything. I haven’t accepted it; somehow, I simply have to continue.” Participant 6 stated: “As I told you at the beginning, I left my job and retired early because of my work history. I couldn’t continue and I had no motivation.” Participant 15 stated: “I can no longer teach romantic poetry. I asked the principal to let me teach only prose and grammar. The principal agreed.”

Daily functioning was also disrupted. Participant 2 stated: “Yes, I have definitely been through a crisis, and naturally the quality of my functioning has declined. I have no choice but to come to terms with it; I can’t do otherwise.” Participant 5 stated: “Yes, I have definitely been through a crisis, and naturally the quality of my functioning has declined. I have no choice but to come to terms with it; I can’t do otherwise.” Participant 9 stated: “This bereavement changed me and turned me into a different person. I used to be very sociable, but since my son’s death, I no longer interact with anyone. Only religious recitation, prayer, and talking with God keep me going in life.” Participant 20 stated: “Now I have no plans at all. When I wake up in the morning, my first question is, ‘Why did I wake up?’ Making decisions is torture for me.”

8. Need to Reconstruct and Strengthen Meaning

The final main theme was **the need to reconstruct and strengthen meaning**, which included grief as loyalty, guilt about failure to prevent the death, confronting a crisis of meaning, and weakening or loss of relationships.

The mothers’ narratives indicated a collapse of meaning in a life without the child. Some mothers attempted to maintain meaning by preserving their relationship with the child through loyalty to their grief. Participant 1 stated: “I live through the memories and do the things he liked. It gives me both comfort and grief—comfort because I think he would be happy if he were here, and grief because he is no longer here. It’s very difficult.” Participant 4 stated: “Can

you believe that when I think about my son and talk to him in my imagination, I can cope better? Everything feels good to me, although it is temporary, and afterward I feel much worse.” Participant 6 stated: “The only time I feel well is when I am at the graves of my child and my husband.” Participant 8 stated: “Thinking about my child and knowing that he knows I haven’t forgotten him gives me comfort and a sense of security.” Participant 11 stated: “I eat the foods my son liked and watch the movies he liked.” Participant 14 stated: “His football shoes are still in the hallway. I don’t dust them. I want dust to gather on them. It means time has passed, but he hasn’t gone.”

Some mothers also described guilt associated with failing to prevent the child’s death or protect the child. Participant 3 stated: “Many times I think about that night when he left the house. We were having dinner when his friends called. I always blame myself for not saying even one sentence: ‘Son, don’t go. You’ve eaten dinner; stay here beside me.’ Why didn’t I say it? Why didn’t I argue with him? And there are a thousand other ‘whys.’ My only reaction is that I become sad, and the grief becomes hot throughout my entire body and erupts.” Participant 7 stated: “I always ask myself, ‘Why did I let him go? I wish I had gone with him. Why didn’t I warn him more to be careful?’ I have a thousand thoughts like that, and they make me blame myself.” Participant 8 stated: “The only person I blame is myself, because I passed the heart condition on to my son and it was my fault. Maybe if I hadn’t been ill myself or hadn’t had children, I wouldn’t be in this situation now. But only this child developed it. I hate myself; I become upset and angry.” Participant 18 stated: “I tell myself, ‘How did you fail to notice the signs and realize that something was wrong so that you could prevent the death?’”

In other accounts, the mothers described life and everything associated with it as empty and meaningless. Participant 1 stated: “Life no longer has any meaning except waiting and death.” Participant 7 stated: “It has changed enormously. I have no motivation or interest in anything, not even combing my hair.” Participant 10 stated: “Yes, I used to believe there was another world, but now I don’t think that way at all. My life used to have meaning; now it doesn’t. Now I have nothing in life.” Participant 21 stated: “Now I think that some events are not God’s will; they are simply disasters of life. Aylar did not deserve to die, but she died. It’s unjust. I can’t call that ‘God’s will.’”

Given this loss and transformation of meaning, the mothers also described reductions in or termination of social relationships. Participant 1 stated: “My relationships have decreased enormously. I used to be happy and sociable despite all my problems, but now I’m nothing more than a walking dead person.” Participant 2 stated: “I’ve become very distant. I mostly want to be alone and not have anything to do with other people, so I’ve restricted my relationships.” Participant 10 similarly stated: “For a long time, I haven’t had the patience for relationships. When I have no goal and everything feels meaningless, all of that negatively affects relationships.” Participant 30 stated: “I’m a grieving mother, so perhaps I don’t really want to be in gatherings. I just sit sadly in a corner. What is the point? It is better if I don’t go anywhere or talk to anyone because I can’t talk about much other than death and the bereavement I carry.”

To obtain final assurance regarding the content validity of the thematic analysis, the Content Validity Ratio (CVR) was calculated, and the results are presented in Table 2.

Table 2

Content Validity Ratio for Relationships Between Meaning Units and Core Themes

No.	Meaning Units of the Two Core Themes	Mean Content Validity Ratio (CVR)
1	Experiencing and managing emotions	1.00
2	Openness to suffering	1.00

Following data analysis, two criteria were used to determine the amount of training emphasis to be assigned to each core category representing the lived experience of emotional difficulties among mothers who had experienced

the death of a child. The first criterion was the frequency of open codes, subthemes, and main themes, and the second was the breadth of components ranging from specific to general within each of the two core categories presented in

Table 1. At this stage, consistent with Krippendorff (1999), the frequency of meaning units was used as one of the most common and widely applied criteria for examining signs and

manifestations of a particular phenomenon. The results of analyses of the frequency and breadth of the extracted categories are presented in Tables 3 and 4.

Table 3

Frequency and Percentage Distribution of Themes Related to Emotion-Processing Difficulties Among Mothers Who Had Experienced the Death of a Child: Main Themes

No.	Theme	Frequency	Percentage	Rank
1	Activation and experience of emotions	4	50.00	1.5
2	Processing painful experiences	4	50.00	1.5
3	Total	8	100.00	—

Table 4

Frequency and Percentage Distribution of Themes Related to Emotion-Processing Difficulties Among Mothers Who Had Experienced the Death of a Child: Subthemes

No.	Theme	Frequency	Percentage	Rank
1	Activation and experience of emotions	18	54.54	1
2	Processing painful experiences	15	45.45	2
3	Total	33	100.00	—

As shown in Tables 3 and 4, analysis of the frequencies and percentage shares of the main themes and subthemes demonstrated the importance and recurrence of both activation and experience of emotions and processing painful experiences, which accounted for equal frequencies at the conceptual level. The relatively balanced distribution of the subthemes indicates structural symmetry and the comprehensive nature of the model in integrating the dimensions of experiencing emotions together with self-management and openness to grief-related suffering and moving through it, providing a sound basis for developing the sequence of intervention sessions. Accordingly, the

sequence of sessions for training emotion processing associated with resilience and self-compassion among mothers who had experienced the death of a child should be organized as follows.

Approximately 50% of the intervention time and sessions should be devoted to training related to the activation and experience of emotions.

Approximately 50% of the remaining intervention time and sessions should be devoted to strengthening the processing of painful experiences during periods of suffering.

Table 5

Counseling Model for Processing Emotions Associated With Resilience and Self-Compassion

Session	Session Title	Therapeutic Content
First	Establishing emotional safety, validation, and introduction to the emotion-processing model	Establishing a safe environment and therapeutic relationship; initial emotional assessment; introducing the emotion-processing model (activation, symbolization, meaning-making, and integration); gentle emotional activation through a grief timeline; initial compassion exercise. Homework: daily emotional check-in and breathing practice/compassionate phrase.
Second	Emotional activation and accurate identification of feelings	Differentiating primary and secondary emotions; attending to bodily sensations; body scanning; precise labeling of emotions; controlled emotional activation; mindfulness exercises to increase emotional clarity. Homework: continuing daily emotional monitoring and recording one salient emotional situation together with accompanying bodily sensations.
Third	Working with shock, disbelief, and trauma-related responses	Processing experiences of shock and disbelief; identifying trauma triggers; examining sudden trauma reactivations; teaching grounding techniques involving sensory awareness, breathing, and present-moment attention; reducing fear of intense bodily reactions. Homework: recording trauma-activation situations and practicing at least one grounding technique each day.

Fourth	Managing intense emotional waves and strengthening emotion regulation	Identifying patterns of emotional waves; analyzing triggering situations; teaching emotion surfing; breathing exercises and emotional anchoring; establishing a safe distance from emotions; managing emotional flooding without avoidance. Homework: recording one emotional wave and how it was managed and practicing one emotion-regulation skill daily.
Fifth	Working with guilt and self-blame and cultivating self-compassion	Identifying the origins of guilt and self-critical thoughts; examining evidence and cognitive restructuring; emotionally processing guilt and its underlying emotions; guided self-compassion practice; developing a kinder internal voice. Homework: writing a compassionate letter to oneself, recording situations in which the self-critical voice is activated, and practicing self-compassion daily.
Sixth	Reconstructing identity after loss and strengthening self-care	Examining identity disruption following loss; identifying personal roles and values; reconstructing identity on the basis of values; designing small, attainable self-care behaviors; reducing grief-related self-neglect. Homework: identifying and engaging in at least one self-care behavior each day, recording situations in which identity disruption is activated, and continuing self-compassion practice.
Seventh	Reconstructing meaning and strengthening the continuing bond with the child	Meaning-making regarding the relationship with the child; examining the child's role in the mother's identity and life; identifying symbolic and behavioral practices that maintain connection; guided continuing-bonds exercise; reconstructing the life narrative after loss. Homework: writing a letter to the child, engaging in one symbolic activity to maintain the bond, and recording situations in which meaning or meaninglessness is experienced.
Eighth	Strengthening social support and establishing interpersonal boundaries	Identifying the social support network; differentiating constructive from ineffective forms of support; processing distressing interpersonal experiences; teaching boundary-setting skills; developing supportive and protective statements; reducing social exhaustion. Homework: strengthening one supportive relationship, such as through a call or visit; practicing one small boundary in a distressing relationship; recording emotional experiences following important interactions.
Ninth	Integrating treatment, strengthening resilience, and planning for the future	Reviewing the therapeutic process and achievements; identifying resilience resources; planning for future meaningful occasions and triggers; strengthening self-compassion; writing a final message to one's future self; consolidating the revised life narrative. Final homework: completing the letter/message to one's future self and maintaining a list of skills and support resources as a "personal toolkit."

As shown in Table 5, the counseling model for processing emotions associated with resilience and self-compassion consists of nine weekly 90-minute sessions.

In the next phase, the developed counseling model for processing emotions associated with resilience and self-compassion among mothers who had experienced the death

of a child was provided to six experts in psychology. The experts were asked to carefully review the protocol and provide their evaluations of the structure, process, and content of each session using the content-evaluation questionnaire supplied together with the protocol.

Table 6

Results of Expert Assessment of the Content Validity of the Counseling Model for Processing Emotions Associated With Resilience and Self-Compassion Among Mothers Who Had Experienced the Death of a Child

Session	Total Number of Experts	Experts Rating the Session as Essential	CVR
First	6	6	1.00
Second	6	6	1.00
Third	6	6	1.00
Fourth	6	6	1.00
Fifth	6	6	1.00
Sixth	6	6	1.00
Seventh	6	6	1.00
Eighth	6	6	1.00
Ninth	6	6	1.00
Mean			1.00

According to Table 6, the content validity of the emotion-processing counseling protocol was evaluated by six experts. The results demonstrated that all nine intervention sessions were rated as **essential** by every expert, and the mean Content Validity Ratio across the sessions was 1.00, exceeding the critical value of 0.99 specified in Lawshe's table for six experts. These findings indicate satisfactory

content validity and complete expert confirmation of the structure, process, and content of the sessions. The protocol was initially provided to the experts together with an evaluation questionnaire, and the experts offered recommendations for improving its content, structure, and process. Following implementation of these revisions, the final version was again submitted to the experts for

evaluation, and their agreement regarding the process, timing, structure, content, and therapeutic homework was calculated. The results are presented in Table 7.

Table 7

Validation of the Counseling Model for Processing Emotions Associated With Resilience and Self-Compassion Among Mothers Who Had Experienced the Death of a Child Using the Delphi Method

No.	Agreement Criterion	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5	Expert 6	CVI	Overall CVI
1	Content congruence between the designed sessions and the process of training emotion processing associated with resilience and self-compassion among mothers who had experienced the death of a child	4	5	5	5	4	5	0.93	0.95
2	Appropriateness of the sessions in relation to the structure and required steps for training emotion processing associated with resilience and self-compassion among mothers who had experienced the death of a child	5	5	5	5	5	4	0.97	
3	Adequacy of the time allocated to each step and skill within the training in emotion processing associated with resilience and self-compassion among mothers who had experienced the death of a child	4	4	4	5	5	5	0.93	
4	Adequacy of the content of the emotion-processing training package associated with resilience and self-compassion for implementation with mothers who had experienced the death of a child	5	5	5	5	5	4	0.97	
5	Overall evaluation of the training package for emotion processing associated with resilience and self-compassion among mothers who had experienced the death of a child	5	5	5	5	5	4	0.97	

According to the results presented in Table 7, expert validation of the emotion-processing counseling model indicated satisfactory validity of the intervention package. The Content Validity Index (CVI) was 0.93 for content congruence, 0.97 for appropriateness of the intervention sessions, 0.93 for adequacy of the allocated time, 0.97 for content adequacy, and 0.97 for the overall evaluation. The overall Content Validity Index across the expert evaluations was 0.95. These findings indicate that the structure, timing, session content, and therapeutic homework incorporated into the emotion-processing counseling model were considered highly appropriate and valid by the experts and that the model has satisfactory scientific and practical applicability for mothers who have experienced the death of a child.

4. Discussion and Conclusion

The present study aimed to develop and validate a counseling model for processing emotions associated with resilience and self-compassion among mothers who had experienced the death of a child. The qualitative findings yielded 381 initial concepts, 33 subthemes, eight main themes, and two core themes: activation and experience of

emotions and processing painful experiences. The eight main themes included intense unpleasant emotions, emotional responses to cues, self-soothing strategies in response to emotion, effects of relational contexts, identification of personal strengths, barriers to emotion processing, failure to redefine identity, and the need to reconstruct and strengthen meaning. Based on these findings and the theoretical literature, a nine-session counseling model was developed and subsequently validated by experts. All nine sessions received a Content Validity Ratio of 1.00, while the overall Content Validity Index was 0.95, indicating strong expert agreement concerning the appropriateness of the structure, content, timing, and therapeutic assignments. Collectively, these findings suggest that emotion processing following child bereavement is a multidimensional process that extends beyond sadness and includes trauma-related activation, bodily distress, social experiences, identity disruption, meaning reconstruction, self-compassion, and resilience.

The first major finding concerned the presence of intense unpleasant emotions characterized by emotional distress, shock and disbelief, persistent emotional arousal, and

somatic manifestations of grief. Mothers described severe psychological pain, yearning, crying, anger, helplessness, confusion, panic-like experiences, and feelings of bodily collapse. These findings are consistent with evidence showing that the death of a child is among the most psychologically disruptive forms of bereavement and may be accompanied by prolonged grief, depression, trauma-related symptoms, and severe functional impairment (1, 2). Research has likewise shown that parents who experience child loss may exhibit enduring depressive symptoms and substantial deterioration in psychological well-being and quality of life (3, 5). The strong somatic component identified in the present study also corresponds with trauma models emphasizing that highly distressing experiences are encoded not only cognitively but also through physiological arousal, sensory memories, muscular tension, respiratory changes, and other bodily reactions (6, 16). Thus, the mothers' descriptions of pain, numbness, trembling, breathlessness, fatigue, and panic-like states suggest that interventions for parental bereavement should incorporate both emotional and somatic regulation rather than relying exclusively on verbal cognitive processing.

The finding related to emotional responses to cues further demonstrated that mothers experienced recurrent emotional activation when confronted with reminders of the child, circumstances surrounding the death, meaningful dates, locations, objects, or other attachment-related stimuli. These findings are consistent with the conceptualization of grief as involving recurrent activation of attachment and trauma systems rather than a continuously declining sequence of emotional reactions. Grief-related anniversaries and environmental reminders can reactivate distress even after periods of relative stability, particularly when such cues are strongly associated with the death or with the relationship to the deceased (32). Trauma literature similarly indicates that conditioned cues may trigger intrusive memories, heightened arousal, and intense emotional responses long after the original event (6). The current results therefore support incorporating anticipatory planning for triggers into grief counseling. This is especially important because bereaved mothers may repeatedly encounter birthdays, anniversaries, educational milestones, family celebrations, and other occasions that highlight the child's absence.

The third theme showed that mothers used a broad range of self-soothing and emotion-management strategies. Some strategies, including emotional acceptance, crying, writing, prayer, mindfulness-like observation, self-talk, and engagement in meaningful activities, appeared relatively adaptive, whereas others, such as self-harm, excessive emotional suppression, compulsive behavior, or intense avoidance, appeared maladaptive. This pattern supports contemporary grief theories that reject the assumption that emotional expression is universally beneficial or that suppression is uniformly harmful. Rather, the adaptiveness of emotional expression depends on the context, function, timing, and degree of flexibility with which emotions are experienced and regulated (11). Emotion-focused therapy similarly emphasizes that effective psychological change requires access to emotion, accurate differentiation of emotional states, symbolization, and transformation of maladaptive emotional responses rather than unrestricted catharsis (12, 13). The findings of the present study therefore support a therapeutic model in which mothers are helped to experience painful emotions within tolerable limits while simultaneously developing strategies for regulation, grounding, and self-protection.

The mothers' reports also indicated that resilience emerged not as the absence of emotional suffering but as the ability to continue functioning while pain remained present. Some mothers described adapting through family responsibilities, religious beliefs, hope, work, step-by-step coping, or the determination to continue daily activities. This interpretation is compatible with contemporary conceptualizations of resilience as a dynamic process of maintaining or regaining functioning despite significant adversity rather than a state of emotional invulnerability (26). In the context of bereavement, resilience may coexist with persistent sadness, yearning, and periods of emotional destabilization. The findings also suggest that resilience resources may be highly individualized and embedded in relational, spiritual, behavioral, and meaning-based processes. Accordingly, the counseling model developed in this study incorporated the identification and reinforcement of personal strengths rather than focusing exclusively on symptoms and deficits.

Another central finding involved the influence of relational contexts. Mothers described emotionally safe

relationships, family support, peer contact, and empathic companionship as important sources of comfort, while judgmental, superficial, or invalidating relationships intensified distress. This result aligns with evidence showing that parental grief can alter social networks and that support from others who acknowledge and understand the loss may facilitate adaptation (7). Cultural expectations and social norms may also shape whether bereaved parents feel permitted to express grief and whether support is experienced as helpful or invalidating (8, 9). Importantly, the mothers in the present study emphasized sustained empathy rather than temporary or ceremonial support. This suggests that social support should be conceptualized not merely as the presence of other people but as the availability of relationships characterized by emotional safety, nonjudgmental understanding, and continuity over time.

The identification of personal strengths constituted another important dimension of the findings. Mothers reported drawing support from children, spouses, grandchildren, personal independence, religious beliefs, meaningful objects, and their perceived capacity to endure hardship. These resources appeared to provide temporary emotional stabilization and help mothers maintain engagement with life. The significance of such strengths is consistent with resilience frameworks emphasizing the interaction between individual capacities and external support systems (26). In addition, religious and spiritual interpretations may play a significant role in grief adaptation, particularly when bereavement raises existential questions concerning suffering, death, justice, and continued connection (31). However, the findings also showed that spiritual beliefs could become unstable or conflicted, indicating that clinicians should avoid assuming that religious belief is uniformly protective. Instead, spiritual resources should be explored in accordance with each client's lived experience and current relationship with faith.

The findings further demonstrated that emotion processing was obstructed by external pressures, difficult life circumstances, insomnia and rumination, and distrust of professional help. The mothers described pressure from relatives to recover quickly, expectations that they should return to previous roles, and the belief that professionals could not understand their suffering without having experienced the same loss. These barriers are clinically

important because they may discourage help-seeking and reinforce isolation. Research on prolonged grief emphasizes that bereaved individuals may experience persistent cognitive and emotional processes that interfere with adaptation, including rumination, avoidance, self-blame, and difficulty integrating the reality of the death (20, 22). The current findings extend this perspective by demonstrating that environmental invalidation and perceived lack of cultural understanding may also impede engagement with treatment. Culturally sensitive assessment and therapeutic validation therefore appear particularly important when working with bereaved mothers (9).

Failure to redefine identity after the loss was another prominent theme. Mothers described themselves as fundamentally changed, unable to resume former roles, less capable of self-care, and in some cases unable to imagine an identity outside that of a bereaved mother. Identity disruption is recognized as a significant component of prolonged grief and reflects the extent to which the loss destabilizes the individual's assumptions about who they are and how they relate to the world (18, 19). Self-care may become particularly difficult when bereaved parents interpret personal well-being, enjoyment, or future engagement as disloyalty to the deceased child. This finding is consistent with longitudinal evidence linking self-care and emotional exhaustion among bereaved parents (33). For this reason, the developed intervention incorporated self-care within identity reconstruction rather than treating it as an isolated behavioral recommendation.

Closely related to identity disruption was the need to reconstruct meaning. Mothers described life as empty or meaningless, expressed guilt over perceived failure to prevent the death, and reported maintaining connection with the deceased child through memories, rituals, objects, food, visits to the grave, and symbolic behaviors. These findings strongly correspond with meaning-reconstruction models of grief, which propose that adaptation requires individuals to reconstruct assumptions about self, relationships, the world, and the future after a loss that challenges previously held beliefs (20, 21). Empirical evidence further indicates that disruptions in meaning are associated with more severe prolonged grief symptoms, whereas meaning-making processes can facilitate adaptation (22). Narrative reconstruction may therefore assist bereaved individuals in

integrating the loss into an evolving life story without requiring them to erase the significance of the deceased person (23).

The mothers' continued psychological connection with their children also supports the concept of continuing bonds. Rather than attempting to detach from the deceased child, many participants maintained symbolic relationships through memories, belongings, rituals, conversations, and acts performed in the child's honor. Contemporary bereavement theory recognizes that continuing bonds can serve adaptive functions when they are integrated flexibly into ongoing life (24). Symbolic rituals may likewise help bereaved individuals maintain attachment while simultaneously recognizing the physical reality of the loss (25). Accordingly, the seventh session of the developed counseling model directly addressed continuing bonds and meaning reconstruction, helping mothers establish forms of connection that preserve love and memory without preventing engagement with present life.

Self-compassion also emerged as a conceptually important component of the intervention, particularly in relation to guilt, self-blame, harsh self-criticism, and difficulty engaging in self-care. Self-compassion encourages individuals to respond to suffering with kindness, mindful awareness, and recognition of shared human vulnerability rather than excessive self-judgment (27). Evidence from trauma research suggests that self-compassion contributes to recovery partly through more adaptive emotion regulation (28). Recent bereavement research has similarly shown important associations among self-compassion, prolonged grief, and posttraumatic growth (29). Moreover, emerging intervention studies indicate that self-compassion-based group programs are feasible and potentially useful in grief-related contexts (30). The inclusion of self-compassion in the present model therefore addresses a central problem identified in the qualitative findings: mothers frequently blamed themselves, judged their reactions harshly, or felt that caring for themselves represented a betrayal of their child.

Finally, expert validation supported the conceptual and clinical coherence of the developed model. All nine sessions were judged essential, and the high overall CVI indicated strong agreement regarding the appropriateness of the intervention. The model's structure—moving from

emotional safety and activation through trauma processing, emotion regulation, self-compassion, identity reconstruction, continuing bonds, social support, and integration—corresponds with evidence indicating that effective grief therapy should address emotional processing, meaning, narrative reconstruction, and individualized coping rather than impose a fixed sequence of grief stages (10, 14). The model therefore appears theoretically consistent with contemporary grief science while remaining grounded in the lived experiences of mothers who had recently lost a child.

Several limitations should be considered when interpreting the findings. First, the qualitative sample consisted exclusively of mothers from Isfahan, and the experiences identified may not fully represent bereaved fathers, parents from other regions, or individuals from different cultural and socioeconomic backgrounds. Second, participants had experienced the death of a child relatively recently, and their narratives may therefore reflect acute bereavement more strongly than longer-term adaptation. Third, the study relied primarily on self-reported narratives, which may be affected by memory, emotional state, social desirability, or difficulty verbalizing highly distressing experiences. Fourth, although expert validation provided evidence for the content validity and conceptual coherence of the counseling model, the present study did not examine its therapeutic efficacy through a randomized or controlled intervention. Finally, the number of experts participating in the Delphi process was relatively small, which may limit the generalizability of the validation findings.

Future studies should evaluate the effectiveness of the developed counseling model using randomized controlled trials with adequate sample sizes and follow-up assessments. It would be valuable to examine changes in prolonged grief symptoms, depression, trauma-related symptoms, self-compassion, resilience, emotion regulation, quality of life, and daily functioning. Future research should also investigate whether treatment effects differ according to the child's age, cause of death, expected versus unexpected loss, time elapsed since bereavement, socioeconomic status, and family structure. Including fathers and other primary caregivers would clarify whether the current model requires adaptation for different parental roles. Longitudinal qualitative studies could further examine how emotional

processing, identity reconstruction, and meaning-making change over several years following child loss. Cross-cultural replication would also help determine which components of the model are broadly applicable and which require cultural modification.

Mental health professionals working with bereaved mothers should assess emotional, somatic, cognitive, relational, identity-related, and existential aspects of grief rather than focusing only on depressive symptoms. Intervention should begin with emotional safety and validation and should proceed gradually toward controlled emotional activation, trauma-informed work, emotion-regulation skills, self-compassion, identity reconstruction, and meaning-making. Clinicians should help mothers prepare for anniversaries and other predictable triggers, identify supportive and invalidating relationships, establish appropriate interpersonal boundaries, and strengthen practical sources of social support. Continued bonds with the deceased child should not automatically be interpreted as maladaptive; instead, therapists should help mothers develop flexible symbolic forms of connection that can coexist with ongoing life. Attention should also be given to sleep, self-care, physical symptoms, guilt, self-blame, and reluctance to seek professional support. The nine-session model developed in this study can serve as a structured framework for integrating these therapeutic priorities while allowing sufficient flexibility to accommodate the individual circumstances and cultural context of each bereaved mother.

Authors' Contributions

All authors contributed substantially to the study and to manuscript development, and all approved the final version.

Declaration

The authors declare that artificial intelligence tools were used only to assist with language editing, translation, and improvement of the manuscript's readability. All conceptualization, study design, data collection, data analysis, interpretation of findings, and final approval of the manuscript were performed by the authors. The authors take full responsibility for the accuracy, integrity, and originality of the content.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

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Ethics Considerations

The study placed a high emphasis on ethical considerations. Informed consent obtained from all participants, ensuring they are fully aware of the nature of the study and their role in it. Confidentiality strictly maintained, with data anonymized to protect individual privacy. The study adhered to the ethical guidelines for research with human subjects as outlined in the Declaration of Helsinki.

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