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GRIEF AND TRAUMA IN FAMILY DEVELOPMENTAL AND CULTURAL CONTEXT

Ester R. Shapiro, Ph.D.

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THE INTERWEAVING OF TRAUMA AND GRIEF

Although theorists and clinicians working with traumatized individuals and their families recognize the inextricable interweaving of trauma and grief, the mental health field's fragmentation has resulted in many generalizations and few in depth discussions of the relationship between trauma and grief. The grief literature, with its roots in psychoanalytic theory, too often uses "trauma" when describing an overwhelming intrapsychic experience, whatever its foundation in a lived reality, altogether trivializing the stunning and life-shattering realities which accompany true trauma. The trauma literature has tended to assume that bereavement processes are already well understood in the mental health literature, and to suggest that once trauma is addressed and integrated. a more normative process of coping with loss can take place (1, 2). The following brief report describes a model of bereavement which describes the integration of death and loss as a life-long developmental process which takes place in family and cultural context (3, 4). This model provides a clinical basis for responding to the grief and loss experiences which accompany so many instances of trauma.

Grief doesn't begin and end, it evolves and unfolds with the continuing growth of the family.

GRIEF AS CULTURAL CRITICISM

As a culture, we now believe we know a great deal about how to cope with grief, including a prescriptive "grief 101" which emphasizes a simplistic, one size fits all path through a series of stages: open expression, you get it all out, and then you let it go, putting it behind

Continued on page 3

Inside this EDITION

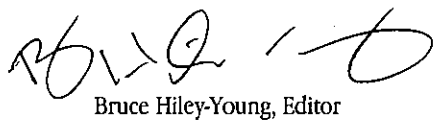
FROM THE EDITOR...

Each hour of every day tragedy strikes and the lives of some men, women, and children are lost while others are forever changed. To single out the victims of one incident is not intended to dishonor the victims of other real tragedies. Thus, we would like to dedicate this issue to the victims, survivors, family members, rescue, medical, and supply workers, stress counselors, police, fire and safety workers, criminal investigators, and the countless other professionals and volunteers who have all been affected by the bombing of the Alfred P. Murrah Federal Building in Oklahoma City. The survivors and their families face enormous challenges in the effort to regain and re-create their lives, challenges which range from engaging in simple everyday tasks to making meaning from senseless murder. Those who helped in the aftermath also face the tremendous challenge of enduring the carnage witnessed and the suffering heard.

The tireless effort by staff of the Department of Veterans Affairs Oklahoma Medical Center, Emergency Management and Preparedness Office, Oklahoma Vet Center and the National Center for PTSD formed part of a tremendous humanitarian response to the community. The National Center for PTSD provided consultants, trainers, and debriefers to the Department of Oklahoma Mental Health and Substance Abuse Services and continues to be involved in teaching disaster crisis counselors about post-traumatic stress disorder. The fall issue of the *Clinical Quarterly* will include two reports from Oklahoma City, including a summary by John Tassey on the DVA role in the aftermath of the bombing, and the comments of Karen Sitterle in her role as mental health coordinator of the death notification center.

Severe trauma always involves grief as trauma always involves loss. Whether it is the loss of a loved one, the loss of physical function, the loss of security or other "shattered assumptions" related to safety and meaning, the forfeiture is grievous. This issue of the *Clinical Quarterly* profiles conceptual approaches to grief work by several distinguished practitioners including Jeffrey Brandsma, Edward Callahan, Lee Hyer, Ester Shapiro, and Jonathan Shay. In addition, we are privileged to present an article by Victoria Cummock whose husband was one of 270 people murdered in the 1988 terrorist bombing of Pam Am 103. President Clinton read Ms. Cummock's words of support to the families of the Oklahoma City bombing victims during the April memorial service. Collectively, our authors offer a framework for understanding the clinical issues related to denial, pacing of treatment, the relationship between client and the deceased, the context of family and culture, and pathological grief.

The fall issue of the *Clinical Quarterly* will focus on treatment approaches to PTSD with articles by Terrence Keane, David Johnson, and Mike Maxwell; in addition, Karen Thompson and Michelle Hamilton will present a strategic approach to working with patients' nightmares and Marylene Cloitre will inaugurate the Women's Clinical Forum.



Bruce Hiley-Young, Editor

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Ester R. Shapiro, Ph.D.

you. This approach, derived partly from work in the mental health field with dying individuals, is well meaning but potentially destructive, because it emphasizes individuals rather than their relationships, and narrowly defines what is normal coping and what is pathological. An individual approach fails to make the best use of the most important human resource for understanding and helping with death, grief and renewal: our family relationships, and our understanding of death and loss as part of a naturally occurring family life cycle process of birth death, renewal and affirmation. These family relationships, in social and cultural context, are the ecology for both individual and family relationships and their growth.

Other cultures do a better job than the Anglo-Saxon North American culture in recognizing the collective nature of the self, and the enduring importance of relationships even after death has severed physical ties to the deceased. Prevailing wisdom in North American culture and among many mental health providers assumes that people who sustain enduring ties to the deceased are suffering from pathological grief. Yet new work in child, adult and family bereavement suggests that the family's ongoing development is best supported by the creation of new ties and a new form of relationship to the person who has died (3-7).

GRIEF AND ITS FAMILY CHOREOGRAPHY

If grief is a shared family process upon which a family's developmental future depends, how should a family handle their grief so as to best create a new foundation for the family's future growth? Grief doesn't begin and end, it evolves and unfolds with the continuing growth of the family. A family's open sharing of their grief may in some instances he a worthwhile goal, but cannot be the family's first priority. The first priority for a grieving family is the restoration of new routines for day to day life which preserve the family's stability in all the area of life which the death has disrupted. Often, these important demands require some emotional control of intense feeling, even if temporarily, until the family feels secure that the work of being a family can go on. The greater the discontinuity and stress precipitated by the circumstances of the death, the greater the need for counterbalancing strategies for stability which can take the form of individual emotional constriction as well as constriction of family communication. If the self is a collaborative choreography, it becomes vitally important to restrict the destabilizing emotions of intense or traumatic grief not only within oneself but also within others so as to preserve areas of emotional continuity and stability. Unfortunately, these initial and necessary emotional controls in the interest of family survival can quickly become enduring family traditions rather than temporary responses to the crisis of grief, producing a family whose developmental processes seem "frozen in time" and unavailable for the necessary challenges of ongoing development.

The creation of new daily routines which preserve family functioning are very much helped by adequate supports. These necessary resources include financial security, a stable home and work, pathways for communication of intense feelings and conflicts within and outside the family, supportive extended family and friends who can help out with tasks as well as provide emotional support, and a community which appreciates the long, painful process of rebuilding which grieving families must experience and which take new forms with new stages and demands in the family life cycle. It will be much harder to re-establish these new routines for going on as a family if the death itself was violent and traumatic, or disrupted family finances and routines, or if the death isolates the family. It is also hard for a family to re-establish themselves if they were already experiencing a great deal of stress due to material conditions or to tensions within the family. Under circumstances of intense stress and disruption, while lacking adequate counterbalancing supports, a family is much more likely to limit the necessary, shared emotional exploration and expression which helps them go on with their lives and resume their shared family growth. Cases of traumatic, multiple family deaths, which disrupt the family's basic living arrangements, are especially devastating because of their disruption of so many areas of stability and interference with potential counterbalancing resources.

It is especially important to permit children a great deal of access to conversation, clarification and reminiscence about a loved one who died, including review of the circumstances of the death in a language which the child can grasp.

Case Example

In the family bereavement center at Judge Baker Children's Center, we worked with one African American family after a fire which began when the family's five children were lighting candles for a private, night time storytelling ritual suddenly blazed out of control. The father died while attempting to rescue the youngest two children, who also died in the fire which consumed their home. In spite of these multiple, devastating losses the mother and surviving children drew a great deal of strength from a supportive community in neighborhood and church, and from a shared sense of the family's mutual love and commitment which survived the traumatic death of three beloved members. Nevertheless, a great deal of the family's immediate energy needed to go into the work of day to day survival, which included finding a new home and required that the mother, who had become the sole provider, increase her work hours so as to provide more of the family's income. Sandra Sutherland Fox, LICSW, founder of the Family Bereavement Center, began her clinical intervention with this family in the burn

center at the father's bedside. The clinical intervention carefully balanced the family's need to tell the story of the trauma and to begin a long process of emotional integration, without in any way interfering with their simultaneous need to re-establish activities of daily life. Mobilization of supportive relationships in extended family, neighbors, church members, as well as facilitating use of public funds were crucial to the initial work with this family. The exploration of intense feelings was not a priority at this stage of the grief work, although the clinician did help both the mother and the surviving children understand what took place and helped them explore the fact that the fire was a tragic accident and not a deliberate act. The work of coping with multiple, traumatic losses in this and other families will be life-long. Yet later stages of the life cycle permit the re-exploration of the death and grief experience once family functioning has been safely re-established and shared intense emotions will not be as destabilizing.

GRIEF IN ADULTHOOD

While grief is a shared family experience, it also affects the family's individuals in ways that are determined by their age and the developmental tasks of their stage in life. Adults, who have primary responsibility for the care of children, also carry primary responsibility for handling the family's grief. For this reason, understanding the personal upheaval that adults go through when they lose a spouse or a child helps us understand the crisis of adult development as a key dimension of the grief reaction for the whole family. Adult development is built up out of a foundation in childhood experiences, but that foundation is given its shape or structure by the active choices and accidents of fate in selecting a spouse, choosing work, and embarking on the care of dependent children. All of these adult life structures and relationships give form to the range of possibilities of what we might become. The loss of a family member precipitates a collapse in these adult life structures, and becomes a crisis of personal identity and even of biological regulation as well as an emotional crisis. Every aspect of adult functioning, from sleep regulation and immune system functioning to emotional regulation and experience of a sense of self require countless check-ins with our loved ones. These mental habits of relatedness are almost altogether unconscious until we lose someone we love. At that time, the countless thoughts and feelings that link us to our loved ones have to be rebuilt so as to adjust to a new reality in which our loved ones are present in memory and spirit but never again in their physical self.

BEREAVEMENT IN CHILDHOOD

The energy it takes to cope with the intense emotions of grief, with the loss of familiar and secure routines of life, while reinventing the adult self, make it extremely difficult for parents to also be available to their children in ways which might meet our ideals. For this reason, children who experience a death in the family are said to lose not only a parent or sibling but also a way of life. Often, children become the resource of last resort for an otherwise resourceless grieving parent. At the very least, children are implicitly asked, or generously offer, or out of necessity offer in the interest of their own survival, to keep many needs and questions to themselves so that they don't disrupt the fragile stability of an overwhelmed parent. Paradoxically, the way to help grieving adults continue to be successful and supportive parents to their children first requires an understanding and sympathetic response to their adult needs.

Children's grief experience is filtered through the child's age and stage of development. At the same time, the intense emotions and disruptions of death and grief affect the child's achievement of tasks of development at that particular age. It is especially important to permit children a great deal of access to conversation, clarification and reminiscence about a loved one who died, including review of the circumstances of the death in a language which the child can grasp. Unlike adult grief, which is immediately intense and then begins to become more manageable over time, children's grief is more uneven from the very beginning. The child's first priority is to go on with the work of development and to create zones of emotional safety where they can take distance from the painful realities of death, loss and grief. Children will ask questions which might be misunderstood by adults as morbid curiosity, but which reflect their attempts to make sense of a death and to find ways to preserve the presence of the deceased in their life. Children need to review the meaning of the death each time they achieve a new stage in their own development and experience the unfolding of new ways of understanding the implications of the death for their lives. Even pre-verbal infants experience the loss of a parent as a disruptive loss. At all ages and stages of development, children need support for the exploration of the image of the family member who died, which grows with their own growth in maturity and capacity for understanding.

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GRIEVING FAMILIES AND THEIR SHARED DEVELOPMENT

So far, we have reviewed the ways adults and children have individual experiences of grief which are at the same time created through collaboration in relationships. Families themselves have a shared organization and pathways through a shared family life cycle which cannot be understood just by summing up our knowledge of its individuals. Family rules for communicating intense emotions while remaining sufficiently stable to go on with the demands of daily life

require mutual sensitivity and careful choreography. When families experience a great deal of stress, they may call upon each other, directly and indirectly, to censor certain kinds of communication in the interest of family stability. Over the course of the family life cycle, families strive to create enough stability and continuity that they can handle the constant flow of developmental change presented by the demands of daily life and by the biological and social maturation of children.

Death and grief present special challenges to family stability, what family therapists call homeostasis or equilibrium, because of the many ways death disrupts the basic pathways by which intense emotions are handled. At the same time, a death in the family presents families wit demanding new work of rebuilding and of emotional containment and support. For families with sufficient supportive resources, in early stages of family development and at the moment of the death, the challenge of grief will stretch their existing resources. In all likelihood even resource rich families will call for a moratorium in the full communication of feelings or in discontinuous developmental processes so as to regroup and restabilize before absorbing more changes. This is especially true if the death was traumatic, or precipitated a great deal of discontinuity in their daily lives, or if the deceased family member performed key functions, instrumental or emotional, which the family cannot easily and flexibly replace.

Some critics of North-American culture claim that its focus on the isolated individual has become a form of cultural pathology. An emphasis on the isolated individual has been especially costly in understanding and responding to grief in its family context.

If a family's development already took place under circumstances of great stress, and with limited resources, then they have already mobilized their relationships so as to support their ongoing development. Families sometimes achieve this necessary stability by restricting certain kinds of emotional expression of its individuals to preserve the family unit. For all families, the death of a family member requires a gradual process of coming to terms with the reality of the loss while rebuilding family relationships so as to support ongoing development. The deceased continues to be a force in the family's development, present in spiritual and psychological ways if no longer physically present. All families have to learn how to rebuild their lives so as to include the decreased in new ways that grow with the family's continued growth and do not require a perpetual moratorium or interruption of ongoing development.

CULTURE AND GRIEF

Modern Western and North American culture emphasizes private individual, time-limited, letting go or detachment and anything else is pathologized. The mental health industry has contributed to this problem, by confusing insurance business practices requiring a diagnostic psychopathology label for reimbursement and ethnocentric cultural assumptions with universal ways of grief. Even when practitioners take account of cultural differences in bereavement, they have a tendency to review ethnic practices globally as if they were monolithic (8). These approaches fail to take into account different processes of acculturation and participation in mainstream culture and economy which are part of these families' developmental realities (3, 4). Even in highly acculturated families, the intense emotions, disruptions and discontinuities precipitated by grief may intensify the need for ancestral and cultural continuities. There may be intergenerational differences associated with acculturation as well as age, family position and developmental location in the family life cycle. In addressing cultural issues as the broadest context for a social developmental perspective on bereavement, we need to take into account cross-cultural differences, social organization and diversity within a culture, and the family life cycle as the universal, organizing context of development with its enormous variability in rules for family functioning. Every culture prescribes its own balance between asserting individual needs and collaborating with others toward a shared goal of harmonious co-existence. Some critics of North-American culture claim that its focus on the isolated individual has become a form of cultural pathology (9). An emphasis on the isolated individual has been especially costly in understanding and responding to grief in its family context.

What does a family developmental approach to grief in its cultural context teach us about cultural diversity and bereavement? First, it allows a focus on family and extended family relationships as developmental resources. Second, it enables a greater appreciation of the spiritual and psychological continuity between the living and the dead. Finally, it encourages appreciation of the need to keep working on relationships, even after a death, so as to create a more optimal shared understanding of family past, present and future. Using a social developmental model of culture and grief, it is also important to recognize that within the North American culture the opportunities for optimal development are not created equal, and that families in communities of color suffer more than their fair share of traumatic grief.

How does a clinician tell the difference between a culturally congruent pattern and a problematic one? First, they must ask the family, and they must be willing to let the family be the expert and educator. Even once a pattern is identified by family members themselves as problematic, it is still important to determine why the person needs this symptom as a stabilizing strategy or compensating resource, and to appreciate the resourcefulness and creativity embodied in the "symptom" as a meaningful act. The process of respectful listening to a family's culturally based understanding does not mean that we do not also make judgments, some of them moral and ethical judgments, which contradict a family's expectations and norms. For example, we do not accept the physical or sexual abuse of children a stabilizing strategies for parents, even if some cultures are more

permissive about the parent's right to determine the nature of family discipline or encourage protection of parents at children's expense. Outsiders to cultural way of grief have to look out for the de-stabilizing

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and disorienting experience of exploring and confronting cultural differences, which might force us to question our own assumptions. The human impulse to turn away from differences with a stereotyping or diagnostic label is automatic, and we have to carefully guard against this tendency in learning to use cultural differences as a clinical resource.

FAMILY DEVELOPMENT AND GRIEF THERAPY

The clinician's major task in helping bereaved families requires identification of the stressors and resources that characterize a particular family's death and grief experience. It is crucial for clinicians to remember that even the most apparently pathological grief reactions, which most severely restrict a family's ongoing development, are paradoxically the family's best attempt to create the necessary stability essential for ongoing development. Even with the most disorganized and troubled families, a resource orientation makes it possible to build on a family's strengths in supporting and enhancing the family's shared ongoing development. An orientation which respects the strengths and cultural contributions from diverse communities is especially valuable when supporting grief among families from communities of color, whose differences are too often associated with defects in the dominant North American culture and the culture of mental health. Family resources, and potential sources of stress, need to be examined at every level of a family's ecology, from the widest cultural assumptions as sources of meaning, through community, neighborhood and friendship networks, through intergenerational and family of origin relationships, to nuclear family relationships, and finally to the individual, whose coping capacity can only be understood in the context of these "nested structures" of stressors and resources.

Culturally diverse families have a great deal to teach us about how to incorporate death and grief into the fabric of life. The lessons learned by grieving families, how to survive and thrive in the face of death and loss, can offer a great deal to all of us as we live our lives within intergenerational cycles of birth, death, renewal and affirmation of life.

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Ester R. Shapiro, Ph.D., is Assistant Professor in Psychology at the University of Massachusetts, Boston, and Research Associate at the Mauricio Gaston Institute for Latino Public Policy and Community Development. She is Practicum Coordinator for UMass/Boston's Clinical Psychology Doctoral Program. She has collaborated in founding interdisciplinary clinical training programs in psychoanalysis, family therapy, grief therapy, and culturally competent therapy. Her clinical practice, supervision, and public health consultations apply a social developmental and problem prevention approach to work with children, parents and families.

ACHILLES IN VIETNAM: COMBAT TRAUMA AND THE UNDOING OF CHARACTER

Jonathan Shay, M.D., Ph.D.

Jonathan Shay, M.D., Ph.D.

The Editor of the *Clinical Quarterly* asked me to make selections from *Achilles in Vietnam: Combat Trauma and the Undoing of Character* that would fit the theme of grief and bereavement in this issue. The excerpts I have chosen do not state the obvious but critical external facts about battlefield bereavement: it is sudden, violent, often gruesome, often pointing fingers of responsibility at the living survivors, who, in Vietnam at least, have frequently had no opportunity to view the dead, to provide services to the them, nor to bid them farewell in a meaningful communal setting. The following are excerpts from Chapter 3, of *Achilles in Vietnam*, "Grief at the Death of a Special Comrade." The book's "Conclusion" contains a section recommending attention to griefwork as a necessary component of any effort to provide secondary prevention of combat trauma. It cannot be too strongly stated that *primary* prevention of combat trauma is the elimination of the social institution of war.

Excerpts from *Achilles in Vietnam: Combat Trauma and the Undoing of Character. New York: Atheneum, (1994).*

The dignity of these humans is to weep.
--Martha Nussbaum (1)

We can never fathom the soldier's grief, if we do not know the deep attachment between comrades which battle nourishes and then amputates. As civilians we have no native understanding of the soldier's grief. Combat calls forth a passion of care among men who fight beside each other that is analogous to the earliest and most deeply felt family relationships. The experiences of Vietnam combat veterans and Homer's *Iliad* illuminate each other, enhancing our understanding or the soldier's relationship to a special comrade, be it Achilles to Pátrolos or an American soldier to his buddy. We often hear that the death of this special friend-in-arms broke the survivor's life into unhealable halves — everything before his death radically severed from everything after....

Any blow in life will have longer-lasting and more serious consequences if there is no opportunity to communalize it. This means some mix of formal social ceremony and informal telling the story with feeling *to socially connected others* who do not let the survivor go through it alone. The virtual suppression of social griefwork in Vietnam contrasts vividly with the powerful expression of communal mourning recorded in the Homeric epic. I believe that numerous military, cultural, institutional, and historical factors conspired to thwart the griefwork of Vietnam combat veterans, and I believe that this matters. The emergence of rage out of intense grief may be a biological universal; long-term obstruction of grief and failure to communalize grief can imprison a person in endless swinging between rage and emotional deadness as a permanent way of being in the world. [Pp 39f] ....

<u>The specialness of the special comrade</u>

A veteran speaks of his dead friend this way:

[He] was the kind of kid that grew on you. He couldn't tell a fucking joke. When he wanted to, he couldn't. Y'know, he would fuck you up a two word joke — and he'd take a half hour to tell it.

If I'd get fucked up and I was drunk and being a nasty motherfucker he would lead me back. If I was losing it — and there was times that I was losing it — I couldn't, I couldn't get my mind operational again. Y'know, he'd fucking shake me and it was like he was the fucking team leader, y'know? He'd pull me back into reality. "We got to move on, ..., c'mon." Y'know, "We gotta get going. We gotta get going."....

Y'know I remember at night, [he'd] be snoring and shit, making these weird fucking noises.... He go, "HHHshh-WHEEee" ... And it seemed like he was always fucking far enough away so I'd have to fucking crawl across everyone to get to him..... You'd wake him up and [whispers] "Don't make no more fucking noises!"

And he'd say, "You gotta stop this fucking drinking, you're getting paranoid and shit, y'know,. hearing these - sounds." Or, uh. . . he was fun to be with.

Y'know, he would argue with me over the map. Like I'd be carrying a lot of shit with me, and he'd say, "Well, I'll carry some of the stuff."

"You ain't carrying shit. You just carry that motherfucking radio, and shut the fuck up....

The parallels here to Pátroklos' character — the buoyant heart, the generous, nurturing disposition — are very clear. In many combat veterans' descriptions of their lost friends-in arms, we hear language strikingly similar to that used by Achilles to pay homage to Pátroklos.
One veteran of the 173d Airborne said,
We called him " the Keeper of the Minds." He was the one who not let you lose it. I can even remember guys calling out, "Get the Keeper over here!" when someone was losing it. His name was_____. When he was killed . . . .

Any blow in life will have longer-lasting and more serious consequences if there is no opportunity to communalize it. This means some mix of formal social ceremony and informal telling the story with feeling to socially connected others who do not let the survivor go through it alone.

. . . . Men learned in combat that to care passionately for the well - being of an individual person is to become vulnerable to pain and grief. Many soldiers drew the logical conclusion from this, and say that after that special comrade was killed, they "just stayed the fuck away — didn't get close to nobody." Often they cannot remember the names or faces of anyone else with whom they served after that particular person was killed. [pp43f]
. . . .

The grief of Achilles

Homer's dramatic method conveys Achilles' grief by showing his actions, such as blunt self-mutilation, weeping, and loss of appetite; by telling us his thoughts, such as self-reproach and intrusive memories of the dead; and by poetic stratagems that make us understand that Achilles is "already dead."

Achilles has a premonition as he watches the battle from a distance, the moment Antílokhos reaches him with the news. (18:2ff) After this moment of anticipatory "gloom and anger" Achilles' grief begins:

A black storm cloud of pain shrouded Akhilleus.
On his bowed head he scattered dust and ash
in handfuls befouled his beautif face,
letting lack ash sift on his fragrant khiton.
Then in the dust he stretched his giant length
and tore his hair with both hands. (18.25ff)

Since Achilles' display of anguish bears similarities to Biblical scenes of grieving (2), it doesn't seem all that remote from what might come naturally to us. "Tearing one's hair" is proverbial in English, but usually for anger, vexation, frustration. In context here, however, it appears to be simple self-mutilation and self-inflicted pain. What comes next seems to confirm this by taking us one step further into impulsive suicide: Antílokhos grabs Achilles' hands to prevent him from slashing his throat. (18:35ff) . . . We hear nowhere else in the *Iliad* of a suicide after the death of a phílos. The impulse to suicide as a part of intense grief was apparently not a culturally assumed expectation. In some cultures suicide is a predicted complication of bereavement, such as among the West African LaDongaa, who tie the hands of mourners as a matter of "natural" precaution(3). Neither was it so alien an idea to Homer's audience that they needed to have it explained to them.

What Homer shows us next, the condolences of Achilles' mother, the sea-goddess Thetis, makes us understand that Achilles is "already dead" before he begins his berserk frenzy. He weeps and wishes aloud to his mother that he had never been born, renounces this life, and wishes that his own death will come quickly. (18:79, 96f, 111) He proclaims his guilt (18:111ff) for not covering Pátroklos in battle. These aspects of grief — weeping, wishing one were dead, self-reproach — are all familiar to us, as are intrusive memories of the dead and loss of appetite:

Now pierced by memory,
he sighed and sighed again, and said:
"Ah, once
you, too, poor fated friend, and best of friends,
would set a savory meal deftly before us
in our field shelter, when the Akhaians wished
no time lost between onsets against Trojans.
Now there you lie, broken in battle. Ah,
lacking you, my heart will fast this day from
meat and drink as well. (19:346ff). . .

So far, Achilles' grief is familiar from our experiences in civilian life. However, unless one has had a terrifying misfortune of comparable captivity, there is little parallel in civilian experience for the role played for Achilles by his mother, the goddess Thetis. I submit that in addition to other dramatic and mythic roles that she plays, Thetis is an "imaginary companion," such as has sustained many in extreme danger and deprivation. One veteran in our program conversed regularly with a guardian angel while on long range patrol in enemy territory. These dialogues became part of the shared life of his unit, with his men asking him what the angel said. Because we have become accustomed to condescending to Homer's gods as "primitive" or "magical: thinking, or

treating them as purely artistic or mythic symbols, we are prone to overlook their function as dramatized embodiments of combat soldiers' inner experience. Guardian angels, imaginary companions, and personal patrons saints to whom one appeals *in extremis* are probably considerably more common and "normal" than mental health professionals care to admit.

Being already dead

"I died Vietnam," is a common utterance of our patients. Most viewed themselves as already dead at some point in their combat service, often after a close friend was killed. Homer shows Achilles as "already dead" before his death in a series of fine poetic stratagems. The transformation begins as soon as Achilles hears the news of Pátroklos' death from Antílokhos:

> "Here's desolation,. . .
> Lord Pátroklos
> fell [keimai],'. . . .
> A black storm cloud of pain shrouded Akhilleus [Achilles]
> . . . . .he scattered [grasped] dust and ash. . .
> and befouled his beautiful face, . . .
> The in the dust he stretched [keimai] his giant length . . . .
> From the hut
> the women . . .
> flocked in haste around him,
> crying loud in grief. All beat their breasts, . . .
> [The sea goddess, Theti,] his mother heard him in the
> depths offshore . . . . [and] cried in sorrow [göoio]:. . .
> Bending near
> her groaning son, the gentle goddess wailed
> and took his head between her hands in pity. . . . .
> (18:20-79)

Homer affirms that Achilles is "already dead" through a decisive set of poetic parallels. "Darkness," "dark cloud," or "blinding cloud" covers a man's eyes when he is killed (e.g. 20:479). Dying men grasp, claw, grip, or clutch the earth with their hands (e.g., 11:485, 13:593, 17:353). Homer uses the same word, keimai, for Pátroklos falling dead in battle as for Achilles falling beside his body in grief. Words and conventional gestures associated with mourning the dead are used in reference to Achilles – concubines and Nereids beat their breasts (18:33, 18:56); Thetis' cry for Achilles is called a death lament [göoio](18:56). The same word is also used three times in this sense as death lament in Book 24 (lines 840, 894, 911). When Thetis came to comfort her son, she "took his head between her hands" (18:79), the gesture of the chief mourner in the funeral for a dead man (4).

Speaking of the time after his closest friend-in-arms was killed, a veteran said:

> And it wasn't that I couldn't be killed. I didn't care if I was killed. . . .I just didn't care if I lived or died I just wanted revenge, and I didn't care. I didn't see myself going home. No....Nope... No, I didn't.

Achilles renounces his return home before Pátroklos' pyre. "Apart from the pyre he stood and cut the red-gold hair that he had grown [as a vow for safe homecoming] for the river [god] Sperkheios. . . . In pain, he said: '. . .[The] vow to you meant nothing, that on my return I'd cut my hair as an offering to you. . . . Now, as I shall not see my fatherland, I would confer my hair on the soldier Pátroklos.' And he closed his dear friend's hands upon it, moving all to weep again." (23:163)

> Another veteran in our program wrote:
> In my wildest thoughts I never expected or wanted to return home alive, and emotionally never have.

The sense of being already dead may contribute to the berserker's complete loss of fear, which we shall see below. It may also be the prototype of the loss of all emotion that defines for combat PTSD the prolonged states of numbness, the inability to feel love, happiness, or that anything matters. [pp49-53]

Another veteran in our program wrote: In my wildest thoughts I never expected or wanted to return home alive, and emotionally never have.

Jonathan Shay received his BA from Harvard College and MD-Ph.D. from the University of Pennsylvania. He is the psychiatrist for a specialized outpatient program for Vietnam combat veterans at the VA Outpatient Clinic in Boston and a faculty member of the Tufts Medical School's Department of Psychiatry.

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NEW DIRECTIONS

Matthew J. Friedman, M.D., Ph.D
Executive Director, NC-PTSD

CURRENT RESEARCH IN THE NATIONAL CENTER

I'd like to tell you about some of the exciting research that is currently being conducted at the National Center for PTSD. A complete description can be found in our Fifth Annual Report.

Development of the Clinician Administered PTSD Scale, CAPS, by Dudley Blake, Frank Weathers, Linda Nagy, and others was a major accomplishment. This scale has become rapidly accepted as one of the best instruments for assessing PTSD. Other scales developed through National Center activities include: the CAPS-C (by Kathi Nader, Dudley Blake, Julie Kriegler, and Robert Pynoos) for assessing PTSD in children and adolescents; the PCL or PTSD Check List (by Frank Weathers and Brett Litz), a brief self-report PTSD scale; the ELS, or Evaluation of Lifetime Stressors (by Karen Krinsley) for collecting reports of traumatic experience across the lifespan; and the ETI or Early Trauma Inventory for documenting childhood traumatic events (by Julie Kriegler, Lisa Zaidi, Dudley Blake, Doug Bremner and others).

All of the data have been collected for Terry Keane and Lawrence Kolb's Cooperative Study #334 on the psychophysiology of PTSD among Vietnam theater veterans. Now that state-of-the-art statistical techniques have made it possible to remove artifacts from the physiological recordings, data analysis on the 1,200 subjects should be completed shortly. This study will provide the best information to date on the sensitivity and specificity of psychophysiological techniques for assessing PTSD.

The Ethnic Minorities (or Matsunaga) Study, which I direct along with Marie Ashcraft, Spero Manson, Jan Beals, and Tony Marsella, has recently completed data collection on over 1,200 Vietnam veterans from Southwestern and Northern Plains Indian nations as well as from Native Hawaiian and Japanese American veterans. This study, closely modeled on the National Vietnam Veterans Readjustment Study (NVVRS), seeks to measure the prevalence of PTSD among these ethnocultural groups that were not included in the NVVRS.

Jessica Wolfe's Fort Devens Reunion Study has been monitoring PTSD among 2,200 Persian Gulf veterans from New England. Although rates of PTSD (e.g., Mississippi scores => 100) were low five days after their return to the USA, rates had tripled 18 months later (4.3% for men and 10.2% for women). Investigators are now evaluating this important cohort to determine whether there is a relationship between PTSD and unexplained medical illness among Gulf War veterans.

Brett Litz, Susan Orsillo, and Pete Ehlich of Readjustment Counseling Service, have data on 3,461 active duty military personnel who participated in United Nations (UN) peacekeeping duties in Somalia. Rates of PTSD ranged between 8 -11%. It appears that there are unique stressors associated with UN peacekeeping missions that differ from traditional combat stressors. Also, in contrast to the Ft. Devens Study, there were no differences between men and women with respect to PTSD and other psychological symptoms. An 18-month follow-up is planned for this cohort.

The July 1995 American Journal of Psychiatry featured as a lead article, brain imaging data from our Clinical Neurosciences Division. Magnetic resonance imaging (MRI) detected a significant (8%) decrease in the volume of the right hippocampus among Vietnam veterans with PTSD. There were no other neuroanatomic differences between PTSD and non-PTSD subjects (Doug Bremner, Steve Southwick, Dennis Charney, Bob Innis, and others). Another important result reported elsewhere by Steve Southwick, Dennis Charney and others, is that there may be two distinct neurobiologic subtypes among Vietnam veterans with PTSD, one marked by noradrenergic and the other by serotonergic sensitivity. Such a finding may have crucial implications for pharmacotherapy of this disorder.

Other important projects at this division include studies of the startle reflex among Vietnam and Persian Gulf veterans with PTSD (Andy Morgan), the genetic epidemiology of panic attacks among veterans with PTSD (Linda Nagy), treatment outcomes from the SIPU (Dave Johnson, Hadar Lubin, and Andy Morgan), preliminary drug trials of clonidine and fluoxetine (Steve Southwick, and others), and a large number of basic science projects on the molecular neurobiology (Ronald Duman), basic neuropharmacology (Ariel Deutch), and brain imaging (Bob Innis) of PTSD.

At the Women's Health Sciences Division, Jessica Wolfe and her staff are investigating gender and PTSD. One project examines how various forms of trauma influence recall and retention of trauma-associated vs. neutral verbal material. Two other studies address the relationship of trauma before, during, and after military service to various domains of physical health among women.

Bob Rosenheck and Al Fontana at the Evaluation Division continue to monitor the effectiveness of treatment of VA specialized inpatient and outpatient PTSD programs. They have monitored (marital, vocational, and social) function in addition to PTSD and other psychological symptoms. This is especially important since it may be more appropriate to focus on functional indices rather than symptom reduction, given the chronicity and severity of PTSD among veterans seeking PTSD treatment.

At the Education Division, Francis Abueg's study on the efficacy of relapse prevention techniques for patients with PTSD/alcoholism is in its second year. Steve Woodward's sleep lab has focused on the psychophysiological characteristics of nightmare sufferers, on sleep in PTSD patients with and without depression, and on the relationship between hyperarousal, neuroendocrinological indices and sleep parameters among PTSD patients. Ron Murphy is investigating the relationship between combat exposure, early trauma, and alcohol problems. Michelle Murburg is investigation sympathetic nervous system function in male and female veterans with PTSD.

At the Pacific Islands Division, Ed Kubany is conducting a validity study on his trauma-related guilt scale. Chalsa Loo has developed a scale to measure race-related stress and is also surveying sexual victimization among women veterans. Tony Gino has developed a computerized, self-administered PTSD scale that allows clients to use a mouse to respond to on-screen questions.

Other work at the Behavioral Science Division includes Brett Litz's project on emotional numbing. He and Frank Weathers have separate projects examining the impact of PTSD on interpersonal intimacy. David Riggs is investigating communication between male veterans with PTSD and female spouses, especially with respect to how they address conflict and potential violence within the relationship. Jeff Knight's research focuses on the impact of PTSD on neuropsychological aspects of memory and concentration.

Finally, at the Executive Division, Paula Schnurr, Julian Ford, Bonnie Green and I have completed a pilot study of PTSD among WWII veterans who participated in the military's secret mustard gas test program. Other projects include PTSD in older veterans (Paula Schnurr), psychophysiological and neurobiological correlates of PTSD in female sexual abuse survivors (Annmarie McDonagh-Coyle) and the relationship between PTSD and chronic pain (Claudia Zayfert).

There are many other projects on the drawing board. Stay tuned for my next report.

PSYCHOLOGICAL INTERVENTION FOR UNRESOLVED GRIEF

Edward J. Callahan, Ph.D.

Edward J. Callahan, Ph.D.

Dealing with death is an unavoidable aspect of human experience. While grieving is usually painful, its disruptiveness is ordinarily time-limited and manageable. The course of grieving reflects prior experience with loss and the selection and use of coping techniques. In a culture with no single ritual for response to loss, many people use avoidance to cope. However, coping by avoidance is associated with poor adjustment to loss (1). Unresolved grief can present by self or family identification, or it can lead an individual to seek medical help for undocumentable complaints (2).

The current paper grows out of treating unresolved grief in primary care, but treatment would be similar across settings. Treatment of unresolved grief reflects how grief is conceptualized. The intervention described below stems from a behavioral conceptualization of grieving (3).

BEHAVIORAL CONCEPTUALIZATION OF GRIEVING

Grief is observed among all social living creatures (4). Developmental theorists such as Bowlby (5) argue for the importance of learning secure attachment in early development with gradual shaping of increasing separation from parents as preparation for loss. A disturbance in attachment learning would predispose an individual or organism to problems with loss. Loss is an aversive event which affects people on biological, behavioral and cognitive levels.

In the animal laboratory, disruption of ongoing learning occurs with the introduction of any aversive event including shock, noise, time out from positive reinforcement, etc. Separation functions as an aversive event as well. For example, the withdrawal of rat pups from their mothers produces profound physiological and behavioral changes reflecting distress on the part of both the pups and the mother (6). When that separation is permanent, a longer term and more powerful impact is expected.

Length of time spent grieving over a loss does not define unresolved grief alone -- degree of disruption of function must be considered as well.

Human grieving can be understood by considering behavior associated with traumatic aversive events. Classically conditioned stimuli associated with the deceased were once predominantly positive, but may now provoke uncomfortable physiological, behavioral, and cognitive changes as conditioned emotional responses (CERs). Continued exposure to CERs results in a diminution of the disruptive power of those stimuli. Avoidance of the stimuli leaves the disruptive power of the stimulus intact; this disruption can even increase over time.

Aversive events can be made less powerful through adaptation or made more powerful through sensitization. In adaptation, the aversive event is presented in small doses with gradual increases in intensity. By pairing electric shock with the availability of reward, Miller observed that animals withstood greater intensity shock over time without a disruption in performance (7). Conversely, when the aversive event was presented rapidly and at great intensity, without being linked with a reward, the animal's reward-seeking behavior was increasingly disrupted by lesser and lesser intensity aversive events. This phenomenon is known as sensitization (8). In human terms, individuals can learn to adapt to loss across the life span; for example, elderly widows are less disrupted by the death of their husbands than younger widows (9). Losing young children appears to be the most disruptive loss that parents can experience. Similarly, young children whose parents die are profoundly affected by these losses which shape the later life course (10).

Flooding is a corrective procedure used when excessive avoidance and escape prevent the griever from prolonged exposure to the feared stimuli, thus maintaining disruption of behavior.

Those who experience loss that is out of the normal developmental sequence and those who learn avoidance as a primary coping technique may be particularly vulnerable to unresolved grieving. If loss is an aversive event which must be confronted to allow resolution, then avoidance or escape from grief stimuli increases the probability of unresolved grief.

Individuals who cope using avoidance may fail to experience and hence, work through, their loss. Under such circumstances, a pronounced focus on bodily symptoms may occur, making presentation to primary care a possible course for unresolved grief. "Somatic amplification" can be a primary means of medical attention-seeking for personally unrecognized grief (11). Not all unresolved grief will manifest in somatic complaints. However, it is important to have a sense of what pathologic grief is in order to allow effective intervention.

PATHOLOGICAL GRIEF

Pathological grief is any response to loss which is excessive in duration, intensity, or topography. However, there is no clear definition of normal grief. Length of time spent grieving over a loss does not define unresolved grief alone — degree of disruption of function must be considered as well. A normal response can include a long term sense of loss, often persisting through a lifetime. Grievers are commonly assumed to take a full year to work through grief. However, some widows experience their most intense symptoms of loss in their second year of grief (12). If individuals experience extreme loss of function, unresolved grief can be noted even soon after a loss. Time is an element also — a person who becomes dysfunctional with tears and cannot cope

for two to three days after a loss is accepted as having a normal response to the loss. Becoming dysfunctional one to two years later would be an excessive response to the loss.

Any grieving response which involves physical harm to self or others may be pathological grief. A woman who had been anticipating the death of her alcoholic mother appeared after her mother's death with deep scratches on her face and chest. She agreed to do no further harm to herself without first consulting her therapist. This grief response was considered excessive in our culture; in other cultures, such self scratching is expected. Thus, in determining whether grief is pathological, one must consider time course, intensity, form of the grief and the culture. While the absence of a clear definition of pathological grief is unsettling, it should not prevent consideration of treatment.

INTERVENTION

The basic rationale for treatment of unresolved grief is similar to that of the rationale for flooding procedures. Flooding involves prolonged exposure to intense stimuli which had been avoided (13). Through exposure, these stimuli lose their power and adaptive functioning returns. Special considerations in flooding with human clients around grieving are outlined below.

Rationale

Flooding is a corrective procedure used when excessive avoidance and escape prevent the griever from prolonged exposure to the feared stimuli, thus maintaining disruption of behavior. In the animal laboratory, flooding can be accomplished rapidly simply by blocking escape in the presence of the aversive stimulus. With humans, flooding requires moderated presentation of aversive events with gradually increasing exposure. Moderation maintains the cooperation of the patient. A therapeutic rationale to enlist the patient is a key part of the treatment plan: "Wounds fail to heal if not adequately cleaned and exposed to the air. If you continue with that wound unexposed and avoid the cleaning process, the wound can deepen and fester. With unresolved grief it is important to open the wound by exposure to many reminders of the loss. This painful exposure will lead step by step to thorough and healthy healing."

A therapeutic rationale to enlist the patient is a key part of the treatment plan: "Wounds fail to heal if not adequately cleaned and exposed to the air. If you continue with that wound unexposed and avoid the cleaning process, the wound can deepen and fester. With unresolved grief it is important to open the wound by exposure to many reminders of the loss. This painful exposure will lead step by step to thorough and healthy healing."

Critical to this therapeutic rationale is that it counters accepted theory about loss. The Freudian notion was that one had to end attachment to the person who died in order to make a successful adjustment to life (14). An alternate rationale is to attach to the deceased so they no longer need to be avoided: Saying hello again rather than saying good-bye (15). Through discussion the therapist helps the griever recall what was special about the lost relationship so that the loss can be more fully appreciated. Discussion of the relationship facilitates exposure to stimuli associated with the loss.

Taking a Detailed History

Another powerful way of accomplishing extinction around loss is to ask the patient to present the story of the loss in great detail. This story can describe the relationship, bringing out issues that may not have been discussed for years.

Immigrants seen for war-related Post Traumatic Stress Disorder often report that they have never told their story to anyone else. Merely taking the history begins the process of flooding and immersion in the stimuli associated with the loss(es). Information about the relationship with the losses will become apparent.

A stumbling block to experiencing emotions around loss can be anger. Children from abusive and violent homes may have more difficulty grieving the loss of a parent.

A stumbling block to experiencing emotions around loss can be anger. Children from abusive and violent homes may have more difficulty grieving the loss of a parent. Without safe expression of anger while the parents lives, the grieving child may have difficulty experiencing a sense of loss. Anger can trigger feelings of guilt since attacks on the deceased are not accepted culturally: Grieving thus becomes more complicated. Recognizing anger at the deceased can be helpful. Use of the Gestalt "empty chair technique" serves as a form of flooding for dealing with anger. With this technique, the deceased can be invited to participate in the session and sit quietly in an empty chair. The therapist can model expression of anger if needed. Similarly the patient can write the deceased a letter, expressing feelings not stated earlier. This letter can be sent through ritual burning or any way that symbolically make sense to the patient, with physical burning reflecting a parallel extinction of CERs. Thus, focus on unresolved attachment may be a necessary beginning to grieving. By expressing anger, the name and image of the deceased comes up more frequently and prompts extinction. Images and memories are brought to the fore rather than being avoided both in therapy and outside. Expression of anger appears to facilitate the focus on the deceased as an opening for a wider array of affective response to the person who died. This wider spectrum of emotion may include a sense of loss.

Pacing

Pacing is critical in flooding therapy. Excessive exposure to aversive images can lead to therapeutic dropout: The patient has an established pattern of avoidance as a means of coping. Indeed, excessive exposure may be dangerous with actively suicidal patients. Thus it is critical that the exposure be paced so that the client does not become overwhelmed. However, experiencing strong emotion is often reported as very therapeutic and sets the stage for the experience of greater emotion. While flooding in the laboratory emphasizes full exposure of events at high intensity to force extinction, the therapist modulates exposure to aversive events in gradually increasing intensity which is not overwhelming to the patient.

Therapeutic Contact

Patients with unresolved grief may have suicidal ideation or plans. These need to be determined early in the therapeutic relationship to ensure development of a safe environment for flooding. A written contract may be needed but is important to obtain at least verbal agreement that the patient will not hurt him or herself without first calling the therapist. Thus, the therapist must be available to the patient in a controlled fashion should a crisis arise. The patient can agree to write out antecedents and potential coping efforts whenever a suicidal thought arises as a bridging step in this process aimed toward greater patient self-control. Patients can use this process to increase their understanding of their urges to hurt themselves and to decrease the need to call the therapist. Contacting and writing can serve as therapeutic tools for fighting against avoidance.

Relaxation Training

Relaxation training was initially advocated with implosive therapy and flooding. Many therapists later decided that a relaxed state is not necessary for these procedures to work. Relaxation training, however, may be useful in bringing the patient to a comfortable place for imagery presentation to provide a safe place to return the patient. Much of the work with unresolved grief involves bringing the patient in conversation to the same places (in thought and emotion) that formerly were reachable only by presenting strong imagery. Once able to reach this level of emotional arousal through discussion, relaxation training is no longer necessary.

Guided imagery can be used for selective aspects of the story around the loss. The elements to be dealt with in guided imagery are selected from the areas of the patient's story in which the greatest avoidance was triggered.

Teaming Social Support

To expand the therapeutic process beyond the four walls of the treatment room, referral to a bereavement group or other form of support can be useful. Similarly, inviting the patient to discuss the loss with others facilitates extinction.

CONCLUSION

Unresolved grief may result from earlier sensitization to loss and an overuse of avoidance of loss stimuli for coping. A modified flooding approach can help facilitate coming in contact with what has been avoided, allowing resolution of the loss. Clinical issues in this flooding process were discussed.

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Edward J Callahan, Ph.D. is Professor and Director of Behavioral Medicine in the Department of Family Practice at the University of California at Davis.

RESOLUTION OF TRAUMATIC GRIEF IN COMBAT VETERANS

Jeffrey Brandsma, Ph.D. and Lee Hyer, Ph.D.

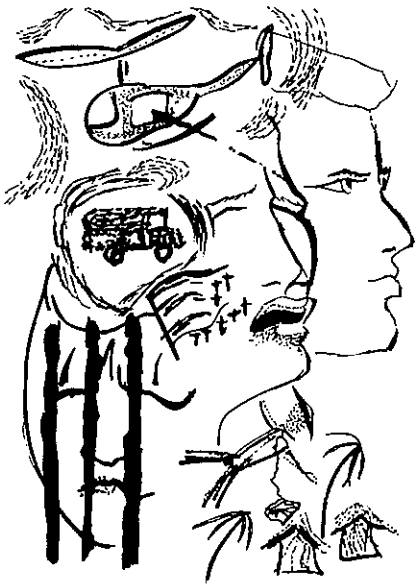
Jeffrey Brandsma, Ph.D.

Among the many mysteries of PTSD, especially the chronic combat-related type, the construct of grief has few equals. There is no universally accepted definition of grief, no widely used grief measures, and seemingly little interest in even basic questions (e.g., how is grief related to PTSD?). The absence of attention to the association of traumatic events with loss and bereavement process is a puzzle. In this brief article we address the "necessary" commingling of grief and PTSD, and propose a model of the processes and steps involved in grief treatment.

TRAUMATIC GRIEF

Traumatic grief is a fitting term used by van der Hart et al (1) to straddle the clinical construct of pathological grief and the diagnostic category of PTSD. It represents the complicated side of loss in PTSD, a state reflective of the "biphasic symptom swings from symptoms of arousal, intrusive traumatic imagery, and anxiety, to defensive numbing and avoidance" (p.264). We have previously argued that states of grief and PTSD are descriptively and conceptually overlapping; they share many features in common (2). Just as most war veterans with PTSD experience guilt (3) and depression (4), most also feel the pain of loss (grief) initially as a result of combat experience (5), and later from other losses and experiences.

The stages of grief (6) are helpful in understanding the PTSD/grief connection. One key feature of combat is the attempted prevention of the third stage – disorganization—which is part of the natural process of psychological survival and crucial to the initiation and integration of the grieving reorganization. In a combat context, this reaction is rarely allowed for legitimate internal (e.g., maintenance of psychological integrity) and external reasons (e.g., safety from combat-related danger). Since this crucial step (disorganization) cannot be tolerated, the person reverts back to other stages, i.e., numbness, anger, and/or acting out in an effort to gain completion of the short-circuited process. This process and repeated exposure to other trauma result in becoming "stuck." Clinicians are familiar with this "defensive" pattern – finding it to be more difficult to have a combat veteran experience loss and pain in therapy than other PTSD victims.



Lee Hyer, Ph.D.

TREATMENT

Grief therapy has been outlined by theoretical orientation, such psychodynamic (7), cognitive-behavioral approaches (8), by components of the grief process (9), by stages of grief (6), and by grief work tasks (10,11). When PTSD is chronic and unrelenting, however, these methods have only loose clinical application. After all, grieving in PTSD is "traumatic," having resulted in an alteration of basic physiological responses as well as enduring dysfunction in basic character structure (5). In working with the soul sick, chronic PTSD client, the healing of the human personality extends beyond that required by the curing of the patient's presenting problem. The work is too often done in a piece meal fashion.

Some curative components of treatment are evident in grief therapy with veterans diagnosed with PTSD. First, veterans with traumatic grief benefit from talk and exposure to the event. Exposure, however, may be done in a gradual (12) and even non-systematic way (13). Second, affect and cognition are the key ingredients in the healing process. The "white heat of relevance" from affect is the omnipresent governor in this effort; the often inflexible state of cognition being the homeostatic resistance mechanism in the personality. Both require the therapist's interest (9). Third, the life span of the grief reaction in the Both require the therapist's interest. survivor appears set during the first few weeks – bad start, bad finish (14). Perhaps as a result of the early adjustment to trauma, the pathological types of complicated grief take form (6). Fourth, the chronic grief reaction of PTSD is individually expressed but tends to follow two paths: numbing and intrusion. The grief reaction tends to either get stuck in the intensity of the experience (unsuccessful avoidance) or in suppressing the response, i.e., being numb to feelings, but more likely acting out (9). The therapeutic goal is to find a balance and modulate more smoothly between these reactions with some observing ego.

STEPS OF TREATMENT WITH WAR VETERANS

Step 1: Verbalization of loss

The verbalization of loss is a stated recognition that sense of loss was or is being experienced. Two emotion ascend to the question of "What are the emotional residuals of you experience?" First, there is

often an angry or guilt-ridden symptom presentation related to loss, often similar to those responses seen at the time of the trauma. The task here is to work through anger, reframing much of it into protest, and to look into the "softer side" of the equation, i.e., the felt loss and dependency. Second, the problem of memories retraumatizing the veteran is present. Here the task is to give cognitive structure —words, concepts, and descriptive processes — to allow some understanding and then mastery regarding what they are going through in order to clarify and objectify their experience.

Step 2: Psychoeducation

Psychoeducation of the grief process is the delicate interplay of normalization and empathy. Issues related to the stuck affect and cognitions as well as the stages, blockages, and tasks of grief therapy are "taught," anchored to the experience of the veteran. As in few other therapies, the role of teaching about grief processes help the clarify and extend the veteran's experience. Ofter the veteran has intense feelings as he has over-identified with the lost object (or function) and feels that has lost part of his own personhood; with some veterans, the relationship is more complex and a great deal of ambivalence is encountered. Anger, in particular may need to be reframed during this time. Also, the fear of being overwhelmed again by feelings requires addressing as the result of interlocking grief reactions from various levels of development and history. To counter this fear, it is important to restate the main losses, organizing these into categories, and focusing on each sequentially until there is an acceptable degree of resolution.

...Affect and cognition are the key ingredients in the healing process. The "white heat of relevance" from affect is the omnipresent governor in this effort; the often infelxible state of cognition being the homeostatic resistance mechanism in the personality. Both require the therapist's interest.

Step 3: Talking through loss

The therapist must be sensitive to exposing the positive and negative aspects of the loss — guided by the affect connected to the various contents expressed. The greater the affect, the better (within personal limits). Done well, an increasing understanding of the "grief strength" of the veteran becomes clear as well as issues that remain unresolved. A tutored catharsis addressing the emotional reasoning of the loss is a needed reflective component of this process.

Step 4: Use of guided imagery

Although not always utilized, guided imagery is often a necessary part of grief work. In some cases, it *is* the grief work. The veteran closes his eyes and accesses the scene, overlapping as many senses as possible. At times, resolution unfolds as in the imagination of a burial and/or funeral service. During this process, there will be several blocks to the "affective flow." Common blockages include the inability to express "softer" emotions such as affection, love, guilt, and caring. Others will "numb out" during the process as this is their habitual pattern. Patience is required, pointing out that the patient *is* expressing feeling — in their voice or body. Often the therapist can note that is not "all or nothing." Also as noted above, some disorganization must occur as part of the process. The phobic response of the combat veteran to this disorganization requires negotiation to obtain a level that is bearable.

Step 5: Saying Good-bye

A public ritual (funeral, memorial) can offer powerful closure to a traumatic memory (14). Other approaches include letter writing to the deceased person and/or empty chair work. Several useful procedures revolve around the concept of forgiveness for both self and others (15).

Step 6: Orienting toward the future

Ideally as the grief processes resolve, the veteran will assume an orientation toward the future imbued with energy, hope, and planning. Imagery may be used to help the individual construct his/her future in terms that recognize the finality of the loss and the need to continue in life. This makes the cycle complete — acceptance of the reality of the loss, (re)experiencing the emotional pain, a digestion of the life that was lived, and a commitment to self and the future.

Despite good work or treatment gains, it will be necessary to remind the patient that grief is pervasive and may reoccur. The purpose of this reminder is to make the continual allowance for the incorporation of future affective reactions necessary for healing and growing. As Heidegger observed, "Life is suffering." Grief is the natural and appropriate human response.

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THE NATIONAL CENTER FOR PTSD: DISASTER ACTIVITIES

Following the bombing in Oklahoma City, Fred Gusman, MSW, Director of the NC-PTSD Clinical Laboratory and Education Division and Bruce Hiley-Young, LCSW, NC-PTSD Disaster Coordinator, were assigned by the U. S. Public Health Service, the Emergency Management Preparedness Office and the Department of Veterans Affairs Mental Health and Behavioral Sciences Service to assess the immediate and long-term recovery needs of the community. In addition, consultation, media briefings, and staff debriefings were provided to Oklahoma Department of Mental Health and Substance Abuse Services. In June, two 2-day trainings on "Post-traumatic stress disorder and substance abuse: Coping with risk post-disaster" were conducted by Francis Abueg, Ph.D., Fred Gusman, and Bruce Hiley-Young.

In May, the National Center participated in "Response 95," the largest and most comprehensive natural hazards emergency response exercise ever conducted in the United States. This national exercise was sponsored by the Federal Emergency Management Agency to test local, state, and federal plans to prepare, respond, and recover from a catastrophic hurricane affecting southeastern Louisiana and Mississippi. Julian Ford, Ph.D., Joe Ruzek, Ph.D. and Hiley-Young presented a two-day workshop on a) understanding the impact of disaster on individuals, organizations, and communities and the factors associated with adaptation to trauma; b) identifying at-risk populations; c) understanding and applying phase-appropriate outreach activities and interventions in various settings; d) identifying diagnostic guidelines to PTSD assessment; e) identifying PTSD treatment modalities; and f) learning stress management guidelines and techniques for disaster workers.

The NC-PTSD continues to serve on the Interdepartmental Task Group on Disaster Crisis Counseling which is reviewing national disaster mental health policy. This task force has representatives from the Federal Emergency Management Agency, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Mental Health, Department of Veterans Affairs (Mental Health and Behavioral Sciences Service, Emergency Management and Preparedness Office, and Readjustment Counseling Service), American Red Cross, Department of Defense, and Office of the Surgeon General. In addition, NC-PTSD, in collaboration with San Mateo County Mental Health, continues to participate and co-coordinate the disaster mental health response for the annual San Francisco International Airport Air Crash Exercise.

THE NECESSITY OF DENIAL IN GRIEVING MURDER: OBSERVATIONS OF THE VICTIMS' FAMILIES FOLLOWING THE BOMBING IN OKLAHOMA CITY

M. Victoria Cummock

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More than six years have past since my husband John was murdered by the 1988 terrorist bombing of Pam Am 103, along with 269 other people. During the course of bereavement — my children's, my own, and that of other Pam Am families' — I became increasingly aware that families of homicide victims have unique needs related to grieving. Subsequently, I have been trying to raise awareness among mental health providers, educators, and counselors about how the needs of families of homicide victims differ from other bereaved families. Recently, I spent eigbt days in Oklahoma City under the sponsorship of the American Red Cross, working with many of the 168 victims' families awaiting death notification at the Compassion Center and in their homes. Much of what I have observed over the last six years about the grieving process of families of homicide victims was confirmed — this brief article attempts to share my observations about the initial stages of coping with the murder of a loved one.

Most mental health professionals are familiar with the different stages of the grieving process: the initial shock, denial, anger, sadness, guilt, loneliness, despair, and gradual acceptance. But when the loss of a loved one is complicated by a sudden, violent, and intentional act, such as murder, the reactions of survivors are also sudden and violent in their own way — intense, severe and profound. Even though common variables affect all survivors' bereavement reactions (i.e., previous exposure to trauma, illness; degree of coping skills; level of social support), the combined affects of the length of time awaiting official notification and the return of remains, the degree of intrusive outside influences (e.g., media/public involvement), and the role of the mental health provider result in a markedly different post-traumatic environment.

THE LENGTH OF TIME AWAITING OFFICIAL NOTIFICATION

The process of waiting for official information is complicated by a range of emotions including disbelief, growing anguish, and deep grief itself. No one is ever prepared to deal with news that someone they love has been brutally murdered. When malice is involved, the process of connecting the horror of such an unthinkable act to the loved one is kept at bay for various reasons.

First and most importantly, are the issues of hope and loyalty. It is natural to hope against all hope that somehow a loved one has been spared the cruel fate of a violent murder. It is not uncommon for families to hold out hope for their loved one's survival for days or even weeks as the effects of shock alter the perception of time to that of endless minutes, rather than hours or days. Holding out for hope is driven by a deep sense of loyalty to the victim. To give up this hope is to abandon one's family during the time of its greatest need. Thus, a strong sense of denial is maintained at all cost and remains in effect until official notification of death received and/or a body is recovered. It is at this juncture, that families can and must let go of life as they have known it and accept the reality of death with the horror and anguish that it brings.

For the families of the 116 victims still left trapped in the Federal building 10 days after the bombing, the parallel process of holding vigil and awaiting notification was striking. Initially, the conversations were of hope of survival. Many spoke of the physical strengtb, stamina and endurance of their loved one and his or her ability to overcome extreme adversity. As the days progressed into weeks, the conversations evolved from hope of survival to hope of recovering a body. Slowly, the degree of denial changed as they gave themselves permission to let go just a little bit of hope and let a bit of reality take its place. The rate in which this process took place varied dramatically from one person to another depending on their ability to deal with the degree of horror, anguish and pain that came with the acceptance of reality.

The identification of a body provided the final closure needed to accept the reality of the loss serving to initiate the other formidable challenges of grieving. In Oklahoma City, prior to notification of death, families appeared somber, glazed, and emotionally constricted. In contrast, notification activated the grieving process which included crying, sobbing, and a general releasing of emotions.

THE EFFECT OF INTRUSIVE OUTSIDE INFLUENCES

Intrusive influences such as media, or expansive public involvement at the outset of a murder can greatly complicate the grieving process. The emotional overload families experience compromises their defenses, leaving them disoriented, vulnerable, and extremely distressed. Families need a supportive environment which encourages private time to identify and connect with the wide ranging feelings of shock, anger, sadness, guilt, resentment and revenge. Families need to be protected from unnecessary intrusions.

Repeated media images of the carnage, devastation, and destruction further intensify the shock and keep survivors confused and isolated. The families need for truth and official information must be protected and held as a priority. Based on their acute emotional state, it is imperative that families are given first-hand official information about their loved ones, thus allowing them a private time to cope with the facts *prior* to public consumption. Again, it becomes an issue of loyalty to the deceased in that the families want to respect, honor, and protect them.

Once the deceased becomes a "public persona" entering the public domain, families have lost another part of that person during a time they have not yet learned how to cope with their initial loss.

Since the nature of news is what is "new," the pace in which the media intrudes in the victims families is uncanny and often quite ruthless. The press often try to sensationalize tragedy when the truth and facts alone are hard enough for the families to cope with. It is important to honor the needs of the families for privacy and minimize unnecessary outside influences to avoid compounding and adding another dimension to their loss. The addition of the media, attorneys and the judicial system into the lives of homicide survivors is so overwhelming and confusing that it prevents families from regaining a sense of balance and control in their lives. Often it prevents or postpones their grief work as it relates to the loss of the victim and around the loss of their own life as they knew it.

...Normalizing and validating the range of intense and often contradictory emotions serves to give the bereaved the confidence to continue through the grieving process and avoid getting "stuck" in any one reaction.

THE ROLE OF MENTAL HEALTH PROVIDERS

Working with homicide survivors requires specialized skills and sensitivity. Regrettably, efforts to encourage survivors to "get on" with their lives by well-intentioned, but untrained grief counselors, may unwittingly exacerbate the effects of the traumatization through subtle but powerful messages that communicate the survivors' failure to adapt or the minimization of their losses.

Unlike other losses in which there is time to mentally prepare and say good-bye to one's loved one, the sudden and violent nature of murder leaves the surviving families with an immense burden. A burden further weighted by the survivors' "unfinished business" with the victim. Unresolved issues related to earlier resentments or conflicts, to hopes and dreams, and to unfulfilled promises require attention. Survivors and those who support them particularly benefit from learning that the depth and duration of the healing process is prolonged, and that the state of acute grief may last longer than a year. Learning that each person grieves separately, differently, and at their own pace can be of great comfort to the bereaved. In short, normalizing and validating the range of intense and often contradictory emotions serves to give the bereaved the confidence to continue through the grieving process and avoid getting "stuck" in any one reaction.

The recovery process is further complicated as families of homicide victims contend with the criminal justice system. The enormous challenge of learning how this system works and its "untimely" demands amplify the already distressing states of disorientation and disorganization. Mental health providers can normalize the emotional highs and lows that next-of-kin frequently experience as they seek to find closure through the attainment of "justice." For many, justice will never be served and it is vital to help the bereaved avoid the demoralizing affects of alienation. Referrals to long-term therapy or participation in support and/or advocacy groups is recommended as a means to give the bereaved on-going support, a sense of belonging, a sense of purpose, and encouragement.

In sum, it is important to understand that denial serves as the primary tool utilized by vicitms' families at the outset of a murder. Denial is an adaptive reaction that protects survivors of homicide from the full force of the tragedy. This coping mechanism is a gradual and graceful way to deal with the murder of a loved one allowing families the time they need to transition from denial into the grieving process.

Victoria Cummock is an activist working primarily in the areas of crisis management, aviation security, and counterterrorism. Her work has brought about many legislative changes including the 1990 Aviation Security Act. Victoria has worked with two president's and their administrations, 18 Congressional committees, and President' Bush's Commission on Aviation and Terrorism. She was instrumental in forming the Pan Am 103 Family Support Group and has represented this group before the United Nations Security Council, the media, and internationally with the Crown and Scottish authorities. Victoria is currently raising her three children in Florida.

CLINICAL TRAINING PROGRAM
POST TRAUMATIC STRESS DISORDER

The Clinical Laboratory and Education Division for the National Center for Post Traumatic Stress Disorder at the Palo Alto CA VAMC, in collaboration with the Long Beach CA Regional Medical Education Center (RMEC) offers an on-site clinical training program in the treatment of Post Traumatic Stress. The training program is approved for category 1 continuing medical education credit.

Psychiatrists, psychologists, social workers, nurses, readjustment counselors, clinical nurse specialists, occupational and recreational therapists combine to provide a comprehensive treatment program and an education experience for the mental health professional seeking to expand his or her understanding of psychic trauma and its treatment. The Clinical Training Program offers a broad range of educational activities including

* Lectures
* Clinical research observation
* Supervised clinical activities
* Use of multimedia materials
* Group discussions facilitated by staff

Training programs are scheduled for a minimum of one week, though longer programs are available if the applicant can justify an extended stay. Programs are scheduled ten time per year, generally on the third week of the month.

At present time, funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or RMEC. For further information, please call FTS 700-463-2673 or commercial number 415-493-5000, extension 2673.

FUTURE POSITION

The Clinical Laboratory and Education Division of the National Center for PTSD is seeking a Staff Psychiatrist. Duties include direct patient care of male and female veterans and opportunities for clinical research and participation in educational activities and projects.

VA Palo Alto Health Care System is affiliated with Stanford University Medical School. Salary is commensurate with professional and VA experience. To apply, send curriculum vitae, a letter stating professional interests and goals, and three letters of recommendation to:

VA Palo Alto Health Care System
Javaid Sheikh, M.D., Chief, Psychiatry
3801 Miranda Avenue (116A MP)
Palo Alto, CA 95304

and fax copy to Tracy Dekelboum, M.S.W. (415) 617-2769