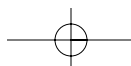
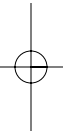
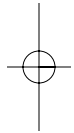
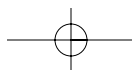
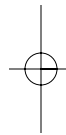
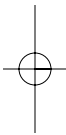


LOSS, TRAUMA,
AND RESILIENCE







Introduction

Loss and Ambiguity

Absence and presence are not absolutes.¹ Even without death, the people we care about disappear physically or fade away psychologically. The Alzheimer's patient, the brain injured, and the stroke victim, as well as the kidnapped or imprisoned, are out of reach. This ambiguity between absence and presence creates a unique kind of loss that has both psychological and physical qualities.

The amalgamation of the ideas of loss and ambiguity has always been—and still is—the stuff of good literature. Bayley (1999) writes an elegy for his beloved but demented Iris, Albom (1997) writes about Tuesdays with his dying professor, Fadiman (1997) writes about the spirit catching you in a new country after forced immigration, and Styron (1990) writes about his own depression. Yet it is only within the past 30 years that the idea of ambiguous loss as traumatic has reached therapeutic circles, and that research has provided us with an initial theoretical base (Boss, 1972, 1975, 1977, 1980c, 1986, 1987, 1992, 1993b, 1993c, 1993d, 1999, 2002a, 2002b, 2002c, 2004a, 2004b; Boss, Beaulieu, Wieling, Turner, & LaCruz, 2003; Boss, Caron, & Horbal, 1988; Boss & Couden, 2002; Boss & Kaplan, 2004). The premise is that ambiguity coupled with *loss* creates a powerful barrier to coping and grieving and leads to symptoms such as depression and relational conflict that erode human relationships. For this book, I extend this work to link ideas about ambiguous loss with a resiliency model that allows for diverse interpretations and interventions.

Loss is not always simply death or physical absence. Human relationships are more complex. For many, the psychological family in our hearts

and minds is as important for assessing stress and maintaining resiliency as the physical family we live with. We do not necessarily disconnect from loved ones just because they are physically gone, nor do we always connect to people just because they are physically present at home or in our daily lives. Such ambiguity can be a benefit or a detriment. In times of trauma and stress, we often reach for loved ones kept present in our hearts and minds, not just the people we live with physically, in order to stay resilient and carry on. On the other hand, not knowing if a loved one is absent or present, dead or alive, can create so much ambiguity that the stress is traumatizing and immobilizing. This new view of loss, trauma, and resiliency centers on this psychological family and making sense of ambiguous absence and presence.

THE CONTEXTUAL VIEW

Many people never achieve the complete detachment described by Western psychotherapists as necessary for normal grieving. A lack of closure after loss, however, is not always an indication of weakness in the individual or family.

The force that causes loss to remain fresh decades later and thus be labeled as pathological often lies in the context *outside* of the person rather than in their ego, psyche, or family. When a person or family suffers loss within an external context of ambiguity, the situation understandably has high potential for causing symptoms of unresolved grief. From this more contextual perspective, pathology is attributed to a client's situational context and environment rather than to the psyche or family. Using this broader view, clients are more receptive to therapy and therapists are better able to treat people in the context of particular loss experiences that range from merely stressful to traumatic.

With a broader lens, we also become more multiculturally sensitive in assessments of *maladaptations* to the trauma of ambiguous loss, which require treatment and change, versus *healthy adaptations* which may be creative ways of coping and being resilient. We can assess perceptions, feelings, behaviors, relationships, and symptoms more broadly by asking questions such as: What losses have you had? Have you experienced any *ambiguous* losses? How do you see this situation? What did you lose? What do you still have? How do you feel about the ambiguity now? Rather than focusing only on problematic symptoms, we are more likely to see the unique ways individuals, couples, and families within diverse contexts manage to live well despite the stress of ambiguous loss.

When contextual factors are outside a client's control, our therapeutic task is to help individuals, couples, and families *differentiate* between what

can and cannot be changed. Specifically, we need to take into account the external factors of culture, history, economics, development, and constitutional heredity (Boss, 2002c). Each of these factors influences how a particular individual, couple, family, or even community perceives and copes with loss and ambiguity. Being born into one culture or another, during times of war or peace, into affluence or poverty, being old or young, having heritable strengths or vulnerabilities, experiencing discrimination or privilege—all can influence human resiliency.

The research on resiliency and family stress within a more contextual view is relatively new. Among the pioneers are Reiss and Oliveri (1991), who broadened the contextual perspective by emphasizing the community context as the major source of meaning and thus a major influence on how families respond to stress, and Conger, Rueter, and Elder (1999) who studied couple resilience in the context of economic hard times. Resiliency and family functioning in African-American families despite the stress caused by discrimination was studied by Murry, Brown, Brody, Cutrona, and Simons (2001). Harriette McAdoo (1995) also studied African-American families but focused on the stress levels, family help patterns, and religiosity of single-parent mothers in middle- and working-class families. Cultural psychiatrists Kirmayer, Boothroyd, Tanner, Adelson, and Robinson (2000) followed that line as well in describing cultural protective factors for psychological stress among the Cree in northern Canada. In addition, diverse contexts are being studied and incorporated into support for the chronically ill. For example, Wood, Klebba, and Miller (2000) linked the hopelessness about chronically ill children with parental attachment issues. Focusing on spirituality in nursing work Lorraine Wright (1997) summarized her ideas in an essay on suffering and spirituality based on her research with colleagues on healing and family religious beliefs (Wright, Watson, & Bell, 1996). From a more secular perspective, Swedish researchers Strang and Strang (2001) provided support for the idea that more secular values such as optimism are also conducive to healing. This sampling of research supports the point that context can influence the complexity of family loss, trauma, and resilience. Knowing this broader perspective is necessary in helping diverse people after the trauma of loss confused by ambiguity (Boss, 2002c; Boss & Mulligan, 2003). What this means is that each couple or family must be viewed within their unique context so that interventions can be tailored to fit their particular needs.

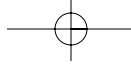
With a broader contextual lens, this research-based theory of ambiguous loss is useful in guiding interventions in diverse situations with diverse populations. Regardless of class, race, ethnicity, generation, gender, or sexual orientation, we have here a less pathology-based lens for viewing unresolved loss and its outcomes of anxiety, somatic symptoms, and relational conflict.

AMBIGUOUS LOSS AND TRAUMATIC STRESS

Ambiguous loss is inherently traumatic because the inability to resolve the situation causes pain, confusion, shock, distress, and often immobilization. Without closure, the trauma of this unique kind of loss becomes chronic. To understand the trauma of ambiguous loss, it is helpful to recognize the distress of more ordinary loss. In modern cultures, loss is difficult to talk about because it reminds family members as well as trained professionals that something could not be fixed or cured. Most people cannot tolerate for long the feeling of being in a situation that is outside of their control. A death in the family may be viewed as failure—a failure to find a cure or make things better. To many in cultures that value mastery, the goal is to win, not lose. Because of this strong value, there is in our culture a tendency to deny loss. Grieving is acceptable, but we should get over it and get back to work. Whereas finding closure is difficult with ordinary losses, it is impossible with ambiguous loss because there is no official recognition of there even being a real loss.

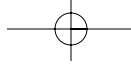
Freud (1917/1957) labeled long-term preoccupation with the lost person *complicated grief* or *melancholia*. Erich Lindemann (1944), who worked with the surviving family members of the people lost in the Coconut Grove nightclub fire, also saw lack of closure as individual pathology. He said that grief reactions depended on how well the bereaved perform their *grief work*. Indeed, in current diagnostic manuals, the inability to complete one's grief work is called *unresolved grief* and defined as pathological due to its lack of resolution or closure. Unresolved grief, they say, can involve a range of emotions, but in general, according to Freud (1917/1957), these emotions result from the patient's refusal to relinquish the "love object." The question for us here, however, is this: What happens when a person is faced with an ambiguous loss, which by its very nature is irresolvable? What happens when it is the external situation, not the person's psyche, that makes letting go of the lost object impossible?

Feigelson (1993), a psychoanalyst, writes explicitly of such a situation. Her husband, also a psychoanalyst, sustained massive brain injury after he fell down an elevator shaft in their apartment building. Feigelson called her experience, an "uncanny" loss due to a "personality death" (p. 331). Using what she learned from this personal experience of ambiguous loss, she firmed up Freud's indirect suggestions about "an 'uncanny' union of opposites" (p. 331). She wrote, "Something unknown amalgamates with something known to produce an uncanny sensation. The anxiety of the uncanny involves something on the border of what we both know and don't know, both cognitively murky and affectively alarming" (p. 331).



From a psychoanalytic perspective, ambiguous loss is indeed an uncanny situation of traumatic anxiety produced by a combination of the known and the unknown (physically present but psychologically absent, or vice versa). The intellectual and relational uncertainty of living with someone both here and not here produces a terrible anxiety of bizarre human experience. Terr wrote, “My intention is not to supplant repressed internal conflict as a possible causality for weird human experience, but to *add* externally precipitated psychic trauma to the very short list of underlying reasons for the ‘uncanny.’ When the ego is overwhelmed by external events, everything outside a person may begin to look spooky, eerie, and overdetermined” (1985, pp. 495–496). This may be why women with husbands missing in Vietnam, after 9/11, and in other settings tell of talking with their mates after they disappear (Boss, 1975, 1999; Boss et al., 2003). Other therapists report similar phenomena (Becvar, 2001; Falicov, 1998). In such cases, the psychological family is very real, and often helps to assimilate sudden loss.

But what of situations where a loved one’s mind is missing instead of his body? Both types of ambiguous losses have in common the trauma-related anxiety that “is felt when there is a sudden change from the ordinary dependable way things are in everyday life to the extraordinary and bizarre distortions that occur when a known person is profoundly altered” (Feigelson, 1993, p. 332). The absent quality of a person who is still physically present distresses even healthy and resilient family members. This idea applies even more systemically to those who are psychologically attached to the patient because of the cessation of reciprocal relationships and clear identity. They feel as loss their mate’s changes in memory and cognitions, but according to Feigelson, “Changes in temperament overshadow by far the most intractable intellectual losses. Profound dependence, egocentricity, eccentric habits of personal hygiene and rigidities of dressing set in. Interests and hobbies wither. Brashness and coarsening of speech, friction with others over trivia, asportaneity, restlessness, irritability, attacks of rage, panic, anxiety, depression, apathy, withdrawal, and loss of empathic fine tuning render many head-injured people complete social outcasts” (1993, pp. 333–334). In such cases, life is altered dramatically for the spouse, children, and the family as a whole. And no one sends a sympathy card or sits shivah for this. Instead, there is a lonely and oft misunderstood mourning with an indefinite beginning and indefinite end. Feigelson asks painful questions: “How is it possible to lose half a person? Half is dead, half remains alive. . . . Unlike a fairy tale whose premise is poetic reality in which nothing can surprise the reader, the uncanny story violates the observer’s trust in reality. Life may then deceive by promising substance and delivering ghosts. The *doppelganger* sits at the dinner table” (1993, p. 335). Reading



her words, I think of my own experience long ago with another kind of doppelganger at the dinner table.

Like Feigelson and me, most clinicians have personally experienced several kinds of ambiguous loss and surely see clients with such uncanny loss. For symptoms from long-term, drawn-out mourning, the ambiguous loss model adds a new lens to our current ways of working with loss and trauma. Whether we specialize in grief or loss, whether we work with individuals, couples, families, or communities, becoming familiar with ambiguous loss helps us be more effective practitioners. Let me explain why.

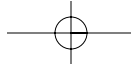
First, there are missing persons in *everyone's* life. Rarely is there absolute presence—or absence—in any human relationship. All of us at some time or place may have faced situations of ambiguous loss, personally or professionally. It is not therefore a condition that only our clients face.

Second, the loss of loved ones creates distress and trauma universally, in all cultures and religions. One needs only to watch the evening news to see this pain. But ambiguous loss adds another dimension of pain. We have the universal pain of loss, *plus* the often traumatizing ambiguity. Broadening our repertoire for helping people find resiliency with ordinary as well as catastrophic losses begins with understanding the traumatizing potential of ambiguity.

Third, regardless of discipline or professional training, therapists need a broader therapeutic vision. The ambiguous loss model allows us to work systemically and contextually at various levels of human interaction without ignoring individual symptoms. We can acknowledge *both* diversity and similarity as we assess and treat different people in different situations.

Fourth, because the cause of ambiguous loss is usually some external force or illness, therapists benefit from a model that looks beyond symptoms to strengths and resilience against that force. Through no fault on the part of the patient, ambiguous loss has no possibility of closure. Finding meaning in situations that defy logic and resolution—and there are many—is difficult, but it is possible if we look for resilience, not just pathology.

Fifth, in times of disaster and trauma, therapists need a treatment model other than PTSD and classic grief therapies to guide work with couples, families and communities when loved ones go missing. Notable exceptions to the standard of individual and medical models for treating posttraumatic stress disorder (PTSD) and grief are the work of Landau (1981), Landau and Saul (2004), Rolland (1994), and Walsh (1999), all of whom call for more family- and community-based approaches. I agree but add that traditional treatments for PTSD and loss after disaster miss a major trauma: that of ambiguous loss (Boss, 2002a, 2002b, 2004a, 2004b). Although ambiguous loss is also traumatic stress, the core issue is unresolved loss and the ongoing ambiguity that causes a pain that never lets up. The torture lies in being



kept in the dark. With the ambiguous loss model, therapists have guidelines to work with children, youth and adults after such disaster.

Sixth, the model is easily taught and understood, even by clients, so in times of disaster and heavy demand, paraprofessionals and community leaders can be used to aid professionals. The psychoeducational quality of the theory (though the model is psychodynamic) means that we can help a larger number of people in times of unexpected ambiguous loss as well as in times of expected family life transitions.

Regardless of the kind of clinical work we do, considering these ideas about ambiguous loss expands our analysis and assessment for more effective interventions when loved ones either change beyond recognition or disappear altogether. How can we help individuals, couples, families, and communities stay healthy and resilient despite the strain of having to live with the uncanny nature of ambiguous loss? To answer this core question, I summarize the theory of ambiguous loss—what it is, why it matters, and how to intervene. As I train professionals to do this work, I use a contextual stress perspective with a focus on health and resilience.

THE AMBIGUOUS LOSS MODEL

We begin therapy first by determining who is perceived as family. In this way, we explicitly bring the client's psychological family into the therapy room. If family members are physically absent but psychologically present, or physically present but psychologically absent, we label the situation as one of ambiguous loss—the most stressful kind of loss due to the ambiguity. Knowing that the source of anxiety is external tends to mobilize resiliency as people realize the pathology is not theirs but rather lies in the outside situation.

There are two types of ambiguous loss: physical absence with psychological presence, and physical presence with psychological absence (See Figure I.1). Both types of ambiguous loss have the potential to disturb and traumatize relational boundaries and systemic processes.

In the first type of ambiguous loss, a loved one is physically missing—bodily gone. Catastrophic examples of such losses include missing persons and missing bodies in the context of war, terrorism, ethnic cleansing, genocide, or natural disasters such as earthquake and tsunami. In these cases, a loved one may be physically absent but kept psychologically present because his or her status as dead or alive is unknown. Without proof of death, family members don't know whether to close out the missing person or keep the door open for him or her to return. Family processes freeze and boundaries are unclear. People become preoccupied with the lost person

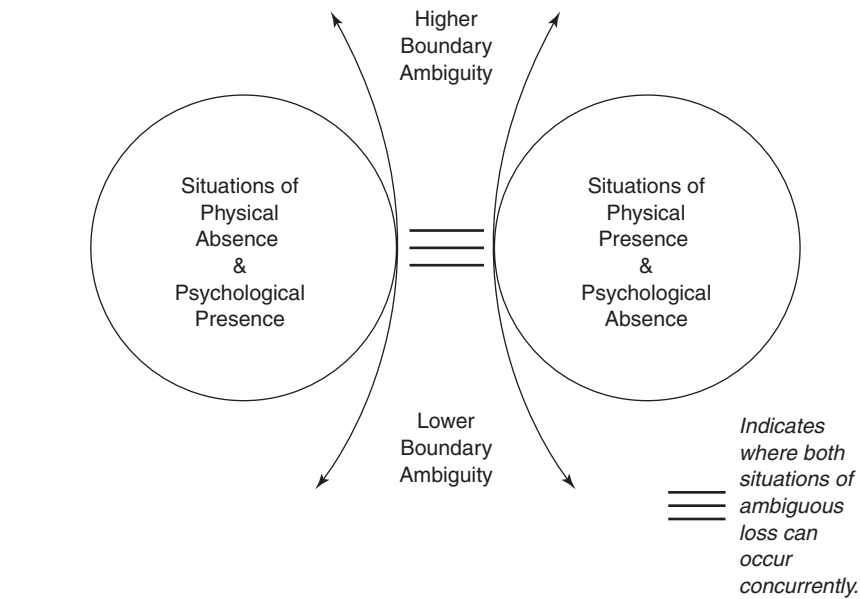
and may think of little else. As a result, they may no longer function in their usual roles and relationships. More common examples of this type of ambiguous loss are absent parents in divorced families, absent biological parents in adoptive families, or babies lost or given up at birth.

In the second type of ambiguous loss, a person is psychologically absent—that is, emotionally or cognitively missing. Examples of this type of ambiguous loss include Alzheimer's disease, dementia, brain injury, AIDS, autism, depression, addiction, or other chronic mental or physical illnesses that take away memory or emotional expression. More common examples include excessive preoccupation with work and homesickness (often resulting from immigration). With this type of ambiguous loss, relational and emotional processes freeze; day-to-day functions and tasks don't get done. Roles and status become confusing. Often people don't know how to act or what to do.

Often we see both types of ambiguous loss overlap in one family or couple. For example, after 9/11, a woman I was working with in New York City had a physically missing husband as well as a mother who had Alzheimer's disease. Indeed, this woman said she felt twice abandoned. Young children may also experience both kinds of ambiguous loss when they lose one parent from a catastrophic event, accident, or illness and the remaining parent becomes depressed and preoccupied with the missing mate. After 9/11, several adolescents said that they felt as if they had lost both parents even though one was still present with them. I have seen the same dynamic when a parent becomes preoccupied with caring for an impaired or ill mate. The child ends up losing both parents, but no one notices because they are still there in the home.

HISTORY OF THE RESEARCH BASE

The first study of a situation of ambiguous loss with potential for high boundary ambiguity began in 1971 with families of United States soldiers missing in action in Vietnam and Laos (Boss, 1975, 1977, 1980a, 1980c). Subsequently, with colleagues, I studied families of missing children (Fravel & Boss, 1992), families with adolescents leaving home (Boss, Pearce-McCall, & Greenberg, 1987), and families of immigrants who were uprooting (Boss, 1993c, 1996; Gates, Arce de Esnaola, Kroupin, Stewart, van Dulmen, Xiong, & Boss, 2000). I also studied the other type of ambiguous loss—where someone is missing psychologically. In this area, the research centered on families where someone was psychologically missing from Alzheimer's disease or other chronic mental and physical illnesses (Boss, 1993d; Boss et al., 1988; Boss, Caron, Horbal, & Mortimer, 1990; Boss & Couden, 2002; Caron, Boss, & Mortimer, 1999; Garwick, Detzner, & Boss,



Catastrophic and Unexpected Situations:

- | | |
|--|--|
| <ul style="list-style-type: none"> • war (missing soldiers) • natural disasters (missing persons) • kidnapping, hostage-taking, terrorism • incarceration • desertion, mysterious disappearance • missing body (murder, plane crash, etc.) | <ul style="list-style-type: none"> • Alzheimer's disease & other dementias • chronic mental illness • addictions (alcohol, drugs, gambling, etc.) • depression • traumatic head injury, brain injury • coma, unconsciousness |
|--|--|

More Common Situations:

- | | |
|---|---|
| <ul style="list-style-type: none"> • immigration, migration • adoption • divorce, remarriage • work relocation • military deployment • young adults leaving home • elderly mate moving to a nursing home | <ul style="list-style-type: none"> • homesickness (immigration/migration) • adoption • divorce, remarriage • preoccupation with work • obsession with computer games, Internet, TV |
|---|---|

FIGURE I.1 Catastrophic and unexpected types of ambiguous loss situations, which cause varying degrees of boundary ambiguity.
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1994; Kaplan & Boss, 1999). Theory was developed (Blackburn, Greenberg, & Boss, 1987; Boss, 1992, 1999, 2004b; Boss & Greenberg, 1984; Boss & Kaplan, 2004) with writings on measurement (Boss, Greenberg, & Pearce-McCall, 1990; Mortimer, Boss, Caron, & Horbal, 1992) and application for specific populations (Boss, 1983a, 1983b, 1993a, 1993d; Weins & Boss, 2006). Other researchers tested the theory with adoption (Fravel, McRoy, & Grotevant, 2000), divorce, addiction, autism, miscarriage, infertility, still-born babies, foster care, adoption, incarceration, AIDS, brain injury, immigration, and cultural loss. This type of loss also includes lesbians and gays with unresolved family of origin loss. Carroll, Boss, and Buckmiller (2003) provided a review of these studies.

When I first began working with families of the missing in 1973, I thought that getting rid of ambiguity was the goal. I quickly realized that this was impossible. My goal shifted to trying to understand how people live well with ambiguity. Elsewhere, I have written in depth about the long process of research, theory development, and application (Boss, 1999, 2004b).² Here I review this process for clinicians.

In 1972, while training with Carl Whitaker and psychiatric residents at the University of Wisconsin-Madison, I observed a consistent pattern in the families treated in the family therapy clinic. These families were intact but the fathers seemed distant and absent. They were there but not there. They continually asked why we needed them in the session because "children were a mother's business." Indeed, in the early 1970s fathers were not expected to be part of child rearing, but children noticed and were distressed by the ambiguity. Based on clinical work, I first wrote about psychological father absence in the intact family. Later, I expanded the idea to a more general level so it could apply to any family member or person who is "there but not there." From 1975 on, I called the phenomenon *ambiguous loss*.

This broader lens considers the psychological family, and thus the subtle structural and perceptual processes of human relations and transitions that develop over time. I included the exits from and entries into the family and how these transitions of ins and outs are inherently stressful (Boss, 1980b). The boundaries of marital and family systems are blurred by the ambiguity and are thus harder to maintain at times of birth, death, separation, deployment, and even reunification. To understand how families remain resilient despite heightened ambiguity during normative and unexpected transitions, I studied the individual and collective perceptions of a family member's presence or absence. Research indicated that situations of ambiguous loss from, for example, dementia and war predicted symptoms of depression, anxiety, and family conflict (Boss, 1977, 1980c; Boss, Caron, et al., 1990; Caron et al., 1999; Garwick et al., 1994). A re-

search-based clinical theory was developed that linked ambiguous loss with frozen grief, ambivalence, mastery, meaning, and hope (Boss, 1999, 2004b). As I continued to work with families of the missing—physically and psychologically—I realized that my awareness of a psychological family in a client's mind was critical to the success of therapy. Since 9/11, I believe this even more strongly.

THE CONCEPTUAL BASE: STRESS AND RESILIENCE

At the root of the ambiguous loss model is the contextual stress perspective discussed earlier, with an emphasis on resilience. What this means is that when there is a situation that cannot be fixed or an illness that cannot be cured, our therapeutic goal is to help the clients live with the inherent stress and anxiety by increasing their resilience. We cannot get rid of the ambiguity, but we can increase tolerance of ambiguity. Our therapeutic goals then are not about closure, as they are in classic grief therapies, nor do we view unresolved grief as an individual pathology as in the medical model.

The focus on the stress of ambiguity allows us to go beyond symptom treatment to build on people's individual strengths. In this way, we discover and reinforce (if appropriate) their ways of rebounding during troubled times. Viewing contextual stress, not a weak psyche or a dysfunctional family, as the source of symptoms gives hope to clients for some positive outcome. I want to clarify, however, that I do not recommend that therapists ignore pathology. Even in a model that prioritizes resilience and strength, therapists need to be aware of individual pathology. Physical and psychological symptoms need to be treated, especially if they are life-threatening. Suicidal thoughts, homicidal threats, violence, and addictions, for example, need immediate professional treatment. Individual pathology can result from ambiguous loss but also causes even more of it.

The conceptual base for the ambiguous loss model lies in family stress theory (Boss, 1987, 2002c; Boss & Mulligan, 2003). Ambiguous loss is an extraordinary stressor—a producer of uncanny anxiety and unending stress that blocks coping and understanding. It freezes the grief process and defies resolution. It understandably encourages denial of loss. It can lead to immobilization and more crises. The clarity needed for boundary maintenance (in the sociological sense) or closure (in the psychological sense) remains out of reach. Symptoms of pathology in individuals, couples, or families are often outcomes of the relentless stress of ambiguity. These symptoms do not necessarily point to a psychic weakness. The stress perspective with an emphasis on context and resilience provides a new lens

for clinicians trained in the medical model but having to face unanswered questions.

Figure I.2 illustrates how the two types of ambiguous loss can immobilize but also lead to resilience. Part A of the diagram signifies the *ambiguous loss*, defined as a situation of unclear loss in which it is not known if a loved one is dead or alive, absent or present (Boss, 1999). How family members (individually and collectively) perceive the situation of ambiguous loss is tied to *boundary ambiguity* which means not knowing who is in or out of your family or relationship (Part C). A high degree of boundary ambiguity becomes a risk factor, which predicts depression, somatic symptoms, and family conflict.

The higher the incongruence between the psychological family and the physical family, the higher the boundary ambiguity in the family system. High boundary ambiguity is a compromise or risk factor for individual and relational well-being; it is a barrier to the family's management of their stress from ambiguous loss. Not knowing who is in or out of one's intimate circle immobilizes and erodes resilience (Boss, 2002c). From a sociological perspective, the family boundary is no longer maintainable, roles are confused, tasks remain undone, and eventually the family becomes immobilized. From a psychological perspective, cognition is blocked by the ambiguity and lack of information, decisions are put on hold, and coping and grieving processes are frozen (Boss, 1993a, 1999; Boss et al., 2003). Note that not all situations of ambiguous loss lead to high boundary ambiguity.

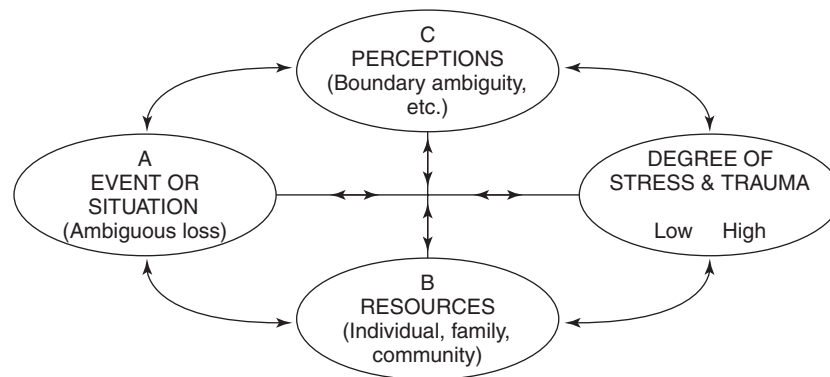


FIGURE I-2. Where Ambiguous Loss and Boundary Ambiguity Fit into the Family Stress Model

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I must clarify here that the stress of boundary ambiguity can be seen as both objective and subjective. For example, no one would disagree that some events—a kidnapped daughter or a drug-addicted son, for example—are objectively stressful, but there are also subjective elements that determine the degree of stress and trauma experienced. These may be one's cultural context or one's psychological health. How boundary ambiguity is perceived is also influenced by the community in which one participates or lives (Goffman, 1974; Reiss & Oliveri, 1991). Subjective or objective, all these elements influence resilience. That is, stress is both a fact and a subjective experience, but the latter more significantly affects whether someone is brittle or resilient. The degree to which an event distresses someone depends heavily on perceptions (Boss, 1987, 1992, 2002c).

Despite family members missing either physically or psychologically, some people view their systemic boundaries as clear even though they may not appear so to some therapists. Aunts and uncles, for example, were often perceived as parent figures in the families that had lost a mother or father after 9/11. Such replacements by expanding the family boundaries are also common when a parent can't function due to mental illness or addiction. Grandmothers frequently become "mothers" in such cases. Culture and ethnicity play a major part in defining such family boundaries as more flexible. African-American families, for example, have more elastic boundaries (McAdoo, 1995) and a more communal focus on homeplace and family (Burton, Winn, Stevenson, & Clark, 2004).

THE TRAINING

How do we go from theory to practice? Typically, therapists are trained to think that if they are doing their jobs right, clients will get over their grief and do so relatively quickly. Healthy people find closure. But resolution after loss is rarely that absolute, and especially not when a loved one vanishes without a trace. When there is no body to bury, the situation defies closure, and individuals and families become symptomatic. Therapists are trained to see the larger picture and the external stressor of ambiguous loss.

To shape effective interventions, therapists need to assess the degree of congruence regarding both psychological and physical families among family members, especially parents and children. This means that instead of one best intervention for every couple or family, interventions are tailor-made based on the psychological and physical structure of one's intimate circle. With this in mind, the following provides the core of training for working professionally with people suffering from situations where loved ones are physically absent, psychologically absent, or both. The overall

objectives, list of questions addressed, and outcomes give you a sketch of the training workshops.

Objectives and Outcomes for Training

The *overall objective* for training workshops is to inform mental health therapists, psychiatrists, clergy, medical practitioners, attorneys, and educators about a newly identified type of loss that has no closure and that is best treated systemically with family- and community-based approaches.

With this goal and the conceptual model in mind, the ambiguous loss training includes the following topics (which will be discussed over the course of this book):

- The psychological family
- What is ambiguous loss and how is it different from ordinary loss?
- What are the two types of ambiguous loss; do they ever overlap?
- How do you know if and when it's a problem?
- How do the causes and effects of ambiguous loss differ from those of PTSD?
- How do cultural values and beliefs influence how people cope with ambiguous loss? Are there religious, class, racial, and gender differences?
- To strengthen resiliency with ambiguous loss, what are the goals and guidelines for finding meaning, tempering mastery, reconstructing identity, normalizing ambivalence, revising attachment, and discovering hope?
- Self of the therapist

It is important to note that these topics are adapted to fit the needs of the professionals who attend. For example, in Tokyo, the focus was on ambiguous loss in three-generational families and the loss elders feel in the erosion of filial piety as more women enter the workforce. In Toronto, a workshop was aimed at professionals who work with couples doubly victimized by ambiguous loss due to current Alzheimer's disease and past trauma from the Holocaust during World War II. In Duluth, the workshop emphasis was on addiction; at the Albert Einstein College of Medicine in New York, on mental illness; at Texas Tech in Lubbock, Texas, on migration and immigration. In New Jersey, I gave a workshop for the chaplains who worked with the ironworkers and uniformed men and women who cleaned up the Ground Zero site. Most recently, in Australia, I trained professionals who work with the ambiguous loss of chronic illness, mental or physical, as well as professionals who worked with tsunami victims.

At the end of every workshop, and congruent with the goal and conceptualization, I expect two outcomes. First, by the end of the training, attendees are able to recognize ambiguous loss, understand its impact, and shape interventions and treatment for their specific clients who manifest symptoms of unresolved grief. Second, attendees are able to recognize and understand an ambiguous loss of their own, its impact, and its meaning. Paradoxically, for professionals who study ambiguous loss, the second outcome usually precedes the first. The two develop in a parallel process in which personal experience grounds the conceptual and therapeutic experience. When it comes to ambiguous loss, the professional outcome cannot be separated from one's personal growth.

Using a more inclusive model for clinical training, professionals from different disciplines can work more smoothly in healing teams. Depending on the situation and the need, teams may include couple and family therapists, social workers, psychiatrists, psychologists, trauma specialists, nurses, journalists, educators, and clergy. Using different approaches and skills, each person contributes toward a common goal—stronger families and stronger individuals. Although a multidisciplinary and multilingual team may add managerial complexity, teamwork is essential today to incorporate the conceptual complexity of the multiculturalism and diversity in couples and families—and in professional expertise.

Nuances in the Model

Any description of the training must address also the nuances of ambiguous loss theory.

First ambiguous loss is not always problematic for families or family members. How do we know when it is a problem? That question has both a structural and psychological answer. Ambiguous loss is a problem structurally when parenting roles are ignored, decisions are put on hold, daily tasks are not done, and family members are ignored or cut off. Rituals and celebrations are cancelled even though they are the glue of family life. Ambiguous loss is a problem psychologically when there are feelings of hopelessness that lead to depression and passivity and feelings of ambivalence that lead to guilt, anxiety, and immobilization.

Indeed, some people manage to live with missing loved ones without negative effects (Bonnano, 2004). Although further study is needed, the valence of outcomes appears to be influenced by attributions and belief systems—the individual's, the family's, and, perhaps most important, the community frame (Reiss & Oliveri, 1991). The old saying "What will the neighbors think?" has merit when it comes to determining whether loss has

a positive or negative effect on a person or family. If the community thinks the loss resulted from an immoral act or a deficiency, the bereaved will experience greater guilt and less resiliency. Some of the survivors of 9/11, for example, believed that their loved one's being in the Twin Towers at the time of the attack was predestined; others thought it was their fault. With Alzheimer's disease and brain injury, I see similar variations. People may attribute the loss of their loved one as punishment from God or Allah, whereas others see it as a challenge to show more love.

Many who believe in God continue to trust in His will to see them through their daily lives. Others with religious faith may not see the event as predestined but still deeply trust that God or Allah will guide them through the current ambiguity. When their community also believes this, they are more able to move forward despite the lack of information and persistent ambiguity. In addition, certain personality traits appear to increase tolerance for ambiguity. These factors notwithstanding, the most important predictor for resilience in the face of ambiguous loss is an individual's ability to learn how to hold two opposing ideas in their minds at the same time. Living well with ambiguity means that people have learned to live with conflicting ideas. A parent of a missing soldier says, "He is dead, but he may still be alive and come back someday." The daughter of a mother with brain injury says, "My mother is still here, but she is also gone." These are vexing truths. Yet many people for differing reasons can live with this uncanny tension.

A second nuance is that naming the ambiguity as an external culprit diminishes self-blame. After traumatic or painful loss, people often blame themselves. They ruminate on thoughts such as, "If only I had done this or done that, she would be alive today." Our therapeutic task is to externalize the blame, as family therapists Michael White and David Epston (1990) recommended. Dementia, brain injury, birth defects, mental illness and other forms of ambiguous loss represent a loss of dreams and an assault on the family and its members, but the situation is no one's fault. One would think this would have been obvious after the 9/11 terrorist attacks, but many family members were nevertheless immobilized by guilt, shame, or anger at themselves. "We had a fight the last night he was with me." "I wasn't there to answer the phone and all he got was my voicemail." After externalizing the problem, the next step is to increase tolerance (both in our patients and ourselves) for not having a definitive answer. As noted earlier, I do not dismiss the presence of pathology. I simply want to relocate it within the context of a situation that is far beyond normal human expectation. Although individual symptoms that require attention may appear, the root of the pathology—the ambiguity that wears down people with its persistent confusion—lies in the context outside the person.



The third nuance concerns us as therapists and the culture of psychotherapy in general. Many professionals believe that people who see an absent person as present or a present person as absent are irrational, even pathological. My work with families with a loved one suffering from dementia and my experience in conducting therapy with families directly affected by 9/11 have taught me once again that closure is a *myth*. It is a myth that unfortunately remains highly touted by many who view closure after loss as a criterion of normalcy. Despite our original training, we must shift our views about loss and take into account the psychological family. Some are already doing this as they shift to the idea of open systems in grief therapy (Rando, 1993; True & Kaplan, 1993; White, 1995).

Perhaps the reason we talk so much about closure is that we can't stand the pain. We assume pain is bad and must be eliminated. But when it comes to loss, especially ambiguous loss, pain often has a function (Cousins, 1979; Frankl, 1963). It leads to change, which in the context of ambiguous loss can be more challenging. The pain of loss can immobilize—or it can give momentum for change. In my experience, people choose change more readily when they can keep the door ajar.

We must take another look at this all-too-convenient concept of closure. Closure is not possible when a family member has in mind or body gone missing. Without verification of death or signs of life, a family's boundary understandably remains open; the inability to find closure and to resolve the loss is normal under such circumstances. Despite varying contexts, closure should not be expected or required when a family member is missing. Closure is *never* really possible even with a clear-cut death. Just ask someone who has lost a loved one in the most common of circumstances. Our hunger for closure is a byproduct of a culture that prizes knowing answers, fixing problems, and moving on. We need to temper our thinking on this point.

The myth of closure is paired with a set of norms regarding how we bring about closure. There is unfortunately a tendency to criticize and actually judge how families grieve their losses, both in terms of how long they take to get back to "normal" and also in terms of whether they grieve in a "proper" or "improper" way. With respect to the latter, I think of the memorial service for Senator Paul Wellstone in 2002, which was heavily criticized for being political when, in fact, only a fraction of the entire service was political in nature. The political talk, however, was all that was reported by outsiders who voraciously criticized this family's way of grieving. Should anyone have been surprised that a portion of the service was political? The Wellstones were, after all, a political family. It was their family's culture. For the two surviving sons and their friends, a political cry for carrying on their father's work was their way of grieving. Many in Minnesota are still not

over grieving for their senator, and I think part of that is because their grief was interrupted and sullied by the shame and blame put on their memorial event. I suspected that a local community event would be needed if the community was to heal. This happened one year later, spontaneously, on the anniversary of the deadly plane crash, when all the theaters and concert halls in the Twin Cities explicitly dedicated their performances to the Wellstones. It was a night he and his wife would have enjoyed.

As therapists we have the opportunity to lead our communities in increasing patience for what may look like unorthodox ways and durations of grieving. Understanding this paradox helps: The more outsiders are critical, the more people withdraw and defend their right to keep on grieving in their own way. If some idiosyncratic ways of grieving become unhealthy or life-threatening, clinical intervention is necessary. Professionals need to give permission to let individuals, couples, families, and communities grieve as it suits them and yet also direct that grieving if it becomes unhealthy.

This brings me to the fourth and final nuance for training. There appears to be a universal human need to honor and bury one's dead, especially those we loved and admired. From Sophocles's *Antigone*, who defied King Creon in order to bury her brother, to more recent reports of mothers roaming deserted battlefields in Kosovo to find their dead, to children still searching in Southeast Asia for bodies of fathers whose planes were downed decades ago, the epics continue to illustrate the lengths people will go to retrieve the remains of those they love. Closure cannot happen when there are no remains to bury. At best, people find some sort of good-enough resolution with substitute remains. One family decided to bury a loved one's guitar to symbolize his body. This was an imaginative resolution and hopefully satisfactory for the surviving family members. But many families disagree over how and whether to do a memorial when a person is missing. Lacking a body, they simply do not know what to do, what rituals to perform or create, or what words to say.

The good news is that many can and do move on to some resolution in spite of never finding the missing person. As therapists we must be patient. We should never push for closure when the loss is ambiguous. The human need to find a loved one and bury him or her illustrates the intersection of cognitive and emotional processes in close human relationships—an uncanny circle of attachment and detachment. We need patience and full awareness when working professionally with this agonizing and complex process.

Nevertheless, loved ones continue to disappear or fade away. Ferries sink, airplanes crash, earthquakes bury thousands, children are kidnapped, and soldiers go missing in action. Less dramatically, but no less traumati-

cally, loved ones slip into comas, are lost to Alzheimer's disease, or become vacant due to addiction. And family members continue to go to great lengths to find the remains of their loved ones or reconnect with their absent psyches. From my work with such families, the reasons for their tenacity vary.

First, the reason may be cultural. In United States culture, the valued and expected goals are to fix, cure, win, and solve. Living with loss is discouraged. Rather, one is supposed to get over it and do so quickly. If Becker (1973) is correct that death is denied in our culture, then ambiguous loss is denied even more fiercely. We all need to participate in more community efforts to break down the public and professional impatience for losses that are not clear.

Second, the reason for needing clarity may concern cognition and rationality. Without a body to bury, people feel confused about both physical and psychological losses. Cognition is blocked by the unfamiliarity of the situation. They can't begin to cope or grieve; they can't make decisions. Their assumption that the world is fair, comprehensible, and manageable is shattered by the terrible mystery of their loved one's status.

Third, a reason why people yearn for clarity about loss is that there are no supportive rituals without clear evidence of death. Families of the physically and psychologically missing are thus left to fend for themselves. After 9/11, some church officials allowed families to bury empty coffins or objects such as musical instruments, bowling balls, or photographs of the missing person, but for the most part, families were on their own in figuring out what to do. They should not have to be. Like families of the emotionally or cognitively missing from brain injury, dementia, chronic mental illness, or addiction, peer support groups and multiple family groups are very helpful.

Numerous surviving family members told me they had made decisions on their own for having a service without a body, but such shifts in their rituals were usually stimulated by support from people of authority—clergy, mayors, therapists, nurses, physicians, and elders in the community. Someone they respected had offered choices, patience, and symbols to help. The urn of ashes from Ground Zero that was used by many families in funeral rites for missing persons was one example. Yet differing perceptions persisted to complicate the makeshift rituals of burial. One young man said, "I choose to believe that part of my brother's body is in these ashes." But the wife of that same missing man did not believe this. Their differing perceptions over remains caused conflict that was eventually minimized at family meetings where such disagreements were talked over and normalized.

The fourth reason why people need clarity in loss depends on their attachment to the lost person. The goal of grieving has been to detach. Based

on Freud (1917/1957) and Bowlby (1980), this means relinquishing the emotional bonds one had with the deceased in order to form new relationships with the living. Without a dead body to verify the end of a close relationship, it is difficult for people to let go and move on with new relationships. Whether the missing adult or child is beloved or simply an acquaintance may determine how persistently one holds out before acknowledging the loss and loosening the bonds by going on with one's life without the lost person. This does not mean forgetting them.

NEEDED RESEARCH

Although my clinical and research teams have increasingly discovered ways to transcend the traumatizing effects of ambiguous loss in various situations and with different populations, more research is needed. Testing will increase, I hope, as a result of this book. The process for theory development is, after all, never-ending, and it is best done as a collaboration between science and practice. What I have written in *Ambiguous Loss* (1999) provides a summary of the work from 1975 to 1999 and was the first step toward disseminating the theory so that it could be tried and tested by others. This book is the second step. It elaborates in more depth how to apply the theory of ambiguous loss. But the bottom line remains a call for continued research and clinical testing.

As I see it, the needs are threefold. First, more study is needed on the long-term effects of ambiguous loss and how resilience can be sustained. With the physically missing, anecdotal clinical evidence suggests that families across cultures appear to manifest remarkably similar family dynamics after ambiguous loss (Sluzki, 1990). Like the 9/11 families, Argentinean families of the *desaparecidos* (disappeared) manifested confusion in boundaries and family roles, denial of facts, and guilt if one dared to give up hope (Boss et al., 2003). The adult children of missing pilots shot down in Southeast Asia in the 1970s still manifest unresolved grief symptoms over 30 years later. Their families then had been told to be silent about their situation, which may explain why their grief processes were frozen. Researchers Cathy Campbell and Alice Demi (2000) found that many offspring of MIA pilots are still preoccupied with frequent intrusive thoughts of their lost fathers. Many are stuck emotionally, but some have found a way to move forward. Campbell, herself the daughter of a missing father, found solace through researching this topic and writing about it after her mother died.

For families of the psychologically missing, more research is also needed on resilience. The existing studies on addiction, Alzheimer's disease, and



head injury focus mostly on negative long-term effects. For caregivers of those with dementia, for example, health is compromised. The Alzheimer's Association reports that spousal caregivers of Alzheimer's disease patients die at a rate 63% higher than their same-age cohorts (Schultz & Beach, 1999). What therapists and families need to know are the success stories, so that together we can more optimistically shape interventions toward resilience and prevention of symptoms in the healthy partner.

Second, research is needed on situations in which both types of ambiguous loss occur simultaneously. I often see dual ambiguity when there is addiction or chronic illness combined with a family member missing from divorce or adoption. More study is also needed regarding the prevention of unintended child neglect after a parent's partner is missing physically or psychologically.

Third, more cross-cultural studies are needed to identify commonalities as well as differences in responses to ambiguous loss. Although diversity is emphasized and unique responses and coping strategies documented, we must also identify the common responses to common stressors such as ambiguous loss. Our clinical hunches thus far are that across cultures, harmful family secrets develop after ambiguous loss if there are no-talk rules and no interventions to encourage the sharing of perceptions (Boss et al., 2003; Imber-Black, 1993).

It seems that across situations and cultures, the ambiguity of missing persons blocks grief, seeds ambivalence, guilt, and relational conflict, and blurs family boundaries and processes. As if on cue, families of the missing argue over what to do, differ in their perceptions of the lost person's status, cancel family rituals and routines, and are often so preoccupied with the lost person that those present—especially children and adolescents—are ignored. Thankfully, because of the previous research, insufficient as it may be, and this new theory of loss, recent teams of therapists have become more alert early on to cues of resilience. They do not ignore symptoms that need immediate treatment, but are, with this broader lens, more able to help people regain resilience to live with the unsolved loss.

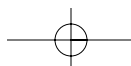
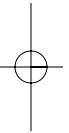
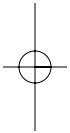
More than ever since 9/11, I am convinced that theory is useful to guide clinical work if we are to really help families stay strong in times of trouble. Without research-based theory on hand, we may lack the understanding of complex family processes and linkages that in times of urgency and uncertainty are even more challenging. With the theory of ambiguous loss as a guide, we could after 9/11 more readily recognize and understand the unique and terrible stress that families of the missing were experiencing. The ambiguous loss model helped us treat families of the missing, first in individual family meetings and then with multiple family groups in community meetings. Without a guiding theory, we could not have been so



inclusive in our work. From this experience and others with families stressed by dementia or brain injury, I am convinced that therapists need more theory and less specific strategy. The ambiguous loss model does not provide one right way for how to do therapy but instead offers a broader framework to guide specific clinical tasks for regular clinical work as well as for catastrophic emergencies.

CONCLUSION

Ambiguous loss is the most stressful loss because its incomprehensibility threatens health and resiliency. When people go missing due to human terror or natural catastrophes, or from the ravages of illness or accident, the anxiety from having no clear solution can immobilize. I am, however, optimistic: People can and do live well *with* ambiguous loss.



Chapter 2

Trauma and Stress

In this chapter, I limit my discussion to one unique kind of trauma and stress—that of having a loved one missing physically or psychologically. I peel the proverbial onion to discuss what ambiguous loss is not in order to clarify the difference between the therapy model for it and the more traditional protocols for trauma intervention. Ambiguous loss is not one particular event which leads to posttraumatic stress disorder (PTSD) nor is it one critical incident. Rather, it is an on-going *situation* that has no closure. The pain may go on forever.

Stress is defined as pressure on the status quo of a system. Like a bridge that is undulating from the pressure of wind or heavy traffic, the misfit between the pressure and the structure's support can lead to collapse. That is, the system is no longer in a steady state. Translated to individuals or families, this means that something created a pressure so great that it threatens a negative change (collapse; immobilization). If, however, one's supports are increased to meet the demands, we may be able to ride out the pressure and regain equilibrium—or, more correctly, a flexible equilibrium. That is resilience (Boss, 2002c).

Trauma, on the other hand, is a stress so great and unexpected that it cannot be defended against, coped with, or managed. The surprise element overwhelms and is part of why people are so quickly immobilized. Metaphorically, the bridge collapses. Supports can no longer absorb the pressure. Far beyond ordinary human expectations, the event stuns and immobilizes. Coping skills are frozen; defense mechanisms fail.

In different professions, trauma has different meanings. In medicine it is defined as a physical wound, in psychiatry as an emotional shock, and more generally as “a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury” (*Merriam Webster’s Collegiate Dictionary*, 2003, p. 1331). Today, trauma is viewed, however, as *both* a mind-body condition linking emotional and physiological responses (van der Kolk, 2002; van der Kolk, McFarlane, & Weisaeth, 1996). However it is defined, the trauma from ambiguous loss is *externally* caused. The disorder and pathology lie outside the client in their relational context and often is incurable.

In my work, I see combinations of stress and trauma. In many cases, the stress of ambiguity can traumatize a child or adult physically and emotionally just as a critical incident might. Having a loved one missing is like a continuously bleeding wound in the couple or family; having a loved one’s mind missing, such as with dementia, is also an ongoing kind of relational wound. In both types, emotions are shocked, jarred, and stymied by the insolvability. For this reason, ambiguous loss is usually traumatic. If the stressor of ambiguity becomes unmanageable, it becomes immobilizing, critical, and thus traumatizing. If people are resilient, however, they are more likely to view the ambiguity as a chronic but manageable stress.

EXPANDING THE REPERTOIRE FOR TREATMENT

In addition to traditional and technical protocols for treating PTSD and critical incidents, I recommend the addition of family therapy and more community interventions. After traumatic ambiguous losses, for the sake of preserving resiliency in individuals, couples, and families, systemic approaches need to be included. Indeed, ambiguous loss, PTSD, and critical incidents all share a common conceptual root—that of trauma and stress—but the current insularity in treatment methods, dictated often by funding, hinders collaboration with family therapists.

Increasingly, when there is large-scale trauma, relational methods with families and communities are recommended (Boss et al., 2003; Landau & Saul, 2004; Sluzki, 1990). Disaster victims themselves call for more resiliency-based interventions (Norris, Friedman, Watson, Byrne, Diaz, & Kaniasty, 2002), and I would add that they must include familiar people, not just outside professionals. My goal in this chapter is to identify the common ground between conventional trauma interventions and conjoint/family therapies so that collaboration is more possible especially when loved ones are missing.

Although many therapists now acknowledge that we would benefit from training for PTSD treatment, I propose that professionals who treat PTSD and critical incidents would also benefit from more relational- and resiliency-based training. At minimum, treatment teams for critical and traumatic events should include professionals trained in family therapy, and community interventions that include children, parents, and grandparents. But right now, including family therapists as part of trauma treatment teams remains a relatively new idea to policy makers, training institutions, and providers.

With the trauma of ambiguous loss, human connections are severed, so it follows that treatment must also center on human connections. This means that protocols for individual and family therapy need to offer human relationships beyond that of the therapist or counselor as professionals can only offer a temporary connection. Survivors need to connect to someone familiar in their community, as such relationships are more likely to be ongoing. Even in individual therapy, I recommend interventions that take into account one's family and community. From my experience, such therapy can include various systemic combinations—a partner, spouse, friend, the immediate family, extended kin, coworkers, neighbors, and often spiritual advisers or elders. But always, it includes the psychological family. Within this self-defined family and community system, professionals can build on the knowledge that we are temporary. Clients and patients ultimately have to go home and live their lives with their own loved ones in their own communities. It is there—in their own homes and neighborhoods—where many people receive the ongoing human connection needed for resiliency.

I first learned that ambiguous loss was linked to trauma during the Vietnam era in the 1970s (Boss, 1975, 1980a). At the Center for Prisoner of War Studies in San Diego, I was studying families of soldiers declared missing in action.¹ In the 1980s I studied families with the second type of ambiguous loss—where the mind is missing (Boss et al., 1988; Boss, Caron, et al., 1990; Caron et al., 1999; Garwick et al., 1994). After 9/11, I studied ambiguous loss from terrorism and the agony caused by loved ones' vanishing physically without a trace. Nearly 3,000 innocent people disappeared that September morning while the nation watched on television in disbelief. But the relatives and friends of loved ones who never came home that night were numb with shock and helplessness. I thought of Fiegelstein's uncanny loss.

For the first few weeks after 9/11, people were sympathetic to the traumatized families yearning for the presence of their missing loved ones. Relatives wandered the streets of New York carrying photographs and posters of missing loved ones, asking, "Have you seen him?" "Have you seen her?" Their loss, so far beyond the normal range of human suffering, led to unorthodox behavior. At Ground Zero, a month after the attacks that collapsed

the towers, I saw a young bride and groom, dressed in full wedding attire, her white veil flowing out behind them, moving toward the smoking rubble with photographer in tow. I wondered who in that pile was meant to be with them on their wedding day. It was surreal, but unorthodox behavior made sense in this terrible context. Reactions varied. Some people zealously avoided Ground Zero, whereas others made daily pilgrimages to lay flowers or light candles. Some people were suicidal or so traumatized that they needed hospitalization; most were just temporarily dazed and confused and were able to regain their composure enough to carry on with daily life. For all, however, what happened on 9/11 went far beyond normal human expectations and shattered everyone's view of the world as a fair and logical place. As with families of missing soldiers, and the families of loved ones whose minds are missing from injury or dementia, there was after 9/11 no satisfying way to grieve or recover. What professionals and the public did not realize, however, was that this state of traumatic numbness would go on for some time. Closure would not be possible with this unique kind of traumatic loss.

Most PTSD experts and grief therapists are not trained to address the trauma that the two types of ambiguous loss can cause. Rarely is ambiguity identified as a source of trauma. My goal, then, is to inform professionals and the general public about ambiguous loss to begin a discourse and ultimately prompt policy changes for broader treatment and intervention.

The aim here is to add a new theoretical lens—that of ambiguous loss—to the conventional repertoire of trauma treatments. Toward this end, I will discuss the similarities and differences between situations of ambiguous loss, trauma, and critical incidents and set the stage for more interventions with children, youth, and adults that take family and community into account.

STRESS AND TRAUMA

Keeping in mind the goal of resiliency and health despite the on-going trauma of ambiguity, it is useful to clarify the links between the stress and trauma fields and ideas about ambiguous loss, and then delineate the similarities and differences among the concepts and methods.

How Do Stress and Trauma Relate to Ambiguous Loss?

In a typology of stressors, none is as unmanageable and traumatizing as ambiguous loss (see Table 2.1).

The stress from uncertainty simply wears people down. Individuals feel helpless, hopeless, and depressed. They become ambivalent and anxious.

TABLE 2.1 Classification of Family Stress and Trauma*Source***Internal**

Events that begin from someone inside the family, such as addiction, suicide, or violence

External

Events that begin from nature or people outside the family, such as floods or terrorism

*Type***Normative
Developmental
Predictable**

Events that are expected during the life course: birth, puberty, adolescence, marriage, aging, menopause, retirement, and death

**Catastrophic
Situational
Unexpected**

Events or situations not foreseen: a young person dies

Clear

Facts are available; family knows what is happening and how things will turn out

Ambiguous

Events or situations that remain unclear, facts about the status of a family member remain unclear

Volitional

Events or situations that are wanted and sought out: freely chosen job changes, college entrance, or a wanted pregnancy

Nonvolitional

Events or situations not freely chosen: laid off, fired, divorced, or abandoned

*Duration***Acute**

Event that lasts a short time but is painful: broken leg

Chronic

A situation of long duration: diabetes, chemical addiction, or discrimination and prejudice

*Density***Isolated**

One event that occurs with no other stressors; easily pinpointed

Cumulative

Events that pile up, one after the other, or situations that have no resolution; families worn down by multiple unresolved stressors

Adapted from Boss, P. (2002). Family Stress Management, Second Edition. Reprinted by permission of Sage Publications.

Family functioning suffers as decisions are put on hold, daily tasks are ignored, and fighting and rifts take place. Resiliency erodes as rituals and celebrations are cancelled. In such cases, individuals, couples, and families experience temporary shutdown. This is a crisis and, because it breaks down coping skills, it becomes traumatic as well.

When ambiguous loss is the stressor, therapists must remember that the source of stress and trauma lies in feelings of helplessness and confusion emanating from the context of ambiguity surrounding the individual. In this kind of context—incomprehensible, illogical, confusing, senseless, unjust, and outside of one's control—rational thinking about how to cope is blocked. Through no fault of their own, people experience trauma and stress because the ordinary facts about the absence or presence of loved ones are shrouded in mystery. No other loss is like this, and no other form of stress is quite so unmanageable.

PTSD: A NEED FOR CAUTION AND COLLABORATION WITH FAMILY THERAPY

PTSD is a medically defined disorder that arose from observations and research during World War II, the Holocaust, the Vietnam War, the fighting between Israel and Palestine, the Gulf War, the ethnic cleansing in the former Yugoslavia, and terrorism outside and inside the family. PTSD is defined as an anxiety disorder produced by an uncommon, extremely stressful event (e.g., rape, child abuse, assault, military combat, flood, earthquake, death camp, torture, car accident, head trauma). The key criterion for PTSD is *an experience that is beyond the normal range of human suffering*. The disorder is characterized by “(1) re-experiencing the traumatic event (e.g., intrusive thoughts), (2) numbing or feelings of detachment, and (3) a variety of autonomic and behavioral indicators of arousal including hyperalertness and other signs of sympathetic arousal, along the dimensions of generalized anxiety” (Goldberger & Breznitz, 1993, p. 727; see also American Psychiatric Association, 2000; Herman, 1992). The medical diagnosis of PTSD emerged in parallel research projects with Vietnam veterans (Figley, 1978) and rape victims (Burgess & Holmstrom, 1979), where individual responses were found to be similar. In 1980, the disorder was formally operationalized for research and clinical diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as PTSD (American Psychiatric Association, 1980). The treatment goal is to return the patient to health. Currently there is debate in the trauma field about expanding treatment for PTSD or advocating more community-based interventions. What is clear is that both are needed. Not everyone after a crisis or disaster devel-

ops PTSD (Bonanno, 2004). After a disaster, most people are stunned temporarily and manage to regain their coping skills and resiliency.

How Does PTSD Relate to Ambiguous Loss?

Loss complicated by ambiguity is a new challenge for most therapists, yet it is a situation experienced by many people. Indeed, ambiguous loss meets a PTSD criterion as an experience beyond the normal range of human suffering. In the DSM-IV-TR (American Psychiatric Association, 2000), PTSD is assessed and treated first as a mental disorder and second as an individual illness. Ambiguous loss, on the other hand, is a relational disorder, not a psychic dysfunction. It is the result of an externally caused stressor. Individual and relational symptoms may result, however, such as depression, anxiety, conflict, and somatization. The cause, though, is the ambiguity. Thus, treatment and intervention must include stress management along with relational and psychodynamic approaches. Unlike PTSD, where the traumatizing event is over but flashing back, ambiguous loss is an ongoing trauma. The assault never lets up. Yet, although they are different phenomena, the outcomes of both PTSD and ambiguous loss can paralyze relationships for a lifetime and even affect subsequent generations (Boss et al., 2003).

Currently, the PTSD diagnosis is being applied to treat victims of torture, rape, terrorist attacks, airplane crashes, school shootings, earthquakes, hurricanes, child abuse, and battering. PTSD therapy is also used preventively to avoid compassion fatigue by supporting professionals and critical incident teams who help such victims (Figley, 1995).

With some notable exceptions (Landau & Saul, 2004; Sluzki, 1990), most PTSD treatment is done with individuals, not families. Such individual treatment for trauma simply does not address the need for patients to go home eventually and live their lives with their families and intimate others. Of course, it is sometimes not possible to go home and find one's family again, and then, as in South Asia after the tsunami of 2004, community-based approaches should be used. Waters (2005) reported that both Eastern and Western trauma experts favor family- and community-based approaches to help survivors after nearly 300,000 adults and children were swept away. Bhava Poudyal, a Nepali psychologist, said, "The society [of Aceh] is very close-knit, supportive, and respectful of each other. Neighbors are taking care of each other, orphans are being taken in by other families" (p. 17). But Poudyal "worryes that aid groups may 'take away people's resiliency, their meaning, and impose the PTSD model—which is new and medical for them'" (p. 17).

Neil Boothby of Columbia University, reported Waters, champions people's ability to go home and rebuild their communities and livelihoods

together. Boothby said, "If a fisherman has a boat to fish and feed his family, that will have more effect on social functioning than any mental-health intervention . . . What heals people and helps them move on is solidarity and interdependence" (Waters, 2005, p. 18).

Although the conventional application of PTSD treatment is primarily individual and medical, many practitioners have adapted such treatments to more family- and community-based approaches (Boss et al., 2003; Landau & Saul, 2004; Sheinberg & Fraenkel, 2000). They are especially useful when the trauma is from relational loss.

**CRITICAL INCIDENT STRESS DEBRIEFING:
A NEED FOR CAUTION AND COLLABORATION
WITH FAMILY THERAPY**

Traumatic stress was used synonymously with a critical incident (Everly, 1989) and, according to critical incident stress debriefing (CISD) pioneers, may be immediate or delayed. (For an update, see Mitchell & Everly, 1993.) Critical incident stress is characterized by a wide range of cognitive, physical, emotional, and behavioral signs that result from a crisis event sufficient enough to overwhelm the usual effective coping strategies of individuals or groups (e.g., first responders: firefighters, police, soldiers, victims of war, terrorism, natural disasters). Such a crisis event represents a disruption in homeostasis (Everly, 1989; Mitchell & Everly, 1993; Everly & Mitchell, 2003; Mitchell & Everly, 2003).

The goal is early intervention, sometimes at the site of the crisis or disaster or nearby, with the rationale that giving opportunity for catharsis and verbalization with others leads to recovery (Everly & Mitchell, 1992). The original protocol is described as the Mitchell Model (1983). It initially had six technical stages, with a seventh added later: introduction, fact phase, thought phase, reaction phase, symptom phase, teaching phase, and reentry phase. The Red Cross also recommends a stage model, but with only four phases: disclosure of events, feelings and reactions, coping strategies, and termination (Armstrong, Lund, McWright, Tichenor, 1995). Such linear models, however, do not take into account human and cultural diversity in patterns and beliefs about coping. More will be said about this later.

Although the principles of CISD are sound, its original protocol was historically designed for the technical debriefing of emergency workers such as police (Mitchell, 1983). Today, the protocol has been updated for broader and more flexible application. For example, after the bombing of the Oklahoma City federal office building, many crisis workers were debriefed at the end of each day's work before they went home to their families. They were indeed vulnerable from the trauma of the sounds, smells,

and pressures of their heroic effort to find the trapped people and missing bodies. The critical incident teams normalized the overwhelming stress experienced by the workers, firemen, counselors, pastors, and survivors of the blast. They helped support clergy and clinical professionals and their spouses who were helping survivors with the injured, dead, and missing.

In looking back, researchers say that in Oklahoma City, people found human connection to be the most healing, and they did come together as a community. But the family and community connections were primarily organized by the families themselves and had not been part of the official intervention protocol (Sprang, 1999). As with most disasters, treatment in Oklahoma had been funded primarily for individual and work group debriefing. Family therapy was—and still is—a relatively new idea for crisis intervention in the United States.

TREATMENT AND INTERVENTION

“The goal of all psychotherapy is to help people change in order to relieve their distress. This is true of individual therapy, group therapy, and family therapy” (Nichols & Schwartz, 2004, p. 381). This is especially true when there is ambiguous loss. The unequivocal aspects borrowed from PTSD treatment to treat the trauma of ambiguous loss involve the recognition and treatment of trauma symptomatology (as well as attention to professionals who may become secondarily traumatized). Major differences are apparent, however, as the original traumatic event continues. Ambiguous loss goes on.

The aspect borrowed from CISD is primarily the idea that telling one’s story can be healing. Rather than following a structured methodology, however, I apply the narrative idea to family and community groups in their familiar settings and only with willing and voluntary participation. Not everyone will want to tell their story, but the premise is that listening is as healing as telling.

With the theory base for stress, trauma, and resilience just described, our methodology is based on these suppositions:

Methodological Suppositions

- The primary assumption is that for a relational condition such as ambiguous loss, a relational intervention is needed. The system may be a couple, a family, a community, or multiple families experiencing the same stressor. Therapists can take this systemic context into consideration even when doing individual therapy.
- Although symptoms that require medical or psychiatric attention are never ignored, there also needs to be focus on resilience, not just

pathology. Building upon resiliency enhances recovery for the majority of survivors.

- Treating just the individual adult or child is insufficient; an exclusive individual focus may erode parental and couple functioning and can be culturally insensitive. Trauma teams must therefore include family therapists, community-based professionals, and professionals or paraprofessionals who speak the language and know the culture of the survivors. Interventions can be tailor-made to fit individual, diversity, and cultural differences. With ambiguous losses from illnesses and disasters, meetings with multiple families in community settings may be more effective for building resiliency than clinical visits one at a time.
- Therapy is collaborative. Healing comes from a person's own resiliency, not just from trauma intervention. Therapists are just temporary connections in this process, so we must set the stage for linking patients and clients to where they live their lives. It is in their community that ongoing human connections build and sustain individuals and families when loved ones are missing.
- Finally, professionals who provide treatment and intervention for trauma must be culturally competent because the understandings of trauma as a disorder vary considerably. Leys (2000) argued that trauma does exist and varies within two camps: (1) one that endorses symptom relief and re-education, and (2) one that argues that beyond the symptoms, there are deeper meanings that emerge from one's family of origin as well as current relational context.

Like Leys, I am interested in meanings, not just symptom relief. But as we attend more to the vast diversity of norms and expectations among the people we see, there are also some common norms and expectations of health and decency. Both are important, so how do we find the balance?

When clients come from cultures different from my own, the therapeutic hierarchy flattens and collaboration becomes a necessity. I listen more. Sometimes, I ask an individual to bring in a family or community elder who can be like a cotherapist and inform me of cultural nuances. For professionals socialized in cultures that value individuality and self-sufficiency, this shift is a challenge. In times of disaster and crisis, those methods of diagnosis and treatment, which are based on finding closure, may be less effective than listening more to family members and elders who bring their own knowledge and survival experiences to the set. In times of stress and ambiguity, we set aside our own socialization and cultural assumptions and take into account those of the people we serve.

Today PTSD is also being reviewed as a condition that can result from a painful and traumatic cultural context, not just from an individual mental or



physical weakness (Boss, 2002c). Cultural psychiatrist Laurence Kirmayer and colleagues (2000) recommended a more contextual approach to symptom diagnosis and treatment with more focus on cultural influences that can result in trauma disorders. Paradoxically it is from physicians that we are learning that the PTSD diagnosis is too medically oriented (Kirmayer et al., 2000; Landau & Saul, 2004; Sluzki, 1990). All emphasize the diversity in cultural meanings about stress, crisis, and trauma. They caution us about cultural differences in the meanings and manifestations of trauma as well as symptoms and adaptation (DiNicola, 1997; Kirmayer et al., 2000; Kleinman & Good, 1985; Wilson, 1989).

What Not To Do

Because PTSD differs conceptually and clinically from ambiguous loss, the assessment of and treatment for PTSD are insufficient when loved ones are missing. Some early practitioners advanced their work to the couple or family level (Figley, 1989; Herman, 1992; Matsakis, 1996), but many have returned to individual work. Today, therapy for PTSD is primarily aimed at the individual and rarely includes family sessions or community work. Although individual medical treatment is needed in some cases after a traumatic experience, it does not specifically address the patient's need to go home and resume life with mates and families. Indeed, the current critique of the PTSD diagnosis and treatment is that it is neither systemic nor contextual and that it is too focused on individual pathology (Kirmayer et al., 2000; Landau & Saul, 2004). In that case, PTSD treatment may miss the contextual cause of the trauma (having a loved one disappear) as well as the real cause of unresolved grief and immobilization.

How Do Stress, Trauma, and Critical Incidents Link to Therapeutic Action?

Some critical incidents become a lifetime of ambiguous loss—a lost person is never found, an accident causes permanent brain injury. A relationship is put on hold with no closure to loss. For this reason, the individual treatment methods therapists may ordinarily use are less effective with the trauma of ambiguous loss. Traumatized children should not be separated from parents (with the exception, of course, of situations where the parent is the perpetrator). However, systemic interviews are complex and require special training. Having a family therapist on the disaster team would be a

real help. Ideally, disaster teams would be trained and aided in addressing the systemic ripple effect of trauma. Whether we do individual or conjoint therapy, however, the client's family would be kept in mind as part of the therapeutic context.

Trauma is the inherent core of PTSD, critical incidents, and ambiguous loss, but ambiguous loss is a relational stressor. It is not psychic pathology and it is not an individual problem. Relational interventions are needed to treat a relational problem.

Influences of Cultural Context on Therapy and the Therapeutic Relationship

Many people from cultures less individually oriented than the United States resist therapy and are frustrated when they are deemed sick by practitioners who miss what they have accomplished through family and community support. This means we have to take a second look at the concept of resistance. It can be ours, too.

After 9/11 in New York, I quickly learned that many of the spouses of workers gone missing were refugees and immigrants who had already successfully survived other traumatic losses in their homelands. The families of workers who serviced the two towers came from 60 different countries and spoke 24 different languages. Many came from Albania, Yugoslavia, Macedonia, and Russia; a small number came from East Asia. Many of the families of the Windows on the World restaurant workers emigrated from the Caribbean Islands, Mexico, Dominican Republic, and Central or South America, and thus spoke Spanish. Others were African or European. Most of these families had come to New York for a better and safer life, so their dream was shattered. Also, because they had uprooted, in their time of need they missed loved ones who were out of reach in faraway places. Their psychological family consisted of, in addition to the missing person, loved ones who had stayed behind and not immigrated with them. We knew that we needed an intervention that could help reconstruct the lost connections of family and community. With a wide array of ethnicities, races, socioeconomic levels, nationalities, and religions, we began our work. The first challenge was cultural competence.

What are the appropriate therapeutic goals for what *to* do when working with the trauma of ambiguous loss? How do we work with traumatized people from diverse cultures? The remainder of this book is aimed at answering these questions.