CHAPTER 1

Sudden, Traumatic Death and Traumatic Bereavement

One hot summer day when she was 6 years old, Emily discovered her father's lifeless body hanging in their garage. It was a grisly scene, replete with horrific sights and smells. Thereafter, Emily saw a succession of therapists. Each one addressed with her the psychological impact of dealing with her father's decision to take his own life, the resulting sense of abandonment that she experienced while growing up fatherless, and her grieving for all she had lost. Although she improved somewhat over the years, Emily continued to experience frequent nightmares, some emotional numbness, fear of intimacy, an exaggerated startle response, and increased agitation in hot, humid weather. Somehow, she felt unable to move on with her life.

It was fully 25 years before one therapist finally asked Emily, "Exactly what did you see when you found your father?" Finally someone had begun to tap into Emily's experience of the grotesque circumstances associated with her father's death, not solely the deprivations it had caused.

For many of us, the description above is disturbing to read. Like other survivors for whom this treatment is designed, Emily experienced the sudden, traumatic death of a significant other. In the instant she found her father dead, her life was fundamentally changed. She struggled on her own with trauma symptoms for 25 years, despite seeking help. As bereaved survivors attempt to pick up the shards of their lives and move forward, what lies ahead for them? If survivors want or need professional help, what sort of treatment would be most useful? This book addresses these questions.

Our goal is to provide a comprehensive treatment approach for therapists working with individuals who have experienced the sudden, traumatic death of a loved one. These mourners face the twin tasks of mourning the loss of their loved one and coping with the trauma that accompanied the death. Some therapists may not bring such a dual focus to their work with survivors of sudden, traumatic loss. Historically, the fields of *traumatology* (focusing on the study of traumatic events and their aftereffects) and *thanatology* (focusing on the study of dying, death, and bereavement) have existed relatively independently of one another, despite their conceptual, clinical, and often empirical relationship (Rando, 1997). This curious phenomenon has persisted despite the reality that most traumatic experiences include loss, and that most major losses have traumatic elements (see Rando, 2000).

This book presents a treatment approach designed to address both trauma and grief. In this chapter, we provide an overview of the psychological consequences of sudden, traumatic death, and broadly describe our integrated treatment approach for traumatic bereavement. Traumatic bereavement arises from an interaction between the circumstances of the death and other situational variables on the one hand, and aspects of the survivor (e.g., gender, attachment style, religious beliefs, personality) on the other, all within a particular social and cultural context.

Sudden, traumatic death is abrupt and occurs without warning. Although lack of anticipation alone can render a death traumatizing to a survivor, a death is more likely to be traumatic if it is untimely; if it involves violence or mutilation; if the survivor regards it as preventable; if the survivor believes that the loved one suffered; or if the survivor regards the death, or manner of death, as unfair and unjust. Other kinds of deaths likely to be regarded as traumatic include a death perceived as random (i.e., the loved one was in the wrong place at the wrong time); a death caused by a perpetrator with intent to harm; a situation where the survivor witnessed the death; a situation where the survivor is confronted with many deaths; and situations where the survivor's own life is threatened. Following a sudden, traumatic death, a survivor may experience *traumatic bereavement*, which is associated with enduring problematic reactions, including symptoms of trauma and grief. Causes of deaths most likely to precipitate traumatic bereavement include accidents, homicide, suicide, natural disasters, and war. In addition, acute natural events (e.g., a brain aneurysm) can have violent or traumatic elements.

TRAUMATIC DEATH PREVALENCE

According to the *National Vital Statistics Report* (Heron, 2012), the largest group of people who die between the ages of 1 and 44 do so as a result of a sudden, traumatic event. In most cases, a single traumatic death triggers a cascade of suffering and heartache, affecting the spouse or partner, parents, siblings, and children of the person who died. The tragedy may also affect extended family members, close friends, and coworkers.

Causes of traumatic deaths change over the lifespan. Accidents are by far the most common cause of death in all age groups younger than 44. For example, those in the 15–19 age group are approximately eight times more likely to die in an accident than to die from cancer, which is the leading cause of natural death in this group. Beginning at age 15, homicide and suicide emerge as prevalent causes of death. Among the 15–19, the 20–24, and the 25–34 age groups, suicide and homicide are among the top three causes of death, along with accidents. Those in the 15–19 age group are approximately six times more likely to die as a result of homicide or suicide than of cancer. Moreover, while deaths from accidents, homicide, and suicide become less prevalent after age 44, deaths resulting from sudden cardiovascular events become more prevalent.

These figures provide a conservative estimate of the prevalence of sudden, traumatic deaths. They do not include deaths from natural disasters, war, or terrorist attacks. They also do not include sudden deaths that result from heart attacks, strokes, or aneurysms.

PSYCHOLOGICAL CONSEQUENCES OF SUDDEN, TRAUMATIC DEATH

Following the sudden, traumatic loss of loved ones, survivors typically experience painful trauma symptoms (such as disturbing, intrusive thoughts), as well as grief symptoms (such as yearning for their loved ones). Because of the way the death occurred, the survivor is typically

flooded with intense and painful affect. The deaths often completely overwhelm their defenses, leaving them unable to cope. As one survivor expressed it, "It was as though someone cut my insides out." In most cases, their symptoms are more intense and prolonged than those experienced by survivors of natural deaths.

If a death was sudden, was perceived as random, and occurred without warning, feelings of shock may be profound. A survivor may feel helpless, confused, and unable to grasp the implications of what has happened. Such deaths are also likely to evoke intense death anxiety, leading these bereaved person to fear her own death as well as that of surviving loved ones. As one father indicated following his wife's murder, "I was terrified that I would also be killed and that my children would be left with no parents."

Untimely deaths often cause distress because survivors feel their loved ones were cheated. If the loss was untimely or viewed as preventable, feelings of anger may be predominant. Most mourners in this situation find it difficult to live with the fact that their loved ones' deaths were unnecessary. Anger is also a common reaction to deaths that are regarded as unjust. Most survivors believe that perpetrators should be held accountable for what has happened. Particularly if a perpetrator intended harm or was cruel or callous, a survivor must confront the human capacity for malevolence. Deaths resulting from intentional acts of violence often trigger powerful feelings of generalized rage, as well as rage specifically directed toward the perpetrator.

A violent death typically results in mutilation of the loved one's body, such as when the deceased died in a fiery car crash or was shot at close range. In such cases, vivid images of the loved one's body are often seared into the survivor's mind. Such images typically emerge even in cases where the survivor did not witness the fatal incident. These disturbing images often return as intrusive thoughts or as parts of dreams or nightmares. In addition, the violence associated with the death and the mutilation of the body are likely to heighten the survivor's concern with what the loved one experienced during the final moments of her life.[1]

As we detail in later chapters, research has identified a set of core issues that survivors of sudden, traumatic death typically experience (Wortman, Pearlman, Feuer, Farber, & Rando, 2012). First, it is common for survivors to question their religious beliefs, or even to feel betrayed and turn against God. In such cases, religious faith can become a casualty of the death. Second, survivors are often preoccupied with whether their loved ones suffered at the time of their death. Third, most mourners are troubled by their inability to make sense of what has happened. Finally, survivors often struggle with feelings of guilt. This was the case for the parents of a young man named Greg, who was an honor student and a varsity athlete. When he turned 17, Greg began working evenings and weekends at a convenience store to save money for college. One evening at about 11:00 P.M., Greg and the manager were murdered during a botched holdup attempt. Greg's parents experienced intense guilt following his death. About 8 months before the tragedy, he had asked his parents whether he could take karate lessons. They said no, reasoning that his schedule was already overloaded. After the tragedy, they berated themselves for this decision, thinking that if he had taken the classes, he might have survived the assault. In Chapter 3, we discuss each of these core issues in more detail.

In attempting to understand why a traumatic death can evoke so many debilitating reactions, we must recognize that such a death typically provokes an existential crisis. The nature of the loss forces most mourners to question assumptions that they previously took for granted (see Bowlby, 1969; Marris, 1975; Parkes, 1971). These include beliefs that the world is meaningful

[1]To avoid awkward "he or she/his or her" constructions, we alternate throughout this book between feminine and masculine third-person singular pronouns.

and operates according to principles of fairness and justice, that one is safe and secure, that the world is benevolent, and that other people can generally be trusted (Janoff-Bulman, 1992).

The traumatic death of a loved one challenges these fundamental assumptions. Often the bereaved simply cannot absorb what has happened; the loss seems incomprehensible. It demonstrates that life is capricious and unpredictable. The dismantling of basic assumptions about the world may also invalidate much of the bereaved's past behavior. For example, two young parents did everything possible to protect their 3-year-old son, such as putting locks on their kitchen cabinets and buying the most highly rated car seat. Despite their precautions, the child was killed in a motor vehicle crash caused by an under-age driver who had been drinking. In addition to the loss itself, it was painful for his parents to recognize that they were unable to protect their child. Should the couple have other children, they are likely to experience intense and prolonged anxiety about the safety of those children.

It is generally well established that the presence of trauma symptoms interferes with the process of accommodating the loss (Rando, 1993, 2013). An important part of successful mourning involves recollecting the loved one and reviewing the relationship that was lost. Gradually, the mourner is able to put her life with the deceased into perspective, and to begin moving forward. When a person has suffered a traumatic loss, attempts to recollect the loved one are often associated with distressing memories or images, such as what happened during the loved one's death. These thoughts and images are so disturbing that in many cases, individuals try to avoid thinking about their loved one, making it far more difficult to process their loss. An additional burden is that survivors often become alarmed at the intensity of their trauma symptoms. As one man explained following the murder of his daughter, "I'm the kind of guy who would never even hurt a fly. But after her death, all I thought about was killing the man who did this to her. I kept thinking about all the ways I could kill him. I really thought I was going crazy."

Trauma symptoms are likely to undermine the resources survivors have available to deal with day-to-day living. Physiological hyperarousal and the resulting sleep and concentration difficulties, for example, can sap a mourner's energy and make it difficult to function well at work and at home. While coping resources are impaired as a result of the tragedy, the demands placed on the mourner often increase dramatically following the loss. For example, one woman whose husband died in an occupational accident experienced major difficulties with her surviving sons. Her 15-year-old quit the soccer team his deceased father had coached; the boy also became sullen and argumentative. Her 6-year-old started having nightmares on a frequent basis and began wetting the bed—something he had not done since he was toilet-trained.

Traumatic deaths are more likely than natural deaths to bring mourners into contact with situations that can be profoundly disturbing. For example, one couple rushed to the hospital to see their teenage daughter, who had been shot by her ex-boyfriend. Upon arriving, they were told that their daughter did not survive. The young woman's mother cried out, "I want to hold my baby." The nurse in charge informed her that her daughter's body was "evidence" for the case against the perpetrator, and that no contact or touch was permitted. Other issues that often emerge in regard to a traumatic death and exacerbate a survivor's distress include removal of the loved one from life support, insensitive death notification, identifying the body, a request for an autopsy (and the autopsy itself), lack of an intact body to bury, media attention, and criminal or civil trials. Most of these situations occur around the time of death. Consequently, survivors are forced to contend with them while in the throes of acute grief.

Many of the factors that can characterize traumatic deaths tend to occur together. A single mother lost her only child, a 10-year-old boy, when he was shot and killed in the home of a classmate. The gun, without adequate safety devices, was loaded at the time of the shooting. It

was stored in a completely accessible, unlocked bedroom closet. The child's death was sudden and, at age 10, was untimely. It was regarded as preventable because if the gun had been stored properly, the accident would not have happened. A subsequent investigation revealed that her son did not touch the gun, but was accidentally killed while his classmate was playing with it. This led the mother to believe that her son's death was unfair. In most cases, the impact of these factors is cumulative: The more of them that are present, the more intense and prolonged the survivor's distress is likely to be.

PERSISTENT AND PERVASIVE EFFECTS OF TRAUMATIC DEATH

Back in the 1980s, one of us (Camille B. Wortman) was contacted by the Insurance Institute for Highway Safety, a private foundation. The foundation was interested in the long-term psychological effects of losing a spouse or child in a motor vehicle crash. A study was designed to investigate this issue. Interviews were conducted with people 4–7 years following the death of their spouse or child in a car accident. The researchers also interviewed control respondents who had not lost loved ones. The purpose of the study was to determine whether people continued to be affected by such losses years after they occurred. Would most respondents be functioning well, or would they still be struggling with the ramifications of the death?

The results provided compelling evidence that the traumatic death of a spouse or child poses long-term difficulties (Lehman, Wortman, & Williams, 1987). Comparisons between bereaved persons and controls revealed significant differences on several psychological symptoms, including depression as assessed on the SCL-90 scale (Derogatis, 1977). Following the loss, bereaved respondents also became anxious that something bad would happen to another family member; this anxiety did not arise among controls.

Bereaved individuals also reported a significantly lower quality of life than did control respondents, as assessed by the Bradburn Affect Balance Scale (Bradburn, 1969). This scale measures the extent to which respondents find their activities interesting and meaningful, experience feelings of pleasure and enjoyment, and feel proud about things they have done.

Whereas some bereaved couples reported that the death of a child had a pronounced negative impact on their marriage, others said that the death brought them closer together. As a group, however, the bereaved parents in this study tended to report more stress in their marriages and were significantly more likely to seek and obtain a divorce than controls. Bereaved parents were also significantly less likely than controls to be working for pay, and to be working at the same job that they held before the loss. When they did remain at the same job, they tended to have difficulty sustaining interest in and motivation for their work. Following the death, bereaved spouses and parents reported earning significantly less family income than controls. Bereaved parents were also significantly more likely to move. Many commented that their prior homes were an endless source of painful memories.

Bereaved spouses reported more difficulty in getting involved in leisure activities and in carrying out their housework. They also scored significantly higher on loneliness than did controls. Both groups also reported more conflict with relatives and friends than controls. For example, they were more likely than controls to indicate that these relationships made them feel hurt and disappointed. As we describe in more detail below, those who lost a spouse or child were more likely than controls to experience problems in their relationships with surviving children—for example, agreeing that they felt more "emotionally worn out." Moreover, in response to an open-ended question about the impact of their spouse's death on their surviving

children, an overwhelming majority of respondents (73%) reported that their children had suffered negative effects. Forty-seven percent of responses were coded as "extremely negative effects," including depression, drug abuse, and suicide.

Negative effects were common even in cases where surviving children or siblings were quite young. Reports of withdrawal, obsessive behavior, and anger were typical. For instance, one mother spoke of her 5-year-old daughter's reaction to the loss of her father: "She stopped playing. She hasn't been the same since then. She doesn't show interest like she used to." Another mother described how her daughter was affected by the traumatic death of her older brother: "[My daughter] was very withdrawn for 1½ years. When her emotions finally came out, it was almost a disaster. She said she didn't love any of us any more because it would only hurt her."

The results revealed significant differences in mortality between bereaved and control respondents. By the time we started the study, more than 6% of those individuals who lost a spouse or child had died; none of the respondents in the control group had died. This is a very high mortality rate for such a young population (most of the respondents were in their early 40s).

The interview also included a number of questions to determine whether the bereaved were still dealing actively with their loss. Over 90% of those who had lost a spouse or child had experienced thoughts or memories of their loved one during the past month. Of those who had such thoughts, 56% of the bereaved spouses and 68% of the bereaved parents reported that these memories made them feel "hurt and pained," and none of the respondents were able to block unpleasant thoughts when they wanted to. Sixty percent of the bereaved spouses and 67% of the bereaved parents reported that during the past month they had had at least one conversation with a friend or family member about their loved one.

Despite the time that had elapsed since their loved ones' deaths, the data indicated that most respondents had not achieved a state of resolution regarding their loss. Nearly 50% of those who lost a spouse or a child stated that they had relived the accident or the events surrounding their loved one's death during the past month. Approximately 60% of the bereaved respondents reported having had thoughts during the past month that the accident was "unfair" or that they and their loved one had been cheated.

If a person is having difficulty coming to terms with the death of a spouse, child, or parent 4–7 years after it occurred, others might conclude that the person is coping poorly with the loss. What these data suggest is that lasting distress following the traumatic death of a family member is not a sign of individual coping failure. Rather, such distress is typical in response to this type of loss.

Since the motor vehicle study was conducted, a number of additional studies have corroborated these findings. For example, in an important study on the impact of losing a child through accident, suicide, or homicide, Murphy, Chung, and Johnson (2002) found that 5 years after the loss, a majority of mothers and fathers were experiencing significant mental distress. The percentage of mothers and fathers meeting formal criteria for posttraumatic stress disorder (PTSD) was still considerably higher than for women and men in the general population. Moreover, a majority of mothers (61%) and fathers (55%) continued to reexperience visual or mental imagery of their loved one's death (Murphy, Johnson, Chung, & Beaton, 2003). These and other studies have shown that following a traumatic death, it is common for a survivor to experience painful symptoms of trauma and grief for many years. Although feelings of distress may decline over time, there is some question about whether survivors of sudden, traumatic death ever recover fully. Thus we prefer to use the term *accommodation* to *recovery* when referring to the goal of the mourning processes. As one bereaved mother expressed it, "You don't get over it; you get

used to it." In fact, traumatic bereavement can become chronic and debilitating. People may experience such profound and persistent changes as feelings of emptiness and alienation from others, a loss of meaning or purpose in life, and feelings of impending doom. Because friends, relatives, and even therapists are often not aware of the enduring impact of these losses, they may convey to the bereaved that they should be adjusting more quickly than they are. In fact, the bereaved themselves often mistakenly regard their continuing distress as a sign of personal inadequacy or coping failure.

THE NEED FOR INTEGRATED TREATMENT OF TRAUMATIC BEREAVEMENT

The description of Emily's traumatic experience at the beginning of this chapter illustrates the importance of addressing traumatic elements of the situation, in addition to those involving loss. Treatment must address integration of the trauma as well as accommodation to the loss. In Emily's case, the therapists she saw had focused on helping her to mourn—a task that seems like the natural thing to do, and that is in fact an important aspect of the treatment process. Yet, because they did not appreciate that she had been traumatized by what she experienced—overwhelmed by the terrible sights and smells, and helpless in the face of all the horror—a significant aspect of her experience remained unresolved. A survivor who is unable to address the traumatic aspects of a death continues to experience trauma symptoms, and these symptoms compromise the survivor's ability to mourn the loss fully. Therapy must address the two in combination. Without this dual and integrated focus, survivors may experience continuing emotional pain and distress.

Given the prevalence of sudden, traumatic deaths and the profound disruptions associated with traumatic bereavement, it is essential that effective treatment be available. In our experience, survivors frequently encounter difficulty in identifying treatment options that address their unique concerns and needs. As we describe in Chapter 7, several papers within the clinical literature have discussed the interaction of trauma and grief. For the most part, however, this work has not been integrated into a comprehensive treatment approach. The twin demands for healthy mourning and trauma integration, and the breadth and intensity of traumatic bereavement responses, call for a multifaceted approach.

AN OVERVIEW OF OUR TREATMENT APPROACH FOR TRAUMATIC BEREAVEMENT

The goal of the treatment approach described in this book is to help an adult survivor address the traumatic stress associated with the death and the way it occurred, so that the survivor can process the grief surrounding her loss. The ultimate goal is to help clients reinvest in their lives in ways that are fulfilling to them. As shown in Table 1.1, this treatment is composed of three core components: (1) building a survivor's internal and interpersonal resources; (2) processing the traumatic death both cognitively and emotionally; and (3) moving through the processes of mourning. Psychoeducation in these areas is an important element, as are between-session independent activities assigned to clients. A supportive therapeutic relationship is essential as well. This treatment is based on theory as well as on empirically validated practices for treating grief and trauma. We have also drawn from years of clinical experience, and from a pilot study

TABLE 1.1. Components of the Treatment Approach

Resource building

- Self capacities
  - Inner connection
  - Self-worth
  - Affect management
    - Recognizing affect
    - Tolerating affect
    - Modulating affect
    - Integrating affect
- Coping skills
  - Breathing retraining
  - Self-care
- Social support
- Bereavement-specific strategies
- Meaning and spirituality
- Values and personal goal setting

Trauma processing

- Cognitive processing
  - Cognitive restructuring of cognitive schemas and related psychological needs disrupted by trauma
  - Identifying and challenging maladaptive automatic thoughts
  - Activity scheduling
- Emotional processing
  - Prolonged (*in vivo* and imaginal) exposure

Mourning

- *Recognize the loss*
- *React to the separation*
- *Recollect and reexperience the deceased and the relationship*
- *Relinquish the old attachments to the deceased and the old assumptive world*
- *Readjust to move adaptively into the new world without forgetting the old*
- *Reinvest*

Psychoeducation and independent activities

Therapeutic relationship

that tested the approach. We describe each of the treatment's components below and in more detail in Part IV, as well as in the client handouts in the Appendix. In addition, we have provided online supplementary handouts that, while not essential, may be useful to clients. These handouts are available at the website supplement for this book (*www.guilford.com/pearlman-materials*).

Resource Building

Clients who have experienced traumatic bereavement need to process the trauma and engage in active mourning. To build the foundation for those two tasks, this treatment approach first focuses on preparing survivors by developing six specific resources. These resources support clients in the therapy process and help them manage day-to-day life. They are woven throughout the treatment; clients are asked to engage regularly in some resource-building activity between sessions. We describe resource-building activities in Chapter 10.

Self Capacities

Self capacities are skills people use to regulate internal states. The three self capacities essential to internal stability are *inner connection* (internal bond with positive images and memories of loved ones or other positive attachment figures), *self-worth* (the ability to feel like a good enough person), and *affect management* (the ability to recognize, tolerate, modulate, and integrate strong feelings). These "feelings skills" are drawn from *constructivist self development theory* (CSDT; Pearlman, 1998) as well as attachment theory (Bowlby, 1969), and are discussed in more detail in Chapters 2 and 10.

Coping Skills

Coping strategies are actions people take to manage, tolerate, or reduce the demands of a stressful situation (Folkman, 2001; Lazarus & Folkman, 1984). We can empower our clients by helping them to examine the coping strategies they are using and by educating them about strategies that may be more effective. Two important coping strategies within our treatment approach are breathing retraining and self-care (i.e., adequate sleep, nutrition, and physical exercise).

Social Support

Emotional and instrumental support from family members, friends, neighbors, and coworkers can help to counter the isolation that survivors of traumatic bereavement may experience. The therapist encourages survivors to identify people who can help them when the treatment is challenging. For example, a support provider might accompany the client in exposure activities, such as visiting the deceased person's grave.

Bereavement-Specific Strategies

Bereavement-specific issues are events or occasions that evoke powerful memories or emotions ("subsequent temporary upsurges of grief"; Rando, 1993, 2013) related to the deceased or to her death. These situations often arise without warning and pose one of the greatest trials for the traumatically bereaved. Our treatment approach addresses these situations directly with clients, helping them to develop constructive strategies for anticipating these challenges whenever possible and coping with them when anticipation is not possible.

Meaning and Spirituality

A sudden, traumatic death can assault a survivor's sense that life is meaningful. An essential aspect of this treatment approach is to help the client create or recover a connection with something that makes her life feel worth living. This connection can serve as an inner resource to be called upon when needed for self-soothing.

Values and Personal Goal Setting

The purpose of *values* work with survivors of traumatic bereavement is to help them regain a sense of purpose and direction in their lives by identifying what matters to them most at this point. Values work helps people choose to move forward in meaningful directions and become

engaged in activities they view as worthwhile. It can also propel movement forward in a client who seems to be stuck in the mourning process. For example, clients can be helped to realize that despite the loss, they have values that are important to them. These may include nurturing young people, learning new things, or maintaining a relationship with members of their extended family. Therapists can assist clients in developing goals that are consonant with their values. This should encourage involvement in activities that will help the client move forward.

Trauma Processing

When the client has adequate resources, trauma processing can begin. Cognitive-behavioral therapy (CBT) provides the empirically validated underpinning to trauma processing in our treatment approach (see Chapter 7 for a discussion of relevant research and Chapter 11 for a description of how to utilize these treatment elements). Another approach that is widely utilized for the treatment of trauma is eye movement desensitization and reprocessing, or EMDR.[2]

Although our treatment approach relies on techniques from CBT to process the loss, therapists trained in EMDR can use that technique for trauma processing (for a discussion of the use of EMDR to treat complicated mourning and traumatic stress, see Sprang, 2001).

Cognitive Processing

We utilize *cognitive processing therapy* (Resick & Schnicke, 1992, 1993; Resick et al., 2008) and cognitive techniques such as identifying, monitoring, and challenging problematic automatic thoughts; the downward arrow technique for identifying problematic beliefs; and the behavioral experiments of activity scheduling. These techniques help survivors change maladaptive cognitions that often emerge following sudden, traumatic deaths. Maladaptive cognitions (e.g., "I can't trust anyone") often present obstacles to the mourning process. Identifying and changing these cognitions can help the mourning process to proceed. CSDT (McCann & Pearlman, 1990b; Pearlman, 2001; Pearlman & Saakvitne, 1995) outlines five need areas that are the basis for core assumptions and beliefs about self and others within CPT (Resick & Schnicke, 1993). These trauma-sensitive need areas—safety, trust, control, esteem, and intimacy (Pearlman, 2003)—are the foundation for the cognitions targeted in this treatment approach.

Emotional Processing

Another aspect of the treatment relies on prolonged (imaginal and *in vivo*) exposures, drawn from *emotional processing theory* (Foa & Kozak, 1991; Foa & Rothbaum, 1998; Rachman, 1980). Exposure helps to counter the avoidance of people, places, and things that remind survivors of

[2]EMDR combines brief imaginal exposure to trauma material with therapist-induced rapid eye movements (or some other type of bilateral stimulation, such as finger tapping or auditory clicks). Investigators have begun to explore the application of EMDR to grief. The most recent edition of EMDR developer Francine Shapiro's book (Shapiro & Forrest, 2004) includes a chapter on grief (see also Solomon & Shapiro, 1997). Solomon and Rando (2007) have delineated how EMDR can be used within a comprehensive framework for the treatment of grief and mourning. They presented specific guidelines for using EMDR to facilitate the mourning process. According to Solomon and Rando, EMDR deserves more attention as a technique for processing the traumatic elements of a loss.

the traumatic aspects of the death and its aftermath. It also assists survivors by reducing the emotional intensity of traumatic memories and images. Imaginal exposure primarily takes the form of written assignments, the main one being written accounts of the death or of learning about the death. Clients are instructed to write an account of the death three times over the course of the treatment and are asked to read the account daily. For *in vivo* exposure, a therapist and client create a fear and avoidance hierarchy of avoided or anxiety-provoking situations. The survivor is then supported in moving through the list at his own pace, starting with the least distressing situation. *In vivo* exposure to situations is primarily carried out as an independent activity. Before initiating trauma processing via exposure, it is important to assess the adequacy of the client's coping resources. If this step is not taken, trauma processing may result in the retraumatization of the client. Therefore, building or strengthening a client's self capacities, in addition to assessing them along the way, is an essential element of this approach.

Mourning

There is a growing consensus that clients can be helped more effectively by treatments that focus on specific mourning processes, such as recognizing the permanence of the loss, rather than a sequence of discrete stages. In this treatment, we rely on the six "R" processes of mourning developed by Rando (1993, 2013) for conceptualizing healthy mourning. These "R" processes are as follows: *Recognize the loss; React to the separation; Recollect and reexperience the deceased and the relationship; Relinquish the old attachments to the deceased and the old assumptive world; Readjust to move adaptively into the new world without forgetting the old;* and *Reinvest*. Healthy mourning is the path to accommodating the many and varied losses that are typically associated with sudden, traumatic deaths. Among traumatically bereaved clients, the mourning process is often impeded by unprocessed trauma. Within this integrated treatment approach, a focus on the individual processes of mourning is interwoven with trauma processing.

Over the years, countless portrayals of the mourning process have appeared in the literature. Two of the most influential are Freud's (1917/1957) concept of *griefwork* and Bowlby's (1969, 1980) and Kübler-Ross's (1969) *stage models* of grief. In this book, we examine these models closely and consider their relevance to grief therapy as it is practiced today. In developing our treatment approach, we have drawn from approaches that have for the most part been developed after the griefwork and stages views, and often in reaction to their limitations. In addition to Rando's "R" processes, these theoretical developments include the *stress and coping* model (Lazarus & Folkman, 1984), which addresses individual differences in response to the death of a loved one, which stage models cannot; the *continuing-bonds* approach, which clarifies that it is not necessary to sever all or most ties to the deceased, and that in fact such ties can be beneficial (Klass, Silverman, & Nickman, 1996); research on *positive emotions* (Folkman, 1997a, 2001), which illustrates the surprising role these emotions can play in facilitating the mourning process and promoting healing; the *dual-process model* of bereavement (Stroebe & Schut, 1999; M. S. Stroebe, Schut, & Stroebe, 2005), which emphasizes that mourners must focus not only on painful aspects of the loss, but on feelings and behaviors that are restorative, and that provide a respite from intense distress; and the *meaning-making approach* developed by Neimeyer and his associates (e.g., Holland, Currier, & Neimeyer, 2006; Holland & Neimeyer, 2010; Neimeyer, 2001; Neimeyer & Sands, 2011; Shear, Boelen, & Neimeyer, 2011), who have demonstrated that a search for meaning is a fundamental part of the mourning process.

Psychoeducation, Worksheets, and Independent Activities

Psychoeducation—providing clients with information about their symptoms, adaptations, and recovery—is a critical aspect of this treatment. It takes place within virtually all sessions, and is reinforced by informational handouts. Other handouts for clients reinforce and expand upon in-session work; the worksheets and independent activities provided in these handouts support resource building, trauma processing, and mourning. Clients can also use these handouts to support their continuing progress after therapy ends. Purchasers of this book have permission to reproduce all of the handouts, which are located in the Appendix and online (*www.guilford.com/pearlman-materials*). The handouts that are essential to this treatment approach are in the Appendix and on the website. Additional, supplemental handouts are on the website only.

Therapeutic Relationship

We list the therapeutic relationship in Table 1.1 as a separate element of the treatment in order to highlight its importance. As in all trauma therapies, the presence of a compassionate guide on the journey is essential in working with survivors of traumatic death (see, e.g., Pearlman & Courtois, 2005; Pearlman & Saakvitne, 1995).

Treatment Structure

The treatment approach described in this book includes a rich array of material that can help traumatically bereaved clients within any theoretical framework, treatment length, or format (structured or unstructured). The therapist can plan the treatment in a variety of ways depending on a client's needs and resources, as well as on the therapist's and client's preferences. In Table 1.2, we list the session topics we have used in implementing the treatment. To provide a more comprehensive overview of our approach, we have expanded this list into a 25-session treatment plan, which is available on the book's supplemental website at *www.guilford.com/pearlman-materials*. The topics we include, and the way these topics are sequenced, are based on our experience with a series of pilot therapies.

The treatment can be tailored for clients who need only certain elements of the treatment or are only able to participate in a limited number of sessions. One can think of the approach as modular, and select all or any of the three core treatment components (resource building, trauma processing, and mourning) as needed for each client. The sample session format described in Chapter 9 (see Table 9.2) can be used to address any of these topics. In using this approach, it is important to integrate the treatment elements. We recommend that each session contain tasks from one or more of the three core treatment components, as well as psychoeducation about traumatic bereavement. These elements are interwoven over the treatment course, with each session having one or more specific topics as a focus.

Session Topics

People experiencing traumatic bereavement present with a vast array of symptoms, adaptations, and needs, and we would not expect that every therapy would address all of these topics. These topics (see Table 1.2) are sequenced as they would be to address a typical traumatically bereaved client. As we describe in Chapter 9, this approach can be adapted for cases in which the client

TABLE 1.2. Main Topics and Subtopics for the Treatment Approach

Session 1. Orientation
- Orientation to the treatment
- Discussion of sudden, traumatic death and traumatic bereavement (T, M)[a]

Session 2. Treatment Goals and Growth
- Treatment goals and tools
- Self-care (R)
- Exploring the impact of the death (T, M)
- Overview of the six "R" processes of mourning (M)

Session 3. *Recognize the Loss*; Feelings Skills (Self Capacities)
- The first "R" process (M)
- Breathing retraining (R)
- Feelings skills (R)

Session 4. Automatic Thoughts
- Introduction to the cognitive therapy model for change (T)
- Identifying automatic thoughts (T)

Session 5. Automatic Thoughts (Continued)
- Challenging automatic thoughts (T)

Session 6. *React to the Separation*; Exposure
- The second "R" process (M)
- First account of the death (T, M)

Session 7. Secondary Losses and Social Support
- Secondary losses (M)
- Building social support (R)
- Second account of the death (T, M)

Session 8. Resource-Building Activities: Social Support and Values Work
- Values work (R, M) and personal goal setting (R, M)
- Third account of the death (T, M)

Session 9. Personal Goal Setting and Psychological Needs
- Personal goal setting (Continued)
- Psychological needs (T)
- Foundation for ending therapy

Session 10. Obstacles to Accommodation
- Obstacles to accommodation (T, M)

Session 11. Review of Previous Topics

Session 12. *Recollect and Reexperience the Deceased and the Relationship*
- The third "R" process (M)
- Positive and negative aspects of the relationship with the loved one (M)

Session 13. *Recollect and Reexperience the Deceased and the Relationship* (continued)
- Review of the relationship with the loved one (M)

Session 14. *In Vivo* Exposure
- Fear and avoidance hierarchy (T)
- *In vivo* exposure activity (T)
- Writing assignment: Relationship with the deceased (T, M)

Session 15. *In Vivo* Exposure and Guilt
- Guilt, regret, and sudden, traumatic death (T, M)
- *In vivo* exposure activity (T)

Session 16. *In Vivo* Exposure and Anger
- Anger and sudden, traumatic death (T, M)
- *In vivo* exposure activity (T)

Session 17. Transforming the Pain
- Anger, regret, and guilt in sudden, traumatic death (T)
- Letter to the deceased (T, M)
- *In vivo* exposure activity (T, M)

Session 18. Bereavement Challenges
- Bereavement-specific issues (M)
- *In vivo* exposure activity (T)

Session 19. The Assumptive World; *Relinquish the Old Attachments to the Deceased and the Old Assumptive World*
- Discussion of the assumptive world (M)
- The fourth "R" process (M)

Session 20. *Readjust to Move Adaptively into the New World without Forgetting the Old*; Spirituality
- The fifth "R" process (M)
- Writing assignment: Meaning of the loss (T, M)
- Spirituality (R, M)

Session 21. New Relationship with the Deceased; Termination
- Writing assignment: Continuing the relationship with the deceased (M)
- Ending therapy

Session 22. Self-Intimacy and Identity
- Self-intimacy (R)
- Identity (R)

Session 23. Other-Trust, Other-Intimacy; Social Support
- Other-trust (R, M)
- Other-intimacy (R, M)
- Social support (R, M)
- Writing assignment: Final impact statement (M)

Session 24. *Reinvest*; Termination
- The sixth and last "R" process (M)
- Termination

Session 25. Final Review and Termination

[a]We have designated subtopics in this table as promoting resource building (R), trauma processing (T), or mourning (M), as appropriate. Some subtopics contribute to addressing more than one of these components. Subtopics without those designations contribute to the development and flow of the treatment. Although the topics are presented according to the sample 25-session treatment plan on this book's website, therapists may select any topics and subtopics that are relevant to a client's treatment.

does not need all aspects of the treatment. However, some of these topics must be addressed before others. Most important, resource building must precede trauma processing, unless you determine the client has the necessary resources to commence with exposure work. In addition, the six "R" processes build upon one another, and the trauma-processing and resource-building work provides the foundation for movement through the six "Rs." Again, the sample session format described in Table 9.2 can be used to address any of these topics.

CLINICAL INTEGRATION

"Hi, Emily. I'm glad to see you back this week." Dr. Sandra Roberts had been working with Emily for just 2 weeks, and she had been unsure whether Emily would return. In their first session, Emily had mentioned being in therapy on several occasions throughout her life and feeling that these therapies had not helped her move through her grief. Why couldn't she just forget the terrible images and smells that intruded on her days and nights? Sandra was hoping Emily would feel optimistic about this new therapy, but she also understood that Emily might be reluctant to expect further change.

Emily launched right in. "You asked me last week what I saw and what I experienced when I found my father dead all of those years ago. You seemed interested in the details. I think about these details often, even now. But I have rarely talked about it. It just always seemed so taboo, and so gruesome, you know?"

Sandra nodded.

"I felt something like relief when you asked me that," said Emily. "I know there's fear there—fear about going into these details, but also relief."

"Well, as I said, I'm glad you're here, and I think you're brave for seeking help in the midst of your fear. Today I'd like to talk about what I think we can do together. I'd like to give you an overview of the treatment plan I have in mind. Does that sound OK to you?"

This time it was Emily who nodded. Sandra continued:

"As you know, at a very early age you experienced a traumatic death. You were left to deal with the loss of your father and the grief that resulted from his sudden absence. This is a lot for a little girl to deal with." Emily was listening attentively as Sandra spoke.

"Mixed in with that was the fact that the experience of finding your father hanging in the garage was traumatic. What I mean by that is that it probably evoked a reaction of shock and horror. It was a scene that was so unexpected—so far outside any framework of understanding that you may have had—that it probably felt pretty unreal. On the other hand, I imagine there was a way in which it was all too real. That is, the sights and smells and your own bodily sensations as you took this in were all in high focus."

Emily felt a wave in her stomach as Sandra described the scene as being "all too real." She became more fidgety in her seat and found that her voice cracked as she tried to speak. "I can remember it pretty vividly. I feel anxious hearing you talk about it—anxious in the way I described last week. Sometimes this anxiety comes up out of nowhere. Right now it feels connected to what you are describing."

"You seem very connected to your experience, and you're able to articulate it. That's great, and it will be helpful as we move forward. I think what you have experienced all these years is *traumatic bereavement*: symptoms, feelings, and a state of

being resulting from a combination of loss and trauma, or from a death that was also traumatic in its circumstances. Does that make sense to you?"

"It does," said Emily.

"I think you've done a lot of grieving for your dad over the years, and you've probably done less work with the traumatic aspects of your experience of his death. If we can work on processing some of the trauma, we may find that the mourning work we do together is different from the work you've done in previous therapies. By also focusing on the traumatic aspects of your experience, the process of mourning your father may go deeper or beyond where you've been so far, and it may feel more complete. That's the idea of this treatment approach, and if you're on board, I will lead you through some exercises designed to process both your thoughts and feelings about the trauma. Along the way, we'll continue to move through the process of mourning your father in steps that I'll introduce during our sessions. My hope is that we will be able to assess where there might be obstacles along your path and to address these obstacles in a way that frees you up. At times, it will be difficult to do this work, but I'll make sure you have the resources and coping strategies to get through it." Sandra looked directly at Emily and asked, "Do we have a plan?"

"We have a plan," said Emily, and from there they launched into the therapy.

CONCLUDING REMARKS

As Emily's case illustrates, traumatic bereavement differs from the experience of losing a significant other to a death that stems from natural causes. Furthermore, as we have stated throughout this chapter, traumatic bereavement is more than the sum of loss and trauma. It is a unique phenomenon, marked by characteristics that include existential crisis, the taxing of an individual's resources, and pervasive and persistent symptoms and problematic adaptations.

Based on research with this population, relevant theoretical information, and our own clinical experiences, we have designed a treatment approach to address traumatic bereavement. Emily's therapist, Sandra, described this approach well: It focuses on assessing obstacles along the path of moving through mourning and addressing these obstacles by first shoring up resources, and then processing the trauma on both the cognitive and emotional levels. This treatment approach addresses the particular obstacles to mourning that a traumatic death presents.

We hope that the theoretical information in Parts I, II, and III paints a comprehensive picture of the experience of traumatic bereavement while pointing to treatment implications, which are then detailed in Parts IV and V. Our intention is to support you, our readers, in your work with traumatically bereaved clients, offering knowledge and tools that you can integrate with your own talents and style of psychotherapy.

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