INTRODUCTION

On the morning of September 11, 2001, people the world over were riveted by breaking news of seemingly impossible events: simultaneous terrorist attacks, using three hijacked commercial airliners, on the World Trade Center in New York City and the Pentagon in Washington, D.C. As America awoke to the devastating reports on television and radio, the drama continued to unfold, until a fourth jetliner filled with passengers crashed into the earth in rural Pennsylvania, apparently falling short of its intended political target. In the subsequent hours, days, and weeks, the terrible cost of the terrorist acts continued to mount, with a death toll exceeding 3,000 people, who only hours before the attacks had begun their day’s work or travel unaware that it would be their last. Some of the losses touched Americans with particular poignancy, such as the tragic deaths of hundreds of New York City firefighters and police officers struggling in and around the damaged towers to evacuate survivors, who themselves were buried in the rubble of the collapsing structures. As the grim day ended, a nation and world community mourned the terrible loss of life.

Immediate images and subsequent reports of the attacks symbolized both the personal and universal dimensions of catastrophe: scenes of individuals falling from windows 100 stories above the earth, contributing to mortality statistics tallying the deaths of citizens of more than 80 nations literally spanning the globe. And these deaths were only the most evident and anguish of an unforeseeable range of losses—of health, livelihood, security, and much else—that would ripple through families, businesses, communities, and whole cultures in the months and years to come.

The traumatic losses entailed by this attack draw attention to the frailty of human life, as well as the obvious and less than obvious impact of loss of life on survivors. This issue of Innovations focuses on the immediate and long-term effects of bereavement. Although untimely and violent deaths pose special challenges for the bereaved, even the anticipated death of a loved one can shake our emotional world, and produce surprising aftershocks. The emotional impact of such losses can be compounded by the misunderstanding, blame, or simple inattention of other people in institutional care settings, the family, workplace or community, adding a burden of private anguish, secrecy, or shame for those whose mourning is “hurried up,” disallowed, trivialized, or unrecognized by those around them.

SYMPTOMS AND SIGNIFICANCE

The loss of an intimate attachment relationship through death—even when the death is non-traumatic by objective criteria—poses profound challenges to our adaptation as living beings. In part as an expression of an evolutionary heritage shared with other social animals, we respond to such separation with a suite of seemingly hard-wired reactions, including weeping, behavioral disorientation, and yearning for the lost attachment figure. Moreover, these grief-specific responses are commonly paired with predictable physiologic symptoms, including shortness of breath, tachycardia, dry mouth, sweating, frequent urination, digestive disturbance, and choking sensations. Taken together with other symp-
toms, such as restlessness, increased muscular tension, and insomnia, these responses can be understood as part of a broader pattern of sympathetic arousal in response to the stress of separation. Although large-scale longitudinal research indicates that the majority of bereaved persons cope effectively with these acute symptoms of distress, as many as 40% display prolonged signs of neuroendocrine disturbance and sleep disruption, as well as diagnosable anxiety or panic syndromes during the first year of bereavement. Thus, the basic biologic impact of loss can be profound, and for a significant minority of the bereaved, sustained.

As critical as these psychophysiological responses to loss are, the pervasive effects of bereavement can only be appreciated if distinctively human levels of disruption and adaptation are given equal consideration. This expanded focus shifts attention from symptoms to their significance, from basic biological reactions to subtly psychological ones. Within this broader view, grieving individuals can be viewed as struggling to affirm or reconstruct a personal world of meaning that has been challenged by loss. This constructivist shift—evident across cutting-edge developments in bereavement theory, research, and practice—places emphasis on the apparently ubiquitous human tendency to organize experience in narrative form, to construct accounts that “make sense” of the troubling transitions in our lives by fitting them into a meaningful plot structure. Major losses, however, undercut our efforts to maintain a coherent self-narrative, as the significant others on whom our life stories depend are cruelly removed. These losses prompt substantial revisions of our daily and long-range goals if our lives are once again to achieve a measure of predictability and hoped-for direction. Moreover, the losses of those who have been the intimate witnesses to our past—our spouses, parents, siblings, or long-term friends—can undermine even our basic self-definition, because no one any longer occupies the special relational stance toward us needed to call forth and validate the unique fund of shared memories that sustains our sense of who we have been. Thus, the death of a spouse at the point of retirement, perhaps after a protracted period of caregiving in the face of chronic illness, confronts the partner with more than symptoms of separation distress, as important as these are. This relatively “normal” form of bereavement also introduces the need to reorganize the daily plot of the survivor’s life, to relinquish jointly formulated post-retirement plans that promised to structure the remaining chapters of their life-narrative, and to recruit new social validation for the survivor’s characterization of who he or she is beyond the marital role relationship. In all of these senses and more, bereavement therefore prompts us to “relearn the self” and “relearn the world” in the wake of loss.

Some indication of how difficult these biologic and psychosocial disruptions can be is provided by evidence of a 40% to 70% increase in mortality in surviving spouses in the first 6 months of bereavement. Much of this elevated risk is attributable to myocardial infarction and congestive heart failure, as the bereaved, literally as well as figuratively, die of “broken hearts.” However, other contributors appear to be psychologically mediated, as reflected in increased use of alcohol and consequent cirrhosis of the liver, as well as a 10-fold increase in suicide for women and an alarming 66-fold increase in self-inflicted death for men in the first week of bereavement. Understanding the factors that contribute to these tragic outcomes, therefore, becomes a high priority for researchers and practicing professionals alike, one that is all the more compelling when the challenges of coping with loss are amplified by the traumatic circumstances that surround it.

TRAUMA AND THE CRISIS OF MEANING

When the circumstances of a loved one’s death are traumatic (as in cases of death through homicide, suicide, or disfiguring accident) or when the loss itself violates the “natural order” (as in the untimely death of children or young adults), then additional challenges to the survivor’s adaptation arise beyond those associated with bereavement per se. As with the basic impact of bereavement, these can be observed on both biophysical and psychosocial levels. Exposure to the traumatic loss of life, whether through immersion in the mass destruction wrought by the terrorism of September 11th or through the discovery of a loved one’s body following a completed suicide, floods the brain with neurotransmitters, “stamping in” vivid sensory memories of the event. Unlike our typical “declarative” memories, however, those associated with trauma frequently take the form of frag-
mented or dissociated images, sensations, and emotions—the spilling of blood, the smell of burning flesh, a sense of horror and helplessness—which reside at the level of the amygdala, relatively unmediated by the conscious control exercised by the neocortex. In an evolutionary sense, the propensity to have this entire flood of traumatic memories triggered by exposure to subsequent similar stimuli (a loud explosion, the smell of smoke, a scream) can be considered adaptive, providing a rapid appraisal system for identifying and avoiding threat. However, when this system is triggered by events that have only a slight resemblance to the instigating trauma, the result is a chronically hyperaroused limbic system and susceptibility to intrusive memories alternating with attempted avoidance.

Framing these physiologic effects in constructivist, meaning-making terms can help suggest healing interventions, as explored below and elsewhere in this issue. In this view, traumatic memories constructed under conditions of high arousal are “pre-narrative,” consisting of unintegrated sensations and perceptions, which can persist in virtually unaltered forms for years or even decades, resisting incorporation into the conscious “master narrative” of our lives. Three years after his chronically depressed wife committed suicide by placing a gun in her mouth and pulling the trigger, for example, the husband who found her crumpled body on the bathroom floor complained of the unaccountable smell of blood and gunpowder overtaking him in unlikely places. Significantly, such sensations are “packaged” together with the overwhelming feelings of fear, anger, and guilt with which they were originally coupled, forming an unmetabolized “emotion scheme” that requires arousal, reprocessing, and narration in therapy. Becoming conscious of one’s own symptomatic arousal (e.g., building panic) in the face of trauma cues permits the development of self-soothing responses, and the gradual construction of a more adequate account of the experience that gives it meaning for self and others. Although preliminary, studies of combat veterans and survivors of mass murders suggest that the elaboration of meaning regarding traumatic life experiences plays a critical role in mitigating continued symptoms and fostering subsequent adaptation.

A second difficulty with accommodating traumatic loss arises not at the above level of “emplotting” traumatic events, fitting them into the story of our lives, but at the level of the underlying thematic structure on which our self-narrative depends. Viewed from this perspective, tragic losses invalidate the basic “core constructs” or “assumptive world” on which we rely. Our taken-for-granted senses of security, predictability, trust, and optimism are profoundly and perhaps permanently undercut by the traumatic experience. As one psychotherapy client formulated it after a life-threatening assault, “I feel like I’ve lost my innocence. I used to believe that people were basically good, and that God was watching over us. But now I know that the world is filled with predators, and no god is going to protect us.” Not only does the invalidation of abiding beliefs strip away the illusory assumptions that once sustained us, but it also poses profound challenges to our sense of self-continuity over time. A bereaved mother exemplified this after the death of her only child from sudden infant death syndrome (SIDS), saying, “It’s like I don’t even know who I am anymore. I can’t seem to get back to who I was, and I don’t know if I can live with the person I have become.” The challenge of grief counseling is therefore not only to help people understand and manage their troubling emotional and physical symptomatology in the wake of loss, but also to assist them in reconstructing a meaningful narrative of self and world, at psychological, social, and even spiritual levels.

THE ASSESSMENT OF COMPLICATED GRIEF

Many survivors of apparently traumatic loss do not develop traumatic grief symptomatology, whereas approximately 15% of nontraumatically bereaved persons do. Diagnosis therefore requires an assessment of subjective reactions to loss, rather than only the objective circumstances of the death considered in isolation. Jacobs and colleagues have identified complicated grief as a cluster of symptoms that include yearning for the deceased, extreme loneliness, intrusive thoughts about the death, feelings of numbness and disbelief, and a fragmented sense of security and trust, which is associated with impaired functioning, sleep disturbance, and low self-esteem. Although survivors of objectively traumatic losses are at special risk for experiencing such symptoms, it is important to emphasize that even
individuals experiencing such normative losses as the death of a parent in mid-life, or the death of a spouse in later life can also respond in this fashion, particularly if the new loss touches on old wounds, such as a complicated history of abandonment or other mental health liabilities, like prior anxiety or depressive disorder. Provocatively, research also has found that this coherent cluster of responses is relatively independent of depression and anxiety, and does not remit even with successful psychotherapeutic or pharmacologic treatment of these psychiatric symptoms. It therefore could merit separate diagnosis and intervention, insofar as the perpetuation of traumatic grief responses 6 months after the loss has been found to predict susceptibility to serious health risks in the future, including cardiac disorders, increased substance abuse, suicide ideation, and some forms of cancer.

Table 1, the “clinician’s toolbox” presents diagnostic criteria for complicated grief, adapted from consensus criteria arising from major programs of research on adaptation to traumatizing loss. Importantly, several of the most significant predictors of subsequent risk (disbelief, meaninglessness, inability to project into a valued future, loss of identity, and shattered worldview) explicitly refer to the effort to accommodate the loss into the plot and themes of one’s pre-existing life-narrative. Identifying bereaved persons who are struggling unsuccessfully to make existential sense of the loss in these terms can permit appropriate matching of therapy to the client’s needs, insofar as these at-risk grievers seem to be uniquely responsive to grief therapy. Although some of the specialized services described below are the province of trained professional and paraprofessional grief counselors, health care workers of many disciplines can play a crucial role in identifying bereaved individuals to whom such services might be offered.

WHAT CAN BE DONE

Although outlining a treatment manual for complicated grief is beyond the scope of this brief editorial, some general pointers can be offered to guide intervention efforts. Just as tragic loss—especially when widespread as a function of terrorism or natural disaster—presents multifaceted challenges to individuals, families, or entire communities or nations, the response to such catastrophes calls for the involvement of many helping professions and institutions. Indeed, the selfless efforts of countless hospice counselors, nurses, therapists, physicians, and other first responders in the wake of the World Trade Center and Pentagon tragedies provided evidence of our compelling need as professionals and as people to offer help and solace to those whose lives are devastated by tragedy. The following recommendations, though far from exhaustive, are intended to illustrate the range of interventions that might be offered to address more adequately the needs of those suffering from traumatic bereavement.

- **Provide practical assistance.** Beyond the obvious medical care required by those injured in horrendous death scenarios like those associated with the September 11th attacks, grieving families can benefit from a carefully coordinated “first response” effort on the part of helping professionals and organizations. Although the jury is out on whether popular debriefing protocols are more helpful than they are harmful, it is clear that families visiting cities where their loved ones were killed or seriously injured benefit from being given practical assistance in finding accommodation, being provided with guides, and transportation

<table>
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<tr>
<th>Criterion A:</th>
<th>Death of significant other</th>
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<td>Intrusive, distressing preoccupation with deceased</td>
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<td>Efforts to avoid reminders of deceased (thoughts, people)</td>
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<td>Purposelessness and futility about future</td>
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<td>Numbness, detachment, no emotional responsiveness</td>
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<td>Feeling stunned, dazed, or shocked</td>
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<td>Disbelief, difficulty acknowledging death</td>
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<td>Feeling that life is empty or meaningless</td>
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<td>Difficulty imagining fulfilling life without deceased</td>
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<td>Feeling that a part of oneself has died</td>
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<td>Shattered worldview (lost sense of control, trust)</td>
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<td>Assumes harmful symptoms of deceased</td>
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<td>Excessive irritability, bitterness, anger</td>
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**Criterion B:** In response to death, marked and persistent symptoms of:

- Numbness and detachment, no emotional responsiveness
- Feeling stunned, dazed, or shocked
- Disbelief, difficulty acknowledging death
- Feeling that life is empty or meaningless
- Difficulty imagining fulfilling life without deceased
- Feeling that a part of oneself has died
- Shattered worldview (lost sense of control, trust)
- Assumes harmful symptoms of deceased
- Excessive irritability, bitterness, anger

**Criterion C:** Duration of disturbance ≥2 months (6 months better)

**Criterion D:** Significant impairment of social, occupational, or other functioning

- **Best performing items.**
in an unfamiliar town, and afforded opportunities for collective and private ritualization of their losses. Enhancing survivors’ sense of support and control (e.g., by granting them the “space” to plan their own onsite memorials) can help mitigate the helplessness and hopelessness that often follow traumatic loss. Many of these services can be provided by trained and supervised paraprofessionals, as was demonstrated by the invaluable assistance of volunteers from Cruse, the U.K.-based bereavement support organization, given to families of the 200 British citizens killed in the World Trade Center. However, it is worth bearing in mind that, in a society in which the impact of traumatic loss is widely dispersed by the geographic mobility of families and the universal reach of the media, significant needs for emotional support can arise for children and adults distant from the site of the tragedy. Thus, many hospices across the United States appropriately offered support services to schools and community groups distressed by the September 11th attacks, which even though geographically remote, touched people with a sense of profound immediacy.

- **Build bridges, not fences.** Response to mass tragedy calls for cooperative rather than territorial relationships among helping agencies. Organizations such as the Red Cross have a long history of coordinating with government and medical institutions, and are well situated to offer immediate medical and psychosocial interventions in the wake of catastrophic loss. But large-scale tragedies similar to those that unfolded in New York, Washington, or Oklahoma City require that appropriate roles be played by many relevant groups, from the National Organization for Victim Assistance to specialized bereavement services such as The Compassionate Friends. Most hospices also have an explicit mission to provide outreach grief education to the communities they serve, and could play a supportive role in response to crisis. One tangible step toward doing so might be the hosting of community-based “networking luncheons” at regular intervals, in which professionals and staff of several relevant organizations might become familiar with their respective strengths, services, limitations, and referral options, and collaborate to formulate a plan for possible crisis response in their community.

- **Screen for complications.** Even in cases of horrific loss, it is not clear that grief therapy will be needed by all those touched by the tragedy. Indeed, indiscriminate provision of grief counseling to the bereaved might actually be counterproductive for those without clear signs of being at risk for complicated adjustment.26 However, early “point of impact” screening for such adverse reactions as elevated suicide risk is indicated to permit timely referral to appropriate psychological and psychiatric services. Equally important, but more logistically challenging, is the implementation of a second round of screening for marked symptoms of complicated grief four to six months following the tragedy, insofar as many bereaved persons will display such symptoms in the immediate aftermath of loss, but only a subset of these will continue to report high levels some months later. At a minimum, health or mental health workers approached by bereaved persons several months after a tragedy should be alert to the presence of such signs, and in the ideal case, public service announcements or outreach services could publicize such risk markers and offer further screening and support to those still struggling with them.

- **Train for trauma.** Unfortunately, the helping professions in general are poorly prepared to assist people dealing with traumatic loss. Even those helpers trained to offer bereavement support are rarely equipped to do so, insofar as they receive little instruction or practicum experience in dealing with non-normative bereavement, the special challenges of traumatic intrusions, and other distinctive features of stress response syndromes. Likewise, the emerging field of traumatology remains customarily naive about recent research, scholarship, and practice in the field of bereavement, instead trading on older and largely discredited models of grief as a predictable series of emotional stages of adjustment to loss. What seems called for is combining the expertise of relevant professional associations such as the International Society for Traumatic Stress Studies (ISTSS) and the Association for Death Education and Counseling (ADEC), to train health and mental health caregivers so that the latter can appropriately “phase in” interventions to address trauma mastery and grief work, depending on their prominence, for the traumatically bereaved patients they serve.
Take the longer view. Implicit in the call for longer term screening is the call for longer term services. Unfortunately, although crisis intervention is often necessary in the wake of traumatic loss, it is often insufficient. Many features of traumatic loss, including the frequent occurrence of violence, mutilation of the body or bodies, the number of lives lost, perceptions of preventability, and assumptions of human malevolence in cases of homicide all assault the assumptive worlds of survivors, and confront them with traumatic imagery of events that are difficult to assimilate into a coherent life narrative. It follows that the profound and idiosyncratic responses to such losses will not be adequately addressed in a few sessions of psycho-educational debriefing to “normalize” posttraumatic symptomatology. This is not to say that there is not a vital role to be played by suitable time-limited group work, however.

Foster the development of healing stories in the wake of loss. Ultimately, empathically listening to the narratives of loss shared by the bereaved and offering opportunities for new meaning-making are at the heart of bereavement support. Although some specialized skills for fostering this narrative elaboration in the wake of traumatic disruption will be the province of more highly trained grief therapists, nearly all professionals and volunteers who work with the bereaved can make an important contribution to this effort. For example, many hospital-based perinatal bereavement programs offer grieving parents precious mementos and photographs of their babies’ brief lives, which can then become a prompt for consolidating memories and accounts of the children’s existence in later storytelling by the parents in the presence of other listeners. Likewise, both volunteer and professional counselors can draw on a large and creative fund of reflective writing applications, to help the bereaved individual explore the biography and life imprint of the deceased loved one, to tease out the implications of the death for the survivor’s sense of identity, to maintain a comforting continuing bond beyond the separation imposed by death, and make use of poetic and metaphorical forms of self-expression to learn the “lessons of loss” in a way that enhances, rather than reduces the life that must now be lived. Recent research has consistently pointed to the beneficial role of such personal, evocative journaling in adapting to traumatic life events, as well as to the impressive “posttraumatic growth” shown by many bereaved persons as they realign life priorities, affirm core human values, and find a progressive sense of meaning and purpose in a life story shaped by tragic loss. Moreover, this growth is frequently observed at collective as well as individual levels, as different professionals, organizations, and communities construct cooperative relationships as they work together to meet the needs of those most grievously affected by the loss.

TRANSLATING THESE RECOMMENDATIONS TO BEREAVEMENT INTERVENTIONS

As noted earlier, the experience of the loss of a loved one can be traumatic regardless of the cause of death. For this reason, as well as the pragmatic recognition that bereavement interventions cannot always be targeted to the exact nature of the loss, it is valuable to point to the ways that these suggestions for dealing with people suffering from traumatic loss can be applied more broadly. In the following interview, Drs. Irwin Sandler and Tim Ayers of the Prevention Research Center at Arizona State University describe the design and implementation of the Family Bereavement Program, a psycho-educational intervention—separate but complementary courses for children and surviving parents—for families in which a parent has died. The cause of death was heterogeneous in their sample of 90 families (135 children, adolescents, and their caregivers). Some of the deaths were from drug overdose, suicide, or accidental causes, while others were from anticipated causes such as terminal illness.

The Family Bereavement Program shows that there can be great benefit in organizing group support for families sharing the trauma of losing their previous family constellation, even when the circumstances that led to death are diverse. A brief overview of the design of their program demonstrates attention to a number of the aforementioned recommendations. Sandler and Ayers’ Family Bereavement Program weaves a narrative thread through the children’s program. In the first session, the children tell the stories of their parent’s deaths. The curriculum explicitly builds skills and vocabulary through weekly grief discussions and so gives the children words to
name their experience and begin to restructure
their self-narratives in the face of this loss. At the
end of the course, children create lessons, in
which they teach others what has been most help-
ful. This attention to narrative and meaning is
complemented by practical assistance to families,
such as providing meals and help with logistics
of getting to the sessions. Last, the intervention
teaches parents and children a highly structured
set of communication, listening, and problem-
solving skills that aim to foster more stable and
predictable family life. By focusing on common
concerns and needs of young families who have
lost a parent, carefully planned group interven-
tions of this kind can offer opportunities for heal-
ing (e.g., through cultivating new familial activi-
ties such as family time), empowerment (e.g.,
through meeting the challenges of constructing
effective discipline strategies for single parents),
and exploration of the developmentally distinct
responses to loss of different family mem-
bers. Such interventions also accord with newer
models of adaptation to bereavement, which
recognize the necessity of the oscillating “dual
processes” of experiencing and working on the
grief, on the one hand, and orienting behaviorally
to a changed world, on the other.32

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Response*

IRWIN N. SANDLER, Ph.D. and TIM S. AYERS, Ph.D.

Robert Neimeyer’s editorial1 generated a number of reactions in us that we think help clarify what we are trying to accomplish in the Family Bereavement Program. We agree that one of the important aspects of the program is that it provides an opportunity for children and adolescents to develop narratives around their grief experiences. The grief discussions in each of the child and adolescent sessions provide opportunity and support for children to discuss their feelings and experiences. A particularly important exercise occurs in the sixth session when the children share a memento of their deceased parent with their caregiver who uses her/his best listening skills to hear the child’s story of why this memento is particularly meaningful for them.

We believe that the opportunity to tell their stories and share their experiences is fundamentally important for children’s healthy grieving. It is important to note that we do not think that it is necessary for everyone to actually talk about their feelings, or to do so in the same way. We think that there are two sources of the positive impact of children having the opportunity to share their grief stories. First, it relieves children of the pressure and the work of “inhibiting” expression of their stories, of hiding what they are feeling and thinking. There is interesting emerging evidence, including studies from our own Center, that the inhibition of expression of feelings that people want to express has detrimental effects on their mental and physical health. Second, the positive impact on children of sharing stories derives from strengthening their relations with others. People have a need to feel a sense of belonging to a caring network of others, and there is no more powerful path to belonging than feeling that others understand your deeply held feelings. One of the important positive effects of the Family Bereavement Program is that it strengthens children’s feeling that their parent or caregiver understands their grief-related feelings. Thus, we think that the healing power doesn’t come from simply expressing feelings, but from relieving the pressure to hide or inhibit expression of feelings that children want to express, and the feeling that others really understand their feelings.

While the Family Bereavement Program is consistent with many of the insights and recommendations made by Dr. Neimeyer, the program adds a focus that sometimes does not receive the attention it deserves: strengthening the processes of adapting to the changed world children live in after their parent has died. Children’s worlds change in dramatic ways following the death. Not only do they suffer the loss of this intimate relationship, but there may be multiple other changes...