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Traumatic Bereavement: Basic Research and Clinical Implications

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Losing a loved one suddenly or under traumatic circumstances often leaves survivors completely overwhelmed, their lives fundamentally changed. Survivors experience what is termed *traumatic bereavement*, which is associated with enduring symptoms of trauma, such as intrusive thoughts, and of grief, such as yearning for the loved one. Research has found that in most cases, the symptoms associated with traumatic loss are significantly more intense and prolonged than those following a natural death. They are also more pervasive, affecting virtually all aspects of the survivor's life. Moreover, it has also been found that survivors of traumatic loss often have difficulty accepting what has happened, struggle with issues surrounding responsibility and guilt, question their religious beliefs, worry that their loved one may have suffered, and live in fear that they or someone in their family will also die. In this article, we review basic research on the domains of life affected by a traumatic loss and the risk factors that heighten survivors' vulnerability to traumatic bereavement. We then describe a comprehensive treatment approach, which is based on the available research on traumatic bereavement, specifically developed for survivors of sudden, traumatic loss. The treatment involves 3 critical components: building resources, processing trauma, and facilitating mourning.

Keywords: risk factors associated with traumatic bereavement, trauma and loss, traumatic bereavement, traumatic grief, treatment of 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 abandonment that she experienced, growing up fatherless, and grieving for all she had lost. Although she improved 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 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.

The goal of this article is to provide an overview of the research literature relevant to traumatic loss, such as the one Emily experienced, and to describe a comprehensive treatment approach specifically developed for such losses. A death is considered traumatic if it occurs without warning; if it is untimely; if it involves violence; if there is damage to the loved one's body; if it was caused by a perpetrator with intent to harm; if the survivor regards the death 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 deaths typically regarded as traumatic include those in which the survivor witnessed the death; those in which the mourner is con-

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The majority of topics addressed in this article receive more detailed coverage in the book *Traumatic Bereavement: A Practitioner's Guide*, published by Guilford Press (Pearlman, Wortman, Feuer, Farber, & Rando, 2014). All case examples in this article are excerpted from therapy sessions discussed in the text.

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fronted with multiple deaths; and those in which the survivor's own life is threatened. Following a traumatic death, a survivor may experience what we term *traumatic bereavement*, which is associated with enduring symptoms of both trauma and grief. Deaths most likely to precipitate traumatic bereavement include accidents, disasters, homicide, suicide, and military combat. According to the *National Vital Statistics Report* (Heron, 2012), sudden, traumatic deaths are the most prevalent type of death in all age groups younger than 44. For example, individuals between ages 15 to 19 are approximately eight times more likely to die in an accident, and six times more likely to die as a result of homicide or suicide, than to die from cancer, the leading cause of natural death in this age group.

As traumatically bereaved survivors attempt to pick up the shards of their lives and move forward, what lies ahead for them? In most cases, mourners' defenses are completely overwhelmed. As one person expressed it, "It was as though someone cut my insides out." As is the case with deaths stemming from natural causes, survivors typically experience all of the sadness and emptiness associated with grief. They are likely to yearn for their loved one and feel that a part of them has died. In the case of traumatic bereavement, however, grief symptoms are overlaid with trauma symptoms. In fact, because the impact of a sudden, traumatic loss is so devastating, it frequently results in symptoms of posttraumatic stress disorder (PTSD), such as flashbacks, sleep difficulties, and concentration problems. Thus, survivors face the dual task of mourning the loss and coping with the trauma that accompanied the death. Following a traumatic loss, survivors' symptoms are typically more intense and long-lasting than those following a natural death. Sadly, it is common for survivors to struggle with the consequences of the loss for many years, if not for the rest of their lives.

Persistent and Pervasive Effects of Traumatic Death

In the 1980s, the second author conducted a study on the long-term psychological impact of losing a spouse or child in a motor vehicle crash. Interviews were conducted with people 4 to 7 years after the death of their spouse or child, as well as with control respondents who had not lost a loved one (Lehman, Wortman, & Williams, 1987). Interviewees who had lost a loved one evidenced higher rates of mortality than people with no such losses. They also evidenced higher depression, more apprehension that another loved one may die, and comparatively lower quality of life. In addition, they reported problems at work, and more problems dealing with surviving children. Those who lost a child reported greater stress in their marriage and were more likely to divorce compared with the controls, whereas those having lost a spouse reported higher levels of loneliness. More than 90% of bereaved respondents reported that they still experienced painful intrusive thoughts.

These findings have been replicated and extended by other researchers. In a study of the impact of losing a child through accident, suicide, or homicide, Murphy, Chung, and Johnson (2002) found that five years after the death, a majority of mothers and fathers were experiencing significant mental distress and PTSD symptoms. They also continued to reexperience images of their child's death (Murphy, Johnson, Chung, & Beaton, 2003). Because friends, relatives, and even therapists are often unaware of the enduring impact of traumatic loss, they may convey to the bereaved that they should be adjusting more quickly. In fact, the bereaved themselves often mistakenly regard their continuing distress as a sign of personal inadequacy or coping failure (Lehman et al., 1987).

Core Issues

Survivors of traumatic deaths are faced with a host of troubling issues that are typically not present following a natural death. They not only have to contend with the harrowing death of their loved one, but with the *shattering of their most basic life assumptions*. These include assumptions that the world is predictable and controllable; that it operates according to principles of fairness and justice; that one is safe and secure; and that, generally speaking, other people can be trusted (Janoff-Bulman, 1992).

It is common for survivors of traumatic loss to have *difficulty accepting the death,* which can hinder the commencement of mourning. This was the case for respondents in the previously described study by Lehman et al. (1987). Even though the crash had occurred 4 to 7 years previously, a substantial minority of respondents—

about 40%—reported that they sometimes felt that the death was not real and that they would wake up and it would not be true.

Most survivors of traumatic loss report that, at some point, they attempted to *make sense of*, or find *meaning* in their loved ones' deaths. However, in many cases, mourners are not able to do so (Wortman & Boerner, 2011). The grieving process is especially painful for those who search for meaning, but are unable to find it, as compared with those who are able to find meaning in their loss (Davis, Wortman, Lehman, & Silver, 2000).

It is common for practitioners and laypeople alike to believe that religious or spiritual beliefs may facilitate coping with loss (Wortmann & Park, 2008). The belief that the loved one is in a better place or that the mourner will be reunited with the loved one may provide solace. However, it is also common for survivors to *question their faith*, and sometimes to abandon it altogether. Wilson and Moran (1998) maintained that following the traumatic death of a loved one, "God is viewed as absent from a situation which demanded divine concern, divine protection, and divine assistance" (p. 173).

Many survivors of traumatic loss experience powerful *feelings of guilt*, even when they are not at fault (Davis, 2001). For example, a year after one woman relocated her family for employment, her 13-year-old son was killed while riding his bicycle. "If we had not moved, he would still be alive," she said. In addition to their own feelings of guilt, survivors are frequently subjected to blame from others (Rudenstam, 1987).

Most survivors of traumatic loss experience troubling *rumination* (Aldao & Nolen-Hoeksema, 2010) over whether their loved one suffered at the time of death. Did they know that they were going to die? Did they experience intense fear or terror? Such ruminations are most prevalent following deaths that are violent or involve damage to the loved one's body. As one father expressed to his therapist, "I have nightmares about how my son struggled with his killer."

Domains of Life Affected

The Nuclear Family

Family relationships that were rewarding before the death may become strained after the loss (Wortman & Boerner, 2011). Consider a case in which a man was killed in a helicopter crash, leaving behind a wife and adolescent son. The son may deeply miss his father's involvement in his sports activities and may become resentful that his mother does not attend his games. His mother may erroneously assume that her son understands the realistic demands placed on her following her husband's death.

Following a traumatic death, most people report a dramatic change in the atmosphere at home (Finkbeiner, 1996). As one mother explained after the death of her teenage son, "He would always walk through the door laughing and joking, often with some of his friends. Now all I hear is silence, and it kills me." As family members struggle with their own anguish, there may be a contagion of negative affect that can intensify each person's grief (Rando, 1993). After a relatively good day at work, for example, one husband plummeted into despair when he returned home to find his wife sobbing.

Marriage or Primary Partnership

The death of a child places strain on even the best partnerships (Lehman et al., 1987; Wortman & Boerner, 2011). For example, discord may arise if one partner feels the need to talk about their child, whereas the other partner prefers to keep feelings inside. As one husband explained it, "When my wife talks about the day our daughter died, I know she is only trying to make sense out of it. But it literally makes me nauseated, and I have to leave the room." Further, spouses often report that they feel "shut out," and are at a loss as to how to establish the closeness that they enjoyed previously (Mehren, 1997).

Parenting

According to Glazer, Clark, Thomas, and Haxton (2010), the death of a partner leaves a surviving parent with numerous problems. For instance, Marlene, the mother of four young children, lost her husband in an airplane crash. Before his death, her spouse was the primary breadwinner and participated fully in parenting and household activities. After his death, Marlene was devastated financially and had problems being emotionally available to her children. Like others, Marlene had difficulty

sleeping after her traumatic loss, which affected her role functioning.

Surviving parents may worry about the absence of a role model for children of the opposite sex. One widower was concerned about raising his two young daughters alone. "Their mother used to braid their hair and do their nails," he said. Also, parents may have difficulty enforcing consistent discipline, and it is common for parents to become overprotective and place new restrictions on children. Such actions often result in feelings of animosity and resentment (Rando, 1993).

Work

For many survivors, work is a means of maintaining a routine and feeling competent. Upon returning to work, however, they may face serious difficulties with concentration and memory, reducing their ability to function (Tehan & Thompson, 2012). One survivor said, "My boss keeps asking me for the sales projections, but how can I finish them when I keep seeing images of the accident?"

Physiological changes related to PTSD—including hyperarousal, headaches, stomachaches, and sleep difficulties—can lead to problems with tardiness, attendance, and productivity. Consequently, survivors may experience considerable anxiety about their work performance (Pearlman et al., 2014).

Leisure and Recreation

One father said, "As my son was growing up, we went fishing together on countless occasions and always had a great time. Since his death, I have no interest in fishing whatsoever. It would be too painful to be out there without him." Such feelings are likely to emerge around vacations, sporting events, and school functions that family members enjoyed before the tragedy.

Mourners sometimes find it hard to relax while watching TV or films because they never know when they will encounter reminders of their loss (Pearlman et al., 2014). One man whose twin sister was shot in a robbery said, "I can hardly watch anything anymore. Shootings occur all the time on TV and in movies. I can't even watch the evening news."

Social Support

Social support helps people to feel loved, cared for, and understood. Unfortunately, available research indicates that survivors of traumatic loss rarely receive effective support (Dyregrov, 2003–2004). It can be especially difficult if the deceased was the survivor's major source of social support. Further, many mourners have a strong inclination to withdraw socially after the tragedy, thereby cutting themselves off from potentially healing interactions (Dyregrov, Nordanger, & Dyregrov, 2003). Some avoid socializing because they are afraid they will be "wet blankets," while others remain at home for fear that they may encounter a distressing reminder of their loss.

Research suggests that the main reason people do not receive effective support is that others do not know how to provide it (Dyregrov, 2003–2004). Bereaved people report that others frequently avoid them or make comments that are intended to be helpful, but are, in fact, deeply wounding (Dyregrov, 2003–2004). Such comments include blocking discussion of the loss or the display of feelings (e.g., "You need to be strong for your children"), minimizing the problem (e.g., "At least he's not a vegetable"), invoking a religious or philosophical perspective (e.g., "She's a flower in God's garden"), giving advice (e.g., "You should not be going to the cemetery every day"), and claiming to know how the survivor feels (e.g., "I know how you feel—I lost my second cousin"; Dyregrov, 2003–2004).

The bereaved typically find it helpful when others convey a supportive presence (e.g., "I'm here for you"); when they express concern (e.g., "I care what happens to you"); or when they offer tangible assistance, such as help with errands or meals. Most survivors also value opportunities to talk about the loss if they choose to do so (Lehman et al., 1986).

Risk Factors Predicting Poor Outcomes

Research has identified many *risk factors* that increase the likelihood of poor outcomes among survivors of traumatic loss. Some of these relate to the characteristics of the death, such as suddenness. Other factors stem from personal characteristics of the survivor, such as spiritual be-

liefs. These factors often interact and their psychological effect appears to be cumulative.

Factors Related to Characteristics of Death

Accidents. Accidental deaths are those resulting from shootings, falls, drowning, fires, choking, hazards at the workplace, medical malpractice, and most commonly, motor vehicle crashes. We normally think of an accident-related death as constituting a sudden loss. Yet over half of those who die in motor vehicle crashes die while being transported to the emergency room or during the first few weeks of hospitalization (Armour, 2007). For many people, making decisions about removing a loved one from life support, or donating his or her organs, are among the most painful aspects of the loss.

Disasters. Disasters are usually classified as either natural disasters, such as hurricanes; or human-induced disasters, such as terrorist attacks. Survivors are likely to view human-induced disasters as due to callousness or malevolence, and perhaps preventable (Kristensen & Pereira, 2011). Consequently, they may experience feelings of anger toward those they perceive as responsible (Christ, Kane, & Horsley, 2011).

After a disaster, there is usually an agonizing period of waiting before survivors learn that their loved one has died. Depending on the nature and magnitude of the disaster, the body may never be found, or if found, may be mutilated. Powell, Butollo, and Hagl (2010) conducted a study of two groups of wives who had survived the war in Bosnia and Herzegovina, to determine the impact of having a loved one who is missing but not yet declared dead. The wives whose husbands were listed as still missing had higher levels of traumatic grief and more severe depression than the wives whose husbands were confirmed dead.

A major disaster is likely to be covered in the mass media for months and sometimes years following the event. After the 9/11 terrorist attacks, for example, images of the collapse of the twin towers were televised repeatedly. Moreover, the 9/11 victims have been commemorated annually. Publicity of this sort can reevoke feelings of intense distress among survivors (Christ et al., 2011).

Opportunities for social support are often limited when disasters affect the entire community, because most of a person's usual support providers are either deceased or dealing with their own losses. This was true after 9/11, when surviving firefighters and their family members faced the deaths of dozens of their friends and coworkers, reporting that attending multiple funerals was extraordinarily difficult (Christ et al., 2011)

Military combat. Over the past 10 years, the leading causes of death in the Iraq and Afghanistan wars have been hostile actions and accidents, often involving violence and mutilation—factors known to enhance the negative psychological impact on survivors (Harrington-LaMorie & McDevitt-Murphy, 2011). Often, a lengthy separation precedes such a death, which itself may necessitate serving as a single parent, as well as living under the constant threat that the loved one may be killed. These chronic stressors become the backdrop against which the death occurs and must be mourned.

Feelings of resentment that the military did not protect their loved ones are likely to be paramount in cases of military suicide. In 2012, the number of suicides among active duty troops was 349, exceeding the 229 soldiers who were killed in combat that year in Afghanistan (Londano, 2013).

Litz and colleagues (2009) have used the term *moral injury* to refer to the state that military service members can experience after "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (p. 700). These occurrences can lead to social withdrawal, self-harming behaviors, reexperiencing, helplessness, and enduring changes in beliefs about oneself and others.

Suicide. Many practitioners believe that deaths caused by suicide pose greater problems for survivors than deaths that come about through other means (Worden, 2009). Sveen and Walby (2008) examined 41 studies that compared suicide survivors with those who were bereaved in other ways. Few significant differences emerged in symptoms of mental health, such as depression or anxiety. However, differences were found in rejection and shame.

Survivors commonly—in ore than 40% of cases—attempt to disguise deaths by suicide as a drug overdose or undiagnosed illness, among

others (Jordan, 2001). Survivors of a suicide loss are also more likely to blame others, such as therapists, physicians, close friends or life partners of the deceased, as well as blaming one another (Jordan & McIntosh, 2010). For example, a woman whose son killed himself may blame her husband because of the harsh discipline he employed.

Homicide. In contrast to other modes of traumatic death, "Homicide violates every norm about what a civilized society stands for" (Armour, 2007, p. 67). It is typical for survivors to be frightened and confused by the intensity of their rage and their preoccupation with vengeance. Those bereaved by homicide typically exhibit higher levels of PTSD and grief symptoms than survivors of suicide or accidents (Kristensen, Weisaerth, & Heir, 2012). Parents of murdered children are also more likely to show declines in marital satisfaction, and to have more difficulty accepting their child's death, in comparison with parents whose children died of an extended illness (Murphy, 2008).

Factors Related to Personal Characteristics of Survivor

Religion and spiritual beliefs. More than 90% of Americans describe themselves as religious or spiritual (Miller, 2007). Among mourners coping with the traumatic death of their child, 70% identified prayer as an important coping resource (Murphy, Johnson, & Lohan, 2003). Those who belong to a faith community are likely to receive social support from members of their religious community. Further, according to McIntosh, Silver, and Wortman (1993), the more important religious beliefs that were in parents' lives, the more likely they were to find meaning in their children's death. Finding meaning, in turn, was associated with less mental distress and higher marital satisfaction (Murphy, Johnson, & Lohan, 2003).

Relationship with the deceased. Carr et al. (2000) and Carr (2008) assessed elderly respondents before the death of their spouses and again 6 and 18 months later. They found that adjustment to widowhood was most difficult for those whose relationships had the highest levels of warmth and closeness. Those involved in conflictual relationships showed improvement in mental health following their spouse's death. Research has also shown that *excessive dependency* on one's spouse, characterized by overreliance on another person in order to feel secure, is a risk factor for powerful and unabating grief (Rando, 1993).

Childhood adversity. Child abuse or neglect puts adults at risk for poor outcomes after a traumatic loss (Silverman, Johnson, & Prigerson, 2001). Childhood separation, anxiety, and harsh parental control have also been shown to impede adjustment to subsequent loss. These findings underscore the importance of assessing damaging childhood experiences (Vanderwerker, Jacobs, Parkes, & Prigerson, 2006).

Treatment

In developing a treatment approach, our goal has been to bring together the accumulated wisdom and research in the fields of grief and trauma. This approach comprises three critical components: (a) building survivors' internal and interpersonal resources; (b) processing the traumatic death both cognitively and emotionally; and (c) facilitating the process of mourning (see Pearlman et al., 2014 for a more detailed description).

Building Resources

It is essential to help clients build the coping resources necessary for the difficult work of processing the traumatic elements of their loss (Cloitre et al., 2010). According to Saakvitne, Gamble, Pearlman, and Lev (2000), an important resource is the ability to regulate emotion. Emotion regulation is developed by helping the client learn to *recognize* feelings, or sense an emotion as it arises; *tolerate* feelings by being open to experiencing, rather than blocking them; and *modulate* feelings by controlling their intensity so they are not destabilizing.

Other important coping skills for survivors of traumatic loss involve actions taken to manage the demands or painful emotions of a specific situation (Folkman, 2001). One such coping skill is *breathing retraining*: taking slow, deep breaths to alleviate anxiety symptoms. Another coping skill is *self-care*: actions that contribute to one's health, such as eating regular meals, exercising, and avoiding harmful activities, such as overusing alcohol.

Social support is known to reduce the impact of stressful life experiences, including traumatic death, on health and well-being (Murphy, Lohan, Dimond, & Fan, 1998). Evidence suggests that social support can protect survivors from the development of PTSD and other mental health symptoms (Hibberd, Elwood, & Galovski, 2010). Thus, it is important to assess the presence and availability of social support. Determining whether clients are withdrawing from others, and validating clients' experiences with those who avoid *them* or inadvertently make hurtful remarks, is also important (Dyregrov, 2003–2004).

Because potential supporters may not understand how to provide effective support, it can be beneficial to use a procedure developed by Shear, Boelen, and Neimeyer (2011), wherein the client invites a support provider to a therapy session. Issues pertaining to social support can be discussed with both parties, along with psychoeducation regarding appropriate responses to traumatic bereavement.

Another important resource is the ability to deal effectively with *bereavement-specific challenges* (Rando, 1993). These are situations that trigger powerful and often unanticipated feelings of grief. For example, a man whose son was killed may be caught off guard when asked how his son is doing in college. When these situations arise, survivors must deal with their emotional reactions, and decide how to respond. Such intense rushes of overwhelming emotion can lead the mourner to feel he has not made much treatment progress. Clients will benefit from understanding the types of situations most likely to trigger such emotional responses, and planning how to respond when such situations arise. It is vital that therapists and clients alike understand that strong reactions to bereavement-specific challenges are a normal part of the mourning process.

There is accumulating evidence that finding meaning in the loss of a loved one can play a constructive role in mourning (Holland & Neimeyer, 2010). Neimeyer and Sands (2011) contend that the quest to make sense of what has happened can occur at many levels, "from the practical (*How* did my loved one die?), to the relational (*Who* am I, now that I am no longer a spouse?), to the spiritual or existential (*Why* did God allow this to happen? p. 11). It can facilitate the healing process by reinforcing clients' desire to become involved in activities that may aid in finding meaning, such as setting up a memorial scholarship for their loved one (Lewis & Hoy, 2011). However, therapists must take care to not impose their own preconceptions about the need to find meaning. Such a dynamic can create an empathetic disconnection (McCann & Pearlman, 1990), set the client up for failure, and invalidate the client's experience. Therapists should instead follow the clients' lead.

The final coping resource emphasized in this treatment is addressing the client's values and goals. This can help clients regain a sense of purpose. For instance, clients are asked to identify their personal values in domains such as health, parenting, career, spirituality, or service to others (Walser & Westrup, 2007). After determining which value matters most to them at that time, the therapist works with the client to develop a list of concrete goals that will bring them closer to their value. One woman who lost her older son decided that what mattered now was to be the best possible mother to her surviving son. "I arranged a sleepover for my son. I cooked him his favorite dinner. It made me feel good," she said.

Trauma Processing

When the client has developed adequate resources, the second component of the treatment, processing the trauma, can begin. It is important that the trauma be processed on both a cognitive and emotional level. Most treatment studies have involved some sort of Cognitive-Behavioral Therapy (CBT). This approach entails identifying distressing automatic thoughts. These thoughts are typically harsh and extreme, such as, "I'm a failure as a parent," or "people always abandon me." The next step involves challenging such thoughts so that their impact on the client's moods and behaviors is reduced (Wenzel, 2014). For example, a mother who believes she has failed as a parent may be asked to produce evidence that supports and contradicts her belief. Over time, clients learn to monitor and then challenge maladaptive thoughts.

Emotional Processing involves confronting situations, activities, and memories that the client avoids because they trigger painful emotions (Foa, Hembree, & Rothbaum, 2007). This work can be very difficult for clients, and it can

be helpful to provide a rationale for it. Clients can be told, for example, that avoidance of feared thoughts and situations may make them feel better in the moment, but that facing their emotions can provide long-term relief.

A treatment approach called Prolonged Exposure (PE; Foa et al., 2007) combines emotional processing with other techniques shown to be effective in reducing distress. PE has four components: (a) psychoeducation about trauma and PTSD; (b) breathing retraining; (c) imaginal exposure—clients are asked to develop a detailed written or oral account of what happened, and review it frequently; and (d) in vivo (that is, actual) exposure to a list of trauma-related situations that the client fears and avoids. With in vivo exposure, the therapist and client work together to develop a hierarchy of anxiety-provoking situations. The client is then supported in moving through the list at his or her own pace, starting with the least distressing situation. Facing anxiety-provoking situations through imaginal or in vivo exposure allows clients to process and habituate to their emotions. Powers, Halpern, Ferenschak, Gillihan, and Foa (2010) conducted a meta-analytic review of studies using PE to treat respondents with PTSD, concluding that, "PE is a highly effective treatment for PTSD that confers lasting benefits across a wide range of outcomes" (p. 639). In addition, this treatment has been found to ameliorate complicated grief (CG), an intense and long-lasting form of grief that involves painful symptoms such as intense longing for the deceased, distressing intrusive thoughts, and anger and bitterness over the death (Shear, Frank, Houck, & Reynolds, 2005).

Another treatment that has been found to be highly effective is Cognitive Processing Therapy (CPT), developed by Resick and Schnicke (1993) for the treatment of rape survivors. This treatment uses components of PE, such as writing detailed accounts of the rape. However, Resick and Schnicke maintain that PE alone may not adequately address the powerful emotions, such as guilt and self-blame, that are often prevalent among survivors of rape. PE is then combined with cognitive therapy to target the distorted beliefs that underlie such feelings.

Despite evidence of its effectiveness, some practicing clinicians are reluctant to implement exposure-based treatments; often feeling ill equipped to deal with the intense emotions that typically emerge in such treatments. As one therapist indicated while treating a survivor of rape, "My initial impulse was to steer her away from her painful feelings and disturbing memories. To be honest, I had a hard time staying with her as she continued her graphic description of what happened."

Clinicians may also be concerned that exposure will exacerbate clients' symptoms and enhance the likelihood that the client will discontinue treatment (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002). Because of these potential problems, some therapists have advocated the use of an alternative treatment called Interpersonal Therapy (IPT) (Markowitz et al., 2015). IPT is an empirically validated treatment for depression that focuses on the client's interpersonal relationships, and that does not include an exposure component. A few studies have shown that interpersonal therapy (IPT) is as effective as PE in treating chronic PTSD (Markowitz et al., 2015) or people with complicated grief (CG; Shear et al., 2005). Importantly, findings from these studies fail to support the notion that PE will result in a higher drop-out rate. In fact, Shear et al. (2005) found that response rate was significantly higher for CG treatment than for IPT treatment. In addition, they found that time to response was significantly faster for those in the CG treatment. Given the realities of managed care and the limited financial resources of many clients, these findings hold considerable importance.

Mourning

As noted earlier, with traumatically bereaved clients, the mourning process is often impeded by unprocessed trauma. Therefore the trauma processing described above helps to pave the way for healthy mourning. In describing how mourning is affected by traumatic loss, we draw from six elements of the mourning process originally developed by Rando (in press), and referred to as the "R" processes.

The first process is to *Recognize the loss.* The survivor must acknowledge that the death occurred. Exposure activities, such as writing letters to the deceased, can facilitate recognition.

The second process requires the client to *React to the separation*. Traumatic death can bring agonizing pain. It is important for clients to acknowledge their painful feelings and express

them in some way. Focusing on the distress should be alternated with activities that the client regards as restorative, such as going to a movie or cooking dinner with a friend. This process also involves identifying and mourning secondary losses, such as the loss of sexual intimacy or financial stability after the death of a spouse.

It is important for the mourner to *Recollect and reexperience the deceased.* This can be done by assisting the client in developing a realistic view of the deceased and their relationship. For example, the therapist might ask a widow not only what she misses about her husband, but also what she does *not* miss.

The mourner must also *Relinquish old attachments to the loved one* by giving up assumptions that were invalidated by their death. For example, a man may have to relinquish his assumption that "my brother will always be there for me." A mother who lost a child may have to relinquish her assumption that "God protects the innocent."

Next, the mourner must *Readjust* his own identity so that it honors his or her relationship with the deceased, but is consistent with the new reality. For example, the mourner may adopt qualities of the deceased, as when a son attempts to be as patient with his own children as his father was with him.

In the final mourning process, the client is encouraged to *Reinvest* in a future without the deceased—such as engaging in new pursuits and relationships that are life-affirming and gratifying. Involvement in these endeavors can be facilitated by setting and working toward new goals, as discussed previously.

Concluding Comments

In sum, when faced with a client who is traumatically bereaved, we recommend the following evidence-informed guidelines:

- Therapists should explore whether traumatic death survivors experienced childhood abuse and neglect, as these factors may contribute to increased vulnerability to symptoms of traumatic bereavement.
- It is important for therapists to assess clients' resources, such as coping skills and social support, and build needed resources prior to exposure work. Otherwise clients may be retraumatized by the treatment.
- Because social support is a critical element to recovery, therapists should ascertain the presence and availability of social support to survivors, and work with them to increase social support if necessary.
- Therapists must help clients understand that avoidance of thoughts, memories, people, places, and things that remind them of the deceased will only temporarily reduce distress. There is overwhelming evidence that clients will benefit more by confronting their fears with the support of their therapist.
- In addition to the primary loss—the death of their loved one—clients must be helped to identify and mourn secondary losses, such as the loss of a coparent or sexual partner.
- One of the most important steps therapists can take is to validate the intense distress that survivors often experience in the wake of their loss (Lehman, Ellard, & Wortman, 1986). The issues listed below are particularly likely to benefit from validation.
    - Feelings of intense rage and revenge following the murder of their loved one, or their loved one's death as a result of another person's negligence;
    - Feelings of disappointment and anger toward members of their support network who avoid them or make insensitive comments;
    - Feeling ashamed that because of memory and concentration problems, they are unable to perform as well at work as they did prior to the tragedy;
    - Feelings of guilt because they were unable to keep their loved one safe;
    - Feelings of inadequacy because they continue to experience intense pain when they encounter reminders of their loss.
- Because of the demands this work places on the therapist, it is highly recommended that therapists seek consultation from their colleagues when difficult issues arise (Pearlman & Caringi, 2009).
- Finally, it is important to recognize that clients benefit considerably if they are helped to understand that their reactions to such situations are typical and are not in-

dicative of coping failure—and that they need not last forever.

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Duelo traumático: Investigación e implicaciones clínicas

Perder a alguien inesperadamente o de manera traumática deja a los sobrevivientes sintiéndose abrumados ya que sus vidas cambiarán repentinamente. Los sobrevivientes posiblemente sufrirán un fenómeno llamado luto traumático, que está asociado con síntomas de trauma, tal como pensamientos intrusivos sobre y relacionado al duelo, síntomas como anhelo por el ser que falleció. A través de la investigación, se ha encontrado que en la mayoría de los casos, los síntomas asociados con una pérdida traumática, son significativamente más intensos y prolongados que aquellos síntomas asociados con una pérdida de muerte natural. Estos síntomas también suelen ser más pentetrantes afectando todos los aspectos de la vida del

sobreviviente. También se ha encontrado que a los sobrevivientes de una pérdida traumáticata tienen un tiempo difícil de aceptar lo que ha sucedido, les cuesta lidiar con sentimientos de responsabilidad y culpa, comienzan a cuestionar sus creencias religiosas, se preocupan al pensar que el fallecido haya sufrido al morir y viven en la preocupación que ellos, o alguno de sus seres queridos, vaya a morir. En este manuscrito se examina la literatura existente sobre las áreas de la vida que son afectadas por pérdidas traumáticas y los factores de riesgo que incrementan la posibidad de que el sobreviviente sufra de duelo traumático. También describimos de manera exhaustiva, un enfoque de tratamiendo que está basado en la literatura de duelo traumático, especificamente creado para sobrevivientes de duelo traumático. En tratamento contiene 3 partes críticas: recursos de construcción, procesar el trauma vivido, y facilitar el luto.

Luto traumático, duelo traumático, tratamiendo para el luto traumático, factores de riesgo asociados con el luto traumático, trauma y pérdida

创伤 精神创伤性丧亲：基础研究和临床意义

突然间或在精神创伤的情况下失去亲人常常使幸存者完全不堪重负，生活发生根本性的改变。幸存者体验到（称作）的精神创伤性丧亲（的经验），与其创伤（事件本身）相关，例如侵入性思想 (or 想法)。这也和悲伤有关，如怀念（or 思念）爱人（or 亲人）。研究发现，在大多数情况下，与创伤性丧亲（or 去世）相关的症状比自然死亡后出现的症状更显著地（or 明显地）强烈和持久。他们也更普遍 （or 无所不在 / 无孔不入），几乎影响幸存者生活的所有方面。此外，人们（or 研究）还发现还发现创伤性损失的幸存者经常难以接受已发生的事情，挣扎于有关责任和内疚的问题，质疑他们的宗教信仰，担心他们的亲人可能遭受了痛苦，并且害怕他们自己或者家人也会死亡。在本文中，我们回顾了关于受精神受创伤性丧亲影响的生活领域的基础研究，并回顾了提高幸存者更易受创伤性丧亲的脆弱性的危险因素 （or 并回顾了使幸存者更容易产生创伤性丧亲的危险因素）。然后，我们描述了一种全面的治疗方法。这种治疗方法基于对精神创伤性丧亲的现有研究，专门针对突发性精神创伤性性丧亲的幸存者开发。治疗涉及三个关键组成部分：构建资源，处理创伤，促进悼念。

精神创伤性丧亲，精神创伤性哀悼（or 哀伤）/ 精神创伤性丧亲的治疗，与精神创伤性丧亲有关的危险因素，精神创伤和丧亲

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