Loss, Hurt and Hope

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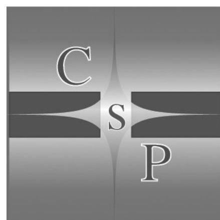
The Complex Issues of Bereavement and Trauma in Children

Edited by

Sandra L. Bloom and Lorelei A. Vargas



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edited by Sandra L. Bloom and Lorelei A. Vargas

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Dedicated to
the memory of
Larry Jamal Warren and Peter Woodruff Ment,
whose untimely passing has brought the Andrus Children’s Center
a deeper, more personal understanding of loss and bereavement;
and in honor of the children in our care who work through loss and
hurt to find hope and healing.

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PREFACE

NANCY WOODRUFF MENT

If you have ever felt your heart slip at a newspaper photo of a young girl reaching tearfully for a dying mother; cried at the frozen faces of children whose village was upended by an earthquake; or clenched your jaw when your neighbor yanked his whining son's arm – then this volume has been prepared for you. You may be a professional teacher, clinician, youth worker; you may be a community volunteer; you may once have been a child who lost someone who mattered to you very much. If you are reaching for this book, something inside you is open to the pain and suffering that children feel but rarely can define. This is a book about children who know loss and hurt in forms that even adults cannot absorb. This is a book for people who want to care for these children by grasping the dimensions of their pain. This is a book for people who want to nurture hope that the future can be different from the past.

I feel privileged to be writing this introduction to a volume that has a deep personal resonance for me. A core of the papers you will read originated in presentations at a conference held in October, 2005 at the Andrus Children's Center in Yonkers, New York. For 20 years I have been associated with Andrus, a haven for vulnerable children founded in 1928 by philanthropist John Emery Andrus whose wife, Julia Dyckman, had been orphaned as a young child. Mr. Andrus believed that children should be treasured and given opportunities to succeed in spite of the losses they had endured. Over the years, our mission has stretched to encompass residential and day treatment for seriously emotionally disturbed children, community-based mental health services and home-centered family strengthening. Like many mental health and social service organizations, we have seen children struggling against increasingly formidable odds: mental illness, developmental discontinuities, family disruption, poverty and community violence. As new theories emerged in our field, we came to understand that trauma was a rich concept to capture the stunning effects of life experiences on our children.

In 2001, we began working with Sandra Bloom, M.D., to adapt her *Sanctuary Model* of trauma-informed care for children. We committed ourselves to perfecting our craft in caring for children whose lives were derailed by single devastating losses, by the steady accretion of hurts, or by the pain of

being chronically outside. Early in our work together, September 11 became a flashpoint. Suddenly what had been "out there" for our children came "inside" for all of us. Trauma and loss became vivid, deeply felt experiences for all of us. Unlike our children, we could find words to convey how dislocated and vulnerable we felt. And yet, like our children, we could *not* find hope.

In time, because we could rely on each other, we came to believe that we could move forward. But life continued to happen to us. In February, 2003 our small community at Andrus was shattered when the beautiful son of Larry Warren, one of our Program Manager's was murdered. Larry Jamaal Warren grew up dearly loved and protected by his father who himself has devoted his life to protecting other people's children. Young Larry, always a role model, intervened in a fight between two young men. A short time later, he was shot in the head, allegedly by one of these young men, but justice has never been served.

In August of 2004, my son Peter Woodruff Ment, died in an accident in Costa Rica where he had been pursuing his latest passion, surfing. He was a joy to me every day of his life. For both Larry and me, the loss of our boys is the worst thing that has ever happened to us. And yet, both of us have come to know safety in our memories of wonderful sons who were loved and cherished. As we have made our way through grief, we have been lifted up and carried by family, friends and colleagues. We have come to benefit from personal resources of language, mature thinking and adult perspectives. We know how to solve problems and to ask for help. We have had reliable incomes, food, clothing and stable homes. But still, we have barely made it through.

Being adults who have endured unspeakable loss has given us a unique perspective on what loss is like for children who cannot apply a sense of reason or self-efficacy. Although we did not believe it could be possible, Larry and I have survived and we have come to know joy again – even in our sadness. The conference *Loss Hurt and Hope* was dedicated to our treasured sons. This volume is dedicated to all the children who have known loss and hurt, all the children whose lives we and you will touch, in the hope that they will master sorrow to know joy and love.

INTRODUCTION

LORELEI ATALIE VARGAS, MPP, MA

Each year millions of children experience some form of trauma. A car accident, a fire, rape, physical abuse, abandonment, homelessness, the loss of a parent, friend, or pet, a natural disaster, domestic violence, community violence — all can leave a child with scars, usually unseen by the human eye, but often more devastating than any physical wound. When left untreated, childhood trauma crosses generational boundaries, developing risk factors that far outpace the threat of any other childhood disease, and yet, most children who have lived through a significant traumatic experience, usually do not get the care they need to begin their healing process. This book gathers the collective wisdom of professionals who have spent years on the front lines of working with children victimized by trauma. Its purpose is to share and celebrate the knowledge and best practices that have proven successful in healing the most vulnerable among us.

In chapter one, "Beyond the Beveled Mirror: Mourning and Recovery from Childhood Maltreatment", Dr. Sandra L. Bloom shares her years of experience working in an inpatient psychiatric unit, how she and colleagues came to understand childhood trauma. Bloom discusses the long-term outcomes of unresolved grief that stem from chronic childhood maltreatment. She outlines the various losses that a child experiences from "loss of wholeness" to "loss of the capacity to establish safe and trusting relationships" to "loss of self esteem". Using anecdotes from her work in the field of psychiatry, Bloom discusses how these losses must be confronted and dealt with in the recovery process.

Kenneth V. Hardy's "Untangling Intangible Loss in the Lives of Traumatized Children and Adolescents" defined tangible and intangible loss. In chapter two, Hardy unveils why most individuals, including mental health professionals, find it difficult to deal with loss. Hardy draws the distinction between tangible loss – "loss of a loved one, a sweater or a limb" and intangible loss – "emotional psychological loss that is usually attached to a tangible loss". Using vignettes from the field, Hardy highlights why intangible loss is often just as devastating as tangible loss.

In chapter three, "Walking Together: A Child Therapist's Journey through Loss", author Kathryn Kehoe-Biggs uses a case study approach to illustrate the complex variations of loss and how multiple losses are layered in a child's life and influence his perception of past, present and future. Using the lens of the therapist, this chapter provides an appreciation of the significant role of the therapist in developing a non-verbal exchange that can often become the basis of interactions between the therapist and the client — with each client having their own non-verbal code. Kehoe-Biggs shares the intricacies of understanding the value of these non-verbal exchanges with children who have experienced loss, as a way to further the healing process.

Chapter four, "Responding to Trauma, Violence and Bereavement Overload in the Lives of Young African American Men: Trauma-Informed Approaches to Health Care" provides a cultural lens through which chronic trauma and loss can be understood. Dr.'s Theodore J. Corbin and John Rich utilize their unique vantage point of working in urban medical emergency rooms and primary care clinics, to discuss the role of trauma in the lives of young African American men who are victims of trauma. Two programmatic efforts shed light on community level prevention and intervention models that were geared to provide more than medical care within a healthcare system. The authors share learned lessons on these approaches, including the importance of having trauma-informed framework to structure their programs, dedicated staff and support from the host institutions.

In chapter five, Valerie Anderson provides a respite from the intensity of trauma and grief in her poem entitled "Acceptable Losses". Anderson reminds the reader of the natural losses that compose life from the "The loss of childhood to adulthood" to "The loss of being under to rising above". This poem offers a simple and approachable understanding to life and loss.

David McCorkle and Sarah Yanosy Sreedhar's work in chapter six, entitled "When Loss gets Lost: Using the SELF Model to Work with Loss in Residential Care", presents considerable insight to the world of residential care. Residential treatment programs offer children 24-hour care in a therapeutic environment. Presenting with a history of failed placement, oftentimes, children entering residential treatment have repeatedly exhausted all other less-restrictive and community-based options. McCorkle and Sreedhar share the perspective that residential treatment is rooted in loss. This chapter illustrates the use of the Sanctuary Model's — a trauma-informed treatment method — SELF acronym (Safety, Emotional management, Loss and Future) in a residential setting. Using a case study approach, the authors share how SELF is used to mitigate grief among children who have experienced severe and chronic trauma.

In chapter seven, "Loss in Human Service Organizations" Dr. Sandra L. Bloom offers an in-depth look at how organizations that are charged with

caring for the most vulnerable populations, manage loss and grief within the organization. Bloom's development of the Sanctuary Model provides the backdrop of this chapter as she shares the delicate balancing act that organizational leaders must endure in managing vulnerable children in a vulnerable environment. Her conversations with the leadership of organizations shed some new light on how personal and organizational loss gets managed and grieved collectively.

Together theses chapters help to identify the numerous individual and contextual factors that should be considered in helping children who have experienced loss. They also provide a broad etiological context in which to consider how loss can be better managed in children, and how professional healers can begin the process of creating hope for the future.

CHAPTER ONE

BEYOND THE BEVELED MIRROR: MOURNING AND RECOVERY FROM CHILDHOOD MALTREATMENT ACROSS THE LIFESPAN*

SANDRA L. BLOOM, M.D.

Introduction

> I had this thing when I was a child, this fantasy. My parents had a beveled mirror in their room and the regular mirror was in the center. I thought that everyone in the world must see me as in the beveled part of it, the part that was screwed up, with the eyes over here and the nose separate, in pieces, in shards, because that is how I felt – disconnected.. . .Before I came to Sanctuary, I never really knew what these symptoms were about because the grief was like something separate from me. Now I am feeling it in my body as well. Now it is all inside of me and I can feel the grief bubbling instead of just being outside of me somewhere.
>
> —Jodie, adult survivor of child maltreatment

When someone close to us dies, society generally accepts and even expects us to undergo a process of mourning. Death presents a tangible and comprehensible loss. Throughout history, cultures have built traditions and customs to provide a passage for the bereaved that enables us to let go of those who have died, in order to prepare us to create new attachments.

But society has yet to recognize the necessity and value of grieving for other kinds of losses besides those associated with death. A common denominator among the thousands of adults treated in the inpatient program we called Sanctuary, are the "little deaths" – of hope, of innocence, of love and of joy. For some, the sources of grief constituted the loss of already established assumptions and beliefs about self, home, family and society. For others, the

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assaults to their integrity began when they were so young that they had no time to even develop a coherent assumptive world before their lives were shattered. Complicating the process of grieving for adult survivors, is the fact that the losses that accompany child maltreatment are cloaked in silence, lost in the shrouds of history, and largely unrecognized. In general, their grief for these losses is unaccepted, rejected, denied and stigmatized. But these "little deaths" remain as unremoved splinters in the survivor's psyche for decades, as Jodie's description illustrates. Although new protective psychic tissue may form over these wounds and new experiences may allow the child to develop assumptions about the world that contradict the traumatic and abusive experiences, the psychic splinters remain, surfacing again in adulthood, often triggered by a new insult to their well-being. Child neglect represents particular challenges for adult survivors because they must grieve for things they never had, and thus never had the chance to lose.

This chapter will focus on these losses. From 1985-2001 my colleagues and I specialized in the treatment of adult survivors of child abuse and neglect in our inpatient treatment programs and we followed many of them as outpatients[1] We have learned about how difficult it is to form healthy attachments as an adult when your childhood attachments have been so scarring that the pain of the past continues in the present. Attachment theory and our growing understanding of the impact of trauma and traumatic grief provided ways to understand how trauma and loss in childhood affects adult relationships and impacts the capacity to grieve.

The lessons they taught us have helped us to understand loss through the eyes of the children they once were. They taught us about the difficulties they encounter in grieving for the omissions that accompany child neglect as well as the more flagrant commissions of physical, emotional, and sexual abuse. In this chapter I will detail many of those losses through the testimony of several people who agreed to be interviewed and describe the process of recovery that for many begins in childhood and continues throughout their lifetime. Our treatment model uses an acronym to describe the phases of recovery that trauma survivors must work through in the process of their recovery: S.E.L.F. The four letters stand for "Safety", "Emotional Management", "Loss" and "Future"[2]. This chapter focuses on the "L" in Loss and we will look at the losses – and the discoveries – that accompany the healing process.

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[1] Bloom, *Creating Sanctuary: Toward the Evolution of Sane Societies;* Bills and Bloom, *From Chaos to Sanctuary*

[2] Bloom, Foderaro, & Ryan, *S.E.L.F.: A Trauma-Informed Psychoeducational Curriculum;* Foderaro, *Creating a nonviolent environment*

Attachment and Grief

The losses that accompany childhood exposure to terror and violence can only be grasped within the context of attachment theory. One of John Bowlby's great contributions was to recognize that attachment behavior is a fundamental part of our evolutionary heritage and therefore is critical to survival. Primates – including humans – need to attach from "cradle to grave" and any disruption in normal attachment relationships, particularly those being established in early childhood, is likely to cause developmental problems[3]. He recognized that "grief and mourning occur in infancy whenever the responses mediating attachment behavior are activated and the mother figure continues to be unavailable"[4]. He went on to discuss how "the experience of loss of mother in the early years is an antecedent of relevance in the development of personalities prone to depressive and other psychiatric illnesses and that these conditions are best understood as sequelae of pathological mourning"[5]. He identified four main variants of pathological responses by bereaved adults: 1) anxiety and depression, which he saw as the persistent and unconscious yearning to recover the lost person, originally adaptive because it produced strong motivation for reunion; 2) intense and persistent anger and reproach expressed towards others or the self and originally intended to achieve reunion with the lost relationship and discourage further separation; 3) absorption in caring for someone else who has also been bereaved, sometimes amounting to a compulsion; and 4) denial that the relationship is permanently lost[6]

Since Bowlby originally made these astute observations, other clinicians and researchers have been busily extending his work to show the relationship between disrupted attachment in childhood as a result of maltreatment and the development of adult pathology[7]. As far back as 1963, Khan discussed the idea of cumulative trauma, and the impact of protective failures: "cumulative trauma is the result of the breaches in the mother's role as a protective shield over the whole course of the child's development, from infancy to adolescence"[8]. He went on to discuss how this can leave a person vulnerable to breakdown later in life. There is a long-established connection between childhood loss and depression[9] and between suicidal behavior in

[3] Bowlby, *Development psychiatry comes of age*
[4] Bowlby, *Grief and Mourning in Infancy and Early Childhood,* p.9
[5] Ibid, p.11
[6] Bowlby, *Pathological Mourning and Childhood Mourning*
[7] De Zulueta, *From Pain to Violence*
[8] Khan, *The concept of cumulative trauma*
[9] Bowlby, *Attachment and Loss*

adolescents as well as adults and disrupted attachment[10]. In the last decades, other workers have concretized the relationship between insecure forms of attachment in childhood and the evolution of personality disorders[11]. Fonagy and colleagues have helped illuminate the important relationship between disrupted attachment and borderline states[12], while Liotti has written about the development of dissociative disorders within an attachment framework[13]. Others have looked at both highly conflicted families and violent couples from the point of view of disrupted childhood attachment relationships[14], while other investigators have provided abundant theoretical and evidence-based data showing how the disrupted childhood attachment relationships of parents can be carried over into the ways in which they parent their own children[15].

Complex Post-Traumatic Stress Disorder

Of the adult patients we treated, most had been victims of severe physical, psychological, sexual abuse and neglect. Some had experienced only one form of child maltreatment, many had experienced two or more. Childhood maltreatment is associated with a wide variety of physical, psychological, and social dysfunction in childhood and in adulthood and there is now a significant body of literature reviewing various aspects of comorbidity[16]. There are well-established connections between chronic depressive disorders, somatization disorder, anxiety disorders, and various personality disorders especially borderline personality disorder and childhood exposure to overwhelming and

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[10] Adam, *Suicidal Behavior and Attachment*

[11] West & Keller, *Psychotherapy Strategies for Insecure Attachment in Personality Disorders*

[12] Fonagy, et al, *Attachment, the reflective self, and borderline states*

[13] Liotti, *Disorganized/Disoriented Attachment in the Psychotherapy of the Dissociative Disorders; Disorganization of Attachment as a Model for Understanding Dissociative Pathology*

[14] Henry & Homes, *Childhood Revisited: The Intimate Relationships of Individuals from Divorced and Conflict-Ridden Families;* Roberts & Noller, *The Associations between Adult Attachment and Couple Violence;*

[15] Main and Hesse, *Parents' Unresolved Traumatic Experiences Are Related to Infant Disorganized Attachment Status:*

[16] Ellason and Ross. Childhood Trauma and Psychiatric Symptoms; Koss et al. Deleterious Effects of Criminal Victimization on Women's Health and Medical Utilization; Grady. Posttraumatic Stress Disorder and Comorbidity: Recognizing the Many Faces of PTSD; Leserman et al. Impact of Sexual and Physical Abuse Dimensions on Health Status: Development of an Abuse Severity Measure.

traumatic events[17]. However, many of the patients we see enter treatment carrying two, three, or even more psychiatric labels, many of the same diagnostic categories that have been implicated as the long-term results of disrupted attachment relationships. In many ways, the trauma-related disorders can be seen as disorders of disrupted attachment.

Children can be maltreated in a number of different ways and it is common for maltreated children to have multiple victimization experiences. In a large survey of an HMO adult population performed by the Center for Disease Control in Atlanta and Kaiser Permanente of San Diego, a third of respondents reported belonging to at least one category of exposure to adverse childhood experiences or “ACE’s”. The categories of adverse childhood experiences included: psychological, physical, or sexual abuse; emotional or physical neglect; witnessing violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned.

The overlapping symptoms and complex clinical picture characteristic of adults who have experienced childhood maltreatment is more comprehensible if we formulate the problem as one of “complex post-traumatic stress disorder”[18]. Field trials for DSM-IV, demonstrated that there are significant differences between survivors of disasters who suffer from post-traumatic stress disorder and childhood survivors of maltreatment[19]. These differences fall into seven major categories of dysfunction: alterations in regulating affective arousal, alterations in attention and consciousness, somatization, alterations in self-perception, alterations in perception of the perpetrator, alterations in relations to others, and alterations in systems of meaning. These symptom clusters have been demonstrated to differentiate acute adult onset trauma syndromes associated with disaster victims from adult victims of childhood interpersonal violence and abuse.

When viewed from the point of view of the grief literature, difficulties with managing affect and alterations in attention and consciousness may reflect two of the final adult personality outcomes of two of Bowlby’s sequelae of pathological mourning. The unrelenting yearning and searching for the lost love relationship, and the defenses built up to protect against this yearning can be seen as an underpinning for many of the symptoms that lead people to seek treatment. The persistent anger and reproach originally intended to achieve reunion and discourage more separation are common problems for our patients in all of their relationships and strongly color the nature of the therapeutic alliance.

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[17] Kessler et al, *Posttraumatic Stress Disorder in the National Comorbidity Survey;* Solomon & Davidson, *Trauma: Prevalence; Impairment; Service Use; and Cost.*
[18] Herman, *Trauma and Recovery*
[19] Roth et al, *Complex PTSD in Victims Exposed to Sexual and Physical Abuse*

Alterations in self-perception, in perception of the perpetrator and in relationships with others all can be understood in the context of an expectable developmental outcome in the face of disrupted early attachments. It is well established from studies of captive victims of all kinds – political prisoners, torture survivors, hostages, and both adult and child victims of family violence – that when people are placed in situations of inescapable danger for prolonged periods of time, they may develop very strange relationships with their captors and alter their perception of themselves. This phenomenon has become known as "trauma-bonding"[20]. Trauma-bonding is a relationship that is based on terror and the twisting and manipulation of normal attachment behavior in service of someone else's malevolent intent. People who are terrorized experience the perpetrator as being in total control, the source of pain but also the source of pain relief; the source of threat but also the source of hope. Victims come to internalize the experience of helplessness and the role of perpetrator and then later in life, unconsciously recreate the pattern of these early and traumatizing relationships in new relationships. Successful grieving means letting go of these patterns as well as letting go of the former abusive relationships, even though these relationships are also associated with a deep sense of fear and foreboding at their loss.

Somatization may represent not just the effects of prolonged stress but also the long-term effects of suppressed grief on the body. In the ACE's study, there was a graded relationship between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied. People who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, and greater than or equal to fifty sexual intercourse partners, and sexually transmitted disease; and 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease[21]. In another study looking at the connection in women between childhood adverse experiences and physical health, a history of childhood maltreatment was significantly associated with several adverse physical health outcomes including perceived poor overall health, greater physical and emotional disability,

[20] James, *Handbook for Treatment of Attachment Trauma Problems in Children*
[21] Felitti et al, *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults.*

increased number of distressing physical symptoms and a greater number of health risk behaviors[22].

Disrupted systems of meaning can be understood as the logical outgrowth of growing up within intimate childhood contexts of mistrust, deceit, hypocrisy and cruelty that are embedded within a larger social context that insists that children are to be valued, loved, cherished and protected from harm. A child's exposure to deliberate malevolence at the hands of a primary caretaker powerfully confuses the ability of the child to correlate his or her own experience of reality with the realities of other people. The contradictions are shattering. Most importantly, perhaps, this bears on the issue of justice, a fundamental human striving, rooted in our primate-derived sense of reciprocity, the basis of all social relationships. If children are treated unjustly, they will seek justice for their hurt. If their family or their larger society denies them justice, then they will seek revenge, either against themselves, others, or both. When children discover that the adults who hurt them were never held accountable for the infliction of harm by the society, not only does this cause disruption in the attachment relationship with the perpetrator, but also with the self, the other members of the family and the society at large. As Charny points out, *"The avoidance of defining perpetration of evil as a disturbance in its own right reaches its bizarre extreme in the classic literature on child abuse – violence to the child. According to the prevailing definitions, the majority of parents who abuse children are not emotionally disturbed. . . it is utter nonsense to ignore the fact that anyone who seriously abuses his or her child is seriously disturbed*"[23].

Traumatic Grief

While attachment theorists have been carefully formulating theory and analyzing data from the perspective of developmental psychopathology[24], clinicians and researchers in the overlapping fields of traumatic stress studies and thanatology have been broadening our understanding of what happens to people who are traumatized and the ways in which traumatic bereavement differs from normal bereavement. Jacobs has described traumatic grief in relation to any death that is personally devastating and is characterized by traumatic separation. Traumatic grief has been shown to be associated with impaired role performance, functional impairment, subjective sleep disturbance,

[22] Walker et al, *Adult Health Status of Women with Histories of Childhood Abuse and Neglect.*
[23] Charney, *Evil in Human Personality,* p. 483
[24] Cichetti & Lynch, *Failures in the expectable environment and their impact on individual development*

low self-esteem, depression and anxiety, as well as a high risk of cancer, cardiac disorders, alcohol and tobacco consumption, and suicidal ideation[25]. Other authors have looked at the various ways that traumatic bereavement and exposure to death and dying affect various populations and age groups[26], while still others have looked at the way entire communities grieve after mass tragic events[27].

Rando has written extensively about the treatment of complicated mourning and has connected unresolved grief to many of the symptoms of chronic and complex post-traumatic stress disorder. She has also looked at the difficulties survivors encounter mourning someone who has victimized them, as is so often the case in survivors of childhood maltreatment[28]. At least since Lindemann's seminal work[29], the connection between the normal somatic manifestations of grief and symptoms of complicated mourning have been recognized[30].

Although the literature is by now rich and persuasive in conceptualizing the relationship between traumatic loss and disrupted attachment, relatively little has been detailed about the losses the do not involve actual death, but that do represent extraordinary loss for adults who were maltreated as children. These "little" losses occur in the context of a long-standing pattern characterized by the absence of sustaining and loving caregiver behavior. As children, our patients often had parents who were physically present, but the nature of their parenting was so abusive and/or neglectful that their losses are not even seen as losses at all, but a way of life.

Nonetheless, recovery from loss requires the working through of a mourning process. Ochberg has described some of the necessary tasks required to complete the process of grief[31]. Mourners must be able to express their emotions, understand the meaning of the lost person or object, be able to surface and work through the ambivalence in the relationship, all of which will eventually free them up to attach trust and love to new significant others and find appropriate replacements for the lost relationships. These tasks are very difficult to complete for adult survivors of child abuse and neglect. Being raised in abusive homes characterized by disruptive attachment relationships almost guarantees that people will have difficulty in managing their emotions. The

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[25] Jacobs, *Traumatic Grief*
[26] Figley, *Traumatology of Grieving;* Figley et al., *Death and Trauma*
[27] Zinner and Williams, *When a Community Weeps*
[28] Rando, *Treatment of Complicated Mourning*
[29] Lindemann, *Symptomatology and Management of Acute Grief*
[30] Engel, *A Challenge for Medical Research;* Rando, *Treatment of Complicated Mourning*
[31] Ochberg, *Post-Traumatic Therapy and Victims of Violence*

problems associated with disrupted meaning schemas will make it difficult for them to understand the meaning of the lost person, lost experience, lost self. Trauma-bonding may make it feel very unsafe to deal with the ambivalence in the earlier relationship, even if it occurred decades before. The consequent lack of resolution interferes with the capacity to establish new, safe, and loving relationships, to even find appropriate people to love in order to replace the old abusive ones. Some people will stay aloof from relationships altogether so as not to become involved in more abuse. Others, having no other internalized standard, use the abusive relationships as their only norm. In this way the past becomes the present.

As has long been pointed out in the field of grief studies, failure to complete the tasks of grieving can impair future development and adaptation. Lack of grief resolution can also impact on physical health. The ACEs study mentioned earlier may provide connecting links between traumatic grief, traumatic stress, disrupted attachment and childhood maltreatment[32].

Recovery From The Impact Of Child Maltreatment

There is by now an extensive literature on the treatment of people who suffer from the complex syndromes related to a past history of child maltreatment. Since Janet first talked about the process of trauma resolution and the need to "liquidate" traumatic memory, there has been an understanding that trauma treatment progresses in stages, or perhaps more accurately, phases[33]. Like the descriptions of bereavement, however, these phases are dynamic, interpenetrating and spiraling, rather than indicative of a clear stepwise progression.

We use the acronym "S.E.L.F." to describe the way we understand this dynamic movement. Our patients have helped us develop the concepts over the last fifteen years, and as a result the S.E.L.F. model has become a practical and useful way for our patients and their therapists to map out a road to recovery. "S" represents "Safety" – the starting point for all efforts at healing. We understand that there are four levels of safety: physical safety or the ability to be safe from physical or sexual harm; psychological safety or the ability to be safe with oneself; social safety or the ability to be safe with others; and moral safety or the ability to live and work within a personal and professional context whose guiding value is a respect for life[34].

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[32] Edwards et al, *Adverse Childhood Experiences and Health-Related Quality of Life as an Adult*
[33] Van der Kolk & van der Hart, *Pierre Janet on Post-traumatic stress.*
[34] Bloom, *Creating Sanctuary: Toward the Evolution of Sane Societies*

In practical terms, adults generally enter treatment because in any of a number of ways, they are not safe. They may be self-mutilating, have attempted or are threatening suicide. They may be abusing drugs or alcohol, have an eating disorder, or are becoming increasingly nonfunctional because of escalating anxiety. They may be in dangerous relationships or placing themselves at unnecessary risk without understanding why or feeling able to control their behavior. Whatever the reason, the first step in recovery is to confront existing issues of safety, develop a plan for the restoration of safety and implement that plan.

In the course of learning to manage safety by inhibiting dangerous or damaging behavior, however, it quickly becomes obvious to people that their unsafe behaviors have been serving a useful purpose. The behaviors have helped them exert control over emotions that are otherwise overwhelming, toxic, oppressive and extremely painful. In order to be safe, they must learn how to manage emotions in health-promoting ways. This process is reflected in the “E” phase of S.E.L.F.: Emotional Management. With enough social support, cognitive restructuring, skill development, inner fortitude and perseverance, our patients allow themselves to trade in their self-destructive behaviors for healthier relationship. But the very act of taking such a relational risk with therapists, teachers, friends, and family opens the door to the next phase of S.E.L.F: Loss.

Unresolved, Stigmatized, Disenfranchised LOSS

Adults who were maltreated as children carry around with them the impact of delayed, unresolved, “stigmatized” loss[35]. According to the descriptions of stigmatized grief, the incidents giving rise to the loss happen suddenly, are associated with violence, result in others fearing contagion and blaming the victim and result in victims believing they should have done something to prevent the events, or that they deserve what happened. Several of the characteristics of stigmatized grief describe the situation of abused children. In some cases, as in sexual abuse, the loss of a secure relationship with the parent can be quite sudden and unexpected. Child abuse is clearly associated with violence and the victims are usually told that they have done something to deserve the violence. Their parents and society-at-large tends to blame them and frequently they are told that if they had behaved differently they could have prevented it. Social denial of the magnitude of the problem is still a prominent feature of our social environment.

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[35] Sprang and McNeil, *The Many Faces of Bereavement*

Victims' grief is delayed because most abused children learn how to adapt to even astonishingly difficult circumstances in order to survive, but they do pay a price. A later crisis or loss in adult life may unmask an underlying vulnerability that has been lurking beneath the apparently normal surface of their lives for years. The losses they sustain are unresolved because for most survivors of childhood abuse, there is no clearly established and socially acceptable pathway for grief resolution if actual physical death has not been involved. Their losses cannot even be acknowledged as loss. Their grief is stigmatized because it is seen as a "blemish of individual character"[36]. The losses associated with childhood maltreatment that are only recognized or surfaced in adulthood are not considered legitimate reasons for grief, by the larger society. They are not "legitimate" mourners.

According to Doka, who has written about "disenfranchised" grief, there are three general types: those individuals whose relationships are socially unrecognized, illegitimate, or in other ways unsanctioned; those persons whose loss does not fit the typical norms of appropriateness; and those people whose ability to grieve is in question or who are not considered to be legitimate grievers[37]. Victims of child maltreatment experience many losses that carry with them no social legitimacy. In the case of victims of sexual abuse, the losses they sustain are often not only unrecognized but are denied by the perpetrator and by other family members. Victims of other forms of maltreatment are frequently labeled as "whiners" or "complainers" who manipulate others with their "victim mentality". As for normative appropriateness, the society at large barely is willing to deal with death as a legitimate cause for bereavement behavior. The social attitude towards most other losses is generally, "get over it". And even among therapists and otherwise supportive others, there may be great resistance to empathizing with the grief victims feel at finally having to give up a relationship with someone who has been abusive, dangerous and cruel or letting go of a behavior that has helped them cope and feel in control, even if that behavior appears "crazy". They are not legitimate grievers because the losses they experience are usually not considered appropriate causes for grief. After all, they survived, didn't they?

Bearing Witness to Childhood Loss

The seven categories associated with complex post-traumatic stress disorder are a useful way to classify the various losses our patients experience. In the following pages, several people were willing to share their experiences of

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[36] Goffman, *Stigma*
[37] Doka, *Living with Grief after Sudden Loss*

loss secondary to childhood abuse and neglect. When interviewed, each person was at a different point in her personal recovery and each one had suffered unique experiences. All, however were able to relate to the concept of loss and the questions I asked them in the interview. I have changed their names and identifying information and after transcribing their conversations, received their permission to use the quotations I have included.

Samantha (S) is in her thirties and has been diagnosed with schizoaffective disorder. She has a history of self-mutilation, suicide attempts, multiple hospitalizations, substance abuse and has been considered to be chronically mentally ill. Along with everything else, she episodically has a thought disorder and has difficulty separating reality from her paranoid ideation. She has been tried on many medications and is currently on antidepressants, antianxiety medication, and antipsychotic agents . She is living in a sheltered apartment, is no longer self-mutilating, and is determined to get well. Despite her long history of mental health problems, Samantha managed to complete college. She recognizes that she is currently grieving for the many losses she has sustained throughout her life as the result of her extremely abusive, chaotic, neglectful, and dangerous home life. She was sexually abused by her father, physically abused and neglected by both parents, both of whom were and still are, active alcoholics.

Jodie (J) is also in her thirties. College-educated, she has a responsible position in business. Sexually abused by a relative beginning at a very young age, she lived with a number of symptoms until seeking treatment. She originally sought treatment because of post-traumatic symptoms secondary to her involvement in a violent relationship.

Helen (H) is thirty-seven years old, college educated and employed by a state government agency. She suffered physical abuse at the hands of her father, emotional abuse by her mother, and severe neglect from both parents. One of five children, her graduate school trained father, refused to spend money on the family home or his children so that there was not even sufficient clothing or shoes or heat in the house when they were growing up. Neither Helen nor her siblings were given sufficient health care as children, and these tangible omissions were paralleled by a complete lack of affection, love, or empathic regard for the children. She originally sought treatment because her frequent negative encounters with authority figures and co-workers made it impossible for her to hold a job.

Rachel (R) is in her early forties and runs a successful hair salon with her husband. She was raised by a mother who she describes as a hippy who ran with the avant-garde set in New York City in the 50’s and 60’s and left her children to fend for themselves emotionally, while at least providing for them financially.

Losses Secondary to Child Maltreatment

Alterations in ability to manage emotions

Children require loving and empathic relationships in order to develop properly. The immature central nervous system needs caregivers who are willing to serve as protective shields against overwhelming arousal. The hallmark characteristic of all forms of child maltreatment is empathic failure[38]. When exposure to abuse and neglect corrupts the family environment, children lose – or fail to develop – the ability to modulate their own level of emotional arousal and as a result they are forced to use whatever coping skills they happen to hit on that calms them down. Often those coping skills are self-destructive – drugs, alcohol, aggression, self-abuse – but these behaviors within the child or the adult's control are preferable to the noxious experience of overwhelming distress. The inability to manage emotions in a relational, constructive way means that later you must grieve for how much more difficult life is and has been for you than it is for other people. It means that you lose a sense of being safe and secure in the world, if you ever had it in the first place. The prolonged effects of exposure to overwhelming stress means that it is very difficult to finish the grieving process that enable you to make more successful relationships because being able to grieve means being able to tolerate and work through very painful emotional experiences.

✓ Loss of ability to manage emotions like other people

Samantha has great difficulty in managing her emotions, especially now that she has given up self-abuse as a way of coping. Samantha provides us with an example of one way in which maltreated children, without supportive adults to help them adequately express themselves, may fail to develop the ability to associate feelings with words, also known as alexithymia[39]. As a result, she lives with what is now a state of pain and finds verbal expression difficult. People from more secure homes learn how to use other people as resources to help manage feelings when they are overwhelming, but children deprived of empathic care have great difficulty relying on others or even knowing how to get the help they need.

> **S.** My day-to-day living now is so painful because I never really felt anything and now I am. I had no words to attach to even asking for help. Even now I struggle with feeling and talking.

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[38] Weil, *Early Deprivation of Empathic Care*
[39] Krystal, *Integration and Self Healing*

S. There was nothing else, nothing else but self-abuse. Anytime I felt anything I had to dissociate. I couldn't handle feelings at all.

✓ Loss of a sense of safety

A basic sense of safety is what serves as the foundation for all developmental achievements. Children who grow up in violent homes are robbed of this basic necessity. For them, emotional, intellectual and creative energy must be put in the service of protecting their minds and bodies from assaults at the hands of the people they are supposed to be able to trust. Samantha's home was so chaotic, violent and deprived that the listener is more amazed at her capacity to go on, despite her limitations, then the extent and magnitude of those limitations. Rebecca talks about the terrible and pervasive anxiety that accompanies a child without context, a child living with emotional neglect, while Helen focuses on the daily fear of living with the violence of physical and verbal abuse.

S. All my life I had to worry about things like how early in the day I should wet my pants so I could go home and check on what was happening at home. It was pure chaos – addiction to drugs and alcohol, sexual and physical abuse. I had to be one step ahead all the time.

S. My sister's best friend was killed in the house too – she was 12 and I was 10. They were playing with guns and it went off accidentally. The girl and my sister were getting high, they got out the gun, I had the gun and my sister went to get the gun from me and the girl was shot in the head. Then my father started shooting at all of the kids to teach them a lesson.

R. I remember always feeling afraid. I was always afraid of going out to the playground for recess at school, but things were even worse if it rained. Then we would have to go to the cafeteria and I would be terrified. I would get so distressed that the teacher would send me home with my brother and I would miss more time from school and make my brother miss school as well.

H. I was always afraid of my father because of his violence, his angry outbursts. My mother was verbally abusive but not violent, just haranguing. I was not safe in those regards. Did I fear for my life? Not really, but there was never a sense of safety or comfort.

✓ Loss of ability to complete mourning

The disruption in the developing ability to manage emotions makes enduring and working through loss extremely difficult. Our patients have great

difficulties in tolerating the painful affects that accompany the resurfacing of unresolved grief. As a result of the process of therapy Samantha has learned about the importance of grieving and is allowing herself to grieve as best as she can. She is even struggling to educate the staff of the transitional living facility where she lives about the importance of the grieving process. Jodie has come out on the other side of the mourning phase of her treatment, at least for now, and has come to recognize how much her failure to grieve has impacted on her developmental progress. Helen has not yet really even begun to grieve. Before she can allow herself to work through her losses, she must allow herself to feel the emotions associated with the losses in the first place. Helen's protective mechanism as a child was to detach herself from relationships and from her own emotional states and now those states have become foreign to her.

> ***S.*** My doctor and the staff of Sanctuary encourage me to work through my grief, but even with them it feels too big to manage sometimes, especially in front of someone. With my doctor, I have to take care of how she is going to manage my feelings and I feel protective of her. With where I live now, a lot is going to be about me educating them. They seem to miss the whole grieving piece. And that makes it harder for me to deal with it, because I need them to understand. I am still struggling to put words to how I feel. I don't have words. One of the things I am working on is staying in the present, keeping the past and the present separate. I get pissed off, because why should I have to educate them when they are supposed to be helping me?

> ***J.*** I am not avoiding grieving any longer but it took a long time to get to it – about twenty-nine years.

> ***H.*** I don't like people seeing me sad or emotional in any way. It is embarrassing to have emotions in front of people. Particularly crying in front of someone. People tell me that I should have sadness about not having a relationship with my parents. I don't talk to them. But I don't feel it. They are probably right. This male therapist I was seeing kept telling me that I have a lot of anger towards my parents and one day I had an explosion of anger towards them. I guess you could be quite debilitated by it, if it is bad enough. But that is just conjecture. Like people don't let themselves get angry because they might do something violent. But that is all intellectual.

Alterations in Attention and Consciousness

Exposure to chronic states of physiological hyperarousal interferes with the capacity to learn, to voluntarily direct attention, and to maintain focus[40]. Traumatized children have little ability to self-protect. Confronted with the

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[40] Putnam, and Trickett, *Child Sexual Abuse;* Perry, *The Boy Who Was Raised as a Dog*

massive physiological hyperarousal that accompanies exposure to violence, there is little they can do to fight back or to flee. But they can dissociate – fragment their experience in a way that protects them against the very real danger of physiological overload. But the price they pay for this protection is substantial – the loss of a sense of wholeness, of an integrated self that adults from functional families simply take for granted.

✓ Loss of wholeness

Jodie's experience gave me the title for this chapter. She offers her childhood experience of fragmentation up as a way of helping us understand what this "beveled mirror" effect looks like, feels like. And then she goes on to describe the separateness, the state of dissociation she felt that she now understands as grief.

> ***J.*** I had this thing when I was a child, this fantasy. My parents had a beveled mirror in their room and the regular mirror was in the center. I thought that everyone in the world must see me as in the beveled part of it, the part that was screwed up, with the eyes over here and the nose separate, in pieces, in shards, because that is how I felt – disconnected. I had this fantasy that my parents must be paying doctors all over the world to fix everyone's eyes so that they would see me as they would see a normal person because nobody knew really, what was going on inside of me. I was around seven or eight.
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> ***J.*** Before I came to Sanctuary, I never really knew what these symptoms were about because the grief was like something separate from me. Now I am feeling it in my body as well. Now it is all inside of me and I can feel the grief bubbling instead of just being outside of me somewhere. I thought of this separate entity as a kind of blackness that was separate from me. It held so much power that it could control me and turn me against myself like wanting to kill myself or wanting to starve myself or just doing negative things to myself. I really thought about it as a separate thing. I knew it had something to do with my trauma – that the trauma was still controlling me. I could tell by the power and the impact it had on me that it had something to do with the past.

Alterations in Relationships

Abused children lose relationships. Some maltreated children, have no one to relate to from the very beginning. But many parents are adequate in supplying an infant's basic needs but cannot handle the demands of a growing, active child. For such a child, the loss of the formerly nurturing parent can be experienced as a death for which there are no words. The loss of early attachment relationship is devastating in its impact upon the capacity to

establish safe and trusting relationships as an adult. And it is not just individual relationships that are affected. It is within the family that we first learn about political, social and economic arrangements between people. Dysfunction in the family relationships will directly carry over into school, the workplace, and the community-at-large. As a result, many survivors of systematic abuse do not feel a sense of place in their social system, and they do not know how to achieve such a place without paying a price similar to the one they have already paid in their families. History repeats itself in the life of the individual inside and outside of the family and then history repeats itself on the part of the whole group.

✓ Loss of attachment relationships

As Samantha's story illustrates, children can lose siblings, friends, pets and other important relationships secondary to the abuse. Her story about the puppy, below, is particularly poignant because in responding with understandable rage to her father's perfidy, she becomes complicit in his murderous behavior, yet another loss that she cannot begin to touch. The priest's failure to respond is another way that her capacity to trust other human beings is compromised, based on a realistic notion of what she could expect from other people. When Jodie's parents failed to protect her from the sexual proclivities of her mother's stepfather, even though he had previously molested her mother, she experiences a secondary empathic failure, one that is possibly even harder to resolve than the original abusive incident. For abused and neglect children, relationships with animals can take on an even greater significance than the usually deep attachment that secure children have with their pets. In Helen's case, the pets were as neglected as the children and there was nothing she could do to help herself or them. Sometimes siblings can serve as buffers against the abuse of the parents, but in cases like Helen's, the children are turned against each other, competitively struggling for what little affection and care that is available.

> ***S.*** My older sister was removed from our home when she was ten by Child Protective Services. I was 8 at the time. I was responsible for the younger children. My little sister that died was my baby doll. My father made me watch while he smothered her. I still have flashbacks about that. I was afraid about what was going to happen next. I got in the crib with her and tried to wake her up afterward, and then when my mother came home, my father blamed me, said I had killed her. Mother didn't believe him. They called it a crib death.

> ***S.*** I had gotten a puppy for Christmas and my father knew it meant so much to me, after my sister was killed. I could attach to the puppy. But he would destroy anything I liked. He took the puppy and me into the bathroom, put peanut butter