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Culturally Sensitive Approaches to Finding Meaning in Traumatic Bereavement

Geert E. Smid and Paul A. Boelen

After the word of prohibition follows the word of judgment: "Thou shalt surely die." What it means to die, Adam of course cannot conceive; but if one assumes that these words were said to him, there is nothing to prevent his having a notion of the terrible. (…) The terrible becomes in this instance merely dread, for Adam has not understood what was said, and here again we have only the ambiguity of dread. The infinite possibility of being able (awakened by the prohibiting) draws closer for the fact that this possibility indicates a possibility as its consequence.

Thus, innocence is brought to its last extremity. It is in dread in relation to the prohibition and the punishment. It is not guilty and yet it is in dread, as though it were lost.

Further than this psychology cannot go, but so far it can reach, and moreover it can verify this point again and again in its observation of human life. (Kierkegaard, 1844/1957; The concept of dread, pp. 40-41.)

Traumatic events such as disasters, accidents, war, or criminal violence are often accompanied by the loss of loved ones. Traumatic grief following the loss of loved ones due to violent circumstances may occur in people surviving cultural conflicts as well as profession related risks. Traumatic grief can be conceptualized as a combination of traumatic distress and separation distress following an unnatural, violent loss. In terms

of conditions distinguished in DSM-5 (APA, 2013), traumatic grief reflects a combination of symptoms of posttraumatic stress disorder (PTSD) and persistent complex bereavement disorder (PCBD) (Boelen & Smid, 2017). PCBD is a condition similar to Prolonged Grief Disorder (PGD) entering the forthcoming ICD-11. Mourning behaviors and ways of dealing with bereavement comprise important aspects of an individual's cultural identity and profoundly affect the way the bereaved survivor finds meaning following traumatic loss. Finding meaning encompasses the bereaved individual's evaluation of the loss of the loved person and its implications for the future—a cognitive, emotional, and spiritual process aimed at strengthening the individual's ability to live with the loss within his or her cultural context.

The aim of the current chapter is to describe culturally sensitive approaches to finding meaning following traumatic bereavement. First, we will describe how the therapist explores the context of meaning. This includes exploring cultural ways of dealing with bereavement and grief, and listening to the story of the loss. In the second part of this chapter we will illustrate how different modes of symbolic interactions with the deceased person may aid in finding meaning in a culturally sensitive way. Selected interventions are presented along with case vignettes of refugees as well as a military veteran illustrating their use.

Exploring Meaning

Exploring cultural ways of dealing with bereavement and grief

The notions of historical trauma, loss, and grief refer to the enduring, intergenerational effects of cultural oppression in the lives of immigrant, minority, and indigenous peoples and communities (Kirmayer, Gone, & Moses, 2014). Specifically, persons from these backgrounds may experience *cultural incongruity* in case of dissimilarity between beliefs, expectations, and practices in the culture of origin and the

dominant culture (Bhugra & Becker, 2005). Consistent with this notion, disaster-exposed persons of immigrant cultural backgrounds who lost a loved one endorsed increased and more persistent stress-responsive distress compared with natives (Smid, Drogendijk, Knipscheer, Boelen, & Kleber, in press).

Rituals provide powerful and affirming experiences for bereaved individuals, in mediating the transition of the individual from one social status to another, affirming the importance of the deceased person, channeling emotions, and offering vehicles for continuity and social cohesion of the social community (e.g., Romanoff & Terenzio, 1998). The loss of loved ones under traumatic circumstances often coincides with an impossibility to perform culturally appropriate rituals. This is illustrated in the following case vignette.

Jack, now 25 years old, from Liberia, was referred for treatment of PTSD and depression. At age14, his house was attacked by the rebels. His beloved grandmother was burned in the house, while lying paralyzed on her bed. Jack wasn't at home; at that time he was forced to be a child soldier. His mother, brothers and sisters are missing and most likely deceased. (His father left the family when Jack was a small child.) Jack has recurrent nightmares in which his grandmother appears with a suitcase in her hand, staring at him. Jack's interpretation is that she accuses him of her death, because he wasn't there to protect her. He thinks her soul cannot find rest because there had been no burial ritual. He wants to accept her death but doesn't know how.

To enable a clinical estimation of the effects of rituals that could not be performed, therapists may conduct an assessment of cultural ways of dealing with bereavement and grief (Smid, Groen, de la Rie, Kooper, & Boelen, in preparation). To this aim, both cultural traditions related to death, bereavement, and mourning as well as coping and help-seeking activities related to the loss of loved ones need to be explored.

Exploring cultural traditions related to death, bereavement, and mourning. A key function of death-related rituals is to provide structured ways to mourn and express grief. Rituals may include time frames for immediate mourning and actions to be completed at specific points in time thereafter, such as a wake or yearly commemorations, prescribe how to handle and dispose of the body of the deceased, and when and in what way it is appropriate for people to talk about the deceased (Cacciatore & DeFrain, 2015). Encounters with the deceased that may occur in dreams or when bereaved persons see, feel, smell, or talk to the deceased, may have cultural explanations. Following such encounters, the person may experience exhortation and feel the urge to perform rituals (Eisenbruch, 1990; Hinton, Peou, Joshi, Nickerson, & Simon, 2013). Many rituals allow the bereaved to settle accounts or convey apologies or gratitude to the deceased. Mourning rituals are often *piacular* (Durkheim, 1995), i.e. not performing them creates guilt. While some rituals may be thought of as having implications for the afterlife (Hinton et al., 2013), performing prescribed rituals may be more generally necessary for proper role fulfillment or just doing things right (Staal, 1979). Within several religions, the mode of death, e.g., suicide, is thought of as having implications for the afterlife (Cacciatore & DeFrain, 2015). Exploring these implications may be helpful to support adaptive coping.

Exploring help-seeking and coping activities related to the loss of loved ones. Many bereaved individuals engage in practices related to spiritual, religious or moral traditions to cope with the loss of a loved one, including prayer and meditation. In addition, they may participate in worships or religious gatherings, speak with other people in their religious group and with religious or spiritual leaders. These activities may be helpful in coping with the loss, especially in dealing with guilt. Survivor guilt frequently occurs among traumatically bereaved survivors, notably refugees

(Eisenbruch, 1990). Concepts of guilt may be linked to broader cultural concepts of fairness and fate that may involve the afterlife. For example, the Buddhist concept of *karma* consists of the consequences of the good and evil deeds committed in all one's previous existences; suffering, therefore, is the karmic consequence of one's past sins and one can only hope for a better existence in the next rebirth by performing numerous acts of merit (Boehnlein, 1987). Other kinds of help may have been suggested by family, friends, or others. For clinicians, it is essential to explore these as well as other kinds of help the client or patient thinks would be most useful at this time to deal with the loss of loved ones.

Examples of questions that may be used to map cultural ways of dealing with bereavement and grief include:

- *If someone from your family, friends, or others in your community dies, how would people usually arrange the funeral?*
- *Are there other rituals after people have passed away?*
- *Is there a prescribed period of mourning or expressing grief?*
- *When and how do people talk about the deceased?*
- *When bereaved people have dreams or other types of encounters with the deceased, what may this mean?*
- *What do your family, friends, and others in your community believe happens after death?*
- *Do you engage in spiritual or religious practices to help you cope with the loss of a loved one?*

The therapist uses gentle Socratic questioning to further explore the associated beliefs, values, traditions, and meanings.

The story of the loss

Important components of psychotherapy for disturbed grief include exposure to memories of the loss and the deceased person, facing the reality and irreversibility of the loss, and confronting the associated pain (Boelen & Smid, 2017). Listening to the patient's narration of the story of the loss, the therapist explores other contextual and psychological determinants of meaning, i.e. the specific events and circumstances comprising the story of the loss. Besides cultural, spiritual, religious and moral traditions and the closeness of the relationship, the therapist learns about several other factors that may influence the patient's appraisal of the traumatic loss of the loved one, such as concomitant loss of resources, judicial procedures, availability of social support, previous trauma or loss experiences, and history of mental health problems. Discerning these factors, the therapist may offer practical advice and emotional support in addition to specific grief-focused interventions, and tailored psycho-education. Several elements of psycho-education following traumatic loss are discussed below.

Traumatic losses may present individuals with information that violates previously held positive beliefs about the self, life, and the future. Such losses can also confirm negative beliefs or *schemas* (Beck, 2008) that are part of the personal meaning assignment system. For instance, early losses and other adverse developmental experiences may foster negative attitudes and biases about the self (Beck, 2008); the meaning of these events may be transformed into a durable attitude (e.g., helplessness, pervasive fear, anger, or guilt), which may be activated by the traumatic loss and increase its negative meaning. Also, the attachment style of the individual and the nature of the attachment relation may shape the grief reaction (Maccallum & Bryant, 2013).

Negative cognitions and assumptions can be addressed in psychotherapy. There, the aim is not to "dispute" and "alter" negative cognitions about these broad themes, but, instead, to explore ways to maintain a positive view of self, life, and the future,

incorporating the painful loss. Self-blame and negative views of responses of the social environment may lead to feelings of guilt and anger. Self-blame may be especially prominent if the death is felt as a failure of caregiving, such as following the death of a child. Therapists should not simply try to challenge the self-blame but rather help the bereaved individual to assimilate the inability to prevent the death into a favorable view of self (Boelen, Van den Hout, & Van den Bout, 2006; Neimeyer, 2006).

Interpretations of one's own grief reactions may be important. Bereaved individuals may interpret their emotional reactions—including intense despair, negative thoughts, and vivid images associated with the loss—as intolerable, unbearable or signs of impending insanity or loss of control. Such negative appraisals may contribute to persistent separation and traumatic distress directly, by intensifying distress, and indirectly, by fuelling tendencies to minimize confrontation with loss-related stimuli.

Direct exposure to horrific details of the traumatic loss of a loved one increases the risk of traumatic grief. This is so because such losses radically invalidate core assumptions about safety, trust, and controllability, posing a greater challenge for the bereaved to maintain a positive view of the world and other people. Indeed, violent deaths are more likely to generate distressing intrusive memories than nonviolent deaths (Boelen, de Keijser, & Smid, 2015). Culturally sensitive care means that therapists try to appreciate and understand the nature and complexities of their patient's lived experiences—including the atrocities the individual may have been exposed to in case he or she fled a country at war.

Ambiguity, i.e. a lack of information such as with missing persons (ambiguous loss) may also be associated with increased distress. Because the situation of ambiguous loss cannot be resolved, the individual's sense of mastery may be impaired (Boss, 2006). Ambiguous loss can lead to disenfranchised grief—a grief that is not acknowledged by

people in the social context, particularly when it is part of a number of traumatic and loss events experienced in the context of war. Western bereavement rituals, based on a model of "letting go", are likely ineffective and inauthentic for non-Western people confronted with ambiguous loss.

Continuous searching for the deceased may lead to strong perceptual priming and a high likelihood of finding *matching triggers*, i.e. trauma and grief reminders that may reactivate memories of the traumatic loss and/or the deceased. In addition, *new stressful life events* may be perceived as more stressful. Stressful life events may include interpersonal tensions within bereaved families that may also be common after ambiguous loss (Boss, 2006). *Stress sensitization* refers to an increased susceptibility to the effects of new stressful events following exposure to extreme traumatic events. A contextual stress sensitization model (Smid et al., in press) specifies processes contributing to enhanced stress sensitivity in three different dimensions: cognitive, interpersonal, and neurobiological. The *cognitive* dimension includes enhanced responses to trauma-related memories, enhanced perception of threat, and reinforced negative interpretations of events. The *interpersonal* dimension includes increased distrust, irritability, detachment or estrangement, and identity disruption. The *neurobiological* dimension includes different neurobiological systems that may show increased responses due to previous excessive stress reactions. The impairments that result from stress-responsive distress may cause loss of resources through contextual mechanisms (for example, job loss after a conflict at work in a trauma survivor with increased irritability), leading to persistence or increases in distress over time. Matching triggers, new stressful life events and stress sensitization can, at least partially, account for the frequently fluctuating nature of persistent grief reactions over time.

Finding Meaning

Culture is represented in the form of intersubjective perceptions, i.e. beliefs and values that members of a culture perceive to be widespread in their group (Chi-Yue, Michele, Toshio, Garriy, & Ching, 2010). Reconstructing the cultural intersubjective reality may be particularly helpful in dealing with a sense of injustice and guilt, which may maintain grief as well as PTSD symptoms (e.g., Tay et al., 2017). This may be achieved by encouraging the client or patient to engage in different ways of symbolic interaction with the deceased person.

Symbolic interactions with the deceased can find expression in writing assignments, imaginal conversations, and culturally appropriate rituals. These interventions are part of evidence-based treatments for PTSD and prolonged grief. Specifically, Brief Eclectic Psychotherapy for PTSD (BEPP), an evidence-based treatment for PTSD (Gersons, Meewisse, & Nijdam, 2015), and Complicated Grief Treatment (CGT), a manualized treatment with proven effectiveness across several randomized controlled trials that has been implemented in different cultural settings (Shear et al., 2014; Shear, Reynolds, III, & Simon, 2016) comprise these interventions.

Writing Assignments

Writing assignments are useful tools to enable patients to evaluate meanings (Neimeyer, 2012) and to help bereaved individuals to confront painful aspects of the loss at their own pace. An ongoing farewell letter is a letter to the deceased in which the patient writes what he has always wanted to say to the deceased, what he misses most, expressing his longing for the deceased. In people who have difficulty allowing feelings of sadness, it may promote emotional processing and finding meaning.

Writing an angry letter may be especially helpful in patients struggling with sense of injustice, who have difficulty dealing with feelings of anger. A letter can be written to a perpetrator of murder, negligent bystanders, the government or another agency that is

held responsible, in which uncensored anger, including insults and diatribes can be expressed. The letter is not sent. Sometimes, burning the angry letter is integrated into a ritual.

Mustaph is a 36-year-old refugee from Iraq who fled with his family to the Netherlands. Two years later, he received a telephone call in which he learned that his younger brother died in an attack on his parental home by the Islamic State. It was unclear whether the other relatives were still alive. Mustaph developed nightmares about this attack. He felt guilty and yearned for his brother. He was often angry with his wife and children. Mustaph felt strong anger toward the terrorists. A letter was written during the next session. Because Mustaph was illiterate, he dictated to the interpreter, and the therapist wrote. The letter started with revenge fantasies. As the therapist normalized his anger he felt free to express his aggressive thoughts in the letter. Afterwards he felt able to hand over the judgment of the perpetrators to Allah. Mustaph also wrote a letter to his brother, saying that he felt sure he was now in a good place.

Imaginal conversations

The therapist may guide an imaginal conversation with the person who died, in which the patient talks to the deceased person, and also answers (Jordan, 2012). This technique may mitigate feelings of guilt and may foster disclosure of things that still need to be expressed toward the lost person ("unfinished business"). As a continuation of the previous vignette on Mustaph, the use of imaginal conversations is illustrated below.

Mustaph felt still very guilty, also because he had not been able to bury his brother. Therefore, it was decided to perform an imaginary conversation where Mustaph would ask his brother for forgiveness and answer on behalf of his brother. His brother forgave him

and hoped that Mustaph would find his parents so that he could take care of them. This conversation felt for Mustaph like saying goodbye.

In the case of Jack, an imaginal conversation has been used in a similar way.

In the course of therapy, Jack engages in an imaginal conversation with grandmother. Grandmother is sitting on an empty chair and forgives Jack. She tells him that he may continue his life. Jack also imagines that he is a judge at the international court, where he sends the rebels to jail. Jack now realizes that he wants to live again.

The role of the therapist in the imaginal conversation is to encourage the bereaved individual to articulate meaningful questions, thoughts, and feelings toward the lost person, and to validate emotions that may arise during the conversation.

Farewell Ritual

Farewell rituals have been used traditionally in funerals where the body of the deceased was not present. The farewell ritual symbolizes a revised attachment bond with the deceased: the memory of the deceased may still be cherished, but the deceased is no longer symbolically kept alive (Van der Hart & Boelen, 2003). Rituals can be a bridge to the patient's culture or spirituality. They may symbolize continuity as well as transition and serve reconciliation as well as affirmation (Doka, 2012).

The patient designs a farewell ritual that he finds appropriate. Examples of a farewell ritual include: visiting a special place; creating a symbol of remembrance; performing a culturally appropriate ritual; renouncing things related to the traumatic circumstances of the death; burning the angry letter. The therapist is not present at the ritual. The ritual also implies a departure from the therapist and a reunion with loved ones, therefore the patient is encouraged to share the farewell ritual with a partner or a close friend.

David is a 55-year old Dutch military veteran, married, and father of two children. During his first mission abroad (he was 17 years old) he had lost one of his closest comrades on site due to an accident. He first came into treatment 33 years later. He suffered from intrusive memories of his deployment experiences, his sleep was disrupted, and he couldn't stand loud noises. His wife reported sudden outbursts of anger. David obsessively kept himself busy and drank too much alcohol. David frequently experienced moments of intense grief over the loss of his comrade, but could not bear the emotions that came along with this. David hadn't visited his comrade's grave. Therapy focused on being able to visit the graveyard and tolerating the associated emotions. When visiting his comrade's grave for the first time in 35 years, he felt overwhelmed with sadness. He wrote a letter to his comrade, in which he expressed his feelings of helplessness and sadness. In the final phase of treatment David decided to arrange a small ceremony at his comrade's grave as a farewell ritual. His plan was to gather some close others at the cemetery and read his letter out loud. Then he would place a small keepsake at the grave. As the end of therapy approached, he felt as if the loss of his comrade had become part of his life. There were hardly any moments of agitation anymore. His wife confirmed this, and was glad that she had a deeper understanding of what he had been through.

Writing assignments may be integrated with the ritual, as illustrated in the case of David, and in the following case.

George, now 37 years old, from Liberia, had lived in the Netherlands since 2001. At the age of 13 his younger sister was killed. When he was 19 his parents were murdered by the rebels. George was forced to witness their murder. He was captured by the rebels and then forced to be a child soldier. George did not know what happened to the bodies of his parents. George had recurrent nightmares and flashbacks in which he relived the murder of his parents. When he tried to fall asleep at night, intrusive memories of the murders kept

him awake for hours. He had difficulties accepting the death of his parents and had strong feelings of guilt. He found his life meaningless without them. In the days surrounding the anniversary of his parents' death, he experienced acute physical pain. George was afraid of losing control and experienced a lot of anxiety about expressing his grief. Explaining the influence of avoidance on symptom maintenance helped him to engage in the treatment. George talked about his safe and happy early childhood years and his warm relationship with his parents. With gradual exposure he talked in detail about the day his parents were murdered and how he was taken by the rebels afterwards. In between sessions he had a hard time and got support from a friend as well as his religion. The therapist encouraged George to write letters to his parents about how he was doing and how he felt about them. First this was very difficult for him but eventually he told that the writing of these letters had given him inner peace. George expressed more of his feelings and told about his struggle to find meaning in their death. He contemplated what his parents would have said about his current life and what advice they would have given him. This contributed to integrating the memory of his parents in a helpful manner. George started planning to visit the places he had lived with his parents and the place where they had died. He wanted to talk to people in that area and see if he could find out what had happened to his parents' bodies. He wanted to give them a proper burial. As a closing ritual of the therapy he made plans to go to a church there and leave the letters to his parents there behind.

Conclusion

For the bereaved survivor, the traumatic loss of loved ones evokes intense emotions as well as uncertainties inherent in trauma, loss, fate, and mortality that are now connected to the deceased person(s). Many cultural conceptions of death and the afterlife aim at filling the void arising from existential uncertainties. The Danish philosopher Kierkegaard, whose importance for psychology has been equated with that

of Freud, explains in his book on the concept of fear (Kierkegaard, 1957) how the unknown, something that people do not understand but that nevertheless evokes many possibilities, is the source of our fear. It is linked to guilt, prohibition and punishment. Nowadays, fear of the unknown and intolerance of uncertainty are still key concepts in explaining the development of psychopathology, including disordered grief (Boelen, Reijntjes, & Smid, 2016). Therefore, a crucial therapeutic goal in grief therapy is to assist the patient in finding helpful meanings that promote emotional processing and grief resolution. Finding meaning refers to, as noted, a cognitive, emotional, and spiritual process aimed at strengthening the individual's ability to live with the loss within his or her cultural context. In culturally diverse patients with symptoms of PTSD and PCBD/PGD following traumatic bereavement, exposure-based treatments may therefore be complemented with interventions aimed at finding meaning that include various modes of symbolic interaction with the deceased person.

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