

THE GRIEF THAT DARE NOT SPEAK ITS NAME

PART I: DEALING WITH THE RAVAGES OF CHILDHOOD ABUSE

SANDRA L. BLOOM, M.D.

EMAIL FROM AMERICA

PSYCHOTHERAPY REVIEW 2(9), SEPTEMBER 2000

When someone close to us dies, society generally accepts and even expects us to undergo a process of mourning. Physical death presents a tangible and comprehensible loss. Traditionally, mourning is not just an individual rite of passage, but a socially conditioned and approved pathway for recovery from loss enabling us to let go of those who have died, and prepare ourselves for new attachments.

Largely unrecognized is the necessity and value of grieving for other kinds of losses besides those associated with actual death. A common denominator for adult survivors of childhood abuse and neglect are less tangible, but nonetheless significant losses of hope, of innocence, of love and of joy. For adult survivors, the losses that accompany child maltreatment, are cloaked in silence, lost in the shrouds of history, and largely unrecognized. But these “little deaths” linger as unremoved splinters in the survivor’s psyche for decades. In general, the expression of grief for these losses is unaccepted, rejected, denied and stigmatized. Child neglect represents particular challenges for the adult survivor because victims must grieve for things they never had, and thus never had the chance to lose.

The losses that accompany childhood exposure to terror and violence can only be grasped within the context of attachment theory. Bowlby recognized that “grief and mourning occur in infancy whenever the responses mediating attachment behavior are activated and the mother figure continues to be unavailable” (Bowlby, 1960, p.9). He discussed 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” (Bowlby, 1960, p.11). 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” (Khan, 1963). He went on to discuss how this can leave a person vulnerable to breakdown later in life.

Bowlby (1963) identified four main variants of pathological responses by bereaved adults and other clinicians and researchers have been busily extending his work to show the relationship between disrupted attachment in childhood as a result of maltreatment, the experience of loss, and the development of adult pathology, especially depression (de Zulueta, 1994). The first variant he described as 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. There is a long-established connection between childhood loss and depression (Bowlby, 1980). Adam has recently reviewed the strong connection between suicidal behavior in adolescents and adults and disrupted attachment (Adam, 1994). There is also a growing body of literature connecting childhood maltreatment 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 (Ellason et al, 1996; Grady, 1997; Koss, Koss & Woodruff, 1991; Leserman et al., 1996; Salmon & Calderbank, 1996; van der Kolk, 1996). Additionally, 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 traumatic events (Kessler et al, 1995; Solomon & Davidson, 1997).

Bowlby’s second variant was that of 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; In the last decades, investigators have concretized the relationship between insecure forms of attachment in childhood and the evolution of personality disorders (West and Keller, 1994). Fonagy

and colleagues have helped illuminate the important relationship between disrupted attachment and borderline states (1998),

In his fourth variant, Bowlby looked at the absorption in caring for someone else who has also been bereaved, sometimes amounting to a compulsion. Linkages may be made between this incomplete form of grieving and dysfunctional, even violent relationships. Others have looked at both highly conflicted families and violent couples from the point of view of disrupted childhood attachment relationships (Henry & Holmes, 1998; Roberts & Noller, 1998), while Main & Hesse (1990) and Solomon & George (1999) 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.

Bowlby's fourth variant focused on a denial that the relationship is permanently lost, a denial that could link attachment, grieving and the spectrum of dissociative disorders (Bowlby, 1963). Recently, Liotti has written about the development of dissociative disorders within an attachment framework (1995, 1999).

Still, when it comes to actually treating victims of childhood abuse and neglect, only rarely does one diagnostic category fit. 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" (Herman, 1992; van der Kolk et al., 1994). Field trials for DSM-IV (American Psychiatric Association, 1994), demonstrated that there are significant differences between survivors of disasters who suffer from post-traumatic stress disorder and childhood survivors of maltreatment. 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 (Van der Kolk et al, 1994).

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 for 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 victims of abuse in all of their relationships and strongly color the nature of the therapeutic alliance. 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. 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. 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 only the effects of prolonged stress but also the long-term effects of suppressed grief on the body. 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 often shattering.

While attachment theorists have been carefully formulating theory and analyzing data from the perspective of developmental psychopathology (Cicchetti & Lynch, 1995), 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, low self-esteem, depression and anxiety, as well as a high

risk of cancer, cardiac disorders, alcohol and tobacco consumption, and suicidal ideation (Jacobs, 1999). Other authors have looked at the various ways that traumatic bereavement and exposure to death and dying affect various populations and age groups (Figley, 1997; Figley, Bride & Mazza, 1999), while still others have looked at the way entire communities grieve after mass tragic events (Zinner & Williams, 1999).

Rando (1993) 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. At least since Lindemann's seminal work (1944), the connection between the normal somatic manifestations of grief and symptoms of complicated mourning have been recognized (Engel, 1961; Rando, 1993).

Nonetheless, 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 that 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.

Over the course of the next two months we will look at the grief that accompanies childhood abuse and neglect more closely. The next column will focus more specifically on the losses that adult survivors must work through in the process of recovery and subsequently, we will look at the process of recovery from these kinds of losses.

REFERENCES

Adam, K. S. (1994). Suicidal behavior and attachment: A developmental model. In M. B. Sperling & W. H. Berman, (Eds.), Attachment in adults: Clinical and developmental perspectives. New York: The Guilford Press. (pp. 275-298).

- American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington, DC: American Psychiatric Press.
- Bowlby, J. (1960). Grief and mourning in infancy and early childhood. The Psychoanalytic Study of the Child, v.15: 9-52.
- Bowlby, J. (1963). Pathological mourning and childhood mourning. Journal of the American Psychoanalytic Association 11: 500-541.
- Bowlby, J. (1980). Attachment and loss, Volume III: Loss, sadness and depression.
- Cicchetti, D and M. Lynch. (1995). Failures in the expectable environment and their impact on individual development: The case of child maltreatment. In D. Cicchetti and D. J. Cohen (Eds.), Developmental psychopathology, Volume 2: Risk, disorder, and adaptation. New York: Wiley.
- De Zulueta, F. (1993). From pain to violence: the traumatic roots of destructiveness. London: Whurr Publications.
- Ellason, J. W.; C. A. Ross; K. Sainton; L. W. Mayran. (1996). Axis I and II comorbidity and childhood trauma history in chemical dependency. Bulletin of the Menninger Clinic; 60(1): 39-51.
- Engel, G. L. (1961). Is grief a disease? A challenge for medical research. Psychosomatic Medicine. 23: 18-22.
- Figley, C. R (Ed.). (1997). Traumatology of grieving: Conceptual, theoretical and treatment foundations. New York: Brunner/Mazel.
- Figley, C. R., Bride, B. E. & Mazza, N. (1999). Death and trauma: The traumatology of grieving. New York: Brunner/Mazel.
- Fonagy, P., Steele, M., Steele, H., Leight, T., Kennedy, R., Mattoon, G., & Target, M. (1995). Attachment, the reflective self, and borderline states: The predictive specificity of the Adult Attachment Interview and pathological emotional development. In S. Goldberg, R. Muir & J. Kerr (Eds.), Attachment theory: Social, developmental, and clinical perspectives. Hillsdale, NJ: The Analytic Press. (pp. 233-278).
- Grady; K. T. (1997). Posttraumatic stress disorder and comorbidity: Recognizing the many faces of PTSD. Journal of Clinical Psychiatry; 58(supplement 9): 12-15.
- Henry, K. & Homes, J. G. (1998). Childhood revisited: The intimate relationships of individuals from divorced and conflict-ridden families. In Simpson, J. A. & Rholes, W. S., (Eds.), Attachment theory and close relationships. New York: The Guilford Press. (pp. 280-316).
- Herman, J. L. (1992). Trauma and recovery. New York: Basic Books.

- Jacobs, S. (1999) Traumatic grief: Diagnosis, treatment and prevention. New York: Brunner/Mazel.
- Kessler, R.; A. Sonnega; E. Broment; M. Hughes; C. B. Nelson. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. Archives of General Psychiatry; 52: 1048-1060.
- Khan, M. M. R. (1963). The concept of cumulative trauma. Psychoanalytic Study of the Child 18: 286-306.
- Koss, M. P.; P. G. Koss; W. J. Woodruff. (1991). Deleterious effects of criminal victimization on women's health and medical utilization. Archives of Internal Medicine; 151(2): 342-347.
- Leserman, J.; D. A. Drossman; Z. Li; T. C. Toomey; G. Nachman; L. Glogau; L. (1996). Sexual and physical abuse history in gastroenterology practice: how types of abuse impact health status. Psychosomatic Medicine; 58(1): 4-15.
- Liotti, G. (1995). Disorganized/disoriented attachment in the psychotherapy of the dissociative disorders. In S. Goldberg, R. Muir & J. Kerr (Eds.), Attachment theory: Social, developmental, and clinical perspectives. Hillsdale, NJ: The Analytic Press. (pp. 343-365).
- Lindemann, E. (1944). Symptomatology and management of acute grief. American Journal of Psychiatry 101: 141-148.
- Liotti, G. (1999). Disorganization of attachment as a model for understanding dissociative pathology. In J. Solomon & C. George, (Eds.), Attachment Disorganization. New York: The Guilford Press.
- Main, M. & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. T. Greenberg, D. Cicchetti & E. M. Cummings (Eds.), Attachment in the preschool years: Theory, research and intervention. Chicago: University of Chicago Press (pp. 161-182).
New York: Basic Books.
- Rando, T. A. (1993). Treatment of complicated mourning. Champaign, IL: Research Press.
- Roberts, N. & P. Noller. (1998). The associations between adult attachment and couple violence: The roles of communication patterns and relationships satisfaction. In Simpson, J. A. & Rholes, W. S., (Eds.), Attachment theory and close relationships. New York: The Guilford Press (pp. 317-351).
- Salmon, P. and S. Calderbank. (1996). The relationship of childhood physical and sexual abuse to adult illness behavior. Journal of Psychosomatic Research; 40(3): 329-336.

- Solomon, S. and J. R. T. Davidson. (1997). Trauma: Prevalence; impairment; service use; and cost. Journal of Clinical Psychiatry; 58(suppl 9): 5-11.
- Solomon and George (1999)
- Van der Kolk, B. A. (1996). The complexity of adaptation to trauma. In B. van der Kolk, B. A., McFarlane, A. C. & Weisaeth, L. (Eds)]. Traumatic Stress: The Effects of Overwhelming Experience on Mind; Body and Society. Guilford; New York. (pp.378-397).
- Van der Kolk, BA., Roth, S, Pelcovitz, D. and Mandel,FS (1994). Disorders of extreme stress: Results from the DSMIV Field Trials for PTSD. Paper presented as 1994 Eli Lilly Lecture to the Royal College of Psychiatrists, London, February 2.
- West, M. & Keller, S. (1994). Psychotherapy strategies for insecure attachment in personality disorders. . In M. B. Sperling & W. H. Berman, (Eds.), Attachment in adults: Clinical and developmental perspectives. New York: The Guilford Press. (pp. 313-330).
- Zinner, E. S. & Williams, M. B. (1999). When a community weeps: Case studies in group survivorship. New York: Brunner/Mazel.

THE GRIEF THAT DARE NOT SPEAK ITS NAME

PART II: DEALING WITH THE RAVAGES OF CHILDHOOD ABUSE

SANDRA L. BLOOM, M.D.

EMAIL FROM AMERICA

PSYCHOTHERAPY REVIEW 2(10), OCTOBER 2000

Adults who were maltreated as children carry around with them the impact of delayed, unresolved, “stigmatized” loss (Sprang & McNeil, 1995). 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.

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” (Goffman, 1963). 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 (1989), 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. 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 that 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?

It is possible to look at the variety of loss experiences that survivor’s must recover from through the lens of “complex post-traumatic stress disorder” (Herman, 1992; van der Kolk et al., 1994). Field trials for DSM-IV (American Psychiatric Association, 1994), demonstrated that there are significant differences between survivors of disasters who suffer from post-traumatic stress disorder and childhood survivors of maltreatment. 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

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 (Weil, 1992). 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 (**Loss of ability to manage emotions like 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 (**Loss of a sense of safety**). 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 the ability to complete mourning**).

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 (Perry, 1994; Putnam & Trickett, 1993). Traumatized children have little ability to self-protect. Confronted with the 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 – memories, feelings, identity are fragmented. This sense of an integrated self is something that adults raised in functional families simply take for granted and is truly known only in its absence (**loss of a sense of wholeness, self-integrity**).

ALTERATIONS IN RELATIONSHIPS

Abused children lose relationships. Some maltreated children, have no one to relate to from the very beginning of their lives. However, 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 (**loss of early attachment relationships**). This loss of attachment is devastating in its impact upon the capacity to establish relational safety as an adult (**Loss of ability to create safe and trusting relationships**). 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 out into the 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 (**Loss of meaningful place in community**). 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.

ALTERATIONS IN SELF-PERCEPTION AND PERCEPTION OF THE PERPETRATOR(S)

We develop a sense of self-esteem in the context of our significant relationships. The baby learns to view himself or herself with the same regard that he or she sees mirrored in the mother's and father's eyes. Likewise, abused and neglected children come to believe the image of themselves that their parents create, an image that often has very little to do with the reality of the children's abilities, skills, or dispositions. They are told they are bad, evil, or worthless, just like their faithless Aunt Sadie or Uncle Bill. Repeat a lie frequently enough and people come to believe it. Children are particularly vulnerable to this kind of parental systematic brainwashing because of the large power imbalance that exists between parents and children.

As adults, people often maintain the same connection with their parenting figures as they had as a child and consequently, experience similar fears, powerlessness and helplessness in the face of their parents, or in the face of their internal image of their parents. We may experience that internal image as "the voice of conscience" and have taken internalized it as our own, without fully realizing that it is the

internalized voice of an abusive parent. As a result, even within our own minds we continue to reenact the childhood trauma between ourselves and our parents. As outsiders, we may look at a young, six-foot-two man, intimidated and quivering before a frail old man, half his size and fail to understand that the grown man is experiencing the same terrors as when his now frail father would beat him into submission every day after school. Our perceptions of ourselves do not just automatically change as we mature, nor do our perceptions of the people who have perpetrated violence against us. Without working through the grief and the anger connected to the relationship we can remain terrorized and humiliated by past figures in our lives, even though they may be out of sight or even dead.

These childhood experiences continue to impact on the adult's self-esteem, even though great success in the world should realistically lead to heightened self-esteem (**loss of realistic sense of self-esteem**). Parents and significant others who have been abusive, irresponsible, and neglectful do not provide adequate role models for intimate relationships or for parenting, leaving the survivor with great holes where relational wisdom should be (**loss of adequate role models**). Authority figures who routinely abuse authority and who use violence to enforce their authority are unable to teach good conflict resolution skills and as a result, adult survivors often lack the requisite skills for resolving the inevitable and demanding problems associated with interpersonal relationships (**loss of problem resolution skills development**). The tendency to reenact the past relationally means that it is very difficult for the adult survivor to engage in learning new and healthier forms of interpersonal engagement (**loss of the ability to let go of the past and move on**). And finally, growing up with abusive parenting produces such alterations in developmental pathways that many survivors miss out on educational and vocational experiences that could have afforded them lifelong benefit (**loss of educational and vocational opportunities**).

SOMATIZATION

Clinical and poetic descriptions of the mourning process have always been strongly colored by the somatic presentations of grief. There is a growing body of literature connecting childhood maltreatment with a wide variety of physical problems in adulthood. In a recent survey of a large HMO adult population performed by the Center for Disease

Control in Atlanta, more than half of respondents reported belonging to at least one, and one-fourth reported to belonging to two or more categories of childhood exposures to adverse experiences or “ACE’s”. The seven categories of adverse childhood experiences included: psychological, physical, or sexual abuse; witnessing violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. In this 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 (Felitti et al, 1998). 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, increased number of distressing physical symptoms and a greater number of health risk behaviors (Walker et al, 1999).

Adult survivors of childhood trauma are grieving events from the long buried past and grieving for events that may not be considered “appropriate” causes for grief. Nonetheless, their descriptions of their own grieving processes reveal to us that when loss is worked through, the body does a great deal of the work along with the mind. The body remembers what the mind forgets, the body keeps the score (van der Kolk, 1994). In the case of chronic grief, this can mean the **loss of health and well being**. In the particular case of sexual abuse, it can also mean the **loss of a healthy and fulfilling sexuality**.

ALTERATIONS IN SYSTEMS OF MEANING

Human beings are meaning-making animals. The structure and function of our minds compels us to make sense of our reality. In a very real way,

we need to put everything we know and experience into some kind of logical, coherent, and integrated framework. Out of this framework, we develop a philosophy of life and derive the basic principles and assumptions that guide our decisions. It is exceedingly difficult to make sense of the world when you have not been cherished and protected as a child, when the very people who were supposed to love you were the people who abused, neglected, and abandoned you. This is particularly true when you grow up embedded in a society that routinely instructs you that children are to be cherished and protected. Victims of childhood abuse must grieve for the childhood that was stolen from them, that they are given to believe is their birthright (**Loss of innocence, loss of childhood**). More subtle issues of neglect mean that survivors must grieve for what they did not have and should have been there (**Loss of what wasn't there and should have been**). Early in their lives, victims of childhood abuse and neglect are exposed to the commission of deeds on the part of their caretakers that are deliberate, harmful and wrong. This early exposure to uncontrollable evil can have grave impact on the child's moral development and make discovering moral clarity even more difficult (**Loss of moral clarity**). As a result of all of these experiences, many adults abused as children make conscious or semi-conscious decisions not to "inflict" themselves on another vulnerable human being and so they sacrifice their own desire to have children and in doing so, their own future (**Loss of ability and/or desire to have children**). The compounded result may be a joylessness, difficulty in finding purpose or meaning in life (**Loss of purpose, meaning, joy in life, will to live**).

In next month's column we will look at what we are learning about the grieving process for adult survivors of childhood adverse experiences.

REFERENCES

- American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington, DC: American Psychiatric Press.
- Bloom, SL.(2000) The Grief That Dare Not Speak Its Name, Part I: Dealing with the Ravages of Childhood Abuse. Email From America Psychotherapy Review 2(9).
- Doka, K. J. (1989). Disenfranchised grief: Recognizing hidden sorrow. Lexington, MA: Lexington Books.

- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D.F., Spitz, A. M., Edwards, V., Koss, M. P., Marks, J.S. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *AMERICAN JOURNAL OF PREVENTIVE MEDICINE*14(4):245-58
- Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. New York: Simon & Schuster.
- Herman, J. L. (1992). Trauma and recovery. New York: Basic Books.
- Perry, B.D. 1994. Neurobiological sequelae of childhood trauma: PTSD in children. In M.M. Murburg, (Ed.), Catecholamine Function in Posttraumatic Stress Disorders: Emerging Concepts.Washington, D. C.: American Psychiatric Press. (pp.253-276)
- Putnam, F.W. and P. K. Trickett. (1993). Child sexual abuse: a model of chronic trauma. *Psychiatry* 56 (1):82-95.
- Sprang, G. & McNeil, J. (1995). The many faces of bereavement: The nature and treatment of natural, traumatic and stigmatized grief. New York: Brunner/Mazel.
- Van der Kolk, BA., Roth, S, Pelcovitz, D. and Mandel,FS (1994). Disorders of extreme stress: Results from the DSMIV Field Trials for PTSD. Paper presented as 1994 Eli Lilly Lecture to the Royal College of Psychiatrists, London, February 2.
- Walker EA, Gelfand A, Katon WJ, Koss MP, Von Korff M, Bernstein D, Russo J (1999). Adult health status of women with histories of childhood abuse and neglect. *AMERICAN JOURNAL OF MEDICINE* 107(4):332-9.
- Weil, J. L. (1992). Early deprivation of empathic care. Madison: International Universities Press.

THE GRIEF THAT DARE NOT SPEAK ITS NAME

PART III: DEALING WITH THE RAVAGES OF CHILDHOOD ABUSE

SANDRA L. BLOOM, M.D.

EMAIL FROM AMERICA

PSYCHOTHERAPY REVIEW 2(9), NOVEMBER 2000

In the previous two columns we looked at the connections between grieving, traumatic grief and disrupted attachment and the specific losses entailed in surviving childhood abuse and neglect. This month we will look at recovery from these losses.

Ochberg (1988) has talked about some of the necessary tasks required to complete the process of grieving. 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 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 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 (Engel, 1961).

RECOGNIZING THE PROBLEM

Completing the tasks of mourning requires, first of all, the recognition that one is suffering from unresolved grief. For survivors of childhood abuse and neglect this recognition and identification of the problem can be a serious barrier to improvement. The stigma associated with many of the losses for which people must grieve further decreases the likelihood that their chronic symptoms will be understood within the context of mourning (Bloom, 2000 a, b).

People suffering from chronic, unresolved grief can present for treatment in many different ways. The most obvious and frequent manifestation is chronic depression that responds only partially or episodically to antidepressant medications. These patients are high utilizers of psychiatric and medical services, repeatedly seeking out some kind of direction or relief. Because of current changes in the health care system in the U.S. that minimizes any form of therapy except medication, these patients are likely to receive inadequate or poor care. Chronic suicidality and a preoccupation with death may be indicators of the same problem. It is not uncommon for patients to make early progress in treatment and then “hit the wall” of grief without knowing that is what is happening. Progress in treatment slows, the patient appears to be continually circling around the same issues that go nowhere, and the therapist may become increasingly frustrated, bored, and angry. The resort to a change in medication or adding medications is a frequent response to this situation.

Chronic somatic complaints often accompanied by the overuse or abuse of prescription pain medications is common. When physical symptoms are a manifestation of unresolved grief, the pattern may be one of “doctor hopping” or drug-seeking while the person and their health care providers seek a physical solution to a nonphysical problem. The result is bound to be an increasing level of frustration, chronicity, and compounded rage on the part of everyone involved.

The inability to play, have fun, experience pleasure is a frequent accompaniment of chronic and unresolved grief. The avoidance of feelings, particularly sadness, an inability to cry while continuing to hold

on to objects representing the loss are other signs of impacted grief. Unresolved grief may also manifest through a preoccupation with violence to self or to others, including children and pets. There may be attempts to escape the sadness through substance abuse, compulsive sexual or other relational behavior, excessive religiosity, or involvement in cults, gangs, political activities, work or other groups that serve to divert attention away from the wounded area.

Continuing to behaviorally reenact negative relationships despite insight and a commitment to treatment can also be a sign that the survivor is avoiding taking on the task of grieving. The yawning dark chasm that grief represents may feel overwhelming, endless, a bottomless pit, particularly when those feelings are not identified as what they are – feelings of bereavement – and legitimized as part of the normal process of mourning.

EXPERIENCING THE GRIEF

The hardest part of the grieving process may be allowing the process to begin. People whose attachments have been disrupted are so ill-equipped to process loss and have confidence that the pain may come but will go again, that they often spend decades doing everything they can think of to avoid confronting the pain of the past. Having toyed around the edges of grief for so many years, they may view it as something they can keep at bay and never have to resolve, not fully realizing just how much the past is robbing them of a vibrant present. So the first task is letting the experience happen, feeling the enormity and uncontrolled nature of grief, and then, coming to recognize that in struggling to control an act of nature, you are simply prolonging and being controlled by a process that would otherwise, pass on. Providing education and support is an essential part of assisting survivors to confront the pain of the past. Knowing that grieving is a process and not a permanent state of being is critical information to hold on to through the darkest hours. During the acute stages, when physiological arousal is at a renewed high, medication may help restore some physiological stability.

LOSS OF PREVIOUS COPING SKILLS

Grieving for the past losses that accompany childhood abuse means giving up reliable coping skills. Coming to terms with loss requires an ability to tolerate working through self-blame, survivor guilt, and normal guilt. As long as the survivor is not safe with himself or herself, s/he

cannot learn to manage affect and without learning how to safely manage affect, it is impossible to safely work through the grief. But this does mean sacrificing habits that have helped manage overwhelming affect for decades – things like drugs and alcohol, compulsive working, smoking, destructive eating behaviors, and self-mutilation. This means that before grief work can really begin, the groundwork must be laid for new and healthier coping skills that involve both self-soothing and relational soothing.

FEARING LOSS OF ATTACHMENTS

For many adults who were abused as children, the key to recovery is the restitution of the capacity to attach. But in allowing oneself to attach there is also the fear of losing the precious attachment to a depriving and abusing past and then losing attachment to a therapist who has served as the transition between loss and restoration. Implicit in the process of therapy is this inevitable loss, because therapy cannot substitute for the creation of a long-lasting support system that you don't have to pay for. The therapist must be committed to the patient's resolution of grief and the ultimate termination of the therapeutic relationship. Balanced properly, the fear of losing attachments, of losing a potentially better future than the awful past, can be a powerful incentive for positive change.

LOSING ATTACHMENTS

Recovery can mean losing attachments as well, and although the relationships may be highly pathological, they are all the person knows, and something is better than nothing. As survivors work through the grief process, they gradually learn to let go of the abusive attachments. This may only mean symbolically letting go, but in other cases, there is no alternative but to actually withdraw from an on-going abusive relationship.

GIVING UP THE FANTASY OF RESTORATION

Inside every adult abused as a child, there is a child hoping to be rescued, actively fantasizing about how different things will be someday. Continuing the symptomatic self-destructive behavior is a disguised way of holding on, of waiting for the rescue that never comes. Grieving for the losses of the past means giving up the fantasy that

amends will be made, that the loveless parents will turn into loving ones, that innocence will be retrieved – the fantasy of restoration.

WORKING WITH THE NONVERBAL

It may not be possible to resolve grief, particularly longstanding, unresolved, traumatic grief, through the use of verbal abilities alone. From what we now understand about the way the brain processes overwhelming experience, we need art, enactment, story and ritual to help us safely integrate the verbal and nonverbal aspects of our experience. So too, a ritual passage for mourning is present in every culture, throughout time, in recognition of the human need for structure and order and process.

THE VITAL NATURE OF SOCIAL SUPPORT

Social support throughout the grieving process is vital to the course of normal bereavement. Just as vital is the restoration of social support for the victims of grief that has been disenfranchised and stigmatized. Much therapeutic groundwork may need to be established to help the survivor recognize and grieve for all the ways in which their sense of stigmatization has negatively impacted on the possibility of recovery before they can even begin to deal with the sources of original loss. To prepare for the grieving process, therapeutic attention needs to focus on helping the survivor develop a substantial support network that extends beyond the therapeutic alliance.

MAKING MEANING

We now understand how vital it is for trauma survivors to make meaning out of their experience (Janoff-Bulman, 1992). But making meaning out of an abusive childhood is a difficult task. Legitimizing the need to grieve for the losses and identifying those losses can help place their experience within a more meaningful context. Connecting their personal suffering with the larger social and political context of human rights and systematic violation of those rights also helps to restore a sense of connectness and purpose.

MAKING SENSE OF THE INTERGENERATIONAL NATURE OF ABUSE

Part of the struggle to make some meaning out of the abusive past is about the struggle to understand how, if not why, this could have happened. The automatic question that arises in some point on the road

to recovery, is “what happened to my parents that they could have so mistreated me?” A review of family biographical information can help the survivor place their own family story in context, as well as illuminating the past familial history of repeated failures at resolving long-standing grief and loss experiences. Largely unexplored is how unresolved grief gets passed down from generation to generation through the intimate nature of the attachment relationships.

TRANSFORMING THE PAIN

As the grieving process progresses, the darkness begins to lift and survivors become involved in the process of moving on, not forgetting the past but no longer compelled to repeat it. Ultimately, we hope that adult survivors of childhood abuse and neglect will be able to transform their pain into something of value to themselves and others, what Judy Herman has called a “survivor mission” (Herman, 1992). The losses that adults must recapitulate and work through in order to recover, are long delayed, sometimes tangible, but at other times, metaphorical, spiritual, or moral losses. When they have successfully transformed this engagement with death into engagement with life, no longer must their lives serve as memorials to the unspoken, stigmatized and unexpressed tragedies of the past.

REFERENCES

- Bloom, SL.(2000a) The Grief That Dare Not Speak Its Name, Part I: Dealing with the Ravages of Childhood Abuse. *Email From America Psychotherapy Review* 2(9).
- Bloom, SL.(2000b) The Grief That Dare Not Speak Its Name, Part II: Dealing with the Ravages of Childhood Abuse. *Email From America Psychotherapy Review* 2(10).
- Engel, G. L. (1961). Is grief a disease? A challenge for medical research. *Psychosomatic Medicine*. 23: 18-22.
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: The Free Press.
- Ochberg, F.M. (1988). *Post-traumatic therapy and victims of violence*. New York: Brunner/Mazel.