

Ambiguous Loss:
A Critical Review of Current Research

A THESIS
SUBMITTED TO THE DEPARTMENT OF PSYCHOLOGY
OF THE STATE UNIVERSITY OF NEW YORK AT NEW PALTZ
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
MASTER OF SCIENCE IN MENTAL HEALTH COUNSELING

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May 2009

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ACKNOWLEDGEMENTS

The writing of this thesis was done with the help of many, but I will begin with my thesis committee members. I would first like to express my gratitude to Dr. James Halpern. Dr. Halpern served as my advisor not only for this thesis, but throughout my graduate studies. He provided support, opportunity for academic and professional growth, and ultimately agreed to serve as my thesis advisor. Most importantly, his encouragement and sense of humor made the time spent working together on this thesis time spent laughing. I could not have completed this without his setting aside time for thesis meetings and readings when events such as a swine flu outbreak and a mass shooting tragedy were in need of his expertise. However, nothing has honored me more than his steadfast belief in my clinical abilities and willingness to accept me as a potential colleague and friend.

Dr. Melanie Hill was gracious enough to serve as a reader for this paper and I am thankful she could add me to an already heavy load of research and student responsibilities. Dr. Hill is an inspirational person with a brilliant and insightful mind and generous heart. I cannot imagine I would have made it through the rigors of the graduate program to the thesis stage without her academic and personal support. Shared interests outside of the Psychology field also provided a sense of kindred spirits with Dr. Hill that made thesis planning through three thesis advisor changes bearable. I cannot express what Dr. Hill's genuine caring and clear feedback has meant to me, she will always be my "Prima".

My third committee member, Robin Cohen-LaValle, was a late addition to the committee who agreed to serve as a personal favor. Her expertise in counseling, disaster mental health, and her personal experiences made Robin an important member of the committee. Robin offered a clear, thoughtful perspective that always added to the work at hand. Most importantly, Robin's willingness to share her first-hand experiences with Ambiguous Loss were invaluable to my understanding of the topic. Robin Cohen-

LaValle was also partially responsible for bringing the next important people into my life as she recommended me for my job.

It would be inconceivable to not give my heart-felt thanks to Antonio Bonilla, Rita Celariste, and the State University of New York At New Paltz Educational Opportunity Program (EOP) staff and students. As Director of EOP, Antonio's willingness to advocate for me to have the time to complete my thesis rather than leave a job I love was an invaluable gift that I will never be able to repay. Rita, our Assistant Director, provided a sane, thoughtful framework for my work and thesis scheduling. Her genuine enthusiasm for my achievement of this seemingly insurmountable task was what carried me through some of the rough days in the writing process. Together Antonio and Rita lead EOP with authenticity and model a team oriented style that makes staff and students feel a part of the EOP family. They do this with humility, grace, and fierce pride of program that makes coming in to work a joy, even on the toughest days. Also making it possible for work and thesis to occur simultaneously was the kindness and understanding of my colleagues: Ivelisse Tuttle, Robert Hancock, Clare Kelly-Barra, Christine Goldston, Ann M. Gill, Mark Rumnit, and Martiza Lewis. This amazing group of professionals was always ready to help me, sing for me, cheer for me, adjust a due date for me, or sometimes just make me smile. I thank them all for those large and small moments. The students of EOP are an inspirational group of individuals and there are too many to name, but each in their way has kept me on my path by staying focused on theirs despite the challenges and obstacles in their way.

Finally, but with more love and deeper gratitude than I can express in words, my closest friends and family deserve mention here. There is no better support in this world than from my friends Shawna Griffin and Erica White. They both know there is no better cure for a wounded soul than a night on the dance floor and some deep discussions on history, psychology, politics, and sex, not always in that order. Yvette and Frank Gonzales know that if there was ever anything they need or want, I will be there for them.

They are my siblings by heart, if not by blood. Consuelo Gonzales, my mom, is responsible for all this. Everything I have become is due to her love, guidance, and encouragement. She taught me to love deeply, think critically, work hard, and that kindness and respect were the proper basis for all interpersonal interactions. Jack makes my heart ache and sing in ways I never imagined. He has been visiting campus with me in every stage of his life and his hugs, smiles, and love washed away the fatigue of full-time work and full-time school. My gratitude to Matthew for all his support is too large for any amount of words, but nothing compared to the infinite reach of my love for him. Thank you for my roots and wings, Mateo.

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ABSTRACT

This paper reviews past and current literature pertaining to Ambiguous Loss (AL), provides critique of current research, outlines possible directions for future research, and evaluates the most effective practices for treating AL. Two specific types of AL will be addressed: Physical and Emotional/Cognitive. In Physical AL the loved one is physically absent with no remains or opportunity for closure. Emotional/Cognitive AL occurs when the loved one is physically present but emotionally/cognitively absent. Lack of breadth and depth of research on this topic, especially as related to effective therapeutic approaches, indicates many possible avenues for further research. Quantitative data on best practices is nonexistent.

INTRODUCTION

“As only New Yorkers know, if you can get through the twilight, you'll live through the night.”

Dorothy Parker (1893- 1967)

Ambiguity and *loss* are aspects of life that human beings have struggled to integrate into consciousness since thinkers have been recording their thoughts on the subject. There are many examples of philosophers, literary icons, and politicians attempting to assuage humanity's worries about life's uncertainties. Ambiguity is defined as:

1 a: doubtful or uncertain especially from obscurity or indistinctness <eyes of an *ambiguous* color> b: inexplicable 2: capable of being understood in two or more possible senses or ways <an *ambiguous* smile> <an *ambiguous* term> <a deliberately *ambiguous* reply> (Merriam Webster, [www.merriam-webster.com])

Above, Dorothy Parker uses twilight as a subjective metaphor for ambiguity.

Children are often fussy and uncomfortable during this transitional time of day, possibly a human predispositional distaste for ambiguity. Science in general, and psychological research specifically, seeks to resolve the ambiguities of the inner life and the universe - searching for precise answers to as many “whys” as possible. Science seems incapable of resting on “maybe” or “yes and no”. Humans in every culture grapple with codifying the ambiguities of sexuality, gender, and politics, ultimately developing a set of traditions and rituals that help establish cultural boundaries and constructs that arrange everything into definable categories. Counselors, therapists, and mental health workers are challenged daily to help clients find the tools and the strength to cope with feelings of

uncertainty, denial, anxiety and some forms of depression. The struggles of the client can often be rooted in an inability to integrate conflicting feelings, to adjust their self identity to new surroundings or information - such as the loss of a loved one.

Loss is an individual experience which involves a grieving process and can become debilitating for some. For example, adjustment to and acceptance of loss can seem insurmountable when a mother has just watched her only child laid to rest after a tragic accident. The grief can be paralyzing, though over time most people are resilient in even the most traumatic of circumstances. Life is full of losses, large or small, which may bring an experience of grief. People have their own individual reactions and responses to grief. Yet grief is a universal human experience. Grief is part of life. Understanding the unique ways in which people experience grief can be helpful for both grieving people and those supporting them. There has been significant research on the nature and process of grief. Notably, Stroebe and Stroebe (1993), discuss the stages of grief as a non-linear process with three partially overlapping stages. Stage 1 is characterized as shock, disbelief, and denial. Stage 2 can be identified by the acute mourning accompanied by acknowledgement of the death and acute feeling states, often entailing social withdrawal. Stroebe and Stroebe refer to the third stage as restitution, a stage of integration and acceptance of the loss and moving on with present and future focus.

The experience of grief becomes even more complex when the loss is inherently uncertain – when there is not an actual death to process. This paper will address those instances that combine high levels of loss and ambiguity. Pauline Boss has called this

combination of presenting issues “Ambiguous Loss” (AL) (Boss 1999). Boss defined AL as a situation of unclear loss. The loss is unclear because the loved one is not known to be dead or alive in some case, or they are not clearly absent or present. Boss explored two types of loss more explicitly the ambiguity of a physical type as in the case of missing persons. The second type describes someone who is present physically, but with new ambiguity cognitively or emotionally, exemplified by cases involving brain injury, dementia, or alcoholism (Boss 1999). In recent years, AL has been defined in many ways and much research has been conducted on the topic. Though some researchers have investigated the potential for application of the concept to situations of loss involving loss of place and culture, for the purposes of this paper I will refer only to the loss of a loved one, interpersonal and relational in nature.

Thesis

“In three words I can sum up everything I've learned about life: it goes on.”

Robert Frost (1874- 1963)

Due to the impact of not only the tragedy of 9/11, but also the ensuing war in the Middle East and Hurricane Katrina, the US is facing an era of profound strain on the mental health field. The sheer quantity of people hurt, lost, injured or missing climbs daily and the families must cope with grief and frequent uncertainty. Some of the uncertainty the families of military personnel face is connected to personal roles in the family structure before, during, and after deployment. It is imperative to have sound research to evaluate best practices when working with those experiencing AL.

Therefore, this paper will address the following questions: Is the success of interpersonal

therapeutic work with patients experiencing relational AL dependent on whether the nature of the loss is physical or emotional? Should we treat physical AL differently than cognitive/emotional AL?

This thesis will critically review the theory and research on AL by first discussing the work of Boss, who has produced the majority of research on the topic to date. Current research in AL and the therapeutic implications will be reviewed. The impact of AL on individuals and families will also be explored. This thesis will explore the literature on AL to consider if making the distinction between physical and cognitive AL is a helpful way of organizing the literature and possibly provide a helpful framework in conceptualizing treatment implications. Specifically, three practiced therapeutic approaches mentioned by Boss (2006) to AL will be addressed and the following specific terms will be used:

Dialectical Behavior Therapy is commonly called DBT, this is a model of therapy which encourages the client to feel comfortable holding two opposing thoughts or beliefs at one time. This type of therapy helps clients build their capacity for dialectical thinking. Dialectical thinking is a rejection of absolutes, acknowledgement that thinking in an “all or nothing” framework does not always apply in working with people, as human nature is inherently complex. Dialectical thinking allows for a loved one to be present and not present at the same time by finding continuity in aspects of presence.

Cognitive Behavioral Therapy is a therapeutic approach uses the client’s ability to rationally accept that some of their emotionally based beliefs are faulty and utilizes behavioral re-conditioning to restructure the responses to specific triggers. This approach

is widely researched and, due to its measurability, is considered by insurance companies to be the most effective therapeutic approach from a fiscal standpoint.

Family Systems entails the conceptualizing the individual as a part of a complex family structure, this approach examines the structures of the family to identify boundary complications and infringements as a means of addressing imbalances in the individual.

Ambiguous Loss is an emotional experience wherein suffering includes the following symptoms: unresolved grief, including outrage; confusion, distress, and ambivalence; uncertainty leading to immobilization; blocked coping processes; experience of helplessness, depression, anxiety, and interpersonal conflicts; response of absolutes, ie: denial; rigidity of family roles; outrage at exclusion of family member; confusion with boundaries and new roles; guilt, if hope is given up; and refusal to discuss individuals or situations (Boss 1999).

Boundary Ambiguity occurs when there is a family member missing whether cognitively, emotionally, or physically. The boundaries and roles of the remaining family member(s) become blurred as the expectations that family member have of one another become vague and uncertain. This can create feelings such as anxiety and frustration in addition to the grief or loss the family may be experiencing (Boss 2006).

Identity Ambiguity is a common aspect of Boundary Ambiguity as the individual roles in the family are unclear, each family member's sense of who they are and how they are identified within the family becomes vague, potentially creating additional stress and anxiety.

Psychological Family is described in Boss's work as those family members who we carry with us even when they are not physically present (2006).

TREATMENT OF AMBIGUOUS LOSS

“No one can confidently say that he will still be living tomorrow.”

Euripides (480 BC – 406 BC)

Boss has done extensive research and writing about AL dating back to 1973. She has worked in collaboration with other researchers who specialize in trauma, grief, and loss. After many academic publications on various topics relating to AL, her first book was published in 1999, “Ambiguous Loss, Learning to Live with Unresolved Grief”. She has become recognized as an expert in this field and her most recent book, “Trauma, Loss and Resilience” (2006) synthesized her research and practical experience into a practical guide for counselors and therapists working with patients suffering from this type of loss. Boss is careful to describe AL not as a single traumatic event or crisis, but as an ongoing situation which brings daily grief, stress, and pain. Boss's recommendations for most effective therapeutic approach to AL are constructed by an overarching family systems framework, with strong cognitive leanings to help re-frame, in addition to a dialectical approach to help the client learn to tolerate the tension of the ambiguity and cognitive coping strategies (2006).

In dealing with AL Boss argued for a family and community oriented approach versus therapy oriented toward the individual. She stated that, in times of relational loss, humans require more support; and individual therapy may inadvertently increase the

impact of the trauma by isolating those struggling to grieve, and in Boss's view, keeping them frozen in the grieving process. In her latest book “Loss, Trauma, and Resilience: Therapeutic work with Ambiguous Loss” (2006), Boss summarized her conceptualization of AL and its impact on individuals, families, and communities. In the majority of the book she addressed the role of the therapist and the therapist’s own methods for coping with ambiguity. She also discussed how the therapeutic process can help both the therapist and participant(s) to resolve their incongruities and move toward being more resilient. The idea of a psychological family is explored, which Boss defines as family that exists in one’s mind (2006). She explained that the psychological family is always present in an individual and permeates their sense of place and self. When AL disrupts that psychological family and new roles are taken on by family members, it can create deep psychological discomfort for some, resulting in difficulty coping with daily activities. The familial adjustments to new roles in times of loss or AL are called boundary ambiguities by Boss.

Boss described the interplay between boundary ambiguities and the degree of stress or loss, as well as the mitigating role that both intrinsic and extrinsic resources can have on the individual's resilience in the face of AL. Intrinsic resources are defined as those inner strengths the client brings to cope with AL, while extrinsic resources are the family and community resources available to the client. Boss proposed the therapeutic goals for building resilience when working with AL as the following: finding meaning, tempering mastery, reconstructing identity, normalizing ambivalence, revising attachment, and discovering hope (2006). These therapeutic goals, aimed at helping specific experiences of those suffering with AL, are described in depth.

Finding meaning is a therapeutic goal that can be achieved in as many different ways as there are individual beliefs for each client. Boss suggested using techniques or resources such as narratives to name the problem, dialectical thinking, religion and spirituality, forgiveness, small good works, rituals, positive attribution, sacrifice for great good or love, perceiving suffering as inevitable, and hope. Boss also suggested that hate, revenge, secrets, violent and sudden death, and disillusionment may hinder the search for meaning.

Tempering mastery is described as helping clients to “soften what mastery and helplessness means” for them (Boss, 2006). Some examples of how this might be accomplished include: externalizing the blame, increasing success experiences, softening attribution, and managing and making decisions. As in finding meaning, there are some things that can hinder the client in tempering mastery, such as self-blame, a belief that bad things don’t happen to good people, and too much mastery.

The next recommended goal Boss discussed is reconstructing identity. She used a social construction framework for this and suggested the reconstruction begin by defining family boundaries, selecting major developmental themes, and developing shared values and views. According to Boss, some of the hindrances to this process are discrimination and stigma, forced uprooting, isolation and disconnection, and resisting change.

Boss considered ambivalence as an inevitable by-product of AL and proposed normalization of that ambivalence as an important therapeutic task. Some of ways she recommended helping clients with their feelings of ambivalence are using cognitive coping strategies, seeing conflict as positive, normalizing guilt and negative feelings, and uncovering latent or unconscious ambivalence.

When Boss discussed the goal of attachment revision she was careful to qualify that she used a general definition of attachment, not the recent definitions associated with attachment theory. She described how the burial process cues a revisiting of attachment for surviving loved ones, however, in cases of AL that is not possible and the client “freezes” in the grieving process. Boss recommended revising the attachment as a means to allow some flexibility and softening of the attachment. Some ways to achieve this are: thinking dialectically, accepting that fantasies of missing persons are common, moving from despair to protest, inclusion of family and community, developing memorial ceremonies and rituals, and watching out for no-talk rules. Hindrances in this task are seen in two major themes, expecting closure and overemphasis on individuation.

The final therapeutic goal Boss discussed is the discovery of hope. She considers this integral to building resilience when it is based on a reasonable evaluation of the situation. Some ways that hope can help the client are by imagining options, laughing at absurdity, developing patience, rethinking termination, redefining justice, and revisiting the psychological family. The hindrances to this healthy hope are given as examples, like the wife who stays with a batterer in hopes he’ll change; this is a type of hope not always based in realistic appraisal of the situation.

Boss takes the conceptual stance that the familial networking is one of the strongest predictors of resilience in the face of crisis or trauma. This is corroborated by the studies on resilience conducted by Bonanno (2004). He argued that the majority of people are resilient in nature and will not require counseling interventions, even in the case of crisis.

Boss advocated, when beginning work with clients, that therapists establish the structure of the psychological family. In her conceptualization the psychological family extends beyond the physical presence of a family member. As those who practice clinical work recognize, there are grandparents, aunts, uncles, siblings, and other extended family members “in the room” during a therapy session, as the client reveals the psychological presence of those who have impacted their life and their way of being in the world. Boss (2006) posited that there are key assumptions linking the concept of a psychological family to AL. First is that in cases of physical presence, but emotional loss, as from brain injury or alcoholism, the stress on the family system can be greater due to the tendency to deny the affliction and expect the person to think/act/ behave as they did before. Contrarily, when there is loss of physical presence loved ones can be kept psychologically present. Boss asserted that the maintaining psychological presence serves to facilitate coping, rather than signal a hallucinatory disorder. Boss reframed the time of waiting for closure as an opportunity to practice dialectical thinking, and hope that the loved one will return to them, which prepares them to mourn, if there is no return. Boss explained that while dealing with the AL, family members can become accustomed to feeling uncomfortable with ambiguity and the discomfort helps build coping skills. Finally, Boss highlighted the social nature of humanity and urges therapists and counselors to be open to the varying degrees of absence or presence in the interpersonal relationships of their clients. She believes that interpersonal relationships are a key factor in overall resilience.

One of the strongest statements Boss made is that a shift in perception on the part of the therapist is required. The idea that a client will find closure is not possible with

AL and the therapist has to be able to cope with that ambiguity. Counter transference here is particularly tenacious. A therapist to someone experiencing AL must be able to tolerate ambiguity personally to help normalize the experience and model coping strategies in conjunction with the teaching and discussion of them.

CURRENT RESEARCH

“Not everything has to mean something. Some things just are.”

Charles de Lint (1951- Present)

There has been research in the years since Boss first published her work applying her concepts to various situations and targeted groups experiencing AL. Unfortunately, little has been done to quantitatively measure and research the therapeutic approaches and their efficacy, but the research does give indications toward that goal. The research reviewed in this paper was chosen because it addressed relational loss of either a physical or emotional/cognitive nature. Research focusing on other types of AL that were less concrete and relationally focused were not included. The first three articles discussed the form of AL when there is a physical presence, but the loved one is emotionally or cognitively unavailable. The next article addressed the type of AL when there is a physical absence with no remains to aid in closure. The final two articles discussed in this paper are less clearly defined as either physical or emotionally based AL. However they provided valuable perspectives and research on both types of loss.

Abrams (2001) presented a qualitative case study of a man and his family as he progresses through a chronic illness that ultimately takes his life. This type of emotional/cognitive AL affects the family, but also the patient. In their interview based

study on siblings of schizophrenics, Kristofferson and Mustard (2000) discussed the emotional “interruptions” that occur when a loved one becomes unavailable cognitively but is still physically present. Landau and Hissett (2008) researchers used a qualitative interview process to explore the experiences and treatments of individuals with MTBI and their families. Di Young and Buzzi (2003) presented a qualitative study, where the loss is of the physical type of AL occurring when a child is missing. Useful in their study was an evaluation of the types of therapy used and scenarios of differing approaches proposed which might prove more effective. The final two articles described the application of AL research and therapeutic approaches to situations that have alternating characteristics of both types of AL. Lee and Whiting (2007) used qualitative interviews and a subjective series of pictures depicting puppies to evaluate the children’s concept of psychological family and how closely the foster children’s experiences parallel Boss’s (2006) guidelines for AL. Faber, Willerton, and Clymer (2008) also used qualitative data collected from families of deployed reservists to explore their experiences during deployment and reunion cycles.

Abrams (2001) used a case study to examine the issues of resilience and ambiguity across a lifespan. The study related the family structure and learned coping mechanism of a client whom she treated over the course of five years during a degenerative illness that led to death. She presented this case as a testament to his own resilience and that of his family and credits their success to a nurturing childhood which provided the family the tools to appropriately nurture their own child. Although this client had dealt with Drug Addiction and Alcoholism, the 12 step approach of AA provided him with yet another method of coping. Abrams also stated that the ability or

willingness to maintain a steady work history throughout the client's life span and varying degrees of adversity were stabilizing factors that added more strength to his resilience. This article provided no quantitative measures of the statements, but was based on anecdotal evidence alone. The author also unintentionally demonstrated the compounding factors such as the stability of the family system prior to the AL, and previously learned coping strategies that can influence resilience and the difficulty in trying to ascribe causal relationships between environmental factors and inherent abilities to cope.

Kristofferson and Mustard (2000) in their paper "Toward a Theory of Interrupted Feelings" examined the experiences of siblings of people suffering from Schizophrenia. This article was based on qualitative research conducted via interviews. The single shared response amongst the interviewees was one of survivor guilt. The authors conceptualized the experiences of the siblings as "interrupted feelings". They concluded that the grieving process is interrupted by AL; the fluctuation nature of the illness; the invalidation of their feelings by professionals and others in their community; and also inhibited by themselves, unable to admit their own anger, sorrow, or shame. These identified feelings seemed to clearly indicate the need for the suggested approaches of DBT, CBT and Family Systems, especially Boss's emphasis of therapists being part of the psychological family dealing with ambiguity.

Landau and Hissett's (2008) research titled "Mild Traumatic Brain Injury: Impact on Identity and Ambiguous Loss in the Family" examined the relationship between Boundary Ambiguity and Identity Ambiguity. They attempted to discern whether the AL

is a major factor in the breakdown of the relationship or the Minor Traumatic Brain Injury (MTBI). With those suffering from MTBI, they experience a type of loss of their past selves, while their families are simultaneously experiencing AL. The stressors involved in coping with variations of loss are compounded by the renegotiation of boundaries in the family system. The findings of this study were that Family Systems counseling as early after the injury as possible would increase the chances of resilience for all members of the family.

DiYoung and Buzzi (2003) in their article “Ultimate Coping Strategies: The Differences Among Parents of Murdered or Abducted, Longterm Missing Children” measured the self reported coping strategies and grieving mechanisms of families whose children were missing. The authors reported that the parents had used similar coping strategies with two variations: first, when the children were confirmed to have been murdered, the coping strategies shifted; and second, while the parents of the murdered children began a new grieving process, the parents dealing with long-term loss coped using varying techniques depending on the likelihood of return as perceived by the time lapsed since the child was missing. The parental group of the children who were missing long term was less likely to view support groups and professional support as helpful, especially when ordered by the court. The parents of children who were murdered were more likely to view their support group experience as positive. This trend was evident in the parents’ views of law enforcement as well.

Emotional responses were also contrasted between the two groups: “Parents of long term missing children listed their responses from most to least dominant as:

frustration, depression, hope, anger, and denial. In contrast, the parents of murdered children reported them as: hope, anger, denial, fear, and depression.” (Di Young & Buzzi, 2003) It is interesting to note that though hope is generally seen as a positive trait, in both groups the researchers saw it as a negative trait, as though hope was intensifying the other emotional responses. This research affirmed Boss's assertion that AL “freezes” the grieving process, as the parents whose children were murdered were able to move through other stages of grief, including learning to trust others and forgiveness, while those whose children were not found remained frustrated and unable to move on (Boss 2006). This research did not attempt to suggest ways that counseling or therapy might be made to better suit the needs of the parents dealing with the long-term loss and ambiguity. This is an important consideration to make, with all the information available to therapists and law enforcement agencies regarding best practice in situations of AL: how to implement programs that help, rather than exacerbate the issue? As evidenced by the reports of the long-term missing group, group therapy only served to make them more depressed.

Lee and Whiting (2007) examined the implications of foster children’s daily state of uncertainty in their manifestations of AL. Foster children have entered the system under painful circumstances, usually due to some trauma or crisis, and at the order of the courts. Once in the system, they can be prone to behavioral issues as well as developmental delays depending on the nature and extent of the circumstances bringing them into Foster Care. The authors of this article reported that the children displayed the following characteristics of AL: unresolved grief, including outrage; confusion, distress, and ambivalence; uncertainty leading to immobilization; blocked coping processes;

experience of helplessness, depression, anxiety, and interpersonal conflicts; confusion with boundaries and new roles; and guilt, if hope is given up .

This host of ambiguity and intense emotional responses in a child who has not entered the foster care system from a stable and nurturing place makes therapy and behavioral interventions imperative. The authors of this article discussed the benefits that foster care children would gain from a similar approach to the one outlined by Boss in her 2006 book already discussed in this paper. Treating the children with a nonjudgmental and actively listening stance gives them permission to express feelings they thought were unacceptable. Psycho-educational work with all parties involved in the children's lives helps normalize their feelings, and some actions, as stemming from self-protective responses to personally unsafe environments. Finally, a family systems approach can further help give a useful framework to understanding the family and where the child fits in, both where they are and where they were.

Faber, Willerton, & Clymer, (2008) reported on a population dealing with both Physical and Emotional aspects of AL. The authors reported that over 375,000 reservists are currently deployed around the globe and that they and their families are experiencing ambiguous boundary issues that can create stress in the family system in ways similar to AL. The family members and reservists experience the physical type of AL while the reservist is away, and then upon the return, there are Ambiguous boundary issues and, in cases of acute stress disorder and PTSD, there is the potential for the emotionally absent type of AL. The researchers used a qualitative method of inquiry and interviewed the families several times over a period of a year after their return from deployment. The

research yielded two types of ambiguity, Ambiguous Absence (Phase 1) and Ambiguous Presence (Phase 2). Each of these stages has degrees of stress related to boundary ambiguity. The family must negotiate a functioning household without the reservist while they are gone, creating new skill sets and responsibilities for all family members. Then the boundary must be re-negotiated when the reservist is re-absorbed into the family. The coping mechanisms employed by the families and the reservists were improved greatly when they were in contact with Family Support Groups. These groups were comprised of other reservist and military families who could empathize and discuss the issues from first hand experience. The researchers of this study concluded that these support groups were an invaluable resource and greatly mitigated the strain on the families. This supports Boss's concept of family systems approach as more effective than individual work in cases of AL.

Implications of the Research for Practice

Does the current research support Boss' theory and approach to practice? How should a clinician interpret the research and integrate the recommendations of Boss into their client therapy? This research can be examined from the perspective of the clinically relevant results. In what way do the therapeutic recommendations of Boss and the research reviewed here address the therapeutic needs of those suffering from either physical or cognitive/emotional AL? Boss outlined a framework for treatment that addressed a broad spectrum of AL specific grief experiences. She advocated family and community based approaches that provide those coping with AL a support system that she viewed as resilience building (Boss 2006). Boss made no differentiation between

treatments for those suffering AL of a physical or cognitive/emotional nature. Her recommendation was for a seasoned clinician: to meet clients where they are in the process and move through the therapy in a client-centered manner. Some of the research reviewed in this paper does not address the effectiveness of the therapeutic approach as much as examine different populations to in the context of AL. .

Abrams (2001) used family and community resources as important components of a treatment strategy. The use of narrative, a treatment method recommended by Boss, was also used. The family members' AL was softened by the narratives. By remembering and telling stories which reinforced the roles they played in the family prior to the cognitive loss, some of the boundary and identity ambiguity was alleviated and they were better able to deal with the cognitive losses of their father. Kristofferson and Mustard (2000) also examined AL of the cognitive/emotional variety. However, the research was aimed at highlighting the specific ways that siblings of schizophrenics were affected by AL and did not provide research on therapeutic efficacy at all. Though this research did not provide specific therapeutic guidelines, it is useful in illustrating the variations of experiences that can be categorized as AL. Landau and Hisset (2008) investigated a different aspect of cognitive/emotional AL in the families of people who had suffered MTBI. A family systems approach to therapy, also recommended by Boss, was shown to increase resilience. These studies seemed to show that in cases of AL with cognitive/emotional loss family systems therapy, community supports, and the use of narratives in therapy were helpful.

DiYoung and Buzzi (2003) examined AL with physical loss. The findings of this research showed that group therapy actually intensified the anger, frustration, and

feelings of helplessness in the participants. Though this could simply be the result of poor group leadership on the part of the therapist, it is a significant result for consideration. It is a stark contrast to the families of deployed reservists in the study by Faber, Willerton, and Clymer (2008) who reported that group therapy and support groups helped lessen their experience of AL. The differences between these two groups may provide some valuable information for future research. Some valuable questions for future research would be: In what ways does group cohesion affect the therapeutic value to sufferers of AL? Is the loss of a child enough of a foundation to form a cohesive therapy group? What part did the more group oriented military culture play in the success of the reservists' group therapy experience? When a family is missing a child are the symptoms more closely related to trauma than AL? What role does the passage of time play in that characterization of the loss? These are all important facets of the group therapy approach to AL that should be studied more carefully.

The research reviewed in this paper did not give a definitive recommendation for treatment of AL when the loss is physical or cognitive/emotional. What was illuminated by the research and literature presented here is that more thinking is called for in the clarification of this useful conceptualization of a very real type of loss. There are issues that need to be better addressed in the research such as the nature of the AL. Though physical and cognitive/emotional are a starting place, Lee and Whiting's (2007) study of the foster children who experience both types simultaneously illustrated the need to study more carefully the ways that the groups are impacted and which therapeutic approaches are most effective. Aside from the nature of the AL, the intensity is another important area for further study. If the parents of missing children are in an intensified emotional

state, would therapeutic approaches more suited to trauma be more effective? Or in the case of military families, there is a definite variation of intensity if the family has regular e-mail contact with their physically absent family member versus a family member who serves in a military branch with no contact for months. Research addressing the best practices in these differing levels of intensity would be very useful to clinicians working with these families. Ultimately, Boss's reliance on the judgment of the client-centered clinician can only be justified when the research provides clinicians with accurate and careful data to base their therapeutic interventions on.

Suggestions for Further Research

In order to begin building a solid foundation for treatment, there needs to be more quantitative research done. For example, a long-term study should be conducted on those coping with AL, with therapists using the treatment guidelines that Boss (2006) describes and providing periodic quantitative measures of symptom intensity that can measure the increase or decrease in AL symptoms over time. This type of study could be replicated and adapted to use cross-culturally to test for efficacy of the treatment protocol and perhaps generate a guideline for not only professionals, but community responders and volunteers.

One important aspect of therapeutic intervention in AL that is completely absent from the research is the cultural context of the family and community. Boss (2006) mentions culture as a factor to consider when treating a family coping with AL. She recommends that clinicians remain open and nonjudgmental about the definition of family and family roles as there are many cultural variations of these concepts. Boss did emphasize a family and community based approach and in that framework there are strong

cultural influences that should be addressed in the research. That is absent completely is a gaping hole in the methodology of the studies being conducted in this field of research.

FINAL THOUGHTS

Boss (2006) uses this poem to viscerally describe the sense of needing things to freeze when grieving:

Funeral Blues

*Stop all the clocks, cut off the telephone,
Prevent the dog from barking with a juicy bone,
Silence the pianos and with muffled drum
Bring out the coffin, let the mourners come.*

*Let aeroplanes circle moaning overhead
Scribbling on the sky the message He is Dead.
Put crepe bows round the white necks of the public doves,
Let the traffic policemen wear black cotton gloves.*

*He was my North, my South, my East and West,
My working week and my Sunday rest,
My noon, my midnight, my talk, my song;
I thought that love would last forever: I was wrong.*

*The stars are not wanted now; put out every one,
Pack up the moon and dismantle the sun,
Pour away the ocean and sweep up the woods;
For nothing now can ever come to any good.*

W.H. Auden

I use it here for a similar purpose. Though loss and grief are a part of human experience, unless one has been through AL they have been able to, as Boss puts it, “silence the piano”, while those experiencing AL are pinned in this state of crying out for the silence and space to grieve and move on. In Boss’s considerable body of work on the subject of AL and its implications for treatment, she has had years of first hand clinical experience and research to base her recommendations for treatment. My research with trauma, loss,

and AL are not as extensive, however, the combination of family systems, dialectical, and cognitive approaches to helping those coping with AL has helped in my own work with victims of trauma and disaster as well as with children in the therapeutic foster care system.

The current research reviewed here uses an exclusively qualitative methodology which is valuable to clinicians working in the field as a means to build a repertoire of best practices. Especially in cases where there are important or conflicting results, such as with the findings of DiYoung and Buzzi (2003), where the families of long-term missing children reported the group sessions exacerbated the symptoms of depression and anger. This finding notably differs from Boss's overarching recommendation of finding community and group supports as a resilience-building technique (2006). Additionally, the findings of Faber, Willerton, and Clymer (2008) where the families of reservists reported the support groups helped mitigate the AL symptoms and increased resilience, parallel Boss's (2006) findings, but contrast DiYoung and Buzzi (2003) .

Humans will always be faced with ambiguity and loss, separately and at times, in combination. The work of clinicians is to seek out the best, most effective means of helping our clients cope. In the current political, social, and economic climate we see increased mental illness, alcoholism, and issues of returning soldiers, all cases where there is a risk of AL for the family members. The topic of AL is particularly timely and may become increasingly pervasive. Research into best practices now will potentially lay the groundwork for a more effective, broad based treatment and mitigate the pain and suffering of many people world-wide.

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