A residential intervention for mothers of terror victims

Using a multi-modal therapeutic approach for traumatic loss

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Abstract: This article examines a programme developed in Israel for mothers bereaved as a result of terrorist attacks. The women are offered a two-day, residential retreat with a varied programme of healing interventions. The approach is holistic in design, integrating a number of therapeutic approaches in a group environment, based on Lazarus's multi-modal approach to brief psychotherapy. The authors show how their programme puts into practice theoretical principles about the integrative treatment of traumatic loss.

Keywords: Terrorist attacks, bereaved mothers, residential intervention, multi-modal, Israel

In Israel there is now a wide range of practical and psychosocial services designed to meet the needs of political terror victims and their families. These services are provided by the government and national charities, as well as local volunteer organisations. Here we describe one programme, offering a two-day residential intervention for bereaved mothers, conducted by a not-for-profit organisation and staffed by professional therapists and lay counsellors. The uniqueness of this programme lies in its multi-modal approach to the treatment of bereaved mothers in a communal group setting.

Recently there have been a number of innovative developments in the designing of clinical and communal strategies to deal with bereavement, with clinicians and clinical theorists offering a wide range of treatment styles. These include meaning construction using narrative techniques, cognitive behavioural therapy, psychodynamic grief therapy, spiritual counselling, group psychotherapy, various somatic treatments and art therapy, among others. Clinicians tend to make choices from among the many interventions based on their training and the necessity to meet the client's most pressing needs. What is missing in most of the bereavement literature is an integrative set of clinical interventions that would address the broad, systemic impact that traumatic loss has on survivors. The multi-modal model presented in this article was developed as a comprehensive, holistic approach for use in a therapeutic group setting.

Healing retreats for women

Goals and rationale

The Koby Mandel Foundation is founded and directed by the parents of a teenager who was murdered by terrorists. It offers various therapeutic programs for families bereaved as a result of terror attacks, including the two-day residential 'healing retreats' for women. There have been 21 such retreats over the past five years, with a total of 290 women participating. Of these, four retreats have been geared for widows and 17 for mothers. This article focuses on the programme for mothers. Each retreat of 15–20 women takes place in a hotel in a different geographical region in Israel, near to the homes of the participants to facilitate formal and informal contact after the retreat.

The major goals of the retreat are to help the bereaved mothers to:

- enhance their coping strengths
- connect with others by participating in a therapeutic community of bereaved mothers
- maintain a continuous bond with their deceased child while nurturing their relationships with the living
- re-construct frameworks of meaning to re-establish a sense of coherence in their lives.

The retreats are based on Lazarus's 'multi-modal way in brief but comprehensive psychotherapy' (Lazarus, 1997). Lazarus identifies seven interactive 'modalities' or

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aspects of human experience that need to be addressed by psychotherapists: behaviour, affect, sensation, imagery, cognition, interpersonal relations and physiology. He found that durable psychotherapeutic outcomes are in direct proportion to the number of these modalities consciously focused on by the therapist. Lazarus's approach has been used and developed by a number of clinicians and researchers in the trauma field in Israel. Their reports suggest that it is effective because trauma, including traumatic bereavement, has a profound impact on all aspects of human experience (Lahad, 1992; Shalev, 1994). The Koby Mandel mothers' healing retreats are a clinical application of this multi-modal approach in an intensive group setting.

Operational aspects

The intervention has a recruitment process involving some screening to make sure all the participants will benefit from the programme. In the event of negative reactions during the retreat, professional members of staff are on hand to provide individual supportive and stabilising interventions that focus on the women's strengths. After the retreat the Foundation staff make follow-up calls to elicit feedback about the retreat and assess overall functioning. In addition, mothers are referred to ongoing support groups, and/or individual therapy where necessary.

Analysis of the retreat

The modalities that are incorporated into the programme are: physical, cognitive, affective, imaginative and interpersonal.

Physical

The murder of a child in a terrorist attack is clearly a trauma-triggering event; indeed, some of the women do have post-traumatic symptoms such as intrusion (mentally revisiting the attack), avoidance behaviours, and a chronic sense of threat and danger. Traumatic memories leave a sensual impact at the most primary level and therefore physical activities are given an important place in the programme (Rothschild, 2003).

Exercises, including breathing exercises, to relieve muscular tension are part of the welcome session designed to help the mothers make the transition from the world outside to the retreat. The first afternoon includes a dance session where the therapist encourages the use of movement, voice, breath, rhythm, music and interpersonal touching. The creativity and spontaneity of dance eases feelings of stress, pain and hopelessness, encouraging body and mind to heal (Loman, 2005; Johnson, 2000). Many of the women arrive feeling very tense and a bereavement masseuse is available during free time to help them to relax. Massage has been found to be effective in reducing symptoms of depression, anxiety, and stress (Moyer, Rounds & Hannum, 2004; Field *et al,* 2005) and its use in the treatment of psychological trauma is growing, although its effectiveness has yet to be evidenced (Becker, 2004).

While not part of the original programme, informal physical contact between the staff and the women, and encouragement of it among the women themselves, has become a conscious intervention. This is an example of what Lazarus (1997) terms 'transcending boundaries,' where therapists take some calculated risks in initiating new methods of intervention. (He stresses, however, that there is a profound difference between violating boundaries and transcending them under certain circumstances.) The loss of a child damages the physical and nurturing aspects of the mother–child bond and therefore, for those who can accept it, bodily contact with others may be particularly therapeutic.

Cognitive

The women usually feel that their experience separates them from others who have not suffered similarly. Their identity now is connected with the murder of their children so, immediately after the

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welcome session, they get to know one another by telling their stories in a group setting and are supported by having their painful memories acknowledged. As each woman introduces herself she passes a picture of her child around the circle so that the group also gets to know the deceased children. This narrative process also encourages a continuing bond with the dead (Klass, 2001).

Another cognitive session is included at the end of the programme to allow the women to process their experiences of the previous two days, reflecting and then sharing what they will take home with them. The facilitator may review the activities, perhaps relating them to any themes that emerged. In the discussion, the focus is on the meaning of their experience for them, the strengths that have been fostered, and on leave-taking. Normally the mothers feel anxious about separating and losing the protective framework of the retreat, but they also comment on the growth they have experienced while they have been together, which sometimes surprises and even perplexes them.

> 'This is the first time I have left home since my son was killed. Here I sang, danced, and laughed. I thought I would have to leave at night to sleep at home. In the end I connected with other women and I was able to sleep here in the hotel.' (Sarah)

Affective

The emotional aspect predominates throughout the retreat and emerges in many ways. Grief is the primary feeling: great waves of sadness and pain sweep over the mothers at times. In the early narrative session there is much expression of raw emotion, weeping, and mutual commiseration. During the rest of the programme the women reconnect with this deep grief from time to time. Some go off to the side to cry silently, some need to be alone, others approach another mother or a staff member to talk, and some act out (for example, by hyperventilating, monopolising a staff member, or talking obsessively in the group). In general it is the ability of the bereaved mothers themselves, as a group, to contain intense emotion that allows for its full expression.

Over the course of the two days we begin to see a wider range of emotions. In addition to acute pain, the mothers are often fearful and worried about their own and their family's safety, angry at the terrorists or at the Israeli government for not safeguarding them, or filled with quiet sadness and longing for their dead children and the life they had before the terror attack. We hear hints of guilt for not having adequately protected their child and jealousy of other mothers whose children were spared.

In total contrast, we find that the women can laugh and have at least some moments of pleasure and fun. There is something in the protective camaraderie of the bereaved mothers that allows them the unusual luxury of laughter; for some this is the first time that they have laughed since their child has died. The presence of other bereaved mothers frees them to ventilate a wide range of intense emotions, knowing their feelings will be respected and validated. The perception of bereaved parents that they can only be fully understood, and are best supported, by others who have experienced similar losses has been well documented (Klass, 2001; Rosenblatt, 2000).

Imaginative

The imagination of the group members is engaged primarily through the use of metaphor in dance and art therapy, recreational activities, and guided imagery in the oral sessions. This is an indirect form of therapeutic intervention that does not generally evoke resistance or confrontation, and can stimulate thinking, engaging and discovering new coping skills (Lankton & Lankton, 1989).

We adopt a theme to run throughout the retreat and tie the activities together. This consistency amplifies the therapeutic impact. On one retreat, by the Sea of Galilee, we used metaphors of sea and sailing. A boat trip offered many images of uncharted waters, new

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destinations, stormy seas, dangers and other challenging situations on the voyage, and the need for new skills etc. Later, the art therapy session picked up these ideas and integrated them. Some women made boats; one added a steering wheel, so that the she could control the boat. In the dance therapy women moved to the sound and feel of waves.

Interpersonal

The death of a child can be accompanied by a bewildering isolation. Although the bereaved parent is often surrounded by well-meaning and supportive family and friends, she is very much alone in her pain and typically feels she cannot be comforted, that no one can begin to conceive of depth of her pain (Rosenblatt, 2000; Klass, 1999). Part of the healing process involves re-establishing a sense of connection with others, a sense of belonging, so during retreats we establish a 'healing community' (Klass, 1999). This has two aspects: the support of the mothers for one another, and the therapeutic alliance between the mothers and the staff.

The efficacy of support groups for bereaved parents has been reported (Rosenblatt, 2000; Schwab, 1995) and the retreat format intensifies and expands the opportunities for meaningful relationships within the group. Our participants cite the relationships they establish with the other mothers as one of the most helpful aspects of the retreat programme.

The therapists participate in all of the scheduled activities except for the massage. However, even more important are the informal encounters: for example, at meals when members of staff sit among the women, between sessions, late in the evening, and during fun activities such as boating, hiking, archaeological digs. The ratio of staff to participants is high, and it is the responsibility of the staff to be with the women as much as possible. The social interactions provide a stimulus for intimacy and disrupt the traditional therapist–client hierarchy. In the outside world, most people close themselves off from the sadness of others but the therapists on the retreat are there to help share the mothers' pain. For these two days the women's grief is part of the normal dialogue: the language and discourse of the retreat allow women to express the inexpressible in regular, everyday conversation, as well as in the therapeutic groups.

The retreat helps to make order of the chaos that the bereaved women are experiencing

The alliance we encourage between the therapists and the bereaved mothers is innovative, in our view. As mentioned earlier, Lazarus (1997) stresses the need for more robust therapeutic methods. We create an environment that is intentionally 'motherly,' nurturing the women and providing a matrix that gives a sense of security. Because they feel protected, safe, and loved, the mothers sense the possibility of growth and expansion. The retreat helps to make order of the chaos that the bereaved women are experiencing.

Programme evaluation

Thus far there is some evidence of the benefits of the healing retreats reported by the participants. For the last six retreats, evaluation forms have been completed by the mothers just prior to leaving (n=85). The responses are overwhelmingly positive. In five items rating satisfaction with the different sessions, 83% gave the highest rating (excellent) and there were only five responses, relating to one particular session, in the lower two categories (not satisfactory/somewhat satisfactory). Responses to three open-ended items ('What did you get out of the retreat?', 'What was missing in the retreat?' and 'Additional

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comments') were coded. The themes that appeared most often were:

- the significance of the 'togetherness' with the other women
- renewed strength
- appreciation of the pampering, warmth and support of the staff
- new perspectives and insights
- calmness and relaxation.

In follow-up phone calls by Foundation staff in the months following the retreat, the mothers referred to the retreat as a significant and meaningful experience. They reported that they continue to be in informal contact with the other mothers. Half of the participants expressed a desire to attend ongoing formal support and therapy groups. (In practice, only 60 have done so because of technical transportation constraints and lack of funds for professional facilitators.) There is a need for a systematic outcome study of the programme to assess the long-term impact of the healing retreats. This is a direction for future research activity.

The target population of this intervention is very specific: namely, Israeli mothers whose children were killed in terrorist attacks. However it seems likely that the format could be effective in other countries faced with dealing with the aftermath of terror attacks. The programme can be developed for other situations of traumatic loss and adapted for groups of bereaved fathers, couples, or entire families. ■

Becker KA (2004). Utilizing bodywork therapy with psychologically traumatized individuals: a study of the demographics of bodywork clients. *Dissertation Abstracts International.* Section B, The sciences and engineering; 64(11B) 5772.

Field T, Hermandez-Reif M, Diege M *et al* (2005). Cortisol decreases and serotonin and dopamine reduction of stress following massage therapy. *International Journal of Neuroscience* 115(10) 1397–1413.

Johnson DR (2000). Creative therapies. In: EB Foa, TM Keane, MJ Friedman (eds). *Effective treatment for PTSD.* New York: Guilford Press, 302–316.

Klass D (1999). *The spiritual lives of bereaved parents.* Philadelphia, PA, USA: Brunner Mazel.

Johnson DR (2000). The inner representation of the dead child in the psychic and social narratives of bereaved parents. In: RA Neimeyer (ed). *Meaning reconstruction and the experience of loss.* Washington DC: American Psychological Association, 356–358.

Lahad M (1992). Story-making in assessment method for coping with stress: six piece story-making and BASIC Ph. In: S Jennings (ed). *Dramatherapy: theory and practice*, vol 2. London: Routledge, 150–163.

Lankton CH, Lankton SR (1989). *Tales of enchantment.* New York: Brunner/Mazel.

Lazarus AA (1997). *Brief but comprehensive psychotherapy: the multimodal way.* New York: Springer Publishing Co.

Loman S (2005). Dance/movement therapy. In: CA Malchiodi (ed). *Expressive therapies.* New York: Guilford Press, 68–89.

Moyer CA, Rounds J, Hannum JW (2004). A meta-analysis of massage therapy research. *Psychological Bulletin* 130(1) 3–18.

Rosenblatt PC (2000). *Parent grief: narratives of loss and relationship.* Philadelphia, PA, USA: Brunner Mazel.

Rothschild B (2003). *The body remembers casebook: unifying methods and models in the treatment of trauma and PTSD.* New York: WW Norton.

Schwab R (1995). Bereaved parents and support group participation. *Omega* 32 49–61.

Shalev A (1994). A multi-dimensional approach to post traumatic syndrome. *Sichot* 8(2) 85–104.

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