

Journal of Marital and Family Therapy
 October 2003, Vol. 29, No. 4, 455-467

HEALING LOSS, AMBIGUITY, AND TRAUMA: A COMMUNITY-BASED INTERVENTION WITH FAMILIES OF UNION WORKERS MISSING AFTER THE 9/11 ATTACK IN NEW YORK CITY

Pauline Boss
University of Minnesota

Lorraine Beaulieu
Project Union Outreach

Elizabeth Wieling and William Turner
University of Minnesota

Shulaika LaCruz
The Restaurant Opportunities Center of New York City

A team of therapists from Minnesota and New York worked with labor union families of workers gone missing on September 11, 2001, after the attack on the World Trade Center, where they were employed. The clinical team shares what they did, what was learned, the questions raised, and preliminary evaluations about the multiple family meetings that were the major intervention. Because of the vast diversity, training of therapists and interventions for families aimed for cultural competence. The community-based approach, preferred by union families, plus family therapy using the lens of ambiguous loss are proposed as necessary additions to disaster work.

The terrorist attacks of September 11, 2001, have heightened our awareness of loss, a subject often denied in United States culture (Becvar, 2001). Although numbers shift, the official tally on the 1-year anniversary of 9/11 remained horrific: 2,819 killed; 289 bodies found intact; 1,717 families with no remains; and 19,858 body parts found. The number of children who lost a parent was estimated at 3,051 (Miller, 2002). The purpose of this article is to provide an account of how the Minnesota–New York ambiguous loss team emerged and how we responded with a family intervention that promoted community connections. We present initial feedback from some family members and therapists in the form of their reflections about participating in the family intervention meetings.

BACKGROUND

On September 13, 2001, Mike Fishman, the President of Local 32 B-J, a union of 75,000 building services members, called Lorraine Beaulieu, his wife, and asked her to help him take care of the families of the workers who were lost in the 9/11 disaster. Lorraine Beaulieu contacted Pauline Boss, and together they headed a team of trauma specialists who worked with the staff at the union headquarters building and helped to stabilize the immediate situation. At the same time, they began efforts to reach out to the families of the missing. After securing on-going help for union staff members, we organized a meeting for the families of

Pauline Boss, PhD, Elizabeth Wieling, PhD, and William Turner, PhD, Family Social Science, University of Minnesota; Lorraine Beaulieu, MS, Project Union Outreach, New York, New York; Shulaika LaCruz, The Restaurant Opportunities Center of New York City, New York.¹

Correspondence concerning this article should be addressed to Pauline Boss, Family Social Science, 287 McNeal Hall, 1985 Buford Ave, St. Paul, Minnesota 55108. E-mail: pboss@che.umn.edu

the missing in which they would be given an opportunity to process their unclear loss with other union families. The first family meeting took place only 32 days after the disaster.²

Our hope for clinicians who read this account is fourfold. First, that what the Minnesota–New York team learned under catastrophic conditions about treating ambiguous loss with family/community interventions may be helpful to you when other natural or human-made disasters occur, as well as with more common occurrences (e.g., divorce, adoption, and immigration). Second, that we might add a new lens to your repertoire of interventions and treatments to increase effectiveness when people, through no fault of their own, cannot find closure. When loved ones vanish without a trace, classic grief therapies and Posttraumatic Stress Disorder (PTSD) treatments are insufficient. Third, that descriptions of our efforts to extend systemic interventions to the community level might provide you with useful guidelines for enhancing opportunities for parents and children to find support among friends and neighbors suffering from similar experiences. Fourth, that all of us as clinicians see as our highest priority the need to become culturally competent regardless of our years of experience, or our own race or ethnicity.

Going beyond awareness and sensitivity, cultural competence involves collaboration with professionals from other cultures with other language skills, listening, and accepting different beliefs. We found that respect for values unlike our own was key to being effective with such diversity. In every city or community today there is also diversity of families, so intervention teams across the U.S. will increase their effectiveness and client participation if they are multi-lingual, multi-racial, mixed genders, and of differing belief systems.

Although cultural competence in areas of diversity and awareness of intergroup differences matters immensely, it also is important to recognize the commonalities among families. Of the families with whom we worked, all found the ambiguity surrounding their loss distressing. All yearned for evidence of life, and later, for evidence of death; all felt pressure from the public and professionals to find closure, even though the concept of finality did not fit their cultural views, even after clear death. All felt helpless and confused whereas previously, they had been accustomed to solving their own problems. They had been resilient in uprooting from distant lands, and finding the ideal job in the World Trade Center, but now they felt powerless. Already, some were labeled as resistant or having a mental disorder, because they were taking too long to find closure. We saw them through another lens—that of ambiguous loss.

When a loved one remains missing, it is the situation that is abnormal, not the family. Even the healthy and strong are paralyzed when a family member disappears. Elsewhere, ambiguous loss is discussed in depth as the most difficult loss (Boss, 1999), but for the purposes of this paper, we summarize the theoretical premise. The ambiguity surrounding a loss complicates grief, paralyzes family processes, and prevents mourning and moving on. Without proof of death or life, and if we were connected to the one gone missing, it is human to hang on to any sliver of hope for some miraculous return. Just enough missing persons were found alive after 9/11 to kindle such hopes. For example, in the immediate aftermath of 9/11, 200 workers in Local 32 B-J were missing, but the final tally was 24. Workers showed up after walking the streets in a daze, or they were in hospitals, or they were found in a foreign country where they had fled for safety after the attack.

FAMILY MEETINGS AS COMMUNITY INTERVENTION FOR AMBIGUOUS LOSS

To set the stage for planning our intervention, we were reminded that unions historically provided community and security to workers and their families. Labor unions began in the early 1900s after a disastrous fire in lower Manhattan (not far from the present Ground Zero) killed women and children working in the Triangle Shirtwaist Factory (Jackson, 1995). Exits had been locked. There were no fire escapes. Workers were trapped inside a burning building. Many were lost. That tragedy marked the beginning of labor unions' efforts to protect workers and their families by protecting minors and making sure safer working conditions were provided for the breadwinner. In the World Trade Center tragedy of 9/11, it was again the unions who made sure the families were all taken care of in the most thorough way possible. In fact, the unions were among the first to reach out to the victims' families to help them come together in a healing process.

To help, we built on the union's existing community framework where members see themselves as belonging to the union family and refer to each other as brothers and sisters. Because of this context, we

selected the Union Hall as the best place for implementing the interventions. We called them family meetings.

The New York therapists who volunteered to help us with these meetings were an eclectic group.³ Those who felt most successful working with families in a community setting, regardless of their original training, could approach multiple generations flexibly and systemically.⁴ Therapists accustomed to quiet professional offices were challenged, because typically, families were large, including parents, children (newborns to teenagers), grandparents, aunts, uncles, friends, and even clergy. The Union Hall was alive with sound and activity, but this was not the case at the first meeting. That was eerily quiet—at first.

Thirty-two days after the attack, on an October weekend, 11 of the 24 families with missing loved ones accepted the union's first invitation to attend a family meeting. In retrospect, it is amazing that we could get any of the 32 B-J families there at all so soon. Everyone was still reeling from the 9/11 attack. Families were afraid, but they came to the meeting in lower Manhattan from all five boroughs and New Jersey. Most arrived late, because the Union building was hard to find, and they had to make their way, children in tow, by subway or bus, with numerous transfers. They arrived tired, hungry and quiet, so lunch was a welcome beginning. We all were anxious, not knowing if this would work.

Sitting at circular tables in the union hall, parents seemed frozen, children lingered anxiously nearby, but grandparents looked surprisingly strong—as if they knew they could overcome this. One grandmother, with her daughter and four grandchildren, one a newborn, walked over to another young woman with a baby and gently brought the two young mothers together. They lifted their heads and spoke for the first time, “Did this happen to you, too?” “Yes.” Sharing anger and tears, and later some smiles, they eventually exchanged phone numbers. They still connect with each other today.

In countless other ways, grandfathers, grandmothers, and other elders enhanced healing connections and understanding for a traumatized younger generation. A grandmother noticed her grandson had not shed a tear for his lost father. She said she knew he was holding out hope, so she took the little boy to visit ground zero to see for himself that his father could not have survived. The process of grieving could then begin. A retired operating engineer whose son (in the same profession) was missing explained to his grandson and other parents and children what most were asking: “Why did they go back into the damaged towers?” He answered, “It was our job to take care of the towers and to fix what broke. This is what we did when I worked there, and this is what my son was doing on 9/11. He went back in because he was doing his job! All the men were doing their job!” His explanation gave new meaning to what some family members had considered thoughtlessness and lack of care for family. Although some still struggled with ambivalent feelings of anger and sadness, this retired man helped many to reconstruct what had seemed irresponsible behavior on the part of the missing.

As a function of years of experience and tested resilience, the older generation provided security and hope for spouses of the missing, which in turn helped to ease children's worries about their remaining parent. They were like cotherapists. Without a community-based intervention, we would have missed the elder's powerful contributions.

On observing the value of cross-generational interactions at the first family meeting, we continued using multiple family groups, which proved so popular that families requested more throughout the following 18 months. To this day, families continue to meet but now mostly without therapists. In addition to sharing concerns about children, grandchildren, and themselves, they now meet together to learn English and job skills.

TREATMENT PRINCIPLES

PTSD Treatment is Insufficient for Families with Missing Persons

After 9/11, most therapists assumed that what they needed to know was how to treat PTSD, but treating loss complicated by ambiguity was a new challenge. In training workshops, the therapeutic distinctions were made immediately. Indeed, ambiguous loss meets a PTSD criterion as “an experience beyond the normal range of human suffering,” but by inclusion in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), PTSD is assessed and treated as a mental disorder in an individual. Ambiguous loss, in contrast, is a relational disorder, and, rather than psychic dysfunction, it is a

situation of dysfunction from chronic ambiguity that freezes grief and the resolution of a loss. Individual and relational symptoms may result, for example, depression, anxiety, conflict, and somatization. With situational ambiguity as the culprit, intervention includes a stress management model (Boss, 2002), focusing relationally on how to live with the chronic tension and strain of not knowing the whereabouts of a loved one. With the ambiguity continuing perhaps for a lifetime, a different lens is required than with PTSD, in which the traumatizing event may be over but flashing back. Ambiguous loss is chronic trauma. Unless those affected learn how to increase their tolerance for ambiguity, the chronic trauma can paralyze their lives and relationships for decades and across generations. Assumptions of the world as fair and manageable are shattered by an unsolvable mystery that can go on for a lifetime.

Understanding Diversity and Cultural Context Are Central to Effective Interventions

The families of workers who serviced the two towers (Local 32 B-J) came from 60 different countries and spoke 24 different languages. Many came from Albania, Yugoslavia, Macedonia, and Russia. Small numbers had emigrated from East Asia. The families of the Windows on the World restaurant workers (Local 100) were different in that most spoke Spanish, having emigrated from the Caribbean Islands, Mexico, Dominican Republic, Central or South America; others in Local 100 were African or European. The families of the operating engineers who serviced the twin towers (Local 94) were born in the U.S. or came from English-speaking countries.

Many of these families had experienced ambiguous losses before 9/11. They had uprooted and migrated from their home countries and islands, leaving behind loved ones they would never see again. They left to seek a better life or escape political terrorism or war in their homeland. The irony is that they came to New York for safe haven. After 9/11, because they had uprooted, many in the time of need sorely missed the support of home-town relatives, neighbors, and friends. For all these reasons we decided on multiple family meetings as the primary intervention. Community and connection could be reconstructed through the Union community. Throughout the year, however, issues of diversity challenged our traditional ways of doing therapy.

Given a multi-cultural and multi-national heritage, the U.S. has always been confronted with the challenge of appreciating and integrating racial, ethnic, and cultural diversity. After 9/11, the need to meet this challenge was even more crucial and relevant because we were asked to provide mental health services to a wide array of ethnicities, races, socioeconomic levels, nationalities and religions. In our efforts to respond with culturally enlightened therapy, we found ourselves in a quandary, facing the dilemma of acquiring ample cultural literacy and competence to understand and to respect the beliefs of the diverse families, while not falling victim to clichéd and stereotypical assessments that deprive families and family members of their individual histories and choices. A further impediment was that we as mental health providers were often limited in the services that we provided by the very concepts and methods we were accustomed to using—namely that our clinical education and training are permeated with the assumptions and ideologies of mainstream American culture. Had the therapeutic teams not discussed this together regularly, with the help of the Roberto Clemente Center therapists among others, we could not have shifted so readily to a more inclusive and collaborative way of working—and being together.

Several therapists (Boyd-Franklin, 1989; Falicov, 1998; Imber-Black, 1992, 1993; McGoldrick 1998; McGoldrick, Giordano, & Pearce, 1996) have advocated the use of contextual and/or an ecosystemic approach in working with all families, especially when working with immigrant families and families of color. This approach integrates into the therapeutic encounter facets of culture along with facets of family relationships. Therapists who employ this strategy take into account the multiple cultural contexts (race, social class, religion, occupation, language) in which both the family and therapist are embedded. From this contextual view, similarities and differences between family and therapist are identified and discussed. This was essential for each family meeting and also for those who chose to have sustained therapy from New York therapists on the team.

Community Based Intervention Increases Human Connection and Healing after Traumatic Loss

From the start, we found that the families of the missing were longing to make sense of the ambiguity that had been imposed on them. The needs of all to feel connected to someone was overwhelming.

Conversations between therapist and family members, and among multiple families began, slowly at first, and then became livelier. How we were similar and different in viewing loss and coping often opened the door for connection to occur. Grieving and coping styles are often a consequence of cultural, religious, and ethnic experiences. As therapists, it was important for us to hear each family member and to understand how all were attempting to make sense of the loss and ambiguity forced on them. When in the second hour of the family meeting we moved to multiple family groups, the mutual appreciation and respect of cultures was continued. Except for ways of coping that were life threatening, there was no judgment about what was normal or abnormal, right or wrong. Some decided to have a funeral without a body; others decided to wait for more information; still others had to develop tolerance for family members who had conflicting views about the loss and how to proceed. By talking explicitly about honoring difference, trust developed and human connections could occur. Cultural, racial, religious, and ethnic differences between therapist and family, and among all families, enabled the formation of bonds that were crucial to meet pressing needs. It was in this broader context of human connectedness that the healing began.

Such a multi-cultural approach also increases flexibility around the notion of cultural matching between family and therapist. To enhance trust and connection between therapist and family, we stopped translations and found more Spanish-speaking therapists. Once therapist and family spoke the same language, we found that any therapist who viewed culture contextually and was sensitive could be effective with families from different cultural and religious groups. This stance is in stark contrast to the more limiting and often divisive approach of ethnic matching that encourages, for example, Latino/a therapists to treat only Latino/a families, or African American clients to be treated by African American therapists exclusively. In times of national crisis, when loved ones are lost and the world has been turned upside down, nothing was more important than community—connecting with others suffering from the same kind of loss.

While working with the families of the victims of 9/11, we learned that culture makes a difference in the meaning of ambiguity and loss. For many of the immigrant families, memories of their homeland, the dangers or supports there, and ambivalent feelings about uprooting returned with force after 9/11. The presence of supportive compatriots who share language, history and values provided invaluable support. Building on family strengths and allowing culturally appropriate grieving, we worked to support family connections and the building of a support network. We became conscious of our own field's narrow cultural assumptions about "normal" grief and mourning—with closure.

There is a cultural chasm dividing European American families and families of color, especially immigrant families, around issues of death, loss, grief, and ambiguity. For the European Americans, there is often the seemingly impersonal and bounded culture—keeping a stiff upper lip and the avoidance of public displays of emotion. Get over it; move on. For African Americans and Latinos, among others, there is often a more direct, intimate, and expressive tradition around death, as well as with ambiguous loss. The cultural differences existed in therapists, too.

For many persons of color, the tumultuousness of the aftermath of the 9/11 bombings was exacerbated by fears of racism, discrimination, mistreatment, and a fear of being neglected or overlooked. Among the many questions asked by persons of color, especially those who are low income, were: "Whom should I trust?" "Are the authorities really making every effort to find my loved one?" or "I know that they care about the stockbrokers and businesspeople, but what about the janitors, cleaning crews, cooks, security guards?" On September 10th, the rules seemed clearer to many persons of color. There was a definite pecking order based on race and income that usually left them in a disadvantaged position. Not only were persons of color traumatized by the ambiguity of loss, but they also were further concerned that the rescue and recovery of their missing loved one would not receive priority status. Several clients voiced this concern.

Another cultural barrier among many persons of color was a distrust of psychotherapy. Before the disaster, many persons of color were leery of the psychotherapy community. Hence, those same reservations were still in place on 9/11 and thereafter. Many persons of color had traditionally resisted psychotherapy, seeing it as a resource only for the severely mentally impaired, a resource for weak people, or as antithetical to spirituality. Often in Black churches, psychotherapy is denigrated and viewed as being in conflict with the values and teachings of God. Therapy is often regarded by low-income Blacks as a luxury for the rich, those who do not have to be concerned with daily cares related to survival and getting by. After 9/11, the need for psychological support was thrust on people who had not previously sought (or valued)

psychotherapy. We were especially mindful of these fears and approached families with a sensitivity and appreciation of their resilience in coming to work with us. For most, psychotherapists had not been a part of their culture of coping.

With circumstances surrounding the losses particularly traumatic and confusing, the need to respect differences in ways of grieving and coping was essential. Different attributions required different assessment, treatment, or intervention strategies. Again, the gulf between expressions of grief in the European American community (and much of the therapy community) versus other cultural communities was even more expansive.

For many, especially families of color and immigrant families, religion played a pivotal role in helping family members deal with loss. However, the rituals that usually provide a sense of involvement and encourage resignation to accept the inevitable are often unavailable for ambiguous loss. Consequently, other rituals were needed. For example, some families took solace in small private masses or prayer ceremonies for the recovery of the missing, or the organization of a community service to pray for the lost victim. Others felt robbed of opportunities to say good-bye in traditionally meaningful ways, and needed others to hear their anger and validate their loss. Creative ceremonies of remembrance in which musical instruments, sports gear, photographs, and other symbols of the missing person were buried, helped console those unable to say goodbye without a body.

THE TRAINING SESSIONS

Therapeutic Goals

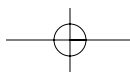
With so many families with missing persons, we knew that the traditional way of doing therapy would not work. After 9/11, there were too few therapists and too many victims, most of whom yearned to be with their own people right now, not strangers. By ourselves, we could not heal, but we could set the stage for healing to begin. We provided a safe holding environment for parents and children to begin to voice their feelings and make connections with others who also had missing family members. We provided structure for family members to voice individual perceptions about the missing person while they learned to tolerate the differing views of others. The conflict and cut-offs, already forming as a result of differing perceptions, were mediated early to avoid permanent rifts.

In the training workshops after 9/11, the New York therapists were already well trained in classic grief therapies and PTSD interventions. What was new to them was learning how to work with families of the missing. This new lens included prevention and systemic treatment for a loss that would likely remain ambiguous forever. Rather than seeing pathology or resistance, we emphasized the normalcy of continued hope, resistance to closure, anger, confusion, and ambivalence. For families—as well as therapists—being frightened was normal after 9/11; wanting to connect with family was normal; distrusting the world as a safe place was normal; shedding tears (for therapists, too) was normal; and not wanting to “get over it” was normal.

If not closure, then what was the therapeutic goal? Naming the situation as one of ambiguous loss was a first step. Knowing their distress had a name and was validated helped externalize the problem. Doing this diminished their tendency to feel guilty and blame themselves (or each other) for the situation. When loved ones go missing, early therapeutic goals (after triage) are to prevent relational conflict and family paralysis, for example, serious cut-offs due to conflicting views about the situation or how to proceed; secrets about the loss kept from the children, and cessation of family processes (weekly rituals special celebrations, daily routines, talking with one another). Although each family differed, the common goal was to increase their tolerance for ambiguity, for flowing with the tide, for trusting, for staying optimistic and hopeful about life despite not having answers. Adults and children gradually caught on that there was a way to do this, and that what happened was not their fault. They began to reshape family rituals early on—letting children trick or treat in a modified way, making Thanksgiving dinner in a new way or in a new place.

This way of working clinically is not new for many family therapists (e.g., Imber-Black, Roberts, & Whiting, 1992), but it was for the therapists trained for individual work. The training sessions provided family therapy information for all, with the following objectives:

1. Train or update therapists from different cultural and disciplinary backgrounds in preparation for



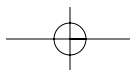
- collaborative work with labor union families whose loved ones vanished after the 9/11 attack.
2. Become familiar with the ambiguous loss theoretical lens: What is ambiguous loss? When is it a problem? When is it not? What are the guidelines for therapists to treat individuals and families experiencing this complicated loss?
 3. Identify strengths and resilience in individual members, and family as a whole, not just symptoms of pathology.
 4. Unpack the link between the stress of ambiguous loss, psychological ambivalence, and symptoms of depression, anxiety, and intergenerational conflict.
 5. Recognize ambiguous losses in our own private or professional lives, so that we have more awareness as we work with families of missing persons.
 6. Prepare oneself to be culturally competent (not just culturally sensitive) to work with different families by using this more contextual and inclusive approach.

Guidelines for the family meetings were essential for such a diverse team, and were discussed during training. Boss (1999, pp. 109–132) formulated the original guidelines and they were adapted for the family meetings:

1. Gather the family (adults and children, whomever they see as family) together in one room, in this case, around a table.
2. Label their experience as ambiguous loss, the most difficult loss there is. Tell them their feelings of confusion and helplessness are not their fault.
3. Help the family gather as much information as possible. (The Union is already doing this for the families, so therapists in such cases skip to #4).
4. Provide a safe setting where family members can share perceptions and interpretations with one another; what has been lost, and what remains the same. Expect disagreement and perhaps conflict. Help them listen to each other's perceptions. Normalize differing perceptions. To prevent family rifts, repeat this phrase as often as necessary: "It's OK if you don't all see it the same way now."
5. Discourage the tendency to cancel rituals and celebrations by helping them talk about and reconstruct them.
6. Do not use the word "closure" with families of the missing; help them to create ways to move forward with a door that remains open.
7. Reconstruct family roles, rules, and rituals so that the family can function in spite of the ambiguity.
8. Check to see if there are family secrets. Have children been told why an aunt is now their mommy, or why their father is so silent? Can the family grieve openly together if this is done in their culture?
9. (Later) Talk about hope and optimism: What one hopes for has to shift if the missing person is gone forever. At the beginning of a session, the wife of a missing husband hopes for "him to come walking up the sidewalk again," but by the end of the hour, she has shifted to hoping for "even a body part" to allow her to verify the death she is just beginning to consider.
10. Move to multiple family meeting to broaden the discussion of meaning, of hope. There are situations, however, especially with horrific losses, when understandably, the only meaning for the family is that there is no meaning. This too is a meaning.
11. Normalize ambivalence. Although some individuals may exhibit symptoms that must be treated (e.g., suicidal ideation, addiction, violence, major depression), it is the situation of ambiguity that is abnormal.

Throughout the training sessions, it was emphasized that the therapeutic goal was to help families resume their lives; help them move on with everyday life despite ambiguous loss. Holding two opposing ideas in their minds simultaneously was helpful—for example, maintaining hope for a miracle while moving on; or thinking about the lost person, but at the same time, paying attention to the children.

Ideally, the training workshops should include a time for reflection about the therapists' own ambiguous losses, but in the urgency after 9/11, training had to be compressed and "self of the therapist" work was done informally with peers. Because most situations of missing persons will have a similar



urgency, we highly recommend that therapists do their own experiential and didactic work, reflecting on their own on ambiguous losses, before crises and disasters occur.

Self of Therapist

The families with whom we work will tolerate only as much ambiguity as we ourselves can tolerate. Can we recognize our own ambiguous losses? The list gets longer as we mature. Hopefully, few are catastrophic, but there remains the possibility of terrorism, epidemics, and the certainty of natural disasters, including hurricanes, tornadoes, earthquakes, floods, and tsunamis. We highly recommend that family therapists enhance their competence in advance.

To work with families of missing persons, we must first understand our own fear of that phenomenon and of having no answers. Guiding questions for "self of therapist" work are: Did you ever experience an ambiguous loss? Was it a physical or psychological loss? Did you and your family manage to move on despite the ambiguity? If so, how did you do that? (Boss, in press).

Dr. Deborah Freed, one of the New York therapists who attended an early training workshop and who became a regular on the therapy team for the family meetings, reflected:

The training further supported my earlier training and experience in relation to my tolerance for and understanding of uncertainties in my own life, specifically ambiguous losses. I was reminded how my capacity to do this for myself, affects how I am able to help my patients.

Dr. Freed had considerable training and experience as a clinical psychologist followed by analytic training, plus some training and experience working with the trauma of populations exposed to toxic chemicals on site, and evaluating immigrants seeking political asylum. She was able to shift easily to a more systemic approach. She reflected:

Meeting with these families was a moving and rewarding experience for me. Listening and watching as individuals and families showed me, taught me how to help them cope with and find meaning for their losses. Each family, as a unit, was made up of those present as well as those not present; each individual was at a different stage of holding on and letting go of those lost.

She was seeing the psychological family as she worked.

A Typical Family Meeting

Our overall goal from the first meeting to the most recent (June 2003) was to create a community from which the families of the missing could draw strength to regain resilience. We worked systemically within the union community because the families considered this part of their familiar community. Within this setting, families defined their own structure and membership, and thus we had many three-generation families, plus aunts, uncles, and cousins.

The first hour was spent with therapists and families sharing a luncheon meal together with the intention of developing a feeling of comfort and warmth. When the families arrived, the therapist at their table invited them to the buffet lunch provided by the union, and then to their assigned table. Each family had a table where they met with one or two therapists who spoke their language. At least one of the therapists had to be from NYC and had to be able and willing to follow up with that family as needed or requested. The first order of business was to get food from the buffet at the side of the room because parents and children were hungry from the long trip into Manhattan. Therapists ate with and acted as hosts for their clients, helping the families feel safe and comfortable in that environment. The children were invited to join the children's art table at the end of the room when they wished, but we encouraged the teenagers to stay at the table with their parents. There was a lot of back and forth, of checking in with parents when they sensed sadness or tension, especially when someone was telling a story about the lost person. For the first hour of the family meetings, individual families stayed at one table.

During the second hour, individual families met with their designated therapist(s). As discussed above, much time was spent on preventing family rifts resulting from conflicting perceptions of what happened and how to proceed. Also, during this hour with the family, the therapist checked for any individual symptoms that might require treatment or hospitalization. In addition, families were encouraged to continue their

rituals, but to reconstruct them, so that they could occur without the lost person's leadership. For example, a mother talked about her missing husband who had had a special guitar made for his 5-year-old son. Every evening at 5 o'clock when he came home from work, he would play guitar with his son. She was distraught about that loss for her son, and we had heard her express those feelings. In the family meetings, the mother and her children (including this young boy) were able to talk about their consequent love of music. They decided it was too painful to continue the ritual of family music at precisely 5 o'clock, as Dad had done, but they worked together at their table to reconstruct this meaningful family activity, finding alternative times and days to sing together. This was one of many examples of family's reconstructing their lives and rituals to help in their healing process.

The third hour was spent in multiple family groups, typically with three to four families sitting in a large circle. The multiple family groups proved to be the best way for the families to begin the difficult process of grieving the loss of their loved one. Sitting with others who shared the same kind of loss allowed family members to hear other reactions and feelings. Learning that others had shared a similar experience broke the feeling of isolation expressed by many. The partners of the missing were able to hear from peers and felt understood and validated. The children found other children who had similar experiences both in school and at home and consequently felt less alone. Even younger children expressed their thoughts and feelings to the playmate who was sitting beside them as they colored: "Did they find your Daddy yet?" "Yes, but not his legs." "That's good, isn't it?"

Spontaneity was the byword of the multiple family groups, and teenagers often participated in their own ways. Three nieces of a victim's husband were singing softly in a corner of the room and then agreed to sing two songs for the group. They had expressed a feeling that the adults did not understand how much they empathized with their loss and so their songs about heroes and missing a loved one let them express those feelings. The adults clearly liked their contributions, and the girls felt good about finding a way to express themselves to the adults.

The evaluations that day indicated that people were pleased with the workshop, felt understood for the first time since 9/11, and wanted to continue meeting in the large group. In that setting, they asked to continue working with the therapist assigned to them. Teenagers and children could join if they wished, but were clearly listening even as they did artwork. They always moved in when stories were being told about their lost parent. The kids seemed hungry for such stories. One of the interactions in the multiple family meetings that was most poignant occurred when a worker spoke up. An operating engineer we shall call Bill (not his real name) had survived, but was injured, burned, and traumatized. On the recommendation of his therapist, he and his wife attended the meeting with his fellow workers' families that day. He wanted to connect with the families of his missing coworkers, but was afraid the wives would ask him about their suffering in the inferno just before he was miraculously blown out. What happened instead was that Bill told a story. After being quiet all day, he shifted in his chair, leaned over toward a young girl who was crying, and said:

Honey, I want you to know that your Daddy led out a thousand people. He knew the building, and it was complicated. He led them out—and then he went back in, but that's what we do. That's our job. He was going in for more people, but he didn't make it out that time. The next time you go to a ball game, I want you to look at the crowd and see what a thousand people looks like and know that your Daddy saved that many people.

For centuries, storytelling has helped heal trauma and loss by providing access to meaning. Nothing a therapist could have done that day would have equaled the healing power of Bill's story for the little girl, her mother, and for himself and his wife. Brothers and sisters in the union family were connecting by breaking their isolation, sharing stories, painful as it was. Everyone, including therapists cried, but with a new and more positive meaning about the tragedy.

To end the day, snacks were offered, partly to close on a lighter note and partly to stave off the children's hunger on the long way home. Children eagerly rushed to gather up the flowers from their family's table. After lingering goodbyes, the therapy team remained another hour to evaluate the day and process our own feelings.

We want to emphasize that follow-up family therapy was offered to every family at the end of these

family meetings, but surprisingly few signed up. Even when therapy was offered again later on, few wanted it. But everyone (parents, children, even teenagers) requested more family meetings as late as 9 months after their loss. This request for family meetings and refusal of individual therapy for a parent or child or for an individual family surprised us, but it was understandable. These families, mostly immigrants, came from cultures that valued the community over individualism, thus they favored multiple family meetings over individual therapies. They also favored the familiar union hall over a clinical office uptown. Because of their value of community, we found enthusiasm more than resistance. Both women and men attended the meetings, but it was the women who brought newcomers to subsequent meetings, telling us, "They need to be here." Over the year, several widows began taking leadership roles in shaping the family meetings. Feelings of helplessness were dissipating.

Another example of growing empowerment was the explicit request from parents to help them prepare for the 1-year anniversary on September 11, 2002. They asked us to have several therapists model for them how to talk with their children about feelings of grief, anger, and sadness. Accordingly, in the first part of the morning at the union hall, the children sat in the middle of a large circle on the floor with four Spanish-speaking therapists from the Roberto Clemente Center. The parents sat on chairs in the outer perimeter of the circle while the therapists (male and female) helped the children to talk about their reactions and feelings about the parent who went missing. Children were asked how they coped with that loss and, when the mothers were crying, they were asked how they felt when their mothers cried. One young girl said that she had never seen her mother cry before now and that it made her feel more connected to her. The girl had cried alone, thinking that crying was bad and it would bother her parent. Another 10-year-old girl reported that she would go into her father's closet and hug his clothes in the dark when she missed him. She, too, did not want to bother her mother with her sadness. As a result of the requested meeting, many parents and children began to share their grief for the first time.

Another example of regained empowerment in the parents was their plan to have their own 1-year anniversary memorial. They wanted their own intimate memorial in addition to the large public service they would attend the next day. They wanted it to take place at the union hall where the family meetings had been held. Candles were used to symbolize lost loved ones. One family at a time went to the front of the hall where the parent lit a pillar candle and the children lit a small tea candle. Most brought pictures of the lost person and held it up while giving a eulogy. The parent and children then placed their candles on a plate and at the end of the day, they eagerly took their candles home. The room was quiet except for sobs heard during the difficult presentations. We therapists cried too and felt immensely privileged to be included in their private tribute.

FOLLOW UP AND EVALUATION OF MULTIPLE FAMILY MEETINGS

Our follow-up objectives are to understand the experiences of families who lost a family member following the World Trade Center attacks of September 11, 2001, so that we may better support families and children to manage their stress and ambiguous loss. In continuing follow up, we ask family members questions pertaining to individual and family life changes after losing their loved one and if the family participated in one or more of the multiple family meetings that were held at Local 32 B-J in fall 2001 and spring 2002. We are interested in knowing about their experiences, both positive and negative. In addition, we are interested in knowing how they perceived their interactions with therapists and other family members who lost a loved family member. If the family did not participate in a multiple family meeting, we want to know their reasons for not attending. When completed, this information will provide us with a better understanding of the perceived usefulness of the multiple family meetings. Although findings from the completed follow-up study will more definitively assess the effectiveness of what we did after 9/11, the following represents preliminary feedback from families attending the February 1, 2002 ($N = 9$) multiple family meeting.

Experience of Participating in Multiple Family Meetings

The following are some of the statements made by participants in the family meetings:

This has been such a big help . . . to be able to share each of our painful experiences with each other.

Even though it is hard, it helped to know that others are feeling like I am.

This meeting was very important. I feel that today people listen to our pain and they understood our situation.

They have been a big help . . . to be able to share with others our experience.

I really liked the way the therapists were involved, they were very helpful.

Learned many things.

It was great therapy, to have support in dealing with and speaking to other families who are going through the same grief.

This was the first time I really talking about some things with my kids present. It was very important.

Most Helpful Aspects of Multiple Family Meetings

Families made the following remarks regarding the most helpful aspects of the meetings:

It was useful to talk about [my husband's] death and how to bring my daughter . . . back to NY.

It helps so much for each of us to share our feelings and experiences with each other and know how others are dealing with it and going on with their lives.

Talking to the therapists because they gave me confidence and encouragement . . . it is more difficult to get that from the other families because they are in the same situation as I.

How competent the therapists were and their solidarity with us . . . with this type of pain there are no class distinctions—the pain weakens us all.

To communicate with other families that are going through the same experience . . . we could feel each other's pain.

Makes me feel less alone—not only one who lost a relative. See ourselves as one—not alone.

Group therapy, sharing stories about loved ones.

Therapeutic Reflections

We noted that the children's artwork over the year indicated a more positive outlook as they participated in the multiple family meetings. Therapists observed significant changes in their perceptions of the Towers, the most common subject of their artwork. For example, a 9-year-old girl who came back for the February 2, 2002, workshop, 5 months after the inferno, ran to the table with the drawing materials and promptly drew a picture of two intact towers surrounded by a heart. This girl had, in the prior family meeting, drawn a picture of towers that were in flames with people falling out of the building. Over time, therapists noted that children began to focus on their concerns and less on the well being of their parent. We also saw more tolerance for different ways of grieving within each family.

The changes that were observed in the families over time were also significant. At the beginning, family members were tense and reticent about talking. Therapists meeting the families for the first time often were unable to engage family members in a discussion of their feelings post 9/11. However, once the families met in groups of four or so, the talking began and often became lively. The therapeutic task then became finding enough time for each person to tell his or her story. Children often listened and later told the family therapist about their thoughts. A young girl told the therapist at her family's table that it was sad that the boys in another family had not been told that their father was dead. This was the same young girl who had told us at the previous family meeting that she thought her father was in a hospital somewhere and that her mom had not looked hard enough to find him. Since the last family meeting, she had moved from the denial that her father was dead to an acceptance that he was gone.

The community-based format for treating traumatized individuals and multiple families with missing persons proved to be a stimulant for disclosure, support for each other, and trust in the process. Shulaika LaCruz also found this context of multiple families helped her to become more disclosing. Her losses were immense, and she could not easily discuss them. She is now a family organizer for the union and volunteers as chef for the family meetings. Formerly, she was the pastry chef at the Windows on the World restaurant and lost her entire shift of coworkers, who had been like family to her. She shares these reflections:

There were 73 people from the Windows on the World restaurant on floors 106 and 107 in the World Trade Center the morning of September 11, 2001. I'm not sure how many bodies or body parts were recovered in all but I know that in the group I worked with, there were only ten or so. Once people were found, it makes you accept that they are actually gone. With the ones that weren't recovered, you think that they may still be alive. Most of us know that they are dead but there is a part of me that thinks they are alive.

After 9/11, I was sad, but tried not to get down. I didn't feel the impact of what happened until 8 months later. I went through a lot of changes since 9/11/01. Lost my job, my coworkers, got a new job, changed jobs in December 2001, and again in April 2002. Too many changes! And eventually, I had to face my many losses.

Organizing and working with the families became part of my life. I started working exclusively with the families in December 2001. I felt that they knew what I was going through. And I knew what they were going through. [Being with them] made me face [the fact] that the disaster happened. It made me deal with what happened to my co-workers. I couldn't get away with blocking out what happened—and it was more difficult for me then. I was depressed. Being with the other families, I had to face my losses finally.

My first ambiguous loss was when my father left. I was 14. We lived in Curacao and then one day we all came here—to America. Three days later he left. I didn't know if and when he would come back. His leaving was just like my coworkers, who left on 9/11 without saying "goodbye." I didn't know when my father would come back. He never really came back. My coworkers didn't either.

Out of the people that were found, I was at two funerals, and one memorial service . . . for Miss Lucy who was my good friend at work. Her body was never found. She and I had worked together for 2 years and 3 months. For me, I didn't get to see that she was really dead. For me, it is still hard because, I didn't see it. As I saw the widows [at the family meetings] dealing with their loss, and believing a bit more, it helped me to accept it [the death of my friends and coworkers] even more.

It was easier with sharing together. Strength in numbers. It makes you feel less alone. Out of the thousands of people you bump into, not everyone can understand what you have been through. If I am with any one of the families [of the missing], I know they will understand what I am going through. We comfort each other. Even a blood sister might not understand as well. There is that bond between the [Windows on the World] families and with me that helps us get through.

CONCLUSION

Our purpose in writing this article was to share what we have learned about families of the missing, so that others can benefit should other ambiguous losses of this magnitude occur. Not knowing the whereabouts of a loved one will immobilize family interactions, cause relational conflict, and freeze grief. We propose that classic grief therapies and PTSD interventions are insufficient in cases of missing persons. Special therapy is needed for ambiguous loss. It is essential to take into account the psychological family as well as the physical, and the complex processes (or lack thereof) when ambiguity freezes the system. Although there are elements of grief and trauma in ambiguous loss, the immobilizing factor is ambiguity.

Preliminary evaluations indicate that what we did was effective and welcomed. Children felt safe and cared for. Parents felt supported and connected with one another, thus benefiting the children. Parents and children felt stronger despite on-going ambiguity, so hopefully future problems of unresolved loss have been prevented or minimized.

The goal of the Minnesota–New York team was to normalize human reactions to a potentially disabling ambiguity. Pending results of our follow-up studies, we believe that family therapy and family meetings in a community-based setting were effective in preventing isolation, building community, mitigating helplessness, providing empowerment, as well as in preventing relational conflict, family secrets, and boundary issues that typically follow ambiguous loss. Yet, the predominant therapeutic models after 9/11

and other disasters remain individually oriented, pathology based, and nonsystemic. We hope this report demonstrates the need for family therapists in the aftermath of crises and disasters. This is, surprisingly, a new idea.

REFERENCES

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Becvar, D. S. (2001). *In the presence of grief: Helping family members resolve death, dying, and bereavement issues*. New York: Guilford.
- Boss, P. (in press). *Loss, trauma and resilience: Helping people with ambiguous loss*. New York: W. W. Norton.
- Boss, P. (1999). *Ambiguous loss: Learning to live with unresolved grief*. Cambridge, MA: Harvard University Press.
- Boss, P. (2002). *Family stress management* (2nd ed.). Newbury Park, CA: Sage.
- Boyd-Franklin, N. (1989). *Black families in therapy*. New York: Guilford.
- Falicov, C. (1998). *Latino families in therapy*. New York: Guilford.
- Imber-Black, E., Roberts, J., & Whiting, R. (Eds.). (1992). *Rituals in families and family therapy*. New York: Guilford.
- Imber-Black, E. (1993). *Secret in families and family therapy*. New York: W.W. Norton
- Jackson, K. T. (Ed.). (1995). *Encyclopedia of New York City*. Yale University Press. http://www.yale.edu/yup/ENYC/TRIANGLE_Shirtwaist.htm
- McGoldrick, M. (1998). *Re-visioning family therapy*. New York: Guilford.
- McGoldrick, M., Giordano, J., & Pearce, J. (Eds.). (1996). *Ethnicity and family therapy*. New York: Guilford.
- Miller, C. (2002). New York. *Prime Media Magazine, Sep. 16*, p. 54.

NOTES

¹ Our thanks to Mike Fishman, President of Local 32 B-J and Tyese Frasier, also from Local 32 B-J, whose volunteer efforts were invaluable. Bill Granfield, President of Local 100, and Michael Carney, President of Local 94, for their invitations for us to work with their families after 9/11/01. We were honored to be of service at this difficult time. We could not have done our work without financial support from the University of Minnesota Ambiguous Loss fund, supported by the University of Minnesota Office of the executive Vice President and Provost; Eugene Allen, Director of International programs; Shirley Baugher, Dean of the college of Human Ecology; and Harold Grotevant, Head, Department of Family Social Science. We would also like to thank the Minneapolis Foundation for their support. In New York City, we thank Phil Coltoff, President, and Warren P. Moses, Director of Finances of the New York Children's Aid Society, and Peter Ward, Hotel and Restaurant Employees Union for their support. We are indebted to Paula Daly of the Central Labor Rehabilitation Council who directed us to the unions and helped us find those with the largest number of losses. For providing consultation and/or therapists for our interventions, we thank Jaime Inclan, Director of the Roberto Clemente Center; Peter Steinglass, Evan Imber-Black, Peter Fraenkel, and Marcia Sheinberg, Ackerman Institute of Family Therapy; Sydney Ratner, Institute for Contemporary Psychotherapy; and June Feder, Director of the New York State Psychological Association, who recruited the New York therapists who helped with family meetings. We thank the New York therapists: Deborah Freed, Tom McAffrey, Andeas Torrens, Paula Crivilli, Karan Caravallow, Raymond Rodrigues, Priska Imberti, Joan Lipton, Keren Ludwig, Sylvia Ramos, Barbara Russek, Yvette Roche, Dinelia Rosa, Luz Towns-Miranda, Henrietta Shannon, Michele Simo, Alec Cecil, Joanne Rolon, Glenda Castro, and Lascelles Black. At the University of Minnesota, we thank the therapy trainees in the Marriage and Family Therapy Program: John Beaton, Jerica Mohlman Berge, Kristen Holm, Christine McGeorge, Tai Mendenhall, and Beverly Wallace.

² After the first meeting we approached the Central Labor Rehabilitation Council (CLRC) to reach out to other union populations that had been directly affected. It was through this CLRC that we were able to contact the unions with the greatest losses and begin our work with them. Paula Daly, of that council, guided us to each union and helped direct our efforts.

³ All family therapy was provided pro bono until May of 2002. At that time, we were able to obtain funds from AOL-Time Warner and the Children's Aid society of New York.

⁴ Although we were able to obtain some Spanish-speaking therapists through New York State Psychological Association, we worked primarily with Roberto Clemente's therapists for the Spanish-speaking families.