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Bereavement and Traumatic Bereavement: Working with the Two-Track Model of Bereavement

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Abstract Bereavement following loss through death is a universal human experience, but how it is experienced and understood is mediated by many variables. In this article, we stress the importance of a bifocal approach to understanding, assessing and intervening following the loss of significant persons using the framework of the Two-Track Model of Bereavement. This model examines both biopsychosocial functioning as well as the nature of the ongoing relationship with the deceased and the death story in working with the bereaved. It is particularly suited to identify adaptive and maladaptive responses to loss and to optimally focus interventions where needed. Two case vignettes are presented to orient the discussion. Traumatic bereavements, a term indicating the interface between trauma and loss, increase the likelihood of complications following loss and these are considered. Bereavements that occur under external traumatic circumstances increase the risk for dysfunction, symptomatic difficulties and complicated grief. In addition, there are forms of traumatic bereavement that arise due to subjective elements related to aspects of the psychological relationship to the deceased and the relational bond with him or her. Clinically, there is a need to identify and understand the various aspects of the traumas of bereavement and to intervene appropriately. Interventions based on the Two-Track Model of Bereavement will be described.

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Vignettes

"Life has changed forever. Two years ago my daughter was killed in a road accident. My life was shattered and I wanted to die and join her. I couldn't stop thinking that she is dead, my beautiful girl … My family was very worried about me and I just couldn't pull myself together. It felt like falling into an endless hole. It was when my son who was then 15 reminded me that I forgot his birthday. It hit me and at that moment I made a decision to continue with life, and think of the family that needs me. I function but there is not one day that I don't think about my beloved daughter. I cry and miss her tremendously. Her memories are with me and I cherish them in spite of the pain. I realize that my decision to continue with life is living with the pain of the loss" (**Lynn**, a mother who lost her daughter 2 years earlier).

"**Life** has lost its meaning. Actually, I don't want to talk about it, talking makes it worse and too painful. Unbearable pain… The only way to keep the pain away is not to talk about it so I keep my thoughts to myself. I can't stop thinking that I didn't save her. I keep on asking myself "why, why did she die? I don't care much about my work and if I feel like staying at home and wander around. That's OK with me even though the family doesn't like it. I am angry and anxious, and nothing can be done about it. I sometimes wish that my life would be over." **(Dave**, a bereaved father who lost his daughter in a road accident 2 years earlier).

Bereavement following loss through death is a universal human experience. The two bereaved parents presented above share characteristics that often follow bereavement, but their responses are unfolding differently. The field of thanatology has undergone tremendous changes in the way we understand the process of grief and bereavement following a loss through death. One such change is the break with Freud's (1917/1957) conceptualization of grief as a normal process leading to withdrawing emotional connection from the deceased. The shift from a view of mourning as a process of breaking the bonds (decathexis) to one that sees grief as the reworking and continuing the attachment bonds with the deceased addresses the ongoing process of reorganizing one's life and world view without the deceased's physical presence (Klass et al. 1996; Malkinson 2007; Rubin et al. 2012). The majority of bereaved individuals find ways to continue life without the deceased, but for some, bereavement increases the risk of developing complications. The estimated prevalence of bereaved at risk to develop variations of prolonged grief disorder (PGD) and complications of grief range between 10 and 15% with some circumstances yielding higher estimates (Prigerson 2004; Silverman and Rubin 2015). Bereavement that occur under external traumatic circumstances increase the risk for dysfunction and symptomatic difficulties and complicated grief (Prigerson et al. 1995; Rubin et al. 2012; Shear and Smith 2002; Stroebe et al. 2001, 2008).

Traumatic bereavement is a term that incorporates elements of both trauma and bereavement thus indicating the interface between the two (Malkinson et al. 2000; Stroebe et al. 2001). There are numerous empirical reports documenting the interface

between trauma and bereavement. For example, Karniel-Laor (2004) compared individuals injured in terror attacks in Israel to individuals bereaved following a terror attack. She found that 51.5% of the interviewers from both groups developed PTSD while 20% of the bereaved were diagnosed with traumatic forms of grief. Similarly, in a web-based survey of adults bereaved in the 9–11 terror attacks assessing them between 2.5 and 3.5 years later, 43% received a classification of complicated grief with PTSD among the major comorbid conditions (Neria et al. 2007).

The DSM-IV and DSM-5 editions describe what constituted the traumas meeting criteria for traumatic events in PTSD (APA 1994, 2013). These enumerate the external objective circumstances required. We believe that there are additional subjectively experienced aspects of trauma that operate in traumatic bereavement as well. These traumas are related to the interpersonal aspects of the relationship to the deceased (Rubin et al. 2008). We will return to this following our presentation of the Two-Track Model of Bereavement.

The Two-Track Model of Bereavement: A Model for Research and Practice

The Two–Track Model of Bereavement created a scaffolding to address response to interpersonal loss from a bifocal perspective considering both the biopsychosocial functioning of the bereaved, and the nature of the ongoing relational bond to the deceased, across the life cycle (Rubin 1981, 1999). As with any major stressor event, how loss is responded to and its impact on the bereaved individual's functioning is of critical interest to the bereaved, to those who live with them, and those who treat them. In common with major life stressors, the death of a significant other can influence the biological, behavioral, cognitive, emotional, intrapersonal and interpersonal ways of one's being in the world (Bowlby 1980; Malkinson et al. 2000). The exploration of negative—as well as positive changes—is important here. This is the first domain or Track I of the model and is similar to the evaluation of all persons facing challenges to their previous mode of living in the world.

At the same time, the model builds on the core understanding that reworking the relationship to the deceased and coming to grips with grief and mourning is an equally critical feature in understanding bereavement. Indeed, it can be thought of as the central feature in what makes the loss process unique (Bowlby 1980). Thus the second domain of the Two-Track framework prioritizes the nature of the relationship to the deceased. Here the current status of a bereavement experience is addressed through the prism of the nature of the current bond to the deceased. These are often best understood in understanding how the nature of the psychological organization of the pre-loss tie to him or her has changed following death and what is "lost" along with the life of the other (Rubin 1984).

Researchers and clinicians primarily focused on the challenges to biopsychosocial functioning and/or the post-traumatic sequelae of loss have often been relatively unconcerned with the significance of the character and texture of the ongoing bond to the deceased. Narrowly focusing on the extent of behavioral difficulties and symptoms of various types is valuable but limited way of conceptualizing the ways in which

bereavement challenges the bereaved to readjust to a new external reality with a level of biological, psychological, interpersonal, and general life functioning that are adaptive. By the same token, those who might wish to assess the extent of the yearning for the deceased as the measure of bereavement adjustment will assist us in understanding how strong the yearning may be, but not to whom or to what aspects of the relationship are yearned for. The degree of yearning and lack of acceptance of the loss are signs of difficulties in the progression in adaptation to loss. Yet, many other aspects of the relationship to the deceased will remain insufficiently charted if we do not seek to learn more about whom was lost and what aspects of that relationship were lost for the bereaved. Seeking to learn about the pre-loss relationship, its meanings for the bereaved, and the impact of the loss on both behavioral ways of living in the world, and cognitive-emotional aspects of the psychological homeostasis of self-regulation in one's living with oneself and with the world, can be significantly affected for the worse upon the death of the persons we are most close to.

The importance of combining the two perspectives of functioning and relationship in broad ways formed the basis for the Two-Track Model of Bereavement (Rubin 1981, 1999). In this model, the process of adaptation to interpersonal loss is understood as linked to the disruption of homeostatic functioning but also as relating and reconfiguring aspects of the relationship to the deceased. The Two-Track Model of Bereavement advocates for the assessment of both functioning and the nature of the continuing attachment to the deceased when significant others die—and this across the entire course of the bereaved person's lifetime. The clinical implications of the model derive directly from its binocular focus. The extent to which potential psychological interventions should privilege one or both domains of the response to loss remains an important clinical question. A visual aid to the basic assessment schema of the Two-Track Model of Bereavement is presented in Fig. 1. A more complete description is available elsewhere (Rubin 1999; Rubin et al. 2012).

Based on this conceptual framework, complications in bereavement are assessed based on the two lenses: The circumstances of the loss and the relationship to the

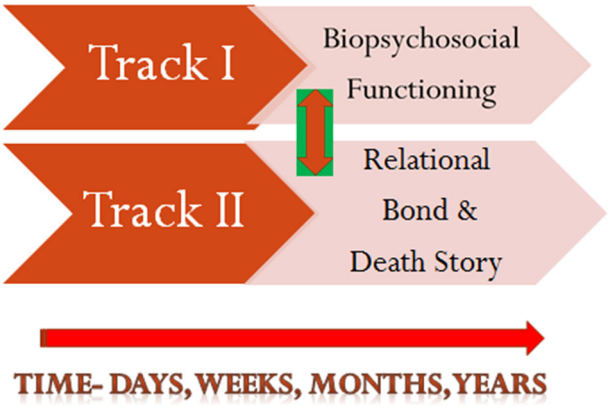

Fig. 1 A Schematic Rendering of the Two-Track Model of Bereavement

deceased (Kosminsky and Jordan 2016; Rubin et al. 2012; Stroebe et al. 2001). Additionally, traumatic bereavement are also assessed based on these two lenses, with the relationship to the deceased particularly attuned to the subjective elements related to the transformation of the inner relationship to the deceased that clinically need to be assessed and considered.

Trauma, Bereavement and Traumatic Bereavement

Somewhat surprisingly, the linking of bereavement to trauma in the general literature has the paradoxical effect of obscuring the decidedly interpersonal and intrapersonal impact of the loss of significant others on the bereaved. The literature on trauma and post-trauma has changed how both clinicians and the lay public think about life-threatening events and their impact (APA 2013). With the passage of time and the expanding literature base, clinical practitioners and the general public are better informed as to the incidence, prevalence, and pernicious deleterious effects of exposure to traumatic events (Herman 1997). Similarly, awareness of the various intervention programs and their reported efficacy (source) has increased as well.

Yet alongside the generally positive effect of the expanding wellspring of knowledge and expertise that has accrued to date in the trauma field, there is a less welcome side effect to this phenomenon as it relates to bereavement. Specifically, since major life threatening events directed either at the self or at a loved one are considered events of significant magnitude as to satisfy the criterion for a traumatic stressor, this categorization is often seen to encompass the death of a loved one. And once the death of a loved one is categorized as a major stressor of potentially traumatic proportions, there is a tendency by some to focus on the "traumatic" nature of the event and its aftermath as framed by an understanding of trauma and to minimize the interpersonal and intrapersonal significance of the adaptation to bereavement related specifically to the attachment bond and relationship with the deceased both pre- and post-loss.

This view of the "traumatic" nature of the objective bereavement also minimizes the understanding that trauma can occur when new and disturbing information related to the specifically interpersonal nature of the relationship is discovered as part of the loss and bereavement process. Information related to the deceased that can be of traumatic relational proportions might include discovery of an illicit love affair, criminal activity, sexual victimization of others and the like. In such cases, the "trauma" is the attack on the relational bond to the deceased which must be re-evaluated and re-worked due to the changes in the inner representations of the relationship (Rubin et al. 2003, 2012).

We believe that a model of bereavement that clarifies the central axes of the loss experience assists conceptual, assessment and intervention goals. We advocate for use of the Two-Track Model of Bereavement (Rubin 1981, 1999; Rubin et al. 2012) as it assists in the conceptualization and intervention planning with the bereaved. Clinical practice as well as research with the Two-Track Bereavement Model and the Two-Track Bereavement Questionnaire (TTBQ) shed additional light on this point (Rubin et al. 2009; Bar-Nadav and Rubin 2016; Rubin and Bar-Nadav 2016). The 70 item

TTBQ2, and the shorter TTBQ2-CG31, provide clinicians and researchers with an overview of the bereaved responses in the area of biopsychosocial functioning and the relationship to the deceased. In addition to the individual items, the measures yield scores on both biopsychosocial indicators of dysfunction as well as on the extent of grief and the relationship to the deceased. Clinical work often brings us in contact with persons for whom the focus of intervention is on regaining balanced biopsychosocial functioning. Treatment is geared to allow them to rejoin life in adaptive and full ways. Although therapy may be focused on function, the clinician may be unaware of how the rebalancing and reworking of the relationship to the deceased may proceed without any assistance or awareness on the part of the therapist. In other situations, the specific bereavement focus of therapy may indeed focus on the nature of the ongoing relationship to the deceased without particular attention to the biopsychosocial status of the griever. Nonetheless, the focus on the relationship may allow the bereaved to reorient the relationship to the deceased in positive ways that have implications for the biopsychosocial realm (event without a specific focus on them). And of course, the more balanced clinical intervention is where a mixture of focusing on both the function and the relationship to the deceased are a focus of concern in treatment. In such interventions, the return to more adequate function, growth, and adaptation to loss over time are most likely to occur. Viewed from CBT-REBT perspective death is an adverse event (A) that affects one's belief system (B) and consequently one's emotion and behaviors (C). Thus, cognitions mediate between the death event and the emotional consequences. The distinction made in CBT-REBT between healthy and unhealthy emotional consequences is most pertinent to grief, its process and outcomes: Grief involving sadness, pain and yearning following loss through death is normal and human and is related to a flexible belief system: "It is sad that she died so young, though my life has changed, they will continue". "Whenever I think of her I miss her, and it's painful, but I can bear the pain". Rigid and inflexible belief system (irrational thinking) is related to emotional distress (depression response, anxiety, guilt, pain intolerance in the way of avoidance) and difficulties in finding the balance between what was prior to the loss and life without the deceased: "my life is worthless without her, and I would rather join her instead of suffering the pain", "I will never forgive myself for not saving her, I failed as a father" (Malkinson 2001, 2007, 2012).

Working Clinically with the Two-Track Model of Bereavement

Let us return to the opening vignettes. In both, loss involved a child 2 years earlier, a loss that is considered a contributor to traumatic response (Neria et al. 2007; Rubin and Malkinson 2001; Rubin et al. 2012). In both, the conditions of the death were external traumatic ones. Using the bifocal perspective of the Two-Track Model for both biopsychosocial functioning (Track I), and the relational bonds and death story (Track II) are apparent and are linked. Life has been shattered for both parents by the death of their child. The relationship to the deceased child and the pain involved appear to be central in Lynn's and Dave's stories. Yet, the processing and reorganization of the relationship to the deceased child differs. Whereas Lynn who had been absorbed in her grief and expressed the wish to join her deceased daughter,

she had chosen life upon her son's comment to her. Dave on the other hand, was expressing difficulties in functioning and in reorganizing relationship with his deceased daughter. Over the years, clinical and research work on bereavement with the Two-Track Model of Bereavement has shown it to be a useful framework for assessing which specific bereavement focus therapy will take and what are the appropriate CBT-REBT techniques to be applied for grief to take its adaptive course (Malkinson 1996, 2007; Malkinson and Ellis 2000; Malkinson et al. 2000). Based on the short vignettes quoting Lynn's experience, the impression is that her traumatic loss was followed by acute grief. Within a period of 2 years, her grief had subsided to reach a balance between continuing bonds with her deceased beloved daughter, and continuing with life. In the case of her potential referral to therapy when yearning to her daughter and pain intensify, especially around anniversaries like a birthday, normalizing and legitimizing these along with her choice to continue with life are significant issues to be discussed. These would allow for stressing the oscillation between the focus on the loss and connection to the deceased and the openness to other aspects of life. The description in Dave vignettes reveals difficulties in reorganizing his life and in managing the inner relationship with his deceased daughter as well as his life following the death. From a CBT-REBT perspective upon request for therapy, an assessment might discover a rigid inflexible belief system: Blaming himself for her death and feeling anxious when experiencing the pain of loss (secondary symptom) are irrational interpretations of the response to traumatic loss blocking an adaptive grief process. Following an assessment and providing information about the differences between healthy adaptive grief and its less adaptive alternative, the connection between beliefs and consequences (B-C connection) that the therapy will focus upon will be clarified as a main focus in assisting Dave transition to an adaptive grief process. Possible techniques can include a letter writing to his daughter, and visiting the grave as outlined in Shear's protocol (see Shear and Gribbin this volume).

Concluding Remarks

The richness of clinical work provides a very human experience for working with the bereaved. Scores on bereavement measures, while informative, rarely serve to touch us in quite the same way. We are moved by human contact in ways that overshadow objective measurements of bereavement. Human stories of loss involve the bereaved, and how they were affected by the loss. Equally important are the stories of the loss and death event, which are often intertwined in the experience of loss with both the impact on functioning, and the experience of the relationship to the deceased (Witztum et al. 2005). Sustained and careful attention to the twin domains of function and relationship capture much of the response to bereavement.

Our clients are always unique individuals. Using standardized measures that allow the bereaved to consider their current life experience, and that make room for the relationship with the deceased, provide both them and us with information that is highly relevant to our therapeutic alliance. At the same time, we recognize that standardized measures are not a substitute for the direct and powerful human

connection to our clients and their unique lives. Combining the standardized format with the uniqueness of direct communication is more powerful than either approach can be on its own. The individual items on the TTBQ, the factor scores, and the total score provide additional ways of tracking the process and content of the bereavement experience over time for both therapy and research contexts.

Impaired functioning and the pain of loss motivate people to seek assistance from both professional and non-professional sources of support. The pain of grief and the wish to be reunited with the loved one can torment the bereaved. How these actually impact the stance of the bereaved *vis-a-vis* their inner and outer lives deserves careful consideration. Impairment of functioning as well as evidence of positive changes and growth following loss are addressed in the first domain of the Two-Track Model of Bereavement. The nature of the relationship to the deceased is addressed in the second domain. Research has been important in demonstrating the ongoing nature of the relationship to the deceased as a normative phenomenon. The specific construction of the ongoing relationship, however, must be understood to determine its salutary and problematic influence on the bereaved. Ongoing research with the bereaved can go much further in specifying those characteristics of bereavements and of the bereaved that facilitate and exacerbate the response to loss (Malkinson et al. 2000). Clinically using the perspective of the Two-Track Model of Bereavement allows us to focus carefully on the nature of grief and mourning. The model's consideration of behavioral outcome as well as the ongoing relationship to the deceased furthers our understanding of these domains and their interrelationship. Working clinically with this double perspective, this double helix, is relevant for tailoring the goals and methods of intervention as detailed above, using CBT-REBT strategies to help the bereaved live life with greater freedom and choice (Rubin et al. 2012, 2016; Witztum et al. 2016).

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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