GRIEF, TRAUMA AND RECOVERY: IDEAS FOR PASSIVE PARTICIPATION IN SHARED PUBLIC EVENTS TO PROMOTE CONNECTION AND HEALING FOLLOWING TRAUMATIC LOSS

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California State University, Chico

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By
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Spring 2016

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DEDICATION

This project is dedicated to my family.
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Thank you M.O. for nurturing my curiosity and enthusiasm for learning, and for being so adept at navigating all things educational (therefore making it impossible to pretend anything academic cannot be done).

My sincerest appreciation to my committee for supporting this project and sharing my belief in its merit and value. I began searching for knowledge on passive participation without being able to clearly define it or call it by name. Many people told me “that is not a thing” or suggested finding a more established topic. Thank you for helping me find a way to explore an idea without a name.

All my love to my “unofficial committee”, you know who you are. Thank you for diligently reading so many dreary papers, and spending endless hours discussing aspects of trauma and posttraumatic stress. You are truly wonderful.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Publication Rights</th>
<th>iv</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedication</td>
<td>v</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>vi</td>
</tr>
</tbody>
</table>

## CHAPTER

### I. Introduction

- Background .......................................................... 1
- Statement of the Problem ........................................ 7
- Purpose of the Project ........................................... 7
- Questions to be Answered ....................................... 8
- Definition of Terms ............................................. 9

### II. Literature Review

- Grief .............................................................................. 11
- Traumatic Loss ........................................................ 17
- Resilience ............................................................... 25
- Recovery ................................................................. 29
- Passive Participation ............................................... 33
- Conclusion ............................................................. 42

### III. Methodology

- Experience of Passive Participation ............................ 44
- Initial Interviews ..................................................... 45
- Analysis of Initial Interviews .................................... 45
- Pamphlet ........................................................................ 47
- Collection of Feedback ............................................. 48
- Analysis of Survey Data ............................................ 48

### IV. Results

- Interview Data .......................................................... 51
- Pamphlet ....................................................................... 53
- Feedback Data ........................................................... 52
<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>V. Recommendations and Conclusion</td>
<td>55</td>
</tr>
<tr>
<td>References</td>
<td>60</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
</tr>
<tr>
<td>A. Pamphlet</td>
<td>69</td>
</tr>
</tbody>
</table>
ABSTRACT

GRIEF, TRAUMA AND RECOVERY: IDEAS FOR PASSIVE PARTICIPATION IN SHARED PUBLIC EVENTS TO PROMOTE CONNECTION AND HEALING FOLLOWING TRAUMATIC LOSS

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This project examines the potential benefits of passive participation in public events or activities for individuals recovering from traumatic loss. To establish the context of this project, the current understanding of grief, traumatic loss, resilience, recovery and passive participation is reviewed. Throughout this review, specific attention is given to how posttraumatic stress and other factors interact to affect recovery outcomes. This analysis suggests posttraumatic stress poses unique challenges to individuals recovering from traumatic loss, especially when posttraumatic stress symptoms interfere with social support. To further inform the project, individual interviews were conducted regarding personal experiences of passive participation, including positive and negative aspects of these experiences. An informational pamphlet was then developed to raise awareness, reduce stigma, and provide ideas for passive participation as a recovery tool following traumatic loss. The pamphlet was distributed to adults in the community and a survey was conducted regarding the clarity and usefulness of the information presented. The survey responses were overwhelmingly positive. In closing, the author suggests avenues of further research, as well as additional ideas for education and outreach.
CHAPTER I

INTRODUCTION

Background

Traumatic loss is indiscriminate and no one is immune from experiencing a loss that is potentially devastating and forever life changing. Although traumatic loss is universal, individual experience of such loss is uniquely personal and subjective. People exposed to traumatic loss have a variety of reactions and outcomes. Some individuals may quickly return to normal functioning, while others find themselves permanently altered by the experience.

The ability to quickly adapt and return to normal levels of functioning after traumatic loss is called resilience. Both resilience and recovery (which involves gradual improvements in functioning) are important concepts in the context of trauma and loss. Research in these areas provides valuable insight into factors that could potentially improve daily functioning and overall quality of life for individuals experiencing posttraumatic distress.

Self-care and connections with others have both been identified as important aspects of recovery and healing following traumatic loss. However, some individuals may feel extremely isolated and find it difficult to connect with others due to functional impairments associated with grief and posttraumatic distress. These individuals may benefit from shared public experiences that require minimal social interaction. This can be better understood by considering what is currently known about grief, traumatic loss, resilience, recovery and passive participation.

Grief is a normal reaction to significant loss (Freud, 1957). Grief can include physical, psychological and social components (Hooyman & Kramer, 2006) that may vary in intensity and duration. All of these components can be impacted by a variety of internal and external factors,
such as personality, culture, and availability of social support (M. Stroebe, Hansson, W. Stroebe & Schut, 2001).

Psychoanalytical grief theory has focused on the concept of detachment and suggested grief is a mental process that assists individuals in letting go of attachment following loss (Freud, 1957). Within this framework, grief is considered a temporary state (Freud, 1957) and clinical treatment for grief focuses on processing negative emotions in order to facilitate detachment and allow the individual to move on (Hall, 2014).

Some experts have criticized psychoanalytical approaches to grief, pointing to evidence that grief does not appear to be a linear process, or have a specific ending point (Hall, 2014; Hooyman & Kramer, 2006; M. Stroebe, 1992). Continued attachment following loss may be both normal and beneficial (Bonanno & Kaltman, 1999; Hooyman & Kramer, 2006; Klass & Walter, 2001) and clinical treatment for grief may be detrimental in some cases (Bonanno & Kaltman, 1999; Bonanno, 2004).

Dual processing theory suggests grieving individuals naturally fluctuate between confrontation and avoidance related to both (a) acceptance of loss and (b) actions needed to deal with the consequences of loss (M. Stroebe & Schut 2001). In this context, some avoidance behaviors are seen as beneficial, since they provide opportunities for grieving individuals to take a much needed break from the pain of loss (M. Stroebe & Schut, 2001). This idea is consistent with socio-functional theory, which suggests grieving individuals can improve functioning and support recovery by regulating or minimizing negative emotions and encouraging positive emotions (Bonanno, 2001).

Emotional regulation may be more difficult for victims of traumatic loss than it is for individuals experiencing normal grief reactions. When a loss is perceived as highly threatening,
unexpected or shocking, it can lead to a variety of distressing posttraumatic distress symptoms in addition to symptoms of grief.

Common reactions to traumatic loss include such things as hypervigilance, insomnia, flashbacks, nightmares, excessive contemplation, numbness, withdrawal and disassociation (American Psychological Association, 2013a; Herman, 1997). Posttraumatic distress has been linked with declines in overall physical health (Boals, Riggs & Kraha, 2013; Pacella, Hruska & Delahanty, 2013), as well as increased risk of mental health and substance use disorders (Pietrzak, Goldstein, Southwick & Grant, 2011). While most individuals are able to successfully adjust to traumatic loss, a significant number of people will experience posttraumatic distress symptoms (Kristensen, Weisæth & Heir, 2012), as well as related declines in overall health and quality of life.

The most common traumatic events reported by individuals in the United States are the injury, illness or death of another person, and personal experience of sexual assault (McLaughlin et al., 2013; Pietrzak et al., 2011). While diagnosable trauma and stress related disorders are more common for individuals who experience sexual assault, military combat or captivity (American Psychological Association, 2013b), it is important to remember that individuals may experience significant posttraumatic distress without qualifying for a clinical diagnosis.

In many cases, traumatized individuals spend significant time struggling to fully comprehend what has occurred and to understand the significance in their lives (C. Davis, Nolen-Hoeksema & Larson, 1998). Researchers have postulated posttraumatic distress may be caused by the inability to integrate traumatic memories into existing mental frameworks (Dalgleish, 2004) or by integration that is so complete it makes the trauma the central reference for all future understanding (Berntsen & Rubin, 2007).
In order to understand why some individuals experience posttraumatic distress while others do not, some researchers have focused on the concept of resilience. This research seeks to identify characteristics associated with individuals who remain relatively unaffected by or recover quickly from exposure to potentially traumatic events.

Resilience has been associated with factors such as sense of control, positive self-judgment, problem solving, and emotional regulation (Agaibi & Wilson, 2005; Bonanno, 2004, 2008), as well as optimism, mental flexibility and social support (Iacoviello & Charney, 2014). It is likely some resilience factors can be learned through training or experience, allowing individuals to increase their own potential for resilience (Haglund, Cooper, Southwick & Charney, 2007). However, the relationship between resilience and specific factors appears to be inconsistent.

This inconsistency may relate to divergent operational definitions of resilience in the research being conducted or point to variability in resilience correlates depending on the circumstances. Rutter (2007) has suggested individuals may be resilient in the face of some events and not others, or be more resilient in particular areas of functioning. For example, an individual may adapt well following a devastating natural disaster, but have difficulty reconciling a tragic accident. Alternatively, after a natural disaster they may be able to maintain a high level of functioning at work while having difficulty in their private life.

Whatever the context, for individuals who do not exhibit resilience, traumatic loss can result in prolonged posttraumatic distress and recovery may be a slow process. Distress, even acute distress, may be a normal reaction to traumatic loss. In most cases, individuals will not require clinical treatment (Bonanno, 2004, 2008; Bonanno & Diminich, 2013) and recovery can occur even when grief and posttraumatic distress symptoms continue (MacDonald-Wilson,
Recovery is a means of regaining a sense of purpose and improving quality of life. This process is not linear and many aspects of recovery may be highly subjective (Pratt et al., 2014). For victims of traumatic loss, recovery may begin with the task of reestablishing a sense of safety and control in a world that seems dangerous and threatening (Herman, 1997). Other aspects of recovery include self-care and reestablishing a sense of connection with others (Herman, 1997).

The importance of social support and connectivity is often referenced in grief and trauma literature. Unfortunately, victims of traumatic loss may find it difficult to relate to others or engage in social interaction. This author suggests some individuals may benefit from passive participation in shared public events or activities where social interaction is not required. Specifically, passive participation provides an opportunity for being around others and an external focus of attention.

Notably, anticipation of social interaction with a stranger has been associated with attempts to alter mood (from happy or sad) to a more neutral state (Erber, R. & Erber, M., 2000; Erber, R., Wagner & Therriault, 1996). This was especially true for unhappy individuals who anticipated interacting with a happy stranger (Erber, R. et al., 1996). In fact, social presence may increase mood regulation even when interaction is not anticipated. Lee and Wagner (2002) found individuals smiled more often and displayed less negative emotion in the presence of others than when they were alone.

Shared public events and activities also provide opportunities for distraction from self-focus. This is significant given that self-focus has been correlated with negative emotion (Mor &
Winquist, 2002) and negative self-judgment (Mellings & Alden, 1999). In light of these findings, opportunities for external focus through passive participation in shared public events or activities may be highly beneficial for survivors of traumatic loss.

Statement of the Problem

Traumatic loss causes high levels of distress and functional impairment for a significant number of individuals. Many of these individuals will not qualify for a clinical diagnosis and may not benefit from professional treatment.

Within this population, some individuals lack adequate social support and may not be aware that social support and a sense of connection are important components of recovery. Furthermore, symptoms of grief and posttraumatic stress may make it difficult for these individuals to reach out for help or successfully engage with others. In fact, some individuals may actively withdraw from people and activities as they struggle to come to terms with their experience and protect themselves from further pain. This withdrawal can lead to further feelings of isolation and disconnection, and leave individuals feeling alienated, vulnerable and without hope.

Outcomes for traumatized individuals may be further complicated by limited public awareness regarding trauma and unrealistic cultural expectations for “appropriate” mourning. In some cases, individuals experiencing posttraumatic distress may lack basic information about impacts of traumatic loss or what is known about promoting recovery. Access to knowledge allows for alternative viewpoints and more effective problem solving. For example, simply knowing trauma can result in negative self-perceptions or understanding that seeking social support may provide temporary relief from acute distress, may allow individuals to better understand their state of mind and develop more successful coping strategies.
Purpose of the Project

This project provides general information on grief and posttraumatic distress in order to assist survivors of traumatic loss in understanding their own reactions and normalizing their experiences. Traumatic loss can leave individuals feeling as if they are irretrievably lost—and lack of information can further exacerbate feelings of isolation or mental chaos. As individuals struggle to regain their sense of self, they may benefit from a better understanding of the potential impact of trauma and the range of normal reactions.

This project is consistent with resilience and recovery concepts. Individuals suffering from traumatic loss may be working hard each day to facilitate their own recovery without realizing the value of what they are accomplishing. By promoting recovery values such as hope, empowerment and self-direction, this project seeks to encourage individuals to embrace their own expertise regarding their recovery and continue to seek solutions that meet their specific needs.

Most importantly, this project addresses the difficulty some individuals may have reconnecting with others following traumatic loss by providing information on passive participation in shared public events or activities. Passive participation provides opportunities for individuals to be with others even when their posttraumatic distress is causing significant impairments in social functioning. This project seeks to support recovery by providing insight into how passive participation may help foster a sense of connection and community.

Questions to be Answered

*How do individuals react to traumatic loss?* Although loss takes many forms and individual experiences of trauma are personal and subjective, research suggests there are common reactions to traumatic loss. This project seeks to identify and summarize information
about traumatic loss in a format accessible by the general public in order to normalize individual experiences and promote a broader understanding.

*What are resilience and recovery, and how can individuals foster resilience and recovery in themselves following traumatic loss?* This project seeks to identify and synthesize knowledge about key aspects of trauma, grief, resilience and recovery in order to provide survivors of traumatic loss with information that may help them cope with their experience, improve their daily functioning and increase their overall quality of life. This includes ideas for enhancing resilience, as well as practical applications for recovery principles in the context of traumatic loss.

*How can passive participation in public events support recovery and healing?* Trauma can leave individuals feeling isolated and alone. Although reestablishing a sense of connection is essential to recovery, some individuals may find it difficult to reconnect following traumatic loss. This project seeks to identify opportunities for reconnection through public activities that allow for participation without direct social engagement. This includes individualized solutions that are self-selected, flexible and optional, allowing for variations in personal interest, energy level and ability.

**Definition of Terms**

**Grief**

Grief is a normal reaction to loss that is unique to the individual and may involve a variety of physical, mental and social symptoms which vary in intensity and duration and negatively impact daily functioning and overall quality of life (Hooyman & Kramer, 2006).
Recovery

Recovery is a self-directed, holistic and dynamic process of empowerment and growth through which individuals seek to improve their daily functioning and quality of life (Substance Abuse and Mental Health Services Administration, 2012).

Resilience

Resilience occurs when an individual is able to adapt and recover quickly from potentially traumatic experiences with little or no functional deficits, or deficits that are experienced for only brief periods of time (Bonanno & Diminich, 2013).

Traumatic Loss

Traumatic loss is any significant loss that is subjectively perceived as shocking, sudden, violent or unexpected, violating essential closely-held beliefs about the safety, predictability, and fairness of the world (B. Green, 2000).
CHAPTER II

LITERATURE REVIEW

Traumatic loss impacts people all over the world in many different ways. It may come in the form of death of a loved one, a terrible accident, a violent crime or a natural disaster. It may also be something less obvious, such as losing a job, getting a divorce or failing a class.

Experience of trauma is subjective and personal. Traumatic distress occurs in the face of a terrible threat or shock that is well outside the norm. Each of these elements (level of threat, level of shock and comparison to the norm) are dependent on both context and the individual.

Although individual responses vary greatly, it is common for people to experience extreme physical, mental and emotional distress in the face of trauma. Individuals experiencing traumatic loss are often grieving, coping, healing, and adapting to the reality of their loss, while still facing the challenges inherent in everyday life. Each person has their own story and their own path to recovery.

There is a variety of literature pointing to the importance of self-care and reconnecting with others as a means of improving well-being and quality of life following traumatic loss. Unfortunately, reconnection may be difficult for traumatized individuals due to the nature of grief and posttraumatic distress. This author suggests some traumatized individuals may benefit from passive participation in shared public events which do not require high levels of social interaction.

This literature review will provide insight into current understanding in this area, with emphasis on the following topic components: Grief, Traumatic Loss, Resilience, Recovery and Passive Participation.
Grief

Grief is an aspect of the human experience that is universal, while being unique to the culture and individual at the same time. Grief is often associated with the death of a loved one, however it can follow any significant loss (Freud, 1957). For example, grief may follow the loss of a pet, a job, a relationship, a possession or even a closely held belief or ideal. In many cases, significant loss may also be associated with practical, financial or social changes to daily life that create additional challenges for the grieving individual.

Grief can have physical components (such as insomnia, loss of appetite, fatigue or fluctuations in body weight), psychological components (such as intense emotion, trouble concentrating, or depression), and social components (such as isolation, a sense of disconnection, or changes in social networks) (Hooyman & Kramer, 2006) and the intensity, duration and expression of grief can vary greatly. Some individuals may experience an array of distressing symptoms, which may impact their lives on many levels, possibly over a long period of time (Bonanno, 2004). Other individuals may experience grief of relative short duration and intensity, or not experience grief at all (Bonanno, 2004).

Grief can be influenced by factors such as individual personality, cultural norms, availability of social support, and the nature and intensity of the loss (M. Stroebe, Hansson et al., 2001). Thus, individuals may have very different experiences of grief, even when they are grieving the same event (M. Stroebe, Hansson et al., 2001).

Considering the scope of this issue, it is not surprising that there are multiple theories concerning the nature and function of grief, the “appropriate” intensity and duration of grief, and the proper individual and professional response to grief distress. For the purposes of this review,
let us consider psychoanalytical theory, the cognitive stress model, the dual processing model, and socio-functional theory.

Psychoanalytical Theory and Grief Work

In 1957, Sigmund Freud published Mourning and Melancholia, presenting his clinical observations and providing a theoretical framework for discussing grief. Freud suggested grief involves a process of detaching from the thing that has been lost, in order to move on with life. Freud referred to mourning as “work” and argued that processing negative emotions associated with loss is essential to successful recovery.

Within this framework, Freud (1957) viewed grief as a natural and healthy reaction to loss, rather than an abnormal state, and proposed that grieving is a temporary mental process, with a clear resolution or ending point, wherein the individual is finally able to let go of the attachment to what they have lost. In fact, the idea that grief is temporary is a key aspect of the psychoanalytical perspective. This model suggests counselors should help grieving individuals process negative emotions as quickly as possible, in order to facilitate detachment and healing (Hall, 2014).

Theorists focusing on grief work have proposed several variations on the hypothetical stages or phases an individual must complete to fully resolve grief. The most commonly known framework is arguably Elisabeth Kübler-Ross’ five stages of grief. This is a linear model, which proposes individuals must progress through five stages (denial, anger, bargaining, depression and acceptance) to successfully complete the grieving process (Kübler-Ross, 1969).

Some experts have criticized the five stages of grief model, as well as other stage and phase models, for failing to account for individual variations in the grieving process (Lazarus & Folkman, 1984). Researchers point to evidence that individual experiences of grief vary greatly,
appear nonlinear, and generally do not have a prescribed ending point (Hall, 2014; Hooymann & Kramer, 2006; M. Stroebe, 1992). Furthermore, a growing body of evidence suggests clinical treatment for grief may actually be detrimental in many cases (Bonanno & Kaltman, 1999; Bonanno, 2004).

Attachment theory. Bowlby (1980), whose work focused on the attachment aspect of psychoanalytical theory, provided evidence that detachment is not the primary function of grief. Instead, Bowlby suggested grief simply changes the nature of attachment. This view is consistent with more recent research suggesting continued attachment to deceased loved ones may be normative and beneficial (Bonanno & Kaltman, 1999; Hooymann & Kramer, 2006; Klass & Walter, 2001). It also allows for cultural variations, such as the practices of some non-western cultures where ancestors and deceased loved ones continue to be part of the conceptual family and may be viewed as sources of wisdom or comfort.

Cognitive Stress (Socio-Emotional) Model

Another framework for understanding grief is the cognitive stress model developed by Lazarus and Folkman (1984). Lazarus and Folkman argued that psychological reactions to stress, including the stress of loss, differ depending on individual perceptions of (a) ability or resources to cope with the loss, and (b) potential for harm or benefit resulting from the loss. Lazarus and Folkman suggested individuals go through a process of evaluating how the loss may harm or benefit them, as well as considering options for reducing harm or optimizing potential benefit. These options, or coping strategies, can then be put into action as needed.

According to cognitive stress theory, individuals apply coping strategies in order to manage problems associated with the loss (problem solving) and maintain control over their emotions during this difficult time (Lazarus & Folkman, 1984). Key coping strategies include
focusing attention towards or away from the loss, changing internal interpretations of the loss, and modifying the external environment (Lazarus & Folkman, 1984). This process is specific and unique, as it is influenced by both the characteristics of the individual and those of the loss itself (Lazarus & Folkman, 1984).

Notably, the cognitive stress model includes several key differences from the psychoanalytical model (Bonanno & Kaltman, 1999). The cognitive stress model expands grief from a solely internal process to a process influenced by both internal and external factors (Bonanno & Kaltman, 1999). It also incorporates the idea that loss may involve both positive and negative emotions depending on individual perception or appraisal of the loss (Bonanno & Kaltman, 1999). Additionally, this model allows for the possibility that coping strategies involving avoidance (or minimization of distress) may be adaptive and healthy (Bonanno & Kaltman, 1999).

**Dual Processing Model**

The dual processing model incorporates aspects of other models with an emphasis on adaptive coping. M. Stroebe and Schut (2001) proposed that grief involves both loss and restoration. Loss oriented grieving is associated with processing the loss itself, while restoration oriented grieving is associated with the consequences of the loss, such as adapting to new circumstances or taking on new roles (M. Stroebe & Schut).

Within these two areas, M. Stroebe and Schut (2001) suggested grieving individuals normally vacillate between confrontation and avoidance. In other words, while it is essential to acknowledge and accept loss, this process is taxing and necessitates periods of avoidance or distraction (M. Stroebe & Schut). According to the dual processing model, this conflict explains why individuals may fluctuate between negative and positive emotions, as well as adopting
seemingly contradictory attitudes or coping behaviors as they shift between accepting the loss, denying the loss, or actively fighting against it (M. Stroebe & Schut).

**Social-Functional Theory**

Within the social-functional model, grief and emotion are considered separate concepts. Bonanno (2001) provided evidence of several areas where grief and emotion diverge. For example, grief includes both positive and negative emotions and is a long term reaction to loss (encompassing months or years) (Bonanno, 2001). Emotions pass more quickly, usually within minutes or hours (Bonanno, 2001). Additionally, emotions generally occur with limited conscious appraisal of the situation, whereas grief involves extensive, ongoing appraisal and evaluation and results in different coping strategies (Bonanno, 2001).

In contradiction to the grief work hypothesis (which focuses on the value of experiencing, expressing and processing negative emotions), the social-functional model suggests there are benefits in regulating negative emotions (Bonanno, 2001). Researchers have found evidence that focusing on negative emotions increases the length and severity of grief (Bonanno & Kelter, 1997) and reduces social support (Diminich & Bonanno, 2014). In fact, recovery appears to be enhanced by regulating or minimizing negative emotions, and encouraging positive emotions (Bonanno & Kaltman, 1999). Regulating negative emotions may also free up energy for problem solving and dealing with everyday difficulties associated with the loss (Bonanno & Kaltman, 1999).

**Complicated or Traumatic Grief**

Grief is ongoing; what is lost cannot be regained or replaced, and grief exists, in varying intensity, throughout life. Intense periods of bereavement, generally characterized by emotional distress, can also impact physical and mental health (Stroebe, 2010; Prigerson et al, 1997). This
is true for both normal grief reactions, where the loss is eventually integrated and the individual is able to move on, and grief which persists at heightened levels for long periods of time.

Persistent or protracted grief is often referred to as complicated or traumatic grief, and is seen in approximately 10% of bereaved individuals (Shear et al., 2011). Complicated grief is characterized by trauma symptoms and separation distress that impair normal functioning and continue for at least six months after the loss (Boelen, van den Bout, & van den Hout, 2006; Shear et al., 2011).

Symptoms of complicated grief may include such things as disruptions to work and other daily functioning, isolation, anxiety, insomnia, depression, suicidal ideation, unhealthy behaviors, or drug use (Boelen et al., 2006; Shear et al., 2011). Complicated grief is also associated with excessive rumination about the loss, a sense that the loss is not real or can be reversed, inability to make sense of the loss, and attempts to find (or feel close to) the thing that has been lost (Shear et al., 2011). While these symptoms are also common in normal grief, their failure to abate over time characterizes complicated grief (Shear et al., 2011) and may lead to reduced quality of life and greater risk of physical and mental health complications (Prigerson et al., 1997). Individuals with complicated grief are also more likely to engage in behaviors that negatively impact health (Prigerson et al., 1997).

Bolen et al. (2006) proposed that complicated grief symptoms are caused by (a) failure to accept the reality of the loss in relation to oneself, (b) negative or pessimistic thinking in relation to oneself and globally, and (c) avoidance behaviors reinforcing the connection with what has been lost while preventing new connections. In essence, individuals suffering from complicated grief seem unable to accept the loss and shift their focus back towards ongoing life.
Risk factors associated with complicated grief include such things as gender, mental health history, perceived social support, attachment style, stress level, temperament, and level of optimism (Shear et al., 2011). Another potential factor (though not emphasized in bereavement literature) is the context and nature of the loss. Traumatic loss affects individuals in ways that are outside the scope of normal bereavement, and, as a result, exploring the concept of traumatic loss seems to require information from both grief and trauma literature.

Traumatic Loss

Traumatic loss has been defined as sudden, violent or unexpected loss that violates core beliefs about the safety, predictability, and fairness inherent in the world (B. Green, 2000). Traumatic loss often highlights personal vulnerability and helplessness. B. Green (2000) suggested that in addition to the external loss, there is an internal shock or realization of death that can profoundly affect the individual. The unconscious assessment of loss is uniquely personal and traumatic stress may occur even if the loss is objectively seen as non-violent, to-be-expected, or predictable (B. Green).

Hobfoll’s conservation of resources theory (as cited in B. Green, 2000) suggests that trauma can be explained as a highly demanding situation that is rapidly depleting valued resources while simultaneously contradicting core beliefs and overwhelming existing coping strategies. This definition points to the fact that traumatic loss is often experienced in the context of other losses, such as loss of income, housing, or social support. While individuals may be able to successfully cope with a variety of stressful situations, traumatic events can be overwhelming and extremely threatening.

Herman (1997) suggested that trauma exposes personal vulnerability to death or annihilation, and permanently alters the individual’s worldview and sense of self. Traumatic
events are life changing, and individuals who have experienced trauma may react in a variety of ways.

**Common Reactions**

People experiencing traumatic loss may initially feel stunned or disoriented (American Psychological Association, 2013a). As these feelings subside, individuals may experience a variety of physical, emotional and social reactions that make it difficult for them to function in their daily lives. These reactions may include symptoms commonly associated with grief, such as difficulty sleeping, strong and unpredictable emotions, or disruptions to relationships with others. However, traumatic loss can also be associated with three symptoms specifically related to extreme stress or trauma: arousal, intrusion and constriction (Herman, 1997).

In the context of posttraumatic stress, *arousal* is characterized by such things as hyper-vigilance, insomnia and an overactive startle response (Herman, 1997). Individuals may be highly sensitive to certain sounds, locations or other factors associated with the loss; in fact, the sympathetic nervous system may be actively engaged in the fight or flight response, even in the absence of an appropriate trigger (Herman, 1997). Individuals may also find it difficult to concentrate in this state, or they may experience intense anger or irritability (American Psychological Association, 2013a).

Another symptom of posttraumatic stress, *intrusion*, includes such things as flashbacks, nightmares, and excessive rumination (American Psychological Association, 2013a). Rumination is characterized as continually thinking about or analyzing the event. Memories of the traumatic events often exist as vivid snapshots frozen in time, rather than evolving autobiographical narratives (Herman, 1997). Trauma survivors may momentarily experience the
traumatic event as the present, rather than the past. They may also experience physical reactions, such as increased heart rate or sweating (American Psychological Association, 2013a).

The *constriction* component of posttraumatic stress involves such things as withdrawal, avoidance, amnesia, numbness, and drug or alcohol use (American Psychological Association, 2013a). Memories and flashbacks of the traumatic event can be very distressing, and individuals may go to great lengths to avoid thoughts, behaviors and situations which could act as triggers (Herman, 1997). They may also tune out or disassociate from everyday life (Herman, 1997), reducing interactions and experiences that bring their attention back to the painful present.

**Prevalence, Risk and Protective Factors**

Stressful or traumatic events do not cause traumatic distress reactions in everyone, and some traumatized individuals experience shorter periods of distress than others (Regehr, 2004). The American Psychological Association (2013b) suggests that prevalence of diagnosable trauma and stress-related disorders appears to vary across cultures, and reported rates in the United States appear to be significantly higher than reported rates around the world. Even so, most individuals coping with traumatic loss will not experience the level of symptoms required to qualify for a clinical diagnosis (Bonanno, 2004).

After a review of the literature in 2012, Kristensen et al. concluded that while most people are able to successfully adjust to traumatic loss, the number of individuals who suffer trauma related distress is significant. In a study of 776 college students, Boals et al. (2013) found that 63% of students reported a life event that could be considered as potentially traumatic, and 14% had scores that indicated they were likely to be experiencing posttraumatic stress. While this study may have limited application to the general population, it may be more
representative than the body of research focusing on soldiers, emergency responders and victims of terrorism or natural disasters.

Pietrzak et al. (2011) found that the most common traumatic events reported by adults in the United States were the serious injury, illness or death of someone else, or personal experience of sexual assault. McLaughlin et al. (2013) found these were also the most common traumatic events reported by adolescents.

Risk of traumatic stress appears to be greater for adults who are young, divorced, low-income (Pietrzak et al., 2011), or have a history of certain mental health problems (McLaughlin et al., 2013). There are also correlations between traumatic stress reactions and prior history of trauma, abuse, or family instability (D. King, L. King, Foy, Keane & Fairbank, 1999). Additionally, the American Psychological Association (2013b) reported higher rates of diagnosable trauma and stress-related disorders for survivors of sexual assault, military combat or captivity.

Pietrzak et al. (2011) found women were more likely to report posttraumatic stress symptoms than men, however it was unclear whether this outcome was due to internal or external factors. For example, women were more likely than men to report existing mood or anxiety disorders, or to be victims of physical or sexual assault (Pietrzak et al. 2011). Further research is needed in order to fully understand the role of gender in individual responses to trauma (Pietrzak et al. 2011).

There is some evidence that resilience to the acute distress caused by traumatic events may be associated with specific personality characteristics, such as sense of control, flexibility and optimism (Regehr, 2004). Other protective factors may include social support and hardiness (King et al., 1999). Hardiness is associated with the characteristics of “sense of control,
commitment to self” and “viewing change as a challenge” (King et al., 1999, p. 166). The American Psychological Association (2013b) has also reported lower rates of posttraumatic distress in children and older adults.

Impact on Overall Health

Prolonged posttraumatic stress reactions can negatively impact physical health. Boals et al. (2013) found college students reporting posttraumatic stress symptoms lasting longer than one month were more likely than their peers to report physical health problems. In meta-analysis of 62 studies, Pacella et al. (2013) found posttraumatic stress was associated with general health problems, increased pain, and increases in documented medical conditions. Furthermore, increases in posttraumatic stress symptoms correlated with increases in physical health problems and decreases in overall quality of life (Pacella et al.).

Posttraumatic stress can also impact mental health. Boals et al. (2013) found traumatized students who reported difficulty in daily functioning were more likely to report depression, negative emotions, and reduced quality of life. Pietrzak et al. (2011) also found adults in the United States reporting posttraumatic stress symptoms were more likely to experience co-occurring mental health disorders, including mood and anxiety disorders. Additionally, these individuals were also more likely to have substance use disorders, and attempt suicide during their lifetime (Pietrzak et al.).

Search for Meaning

Some researchers have focused on how individuals seem to look for a deeper meaning in traumatic experiences (C. Davis et al., 1998; C. Davis & Nolen-Hoeksema, 2001; Park, 2010). C. Davis et al. (1998) proposed two different ways meaning can be attributed: significance and comprehension.
C. Davis et al. (1998) suggested *significance* is related to developing a personal understanding of how the traumatic event changed one’s life. This includes both understanding how the event altered personal goals or expectations, and the ability to look forward after the event by developing new goals that are compatible with the new situation (C. Davis et al.). On the other hand, *comprehension* is associated with explaining or making sense of traumatic loss in relation to one’s overall worldview (C. Davis et al.). This could include religious or spiritual meaning, however it is not limited to these constructs.

Some researchers have suggested events are stressful to the extent they do not fit within the individual’s existing beliefs (C. Davis & Nolen-Hoeksema, 2001; Park, 2010). In other words, trying to make sense of events and experiences may be a mechanism for understanding the world and being able to reasonably predict what will happen in the future (C. Davis & Nolen-Hoeksema, 2001; Park, 2010). Interestingly, C. Davis and Nolen-Hoeksema (2001) found that making sense of traumatic loss was associated with reduced emotional distress only when the meaning was conceptualized within a few months of the loss. Meaning that was found later did not appear to significantly reduce distress (C. Davis & Nolen-Hoeksema).

C. Davis et al. (1998) and C. Davis and Nolen-Hoeksema (2001) also examined how individuals often seem to discover possible benefits after traumatic loss. In both studies, researchers found that identifying benefits generally occurs later in the recovery process than developing meaning, and, unlike developing meaning, finding benefits was consistently associated with reductions in emotional distress (C. Davis et al., 1998; C. Davis & Nolen-Hoeksema).
Integration of Memories

There are several theories about why traumatic events may lead to prolonged distress and disruptions in daily functioning. Dalgleish (2004) explains that theories regarding mental representations of knowledge have been extensively applied to research regarding posttraumatic stress. The basic component of these theories is that memories of the traumatic event have not been integrated into existing mental frameworks (Dalgleish).

Some proponents of this hypothesis explain intrusion (characterized by flashbacks, nightmares and excessive thoughts of the traumatic event) as an attempt by the subconscious to process and integrate the experience (Dalgleish, 2004). Others explain posttraumatic symptoms as the result of maladaptive or incomplete mental associations after the event (Dalgleish, 2004). Within this context, treatments related to integration of memories may focus on integration and desensitization. This may include such things as exposure therapy or adjusting mental representations through cognitive therapy (Dalgleish, 2004).

Berntsen and Rubin (2007) proposed that contrary to the theories of poor integration, traumatic memories are too well integrated, vividly drawn, and accessible to the individual. Berntsen and Rubin (2007) argued that traumatic events are viewed as forever changing one’s life, becoming central to personal identity and autobiography, and subsequently become key references for understanding and interpreting subsequent life events. In this way, traumatic experiences may lead individuals to permanently define themselves in relation to the traumatic loss, long after the loss has occurred (Berntsen & Rubin, 2007). Notably, these interpretations are highly personal, therefore traumatic reactions may occur following experiences that could be objectively viewed as unlikely to be extremely stressful or traumatic (Berntsen & Rubin, 2007).
Berntsen and Rubin (2007) presented evidence that measuring individual perceptions regarding the centrality of traumatic events is a valuable tool for determining individual responses to potentially traumatic events and predicting levels of posttraumatic stress. Berntsen and Rubin also suggested therapeutic interventions that focus on making traumatic events epic and central to the individual’s life story may be detrimental, rather than facilitating healing as intended.

Groleau, Calhoun, Cann & Tedeschi (2013) found that centrality of event has a small but significant correlation with both traumatic distress and personal growth following trauma. This was true even though posttraumatic “distress and growth can exist independently of one another” (Groleau et al., p. 481). Groleau et al. suggested that further research is needed to understand the consequences of individual assignment of the self as either a victim or victorious survivor, since role assignment could potentially impact centrality of event research outcomes.

**How Trauma Relates to Grief**

Both grief and traumatic distress are associated with decreases in physical and mental health, disruptions to social support, and decline in overall quality of life. They may also result in feelings of being out of control or completely cut off from the rest of the world. While grief is generally considered a normal response to loss, traumatic loss may result in physical, emotional, and social distress that is outside the realm of normal grief. In some cases, traumatic loss distress results in significant functional impairments that remain well beyond the timeframe generally associated with acute grief symptoms.

Boelen (2009) pointed to research suggesting traumatic memories may interfere with the grief process by taking precedence over other memories that might allow for alternative views of
the self and what the future may hold. These memories could also affect the individual’s willingness to engage in activities or take on roles that are separate from the loss (Boelen, 2009).

Treatment

There are currently many different approaches to treatment of posttraumatic stress, however the ability to treat symptoms of traumatic loss may be limited by a lack of knowledge about internal and external factors affecting the individual prior to, during, and after loss (Dalgleish, 2004). While research has identified some factors that may predict individual reactions, more work is needed to provide a comprehensive model for supportive and therapeutic solutions for posttraumatic distress. One promising avenue of research is focusing on the concept of resilience.

Resilience

Resilience is a multi-faceted concept. Early resilience research focused primarily on children who functioned well or excelled despite exposure to chronic and pervasive adversity (Bonanno & Diminich, 2013). This research was especially interested in factors (such as personality traits, or environmental and social resources) that might predict or promote resilience over time, as well as factors that might interfere with it (Bonanno & Diminich, 2013).

More recently, research has focused on adults in the context of specific events involving trauma or loss (Bonanno & Diminich, 2013). This research examines why some individuals are able to adapt and recover from traumatic events more effectively than others, and tends to focus on psychological flexibility and the ability to recover quickly from adverse or demanding experiences (Agaibi & Wilson, 2005). Specific areas of interest to this project include: a) factors that correlate with enhanced resilience to trauma; b) how individuals may promote resilience in
themselves; and c) how distress in the face of trauma may lead to personal growth or transformation.

**Resilience Correlates**

Resilience is often described in terms of factors such as hardiness (a sense of purpose, mastery, and potential for growth from adversity), self-enhancement or self-esteem (tendency to show positive bias in self-judgments), effective coping or problem solving, and ability to regulate emotion (Agaibi & Wilson, 2005; Bonanno, 2004, 2008). Other commonly cited factors include optimism, flexibility and supportive relationships (Iacoviello & Charney, 2014).

It may be important to note that the correlations between specific factors and resilience appear to be supported in some studies, while not significant in others. For example, social support was found to be an important factor for veterans following deployment, however the only other significant factors noted were perceived self-control or mastery, and a willingness or ability to accept change (Pietrzak, Johnson, Goldstein, Malley & Southwick, 2009). In another study after the September 11, 2001 terrorist attacks in New York, Bonanno, Galea, Bucciarelli and Vlahov (2007) found resilient individuals were more likely to be male, over sixty-five, free of chronic illness, without a college education, and with adequate social support. These diverse findings could be due to different conceptualizations of resilience. Another possible explanation is that individual factors could be more or less adaptive depending on the individual and the nature of the traumatic event.

It is postulated that resilience may not be a completely stable characteristic (Bonanno & Diminich, 2013). Individuals may be resilient in the face of some events and not in the face of others, or they may be more (or less) resilient at certain periods in their lives (Rutter, 2007).
Additionally, individuals may exhibit resilience in some aspects of functioning, while not exhibiting it in others (Rutter, 2007).

Resilience is likely to correspond to interactions between genetic or physiological factors and environmental factors (Rutter, 2007). As Southwick and Charney (2012) pointed out, there may be many “genetic, developmental, cognitive, psychological, and neurobiological… factors” (p. 79) related to resilience. Resilience may include aspects from multiple domains, including cognitive, behavioral and existential (Iacoviello & Charney, 2014). It may also be a process, rather than a variable, and could be related to how individuals problem-solve and react to stressful events (Rutter, 2007).

Mastery, Personal Development and Coping

Many proposed resilience correlates can be learned, and may function to support or enhance other protective factors (Southwick & Charney, 2012). Haglund et al. (2007) suggested individuals can increase their resilience in the face of stress and trauma by improving their functioning in key life areas. There are a variety of relatively inexpensive and readily available personal development tools online and in the community. These tools may be more targeted and personally meaningful when selected by the individual. Griffiths et al. (2015) have found the use of personal development strategies correlates with future reductions in rates of clinical depression.

Frazier, Steward and Mortensen (2004) found that perceived control over current recovery process was consistently associated with lower levels of distress or functional impairment in women who had experienced sexual assault or sudden bereavement. A sense of control over future trauma of the same kind was also correlated with positive outcomes for victims of sexual assault, but not for bereaved individuals (Frazier et al.). Frazier et al.
postulated that perceived control may only be beneficial to the extent that aspects of a traumatic event are actually controllable.

Individuals seeking to enhance their sense of control can develop specific knowledge or skills related to coping in stressful or dangerous situations (Southwick & Charney, 2012). This could include such things as first aid, self-defense, or relaxation techniques. Individuals may also develop other skills that build confidence and increase their general sense of mastery.

There are also techniques (such as mindfulness or cognitive behavioral therapy) that allow individuals to be more aware of the current circumstances. These techniques could help individuals to self-regulate by consciously selecting which mental, emotional and environmental information they direct their energy and attention to (Southwick & Charney, 2012). Cognitive behavioral therapy can also be used to learn to reappraise negative thoughts or events in a more positive and personally useful way (Southwick & Charney, 2012).

**Personal Growth and Transformation**

Personal growth following traumatic loss is growth gained on extremely hard terms. It implies suffering, bereavement, and enduring pain as one comes to terms with unwanted and life altering changes in the face of a loss that cannot be reversed. This may be why posttraumatic growth seems to have an uneasy relationship to resilience. While some researchers report personal transformation is highly correlated with resilience (Tebes, Irish, Vasquez, & Perkins, 2004), others argue that this is clearly not the case (Westphal & Bonanno, 2007).

Westphal and Bonanno (2007) proposed that in order to exhibit posttraumatic growth, individuals must experience distress, exhibit some successful coping, and have both behavioral and cognitive changes as a result of the distress. Resilience, Bonanno (2004) argued, implies a lack of distress, or distress that was short lived, where individuals continue to experience and
express positive emotion. If resilient individuals bounce back, and quickly return to normal
levels of functioning, then there is no reason for them to grow or change.

Posttraumatic growth does appear to be associated with severely challenging and highly
negative life changes. Cook, Aten, Moore, Hook & D. Davis (2013) found posttraumatic growth
was significantly tied to higher resource loss for college students in Mississippi following
Hurricane Katrina. This was true even though resource loss was also tied to more reported
mental and physical health problems (Cook et al.). Cook et al. maintained this finding supports
the idea that posttraumatic growth follows efforts to cope in the face of trauma or severe stress.

Bonanno (2004, 2008) has argued that resilience and recovery, though often lumped
together, are substantially different processes. Recovery suggests psychological distress that
gradually declines over time as the individual returns to normal functioning (Bonanno, 2004).
This is substantially different from the concept of resiliency or quickly “bouncing back”. If
resilience is an adaptive and self-protective ability to return quickly to life as usual (at least in
some areas of functioning), perhaps recovery is a more profound adjustment towards learning to
live a substantially altered life that is still purposeful and personally meaningful.

Recovery

In a purely clinical sense, recovery implies a process that restores a sick or injured person
to health (Sandler, Wolchik & Ayers, 2008). In some ways, this term is linguistically
challenging in the context of traumatic loss (Paletti, 2008; Rosenblatt, 2008; Sandler et al., 2008;
Shapiro, 2008; Tedeschi & Calhoun, 2008). While traumatic loss may lead to diagnosable
physical or mental health problems, addressing these problems is not the same as healing the
traumatic loss.
In the context of traumatic loss, recovery is not a cure. It would be unrealistic to think of recovery as the absence of grief or traumatic distress, or focus on restoring whatever “normal” was before the loss (Deegan, 1997). In reality, traumatic loss may have dramatically altered the individual’s world view. It may have changed their goals, expectations, capabilities, support systems, living situation or other factors that may make it impossible for the individual to go back to the way things were.

Recovery may be about looking forward even though you are still suffering (Deegan, 1997). Responses to traumatic loss are unique and diverse, and it is important to remember individuals may experience a range of grief and posttraumatic distress symptoms without qualifying for a mental health diagnosis. Distress, even acute distress, can be a normal reaction to traumatic loss. In most cases, individuals do not require medical treatment or clinical intervention (Bonanno, 2004, 2008; Bonanno & Diminich, 2013), and personal recovery can occur even if an individual continues to experience grief or traumatic distress symptoms (MacDonald-Wilson et al., 2013; Palmer & Scott, 2004; Pratt et al., 2014).

Many aspects of recovery may be highly subjective (Pratt et al., 2014). Because individuals who have experienced trauma often view the world as a dangerous and threatening place, the first stage of recovery may be simply reestablishing a sense of safety (Herman, 1997). Herman (1997) argued that only after security is restored can individuals move on to appropriate self-care and reestablishing a sense of purpose and community.

Experts from the mental health field point to recovery concepts such as empowerment, hope, purpose, and meaning, as well as recovery principals like self-directed, individualized and holistic (Jacobson & Greenley, 2001; Mead & Copeland, 2000; Pratt et al., 2014; Salzmann-Erikson, 2013). These words convey the sense that recovery is a dynamic process driven by
individual needs and goals, and may be substantially different in different individuals, or in the same individual on different days. Thus, one essential aspect of recovery is identifying what “recovery” means on a personal level, rather than relying on clinical frameworks or assumptions (MacDonald-Wilson, Deegan, Hutchison, Parrotta & Schuster, 2013; Palmer & Scott, 2004; Pratt et al., 2014).

Personal

Recovery is a personal journey (Deegan, 1997; Salzmann-Erikson, 2013; Stanhope & Solomon, 2008). Each person has a unique story, including their own hopes and dreams for the future. Coping with traumatic loss often means mourning the loss of some dreams, in addition to adjusting to a variety of internal and external changes from the way life was.

Individualized

People have a variety of ways they care for themselves (MacDonald-Wilson et al., 2013). For example, some people use music for relaxation or motivation, while others may chose physical activity, or calling a friend. Whether they realize it or not, individuals who have experienced traumatic loss already know a variety of ways to sooth and heal themselves.

Unfortunately, the importance of self-care is sometimes overlooked in traditional medicine (MacDonald-Wilson et al., 2013). The medical model, which defines the professional as the expert and the patient as essentially helpless, may leave individuals feeling that they cannot help themselves (Herman, 1997). This view is detrimental for victims of traumatic loss, who may already be feeling helpless and overwhelmed (Herman, 1997).

Strength based

Cultural values and beliefs about wellness are often internalized (Pratt et al., 2014). Anderson and Goolishian (1992) have suggested others can support personal recovery by
viewing the individual as an expert on their unique situation. This means assuming the individual is in the best position to define both the problem and the solution (Anderson & Goolishian).

Individuals have unique strengths and abilities that may help them to recover (McDonald-Wilson et al., 2013; Pratt et al., 2014), and it is important for individuals to have the opportunity to seek solutions that fit their own lives. In some cases, individuals may seek additional knowledge or opportunities that allow them to increase their understanding, build self-confidence or give them a sense of purpose.

Holistic

Recovery is multifaceted. It encompasses every aspect of the individual’s life (McDonald-Wilson et al., 2013; Pratt et al., 2014). Recovery is self-care and support from others that ultimately improves quality of life. This may mean reading a book, joining the gym, taking a class, becoming a volunteer, finding a job, or simply getting out of bed in the morning.

Recovery seeks to address immediate needs and promote overall well-being in the long term. In a five year study of individuals using psychiatric medications, MacDonald-Wilson et al. (2013) found individuals who reported using self-care reported greater improvements in functioning in several areas, including improvements in physical, mental and daily life functioning, as well as reductions in psychiatric symptoms (MacDonald-Wilson et al.).

Empowerment and Hope

Choice is also an important aspect of recovery (Palmer & Scott, 2004, Pratt et al., 2014). Some individuals may choose to use medication, while others do not. Some may seek to reach out to those around them for support, while others seek solitude and reflection.
Taking a lead role in their recovery can help individuals regain a sense of control and hope for the future. The California Association of Social Rehabilitation Agencies (2007) has suggested that believing “you can recover is vital in the recovery process” (p. 16). Healing and recovery can occur through learning to value yourself (Deegan, 1997), rediscovering your skills and strengths, and coming to peace with a new life.

**Non-linear**

Recovery is not a linear process (Pratt et al., 2014). Mourning and recovery from traumatic distress may take time and effort. Individuals will face a variety of challenges and setbacks, and may need time to learn to accept and value their new self and accept their current circumstances (Salzmann-Erickson, 2013). Salzmann-Erickson identified several themes in recovery literature, including individual healing, connections with others, and participation in “social and meaningful activities” (p. 185).

Although social activities may be highly beneficial, there are a variety of reasons some victims of traumatic loss may find it difficult to engage with others. This author suggests passive participation in shared public events may be a way for these individuals to begin to bridge the gap between themselves and the rest of humanity.

**Passive Participation**

The role of social support and connectivity is often referenced in bereavement and trauma literature, where availability of social support and a sense of connectivity with others is generally associated with positive resilience and recovery outcomes. Unfortunately, individuals experiencing grief or traumatic stress often face difficulty interacting with and relating to others for a variety of reasons. This author suggests that these individuals may benefit from
opportunities for sharing public social experiences without having to engage in direct social interaction.

This author views the key elements of passive participation in shared public activities and events as: a) opportunity for being present in a social context; b) lack of requirement for direct interaction with others; and c) opportunity for external focus of attention. One way of engaging in passive participation is to engage in a non-interactive activity in a shared public space such as browsing in a bookstore or sitting in a coffee shop. Another alternative is to passively participate in shared public events as part an audience or crowd of spectators. In these situations, since everyone is attending for the purpose of engaging in an activity or viewing an event, there is little or no pressure for social engagement and no expectation of active participation or interaction (with the event itself or with each other). Individuals become part of the group simply by being present.

Prior research on passive participation as a therapeutic intervention for individuals experiencing grief or traumatic loss has not been located by this author. In order to explore the possible implication of passive participation in this context, this review will focus on the key elements identified by this author, specifically: a) opportunity for being present in a social context; b) lack of requirement for direct interaction with others; c) and opportunity for external focus of attention.

Opportunity for Being Present in a Social Context

For the purposes of the current study, opportunity for being present in a social context means being in a shared space where others are gathering for the same purpose. Examples of public activities or events of this type include activities in public spaces (such as eating, shopping, or people watching); public performances (i.e., plays, recitals, concerts); classes or
educational events; athletic activities, games or competitions; cultural demonstrations, and potentially some religious or political events, depending on the nature of the event. All of these examples are intended to represent shared activities where patrons, audience members or spectators attend for purposes of viewing the same central event or engaging in the same activity.

Early sociological theorist Émile Durkheim proposed that shared activities result in collective conscience which in turn affects individual values, views and behaviors (McGee & Warms, 2008). Durkheim argued that shared events help achieve social solidarity by promoting and reinforcing consistent world views within groups (McGee & Warms, 2008). The idea that shared activities create a sense of group cohesion and affect individual world views seems especially relevant in the context of traumatic loss. As we have seen, individual world views can be negatively affected by traumatic loss, and traumatized individuals may feel isolated or alienated from others. In this context, rebuilding a sense of community and fellowship is viewed as a key task for trauma survivors (Herman, 1997).

Another potential benefit of shared events is that they may impact a distressed individual’s overall mood. In some studies, individuals who anticipated interaction with a stranger attempted to alter their mood (from happy or sad) to a more neutral state prior to the interaction (Erber, R. & Erber, M., 2000; Erber, R. et al., 1996). Erber, R. et al. (1996) reported this effect was especially strong when an unhappy individual anticipated interacting with a stranger who was expected to be happy.

In the absence of anticipated interaction, individuals were more likely to make choices that appeared to reinforce their current emotional state (Erber, R. et al., 1996). Erber R. et al. (1996) found sad individuals who did not anticipate stranger interaction chose sad news over happy news, while sad individuals anticipating stranger interaction selected happy news instead.
It is interesting to note that this effect was not found when individuals were anticipating interaction with a romantic partner (Erber, R. & Erber, M., 2000). This author believes that taken as a whole, these findings suggest preparing for a public event may increase mood regulation, and could potentially assist individuals in moderating emotions after traumatic loss.

There may also be mood altering benefits inherent in some public events. For example, researchers indicate that individuals frequently listen to music in order to relax, improve their mood, or increase their overall energy level (Chen, Zhou & Bryant, 2007). Individuals may also consciously or unconsciously select activities and entertainment with the goal of mood regulation (Zillmann, 1988). However, this finding may not be true of sad or distraught individuals, who may actively avoid activities that could improve their mood (Chen et al. (2007).

This author found two treatment approaches that seek to address individual withdrawal and avoidance behaviors in different manners. Cognitive behavioral therapy focuses on reconditioning individuals to think more critically about the way they make decisions with mental frameworks that may be outdated or incorrect. Alternatively, behavioral activation therapy seeks to address this problem by focusing on increasing activity levels in meaningful ways.

**Cognitive behavioral therapy.** The cognitive behavioral model was originally designed to treat depression and anxiety (Pratt et al., 2014). This model focuses on how perceptions affect mood and activity. Cognitive behavioral therapy is designed to be short-term and provide individuals with tools for replacing negative and self-defeating thoughts with more constructive and realistic ones (Pratt et al., 2014). Cognitive Behavioral Therapy can include multiple techniques for identifying and correcting erroneous perceptions (Pratt et al., 2014). This may
include logically testing perceptions, considering arguments for and against perceptions, or learning to focus on the current situation rather than ruminations.

In the context of trauma recovery, cognitive behavioral therapy could focus on how events or situations may have been misidentified as unpleasant or dangerous in the mental schema. Cognitive behavioral therapy may lead to reductions in stress response over time as cognitive networks are reorganized and situations are correctly identified by the individual as beneficial rather than harmful. This may be especially helpful with events or activities that are viewed by the individual as potential triggers.

**Behavioral activation therapy.** The behavioral activation model looks to counteract lower activity levels in depressed individuals through identification of activities that tie back to personal values (Lejuez, Hopko, Acierno, Daughters & Pagoto, 2011). Behavioral activation therapy is short term, with only 10 clinical sessions recommended, and is flexible and cost effective since individuals identify their own values and select their own activities (Lejuez et al.). Values are directly related to specific areas of functioning, such as family, work, leisure, and personal responsibilities; individuals select targeted activities only after clarifying their own values and goals (Lejuez et al.).

Lejuez et al. (2011) noted that individuals who are depressed may chose activities that are negative or likely to result in failure. It is important for activities to be personally meaningful and clearly achievable so individuals can experience success, behavior reinforcement and increased confidence (Lejuez et al.). This may mean identifying a series of smaller activities that lead towards an ultimate goal.

While behavioral activation therapy was originally designed to treat depression, Wagner, Zatzick, Ghesquiere & Jurkovich (2007) suggested it may also be beneficial for individuals
exposed to trauma or suffering from posttraumatic stress. This hypothesis was supported in a small study comparing six sessions of behavioral activation therapy to therapy-as-usual for eight individuals suffering from traumatic injury (Wagner et al., 2007). Wagner et al. (2007) found a significant reduction in posttraumatic stress symptoms and improved physical functioning for individuals who received behavioral activation therapy. While the size of the study limits generalizability, these findings lend support to the hypothesis that increased activity through behavioral activation therapy may be a way to foster recovery following traumatic loss.

**Lack of Requirement for Direct Interaction with Others**

Lee and Wagner (2002) found that social context was a factor in individual experience and expression of emotion. Individuals tended to display less negative emotion and smile more often in the presence of others than when they were alone (Lee & Wagner). This points to social presence, not just social interaction, as potentially beneficial in mood regulation.

The definition of passive participation proposed in this project includes the absence of pressure to engage in social interaction. The public activities and events previously noted all share the common theme of providing the opportunity for being part of a group without requiring direct interaction with others. This lack of pressure for social interaction is an important factor, considering the reasons traumatized individuals may prefer not to interact. These may include withdrawal and avoidance, deficits in social functioning, negative reactions from others, and negative appraisals of social interactions.

**Withdrawal and avoidance.** Individuals recovering from traumatic loss may not seek social interaction. In fact, individuals with depressive symptoms have a tendency to withdraw from interaction (Lejuez et al., 2011), and as we have seen, withdrawal and avoidance are also common reactions following trauma (American Psychological Association, 2013). Depressed
individuals have reduced social interactions compared to their peers, and these individuals also have fewer friends and smaller support systems (Rottenberg & Gotlib, 2004).

**Deficits in functioning.** While some individuals may naturally exhibit more social skill than others, there is some evidence that reductions in quality of social interactions for depressed individuals may be due to functional deficits (Rottenberg & Gotlib, 2004). Depressed individuals offer blunted responses to positive stimuli, and are more likely to suppress spontaneous smiles (Reed, Sayette & Cohn, 2007).

Rottenberg and Gotlib (2004) noted that research has found depressed individuals smiled less, engaged in less eye contact, spoke more slowly, were more self-absorbed and expressed more negativity than individuals without depressive symptoms. These deficits in social functioning could explain why others may seek to avoid individuals with depressive symptoms (Rottenberg & Gotlib).

**Negative reactions from others.** Distressed individuals are likely to encounter negative reactions from others due to their inability to demonstrate positive affect (Keltner & Bonanno, 1997). Absent or inappropriate reactions in social situations can be due to either natural interaction style or functional impairments from a high level of distress (Keltner and Bonanno, 1997).

Libet and Lewinsohn (1973) conducted a study of college students scoring high on depressive symptoms and found that regardless of gender, depressed students were less socially active, exhibited fewer positive responses, and had a greater lag time in responding to others. Libet and Lewinsohn proposed that depressed individuals are receiving less social reinforcement in their interactions due to their lack of sociability and failure to provide appropriate positive reinforcement to others.
Negative appraisals. Bylsma, Taylor-Clift and Rottenberg (2011) found that adults with major or minor depression reported fewer pleasant experiences than control subjects. Interestingly, depressed individuals reported a greater decrease in negative emotions following their pleasant experiences, however, this mood improvement only occurred when individuals appraised the events in a very positive manner (Bylsma et al.). In other words, objectively pleasant activities may or may not have this affect, depending on individual perceptions of the experience.

When the various factors effecting social interaction for distressed individuals are considered, it is easy to perceive why some individuals suffering from traumatic loss may prefer not to engage in activities requiring social interaction. In these cases, passive participation may allow for social engagement without direct interaction. Additionally, it may allow for a shift in focus of attention.

Opportunity for External Focus of Attention

While individuals experiencing traumatic loss may naturally turn inward in an effort to process their grief or find meaning in their loss, this self-focus may have some negative consequences. Self-consciousness, or self-focused attention, has been found to correlate with negative emotion (Mor & Winquist, 2002; Wood, Saltzberg, Stone & Rachmiel, 1990).

Wood, Saltzberg, Stone et al. (1990) found that married men who reported self-focus also reported more negative emotions, more rumination and less problem solving oriented coping. This finding was specifically found between individuals, but not within them, which points to self-focus as a relatively stable trait over the days of the study (Wood, Saltzberg, Stone et al.). Wood, Saltzberg, Stone et al. postulated self-focus could be an individual risk factor for depression and anxiety symptoms.
Mellings and Alden (1999) also found that self-conscious individuals showed a bias towards judging themselves negatively, especially those individuals who reported rumination during downtime. This bias was found for both self-conscious individuals measuring high in social distress and avoidance, as well as self-conscious individuals without these symptoms (Mellings & Alden). This points to a general correlation between self-focus and negative self-judgments, something which could become more apparent during grief or traumatic distress.

In an analysis of prior research, Mor and Winquist (2002) found that self-focus and negative emotions are generally correlated for all populations, with higher correlations for women and individuals with a clinical mental health diagnosis. However, this correlation appeared to be dependent on context, since self-focus regarding positive beliefs or events was not correlated with negative emotions (Mor & Winquist). Additionally, high levels of self-focus in public settings was correlated with anxiety, while private self-focus was correlated with depression (Mor & Winquist). Mor and Winquist expressed concern that researchers have been taking too narrow a view of self-focused attention, without regard to context or content, and therefore findings may have been misrepresented.

Nystedt and Ljungberg (2002) looked at two different types of self-consciousness, rumination and self-awareness regarding emotional status. Rumination was tied to emotional instability, physical tension, anxiety, and irritability. This was not the case with emotional self-awareness, which was only tied to contentiousness. Nystedt and Ljungberg (2002) pointed to research indicating while individuals with high levels of self-focused attention tend to have a more accurate and balanced understanding of themselves, they are also more prone to report depression and anxiety. However, the causality between self-focus and emotion may not be that simple. Some studies have pointed to a bi-directional relationship between self-focus and
emotion. For example, negative emotions have been found to induce self-focus (Wood, Saltzberg & Goldsamt, 1990), and happy emotions have been found to decrease it (J. Green, Sedikides, Saltzberg, Wood & Forzano, 2003).

J. Green et al. (2003) noted that positive emotions that are socially based are more likely to result in reductions to self-consciousness. Furthermore, “positive mood often leads to superior self-regulation relative to negative mood” (p. 155), and may provide a cushion or buffer when encountering negative events (J. Green et al.). This assertion supports the view that passive participation in public events may be beneficial for individuals recovering from traumatic loss simply by providing an external focus of attention.

Conclusion

As we have seen, traumatic loss can cause high levels of distress and lead to disruptions in multiple areas of daily life. Individuals suffering from grief or posttraumatic distress may withdraw or avoid contact with people or situations that remind them of their loss. They may also lack the energy or resources to engage in activities they previously enjoyed, and may feel shunned and isolated from others.

Finding ways for individuals to re-engage with the community in personally meaningful ways is an important goal for recovery and healing. Historically, research focused on theoretical models and practitioner driven therapies. More recently, some researchers have shifted their focus to resilience and recovery. This has led to more emphasis on how individuals can help themselves heal and move forward with their lives. These ideals, while primarily associated with mental health disorders in current literature, are also applicable to victims of traumatic loss who may not meet the criteria for a clinical diagnosis.
Participation in shared public events may provide opportunities for individuals to create new memories, adopt a broader worldview, consider themselves in a new or altered role, or see new possibilities for the future. Individuals may feel “normal” sitting in an audience. The presence of others is likely to help them regulate negative emotions, and although they may still be experiencing significant distress, individuals will be able to fit in just as they are, without pretending to be happy or engaging in difficult conversations.

It is important, however, to consider that not all events are positive experiences. Some events may have negative associations, while others may focus on contentious issues, or require excessive energy to attend. In addition, it is possible that some individuals would experience shared public events as lonely or that these events could increase their sense of isolation.

As noted in behavioral activation therapy, and consistent with recovery ideals, it is important for individuals recovering from traumatic loss to identify activities that would best suit their unique situation. This author suggests passive participation in shared public events may provide the opportunity for some individuals recovering from traumatic loss to feel a connection with the community without having to fully engage in interactions that exceed their current capabilities. Notably, shared public events can potentially provide a space where individuals are free to interact or not, depending on their current symptoms, mood and energy level.
CHAPTER III

METHODOLOGY

Experience of Passive Participation

This project focuses on how passive participation in public events or activities may support recovery following traumatic loss by allowing a sense of connection and community without requiring direct social interaction. This author originally became interested in the concept of passive participation as a result of personal experience of traumatic loss. This experience led to the realization that when a person is feeling isolated and alone, when they are most in need of human connection, they may be least able to reach out to others. In fact, there are times when even basic social interactions, such as smiling or making eye contact, may seem overwhelming, threatening, or painful.

In this situation, self-isolation can be tempting because solitude seems to provide comfort and security, whereas social contact can lead to increased feelings of alienation. On the other hand, the apparent benefits of solitude can also be accompanied by feelings of isolation and hopelessness that become more amplified over time. In this context, attending community events or spending time in public spaces can provide opportunities to get out of the house and be around other people without pressure to engage in difficult social interactions.

Although this author sometimes felt uncomfortable or self-conscious going out alone, especially when the activity or location was unfamiliar, the overall experiences were generally positive. This is not to say the day-to-day pain of the loss went away; however, having activities to look forward to and new things to think about provided a reprieve. In addition, many of the
activities also included opportunities for brief, friendly and inconsequential interactions with other people if this author felt capable of it at the time.

Given these experiences, this author found it interesting that no one ever suggested passive participation as an option for improving mental or emotional well-being. In fact, some people expressed concern this type of behavior might be unhealthy because it would be “so lonely.” At the time, this perspective seemed oddly out of touch with this author’s own experience; however, it is more understandable now—years later. This may be because passive participation seems more extreme and lonely when a person has a variety of preferable options for socialization. In fact, it may be difficult to fully understand the benefits of passive participation without personal experience of mental and emotional isolation accompanied by difficulty engaging in social interaction.

For this author, passive participation was soothing and helpful, providing nonthreatening and flexible opportunities to rebuild a sense of connection. This experience led to a desire to understand more about the impact of traumatic loss, including why being around other people may be extremely difficult and necessary at the same time, and eventually evolved into the current project. The goal of this project is to help people suffering from traumatic loss by providing basic information about posttraumatic stress, the importance of reconnection, and how passive participation can support recovery.

This project includes three parts: initial interviews to gather individual perspectives on passive participation; development of an informational pamphlet; and collection of feedback regarding the pamphlet.
Initial Interviews

Initial interviews were conducted to gather qualitative data regarding personal experiences of passive participation. In order to find individuals who could provide feedback about this concept, participants were located from within this author’s professional, social, and scholastic networks. Participants included adults in the United States who were ultimately selected as a result of their apparent understanding of the concept of passive participation as explained by this author and their willingness to take part in this project. Notably, individuals who seemed confused about the concept or dismissed passive participation as undesirable or inappropriate were not approached for interviews, as these perspectives were not considered compatible with the intended purpose of the interviews.

Participants were advised that interviews generally took forty minutes to an hour, during which time this author would take written notes. The design of the interviews was intentionally informal and participants were encouraged to choose a location for the interview where they felt comfortable, including being interviewed over the phone if they preferred. Participants were also given the option to contact this author after the interviews if they found they had additional thoughts to share.

Interview Questions

The format of the interviews was semi-structured. The author asked a series of questions about passive participation, including optional follow up questions as necessary. The interview questions were as follows:

1. How old are you?
2. Gender [identified by this author based on gender presentation]
3. Tell me about your experience with shared public events or activities where you purposefully went alone and were around other people without really interacting with them. Describe a specific event or activity, and what that was like for you.

[Possible follow up along the lines of:]

a. What made you choose this event/activity?

b. Why were you there alone?

c. What were the positive aspects of this experience?

d. What were the negative aspects?

e. Would you recommend this activity to someone who was feeling isolated but did not want to interact with others? Why or why not?

   i. [If yes] Is there anything they would need to do to prepare for this event/activity to make it a more positive experience?

f. Can you think of other activities that might suit this population?

4. Would you describe yourself as a social person?

5. Do you consider yourself an introvert or an extrovert? Do you think that has any relevance to what we’ve been talking about? Why or why not?

6. Is there anything else that has come to mind while we’ve been talking that you want to share, either about your own experience with passive participation, or some other thoughts or ideas about this concept?

Analysis of Interview Data

The data gathered from the interviews was analyzed to identify a) ideas for passive participation; b) themes regarding positive and negative aspects of passive participation; c) whether participants would recommend passive participation to isolated individuals; d) themes
regarding successful preparation for passive participation activities; and e) how participants rated their own social predispositions. This information was then used in the development of an informational pamphlet.

Pamphlet

An informational pamphlet on passive participation was developed using knowledge gained from personal experience, master’s project coursework, the review of literature, and data from the initial interviews. In developing the pamphlet, priority was given to providing basic information in a format that was easily accessible and would not be overwhelming to someone suffering functional deficits associated with posttraumatic stress. Emphasis was placed on a) providing insight into the potential connection between traumatic loss and symptoms of posttraumatic stress; b) identifying connection with others as an important aspect of recovery; c) sharing brief examples of passive participation; and d) providing a variety of passive participation activities for readers to consider.

Following the development of the pamphlet, an effort was made to evaluate its effectiveness and relevance. This was accomplished through the collection of reader feedback.

Collection of Feedback

Feedback was gathered by sharing the pamphlet with adults in the United States and requesting they complete a short questionnaire or survey. The questionnaire was available in both hardcopy and online format. In order to facilitate responses, this author reached out to individuals in a variety of venues, including university students enrolled in a trauma and recovery class, members of a local quilting group, general students on a university campus, co-workers, and general acquaintances. To increase the reach of the project, participants were asked
to share the pamphlet with others, especially individuals who had experienced loss, and encourage everyone they shared the pamphlet with to take part in the online survey.

**Survey Questions**

The questionnaire was designed to gather qualitative data regarding the perceived clarity and usefulness of the pamphlet within the context of individual experience of passive participation. The format allowed for comments after each question. The following questions were included in the survey:

1. Was the information in the pamphlet clear?
2. Did the information in the pamphlet seem useful?
3. How would you improve the content or organization of the pamphlet?
4. Do you engage in passive participation? If yes, please describe the types of activities you prefer.
5. Did the pamphlet provide you with any new information or ideas? Please explain.
6. Would you share this pamphlet with a friend or family member?
7. What is your age?
8. What is your gender?
9. Please feel free to add any additional comments.

**Analysis of Survey Data**

The data gathered from the surveys was analyzed to determine a) if participants felt the pamphlet effectively conveyed the concept of passive participation; b) if participants felt the information provided in the pamphlet was beneficial; and c) how participants suggested the pamphlet could be improved.
In order to complete this analysis, the survey data was copied into a table where it could be reviewed by respondent, by question, or in a matrix that included both elements. The data was then analyzed: a) by respondent; b) by question; c) by the relevance of the narrative response to other questions in the survey; and d) by outlying responses. To begin this analysis, the answers given by each respondent were reviewed to provide a general sense of who was responding and what their individual responses were. This review also provided a sense of the overall content of the survey responses.

Following the initial review, all of the responses for each individual question were analyzed to look for themes that might emerge or answers that might stand out from the others. Notably, no attempt was made to fit the answers into preconceived themes or categories during this process. Themes were identified and labeled as they emerged based on the survey data.

To ensure all pertinent responses were considered for each question, narrative responses were then analyzed to determine whether they provided information pertaining to a different question in the survey. For example, sometimes narratives inadvertently answered questions that appeared later in the survey. In the final review of the data, responses that stood out from the others were analyzed again from the context of both a) all of the responses for that individual respondent and b) the other responses to the same question. The outcome of this analysis is included in the results.
Interview Data

Initial interviews were conducted with six adults in the United States. Participants included two men and four women, aged 29 to 47. Two interviews were conducted over the phone due to the geographical distance of the participants. The remaining interviews took place in a variety of public spaces, including an office, a coffee shop, a park, and a public space on a university campus.

Participants described a variety of passive participation events and activities they engaged in, including trail running, concerts, movies, dancing, classes, art galleries, shopping, and walking in the park. Four participants indicated they regularly engage in passive participation, while two participants reported passive participation is rare for them. Three participants associated greater levels of passive participation with periods of heightened mental or emotional distress in their lives.

Participants reported positive aspects of passive participation related to four main themes. All participants reported benefits related to having something different to do, including having something to look forward to, gaining a different perspective, being exposed to new sights or experiences, and having great stories to tell afterwards. Five participants also associated the experience with a physical or mental boost. For example, two participants talked about feeling energized by the people around them. Two participants also reported a feeling of camaraderie or support, although they were not interacting with anyone. Additionally, three participants associated their passive participation experiences with a sense of empowerment or control.
There were also negative aspects of passive participation reported by participants. All six participants reported high levels of self-consciousness, including feeling like everyone was noticing them or they stood out in some negative way. Four participants reported feeling nervous, anxious or awkward, and three participants reported negative self-talk, including feeling stupid, ugly, or weird. For example, one participant reported feeling they were alone because no one liked them enough to spend time with them. Two participants also reported being annoyed by people around them or having to put up with people who got on their nerves.

Despite these challenges, all of the participants indicated they would recommend passive participation to someone who was feeling isolated but did not want to interact with others. Four participants emphasized the importance of choosing an activity based on personal interest and not feeling obligated by external expectations. Three participants suggested outdoor activities or activities involving exercise, emphasizing these activities might have added benefits in terms of overall health and well-being. Some other activities, such as arts and entertainment, and leisurely shopping or browsing were also suggested by multiple participants.

Participants suggested individuals could do a variety of things to prepare for passive participation. Overall, recommendations seemed to coincide with the idea of meeting yourself where you are, rather than where you would like to be or think you should be. Specifically, three participants noted the importance of self-care and taking steps to boost self-esteem prior to activities. This included things like dressing comfortably, eating appropriately, or doing things that boost self-confidence. For example, one participant mentioned taking a bath as a way of self-soothing and preparing for an event. Other themes included being conscious of safety, making an effort to maintain a positive attitude, anticipating a variety of negative thoughts and emotions, and allowing for flexibility. For example, one participant suggested planning to leave
early (with the option to stay longer), rather than starting with the expectation of staying for the entire event.

After the interviews, three participants contacted this author to share additional thoughts. Their feedback included additional ideas for passive participation and personal stories of feeling support or connection while participating in group they were not directly interacting with. The additional feedback, and especially the animation with which it was conveyed, suggested these participants felt ongoing interest and enthusiasm regarding the positive aspects of passive participation. Overall, the initial interviews provided valuable information regarding individual experiences of passive participation and supported passive participation as a recovery tool. This data informed the development of an informational pamphlet on promoting healing from traumatic loss through passive participation.

Pamphlet

The pamphlet is located in Appendix A. (Note: the pamphlet has been modified from the version used in the survey. In the suggestions for passive participation in the final section, “go dancing” has been shortened to “dance”.)

Feedback Data

Questionnaires were completed by thirty-five adults in the United States, with ages ranging from eighteen to seventy-four. Respondents included ten men, twenty-four women, and one individual who declined to state their gender. Eleven questionnaires were completed in a hardcopy format and twenty-four were completed online.

Respondents overwhelmingly rated the pamphlet as both clear and useful, with one partial exception. One respondent commented that the pamphlet was confusing because it
associated traumatic loss with posttraumatic stress; however this respondent subsequently indicated the pamphlet was useful and commented that learning there was a link between traumatic loss and posttraumatic stress validated his own feelings.

Overall, respondents commented that the personal stories and variety of ideas for passive participation in the pamphlet were helpful and made the information accessible. Positive comments were also made about the emphasis on finding activities that suit the individual. Several respondents appreciated that the pamphlet was informative without telling the reader what to do, and two respondents liked that there was no sense of shame about being introverted.

Twenty-nine respondents (83%) indicated they engage in passive participation themselves, while three (9%) indicated they do not, two (6%) indicated they were not sure, and one declined to answer. For those respondents who reported passive participation, favorite activities included walking in the park, people watching, shopping, going to the movies, and hanging out in bookstores or coffee shops. Twenty-five respondents (71%) indicated the pamphlet provided them with new ideas or a new perception of passive participation, and thirty-one (89%) indicated they would share the pamphlet (or the information it contains) with a friend or family member. Two respondents also suggested it would be beneficial to make pamphlets available in primary care waiting rooms.

Several respondents indicated the pamphlet reflected or validated their own feelings or experience of traumatic loss and recovery. Although most respondents felt the pamphlet was well organized and thorough, there were a variety of suggestions for how the pamphlet could be improved. Recommendations included 1) adding pictures of various activities; 2) devoting a section to clearly defining passive participation; 3) providing information on local resources; and 4) explaining the benefits of passive participation in more detail.
CHAPTER V

RECOMMENDATIONS AND CONCLUSION

Traumatic loss and posttraumatic stress can have significant implications for individual health and well-being. Moreover, posttraumatic stress symptoms have been correlated with a variety of physical and mental health problems, including co-occurring disorders such as depression and substance use disorders. Fortunately for many individuals, research indicates the negative impacts of traumatic loss and posttraumatic stress can be moderated by a variety of factors associated with resilience and recovery. One such factor is social support.

Social support and a sense of connection have repeatedly been identified as important aspects of resilience and recovery following trauma. Sadly, the nature of grief and posttraumatic stress are such that individuals may feel disconnected or actively withdraw from interactions with others following traumatic loss. In addition, some individuals may lack effective support systems, or normally supportive relationships may be affected by lack of awareness regarding traumatic loss or cultural expectations regarding “appropriate” grieving. In this context, passive participation may provide an opportunity for fostering a sense of connection without direct social interaction.

The findings of this project indicate passive participation can have a variety of benefits, including providing a distraction or external focus of attention, boosting mood and energy levels, fostering a sense of camaraderie, or prompting feelings of empowerment. These findings suggest avenues for future research, as well as providing information for practitioners, individuals looking to engage in passive participation, or anyone seeking to develop informational materials on this topic.
Recommendations

Recommendations for Further Research

There is much to learn in this area, and one avenue of future research would be to examine the short and long term benefits (or potential drawbacks) of passive participation in more detail to determine how passive participation ultimately impacts recovery. Some potential study questions include: how are mood and energy levels affected before, during, and after passive participation?; are self-reported changes in mood and energy levels noticeable to others?; how long do these changes last?; and how much passive participation is required to see sustained benefits? It may also be helpful to study the impact of passive participation versus social interaction therapies for individuals with withdrawal and avoidance symptoms.

Another consideration is whether the perceived value of passive participation may be affected by variables such as type of trauma, characteristics of the individual, acuity of grief or trauma symptoms, or severity of co-occurring physical or mental health problems. This type of information could help practitioners determine when passive participation would be most useful to individuals recovering from trauma, versus when it might be more likely to be ineffective or potentially cause harm.

Recommendations for Practitioners

Feedback gathered during this project suggests some individuals recovering from traumatic loss are looking for validation and reassurance that their thoughts and feelings are normal. This may be especially important for individuals who do not seek mental health treatment or qualify for a mental health diagnosis because these individuals may not have a venue to discuss their experiences with professionals who understand the impact of trauma. Primary care practitioners can support recovery by providing information about traumatic loss
and posttraumatic stress in their waiting rooms, and taking time to discuss information and
resources with individuals who disclose traumatic loss.

While passive participation may not be for everyone, recovery principles suggest
practitioners should encourage solutions that are individualized, person-centered and
empowering. Passive participation clearly fits within the recovery paradigm, and practitioners
should work to increase awareness of outside-the-box options such as passive participation and
courage their patients to consider whether these options are right for them.

**Recommendations for Engaging in Passive Participation**

The personal stories gathered during this project suggests individuals who want to engage
in passive participation will be more successful if they seek activities that interest them or peak
their curiosity. It is also helpful for individuals to prepare for passive participation—not just in a
practical sense, but also by preparing mentally. Some questions for individuals to consider are:
do I have enough energy for this activity?; is it safe; what are my expectations and are they
realistic?; how will I encourage myself before, during and after this activity?; and is my plan
flexible enough? It is important for individuals to set themselves up for success by setting
realistic expectations and being flexible when things do not work out. One of the benefits of
passive participation is that individuals may chose the level and length of their engagement with
public spaces or activities, and change their plans at any time.

Although it is not obvious by any means, fostering feelings of safety and security is
central to recovery from traumatic loss. This suggests engaging in passive participation, though
it may naturally be challenging and uncomfortable at times, will be counterproductive if it feels
hostile or threatening to the individual. When planning for an activity in an unfamiliar location,
some people may want to consider visiting the site before the event occurs so they have the
opportunity to familiarize themselves with the layout. Another option for increasing familiarity
may be to look for activities where acquaintances are likely to be competing or performing.

The key to successful passive participation seems to be being thoughtful and
compassionate towards oneself, recognizing that engaging in solo activities can be challenging
for anyone, and may be especially challenging for individuals suffering from grief, loneliness,
depression or posttraumatic stress. Recovery is not the end of a journey—it is the journey. In
the same way, successfully engaging in passive participation is not necessarily having everything
work out perfectly. Sometimes it may be leaving early, or going on a different day, or deciding
the activity is not a good fit. Passive participation is a means of easing slowly back into the ebb
and flow of life, with all of its variety and imperfection.

Recommendations for Improving Informational Materials

The response to this project suggests many people are receptive to the idea of passive
participation and want access to more detailed information about traumatic loss, posttraumatic
stress and passive participation. The current pamphlet format, while helpful to individuals who
may feel overwhelmed or have functional deficits associated with grief or posttraumatic stress, is
limiting. A pamphlet is not the appropriate format to provide detailed explanations of these
concepts. It may be helpful to develop additional materials in a handbook format, which also has
the benefit of being more easily viewed electronically. Another option would be to develop an
informational website or a website where individuals could post information about local
activities or public spaces they have enjoyed.

Targeted informational materials may also be helpful. Whereas the informational
materials developed in this project were designed for adults recovering from traumatic loss,
future outreach efforts could be enhanced by developing materials for other targeted populations,
such as teens, older adults, family and friends, or health workers. Of particular interest to this author is how family and friends may be able to support passive participation in a variety of settings. Although some individuals recovering from traumatic loss may find it difficult to interact with their loved ones, especially in groups, there are many opportunities for passive participation within social networks. Targeted information about traumatic loss, posttraumatic stress, and passive participation may help family and friends support their loved ones more effectively.

Conclusion

Ultimately, improving community knowledge and understanding of traumatic loss allows for more flexible and outside-the-box solutions, which in turn promotes recovery and increases health and well-being for individuals recovering from traumatic loss. This project, while limited, supports passive participation as a recovery tool and suggests there is value in exploring this concept more fully.
References


Feeling isolated... but not comfortable being social?

Try one of these ideas:

- Spend some time relaxing in the park or at a local coffee shop
- Attend a concert or play
- Take a walk on a well-used path or hiking trail
- Go to a local sporting event
- Take a class
- Join a gym where you feel comfortable

The important thing is—pick an activity that feels right to you.

Avoid pushing yourself too far. Your current limitations may discourage you at first—start small and encourage yourself along the way.

Pay attention to your energy level and overall mood—be flexible with your plans.

Bring water and snacks if needed.

Looking for more ideas for passive participation?

- Visit a museum or art gallery
- Explore downtown or go window shopping
- Browse in a local bookstore
- Dance
- Eat breakfast at the counter in a restaurant
- Applaud runners finishing a race or try running yourself
- Brainstorm your own ideas

Masters Project, Spring 2016.
Your feedback is greatly appreciated!
www.surveymonkey.com/r/377CSPR

Healing from Traumatic Loss

Ideas for connection and recovery through passive participation
Traumatic Loss is Personal

Each person experiences loss in their own way.

Regardless of the situation, loss is often associated with sadness and grief. When you experience a loss that is unexpected, threatening, or shocking it can also lead to symptoms of post-traumatic stress.

Symptoms can include:
- Persistent negative thoughts and emotions, including self-criticism
- Disturbing memories, flashbacks, or nightmares
- Insomnia, feelings of danger or intense anger
- An overall sense of numbness or disconnection, including avoiding or withdrawing from contact with those around you

We all need a sense of connection.

Social support and a sense of connection are important aspects of recovery and healing after traumatic loss. But what do you do if you are naturally an introvert, or feel isolated and find it difficult to connect with others?

Passive participation may provide a sense of connection without social interaction.

Public Spaces

After Maria lost her husband, everything seemed broken and upside down. She could not stop thinking about the accident. She also had trouble sleeping and found it difficult to talk to other people—even people she cared about.

“Sometimes it helps to be around other people.”

Maria sometimes felt better if she went to a coffee shop for an hour or so. She would read a book, watch other people, or just sit and relax. The room was warm and light, Maria felt safe, and the hum of people talking around her was comforting somehow.

Public Events

Charlie was looking for a way to escape, trying to get out of the house and forget his life would never be the same. The first time he went to a baseball game, he sat alone in the back of the stands, feeling out of place and uncomfortable. He almost left in the first inning.

The thing is... the game was interesting.

“I knew something was different when I noticed how blue the sky was.”

The kids were determined and did their best, and Charlie decided to go back the next week to see them play again. In fact, Charlie went back week after week. It was something he looked forward to, and he started to feel like he was part of something—like he belonged.

How does this relate to your recovery?

Passive participation may provide a sense of connection or comfort when you are feeling isolated or alone.

There are many opportunities for passive participation in your community. Think about activities that interest you or give you a sense of wellbeing.