



Multiple Loss Assessment Questionnaire

Tell us a few things about yourself:

1. Please indicate your HIV status:
 - HIV-positive
 - HIV-negative (proceed to question 3)
 - Don't know (proceed to question 3)

2. When were you diagnosed with HIV (month/year is fine)? _____

3. How old are you? _____

4. Are you: Male Female

- b) Are you also: Transgender or Transsexual

5. Do you identify as:
 - Gay
 - Straight
 - Lesbian
 - Bisexual
 - Queer

6. How you identify culturally (for example, Filipino)? _____

7. What city do you live in? _____ b) for how long? _____

8. **On a scale of 1 to 10, where 1 is 'not at all attached' and 10 is 'very attached'**, How attached to, or a part of the following communities do you feel?

1 (not attached) – 10 (very attached)

A	Women's community	
B	People living with HIV/AIDS (PHA) community	
C	Gay community	
D	Other? Please specify below:	

9. Can you estimate how many friends, acquaintances, or partners/lovers in your life have died from HIV/AIDS? _____

10. Can you estimate how many people in your life have died from other non-HIV/AIDS causes? _____

11. Are there other losses that you have experienced that you think are important (for example, pets, etc.)?

12. **On a scale of 1-10, where 1 is 'Never or Not at all' and 10 is 'All of the time'**,

When thinking about your grief/loss/sorrow, how often do you feel:

1 (never) – 10 (all the time)

A	that you are grieving too long	
B	that you should 'get on with it'	
C	like your losses are somehow not real	
D	that your losses are not important	
E	that you don't have enough supports in your life	
F	that you just don't understand your feelings	

13. On a scale of 1-10, where 1 is 'Never or Not at all' and 10 is 'All of the time',

When thinking about how your grief/loss/sorrow affects you, how often do you feel:

1 (never) – 10 (all the time)

A	like having more sex	
B	like having less sex	
C	that sex is more important to you	
D	that sex is less important to you	
E	like withdrawing from social activities	
F	that there is no point to life anymore	
G	that you somehow don't measure up	

14. On a scale of 1-10, where 1 is 'Never or Not at all' and 10 is 'All of the time':

I believe that my grief/loss/sorrow affects my:

1 (never) – 10 (all the time)

A	ability to conduct my day to day responsibilities/activities	
B	frustration with others	
C	sex drive	
D	use of alcohol	
E	use of drugs for recreational purposes	
F	ability to make new friends	
G	ability to take care of myself	

15. On a scale of 1-10, where 1 is 'Never or Not at all' and 10 is 'All of the time',

How often do you feel:

1 (never) – 10 (all the time)

A	sad	
B	lonely	
C	depressed	
D	like crying	
E	unhappy about the way life is going	
F	worried about your future	
G	anxious	
H	that there is nothing worth planning or saving for	
I	frustrated with sexual relationships	
J	helpless	
K	that you just can't cope	
L	guilty for still being alive	
M	guilty for being HIV negative	
N	like you are watching your life from a distance	
O	like taking your own life	
P	afraid of dying	

16. Where do you **currently** get support for feelings associated with grief, loss, sorrow or other issues in your life? **(Check all that apply)**

- | | |
|---|--|
| <input type="checkbox"/> AIDS service organization | <input type="checkbox"/> Another type of service agency |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Private therapist | <input type="checkbox"/> Priest or other spiritual adviser |
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Friends |
| <input type="checkbox"/> Supervisor | <input type="checkbox"/> Family |
| <input type="checkbox"/> Someone /Somewhere else? Please specify: | |
-

OR

- I am **not currently** getting support – *but I would like to.*
 I am **not currently** getting support – *and I don't feel I need to.*

17. Have you experienced any **physical effects** (for example, stomach upset, fatigue or tiredness, difficulty sleeping, etc.), which may have been due to your grief?

- yes no

If yes, please describe them: _____

18. Have you experienced any **emotional effects** (for example, anxiety, nervousness, difficulty concentrating, depression, etc.), which may have been due to your grief?

- yes no

If yes, please describe them: _____

19. Are there **other effects** (mental, social, spiritual), which may have been due to your grief?

yes no

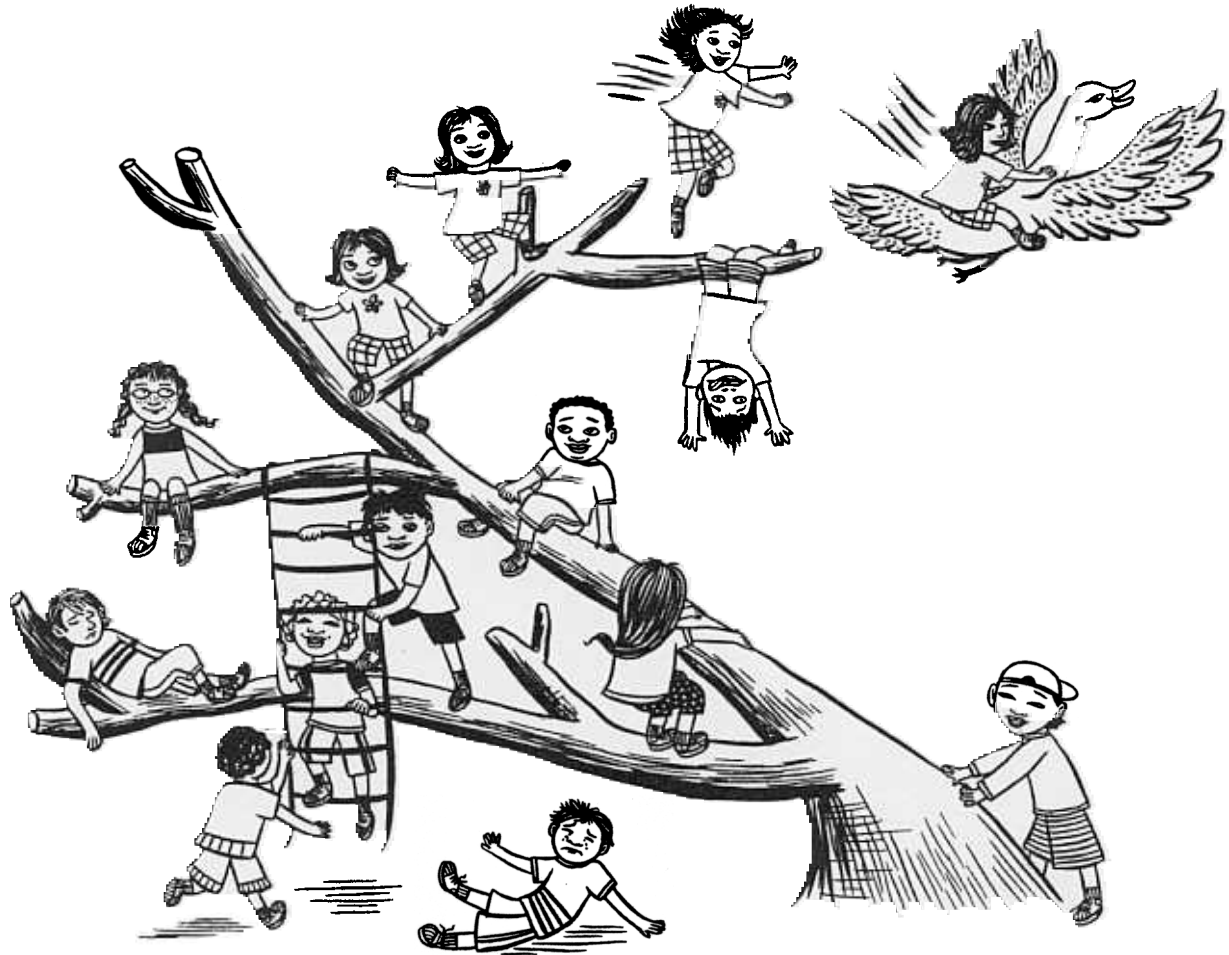
If yes, please describe them: _____

Thank you !

CLIMBING the TREE of LIFE

Picture yourself as a child on this tree.

Circle the child which best represents where you feel you are at this moment in your life.



How does this child represent what is going on in your life at this point?

DEFINITIONS OF ATTACHMENT, GRIEF & LOSS

Attachment

- a bond of affection or loyalty
- requires an investment of emotional energy
- to grieve is to honour the profound truth of the attachment

Bereavement

- the state of having suffered a loss: physical or symbolic

Grief

- the process that allows us to say good-bye to what was and to get ready for that which is yet to come

Anticipatory Grief

- the process stimulated by awareness of impending loss/death

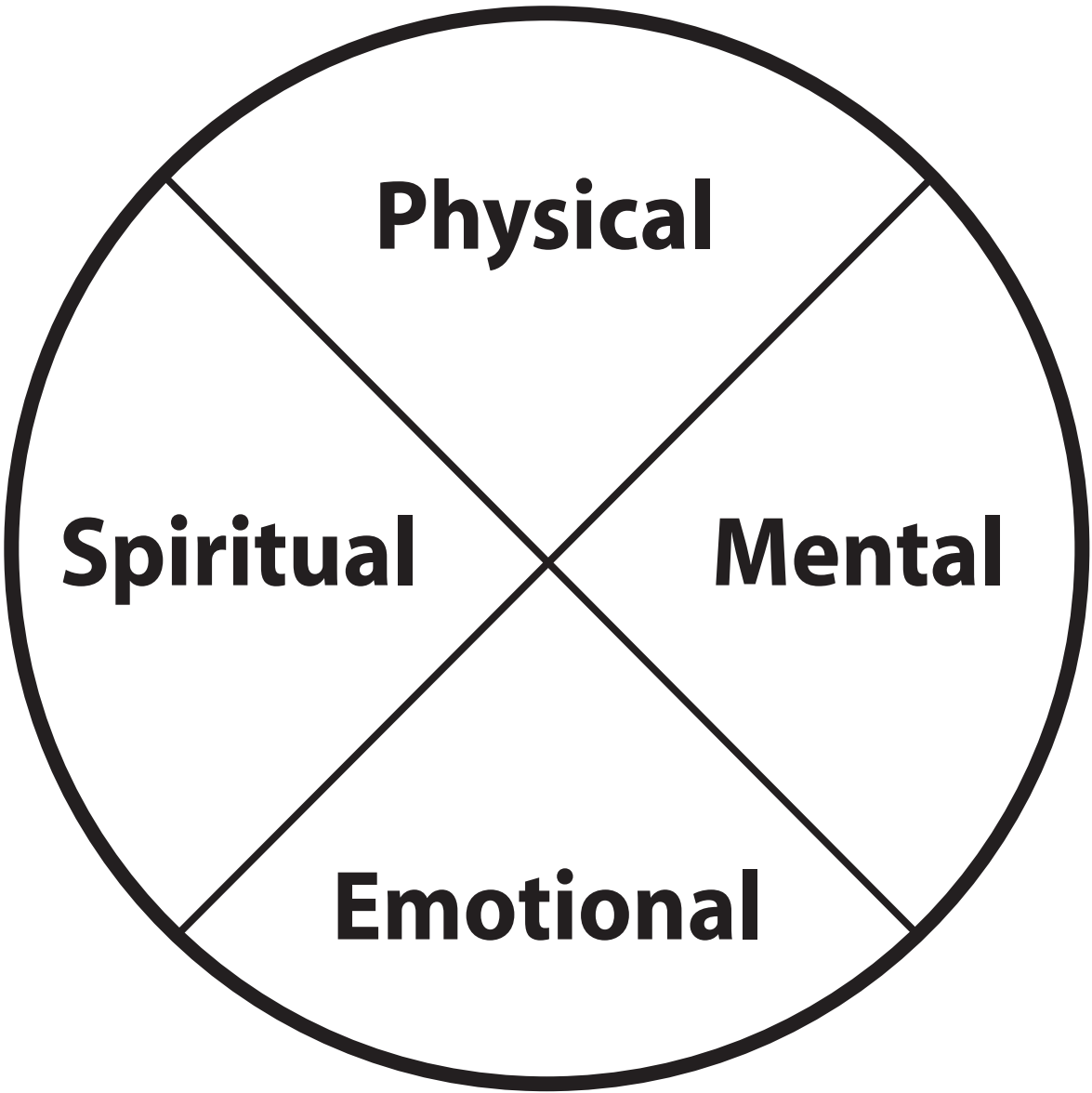
Mourning

- any public shared expression of a person's thoughts, behaviours and emotions related to the loss

Multiple Loss

- experiencing constant and sustained loss, often while **anticipating** further losses

HOLISTIC HEALTH FRAMEWORK



SIGNS & SYMPTOMS OF GRIEF

1. Physical

- ♦ I'm exhausted
- ♦ I have spasms in my back/my neck is seized up
- ♦ My head aches all the time
- ♦ I can't shake this flu
- ♦ My ulcers are acting up
- ♦ My Jaws are so sore – I must be grinding my teeth at night
- ♦ I have such a tightness in my chest/difficulty breathing
- ♦ Sometimes I don't care about sex, then I have the urge to have sex a lot
- ♦ My stomach feels like its in knots half the time

2. Emotional

- ♦ I'm always on the verge of tears
- ♦ Those kitten commercials make me weep
- ♦ I'm so irritable I've been biting people's heads off lately
- ♦ I'm just pissed off at everything and everybody
- ♦ I can't feel anything – I'm numb – I'm not really connected
- ♦ I'm having nightmares
- ♦ I don't want to feel
- ♦ I am anxious all the time these days

3. Mental/Attitudinal

- ♦ I just can't seem to concentrate/my mind is not here
- ♦ I walk into a room and forget why I'm there
- ♦ I completely forgot about that meeting yesterday
- ♦ I can't slow down/I can't stop my mind from racing
- ♦ I can't get to sleep even though I'm exhausted
- ♦ I just want to be distracted

4. Spiritual

- ♦ What am I doing here? There's no point in doing this work
- ♦ These deaths are relentless/the suffering is so enormous
- ♦ Why is this happening to me? to us?
- ♦ This is not how life is supposed to be
- ♦ I can't make one more new friend
- ♦ No use in making attachments which won't last
- ♦ I so desperately want some joy in my life/want peace of mind
- ♦ I'm not creative anymore

Common Myths About Grief:

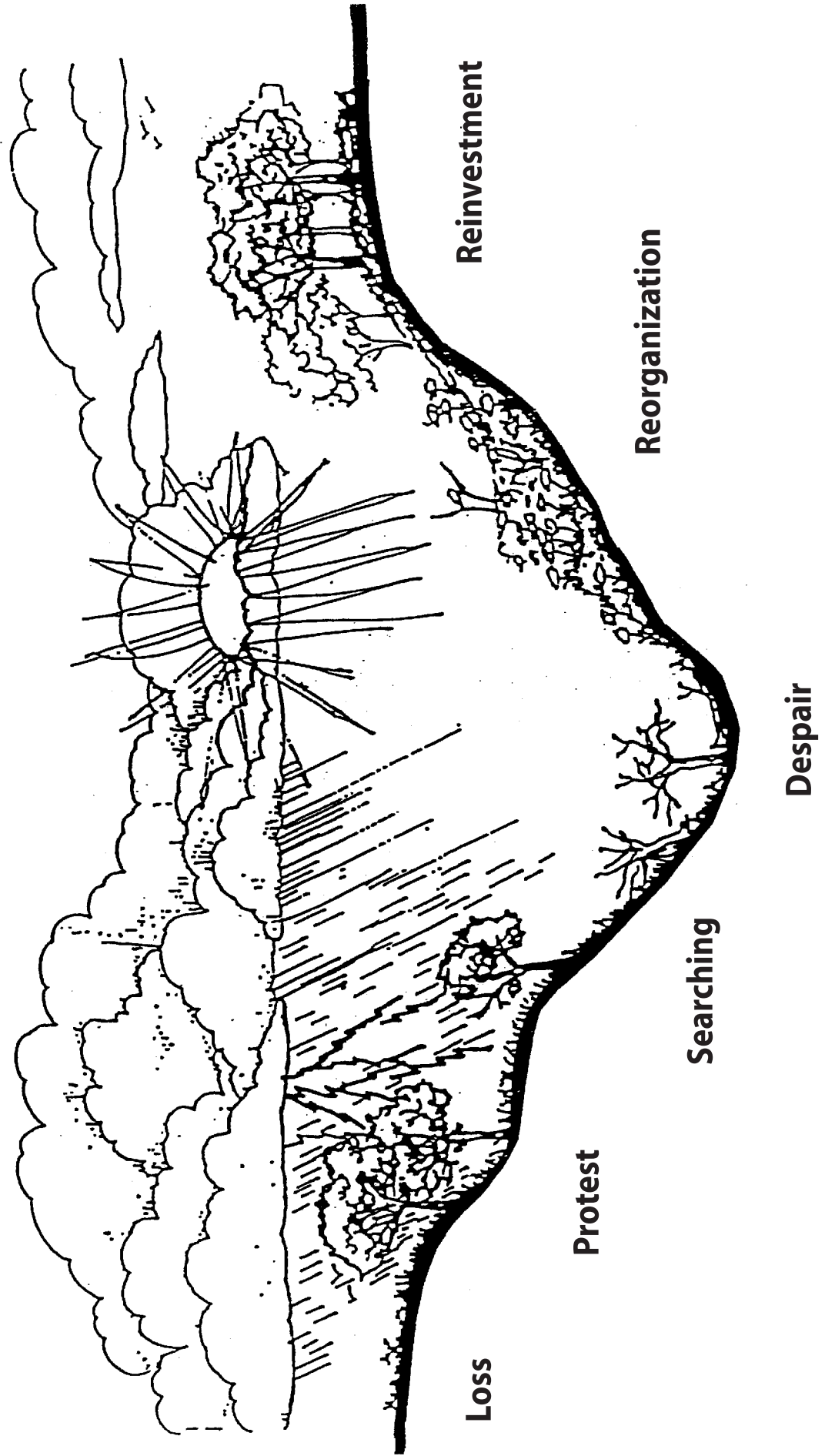
- **all losses result in the same type of grieving**
- **bereaved individuals only need express their feelings in order to "resolve grief"**
- **to be healthy after the death of a loved one, just put that person out of your mind**
- **the intensity of mourning is a testimony to your love for the deceased**
- **grief should be over in a year**
- **grief declines in a steadily decreasing fashion over time**
- **sudden, unexpected death is the same as losing someone to an anticipated death time alone heals all wounds**

Some “Truisms” About Grief and Bereavement

- **Bereavement is a normal, natural experience - although traumatic and disruptive.**
- **Response to loss is not a uniform phenomenon-variability must be recognized. Some show intense distress and others don't.**
- **Grief has no timetable. A major loss tends to resurrect old issues and conflicts for the mourner.**
- **Grief is not a linear process, but more of a spiral as mourners revisit aspects of grief again and again.**
- **Grief is experienced within a social context. Society's view of death and expectations of “appropriate grieving” influence expression of loss.**
- **The goal of grief work is to grieve “well” not to grieve “right”.**
- **Support is about stimulating the mourner's own coping skills.**
- **While grief and loss are an inevitable part of life, most people lack a language and an understanding of grief that would help them identify and cope with normal, natural responses to loss.**

The Journey of Grief

devised by Bess Will



GRIEF JOURNEY DEFINITIONS

Loss

Assumptions shattered. The initial responses to a loss are:

- Shock, numbness, confusion, disbelief, anger, some physical symptoms

Protest

Protesting the acceptance of the loss. Anger at:

- Caregivers
 - The 'unfairness of everything'
 - The deceased
 - The self
- } anger at self/the deceased can become shame/guilt

Searching

The felt experience of the missing

Despair

The 'Pit'

- hopelessness
- agony/anguish
- depression

Reorganization

The 'slippery slope'

- bursts of energy
- fatigue
- detachment
- indifference

Reinvestment

- able to recognize and consolidate gains from the period of active grieving
- new, sustainable interests
- the ability to talk about the loss without experiencing the pain and anguish
- the experience of meaningfulness, purpose and hope for the future



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Multiple Losses in HIV/AIDS

The following pages outline the “Journey of Grief” and the tasks of grief that make it possible to shift along the path. Conceptualizing grief as a journey allows us a sense of purpose and movement, with names for aspects of a process that can at times feel overwhelming. While this journey is based on a single loss model, it can be a useful tool in working with multiple loss as the experience of successfully working through a core grief can provide a sense of mastery and accomplishment which results in the internalisation of skills for further grief work. **While simplified in the linear form of a journey, most people report a kind of “meandering through” the peaks and troughs.**

All grief work is based on attachment and honours our capacity to feel, care and love as human beings. Working through grief ensures we do not have to lose these highest qualities of our being.

Because grief work involves emotional pain, often intensely felt, it is understandable how we would want to avoid the experience. Unfortunately, the emotional pain of grief work is unavoidable. Listed below are the most common ways people will (often unconsciously) seek to avoid the work of grieving. Most of us will use predominantly one strategy, with others periodically coming into play. Recognizing how I avoid provides new choices: *‘Do I wish to continue avoiding these feelings; or am I ready to begin?’*

COMMON AVOIDANCE PATTERNS

- | | |
|---------------------|---|
| POSTPONING | “I’ll deal with it later - it hurts too much right now and I feel like I’m falling apart.” |
| DISPLACING | <i>Projected/externalized grief</i> – “I’m furious at the stupid photocopier; my anger has nothing to do with grief!” <u>or</u>
<i>Internalized grief</i> - “I’m feeling so unhappy and I get mad at myself for little things.” (making no connection to a recent loss). |
| REPLACING | Premature reinvestment (new relationship, overwork) - “I’m just going to refocus my energy and feelings into these new projects.”, in an attempt to keep the difficult feelings of grief at bay. |
| MINIMIZING | Cognitively diluting feelings through rationalization – “I wasn’t that close to him.” or “I’m just the volunteer, so I can’t be grieving.” |
| SOMATICIZING | Unexpressed feelings manifested as physical symptoms – “My aching chest and exhaustion have nothing to do with Dad’s death.” |

Worden's Tasks of Mourning with Negation of those Tasks:

1. To Accept the Reality of the Loss

- The mourner must talk about the death, body, and funeral.

- **Negation** is not believing through prolonged denial involving either denial of the facts, the significance of the loss or the irreversibility of the loss.

2. To Experience the Pain of Grief

- It is impossible to lose someone you are attached to without feeling some pain. The survivor will have to deal with the pain at the time of the loss, or will confront it many years later; but s/he will have to deal with it!
- Emotional acceptance occurs when the survivor no longer needs to avoid reminders of the loss for fear of experiencing intense pain or remorse.

- **Negation** is not to feel resulting in increased physical or psychological problems.

3. To Adjust to an Environment in Which the Deceased is Missing

- Survivors are not usually aware of all the roles played by the deceased until well after the loss occurs. This is the task where 'secondary losses' need to be identified and mourned. A secondary loss may be defined as "a physical or psychosocial loss that coincides with or develops as a consequence of the initial loss." Examples would include the role of the 'cook' in a relationship, which may have belonged to the deceased; or the identity of a mother once a child has died. Each of these secondary losses initiates its own grief and mourning reactions, "every physical loss will engender psycho-social loss".

- **Negation** is not adapting to the loss and promoting their own helplessness.

4. To Withdraw Emotional Energy and Reinvest in Another Relationship

- Mourners sometimes believe they are dishonouring the dead if they withdraw emotional attachment. They may fear another loss if they reinvest.
- When "all the feelings, thoughts, memories, and expectations that bound the griever to the deceased are gradually worked through by being revived, reviewed, felt, and lessened" (Rando, 1984), this task may be considered complete.

- **Negation:** people may get stuck at this point and later realize that, in some way, their life stopped at the moment the loss occurred.

To complete the tasks it is necessary to:

- ⇒ *Vent feelings, talk about the relationship and feelings of loss*
- ⇒ *Validate all aspects of the relationship, including normal ambiguities*
- ⇒ *Resolve any guilt that arises*
- ⇒ *Internalize the memory while reinvesting feelings*

AIDS-related Loss

AIDS Stigma

AIDS makes People living with HIV and AIDS (PHAs) 'other' because AIDS is seen as:

- Deadly, incurable and progressive
- Cause of immense suffering
- Transmissible (therefore PHAs are dangerous)

Herek & Glunt (1998) Gallup Poll results (U.S.) showed more than 50% Americans agreed with the statements:

- "Most people with AIDS have only themselves to blame."
- "It's people's own fault if they get AIDS."

Survivors of AIDS-related losses, receive little support for their grief ("You knew what you were getting into.") and are also made 'other' through stigma and blame.

Stigmatization Affects Bereavement and the Working Through of Grief

Grief: the Process and Work of Adjusting to Irrevocably Lost Objects, Relationships, and Dreams'

Because our AIDS losses are not supported, we may sometimes "act as if the loss did not happen" (Worden, 1991). This both aggravates the pain of our grief, as well as hindering the process of adjusting to a world where loved ones and dreams are gone. Permanently.

Unresolved Grief and Complicated Bereavement may be:

- Chronic (extended or excessively intense)
- Absent (fending off usual grief-associated emotions, "I'm fine")
- Delayed (normal symptoms arise after a long period of absence)
- Distorted (interpersonal: isolation, excessive irritability, avoidance, other changes in interpersonal dynamics)

And may show up as:

- Social withdrawal
- Preoccupation with detail of the death
- More difficulty accepting the reality of the loss
- More disorganization through life
- Anxiety
- Pessimistic future outlook

AIDS Losses Are Not Only the People

- ❖ Grieving arises from lost communities, dreams, material goods, expectations as well as people.
- ❖ Attachment to loved ones provide “for us the center of the universe, the place where all the threads of our life, of our world, come together”, what we love “appears to us as something indispensable”.

AIDS-related Multiple Loss

Community Loss

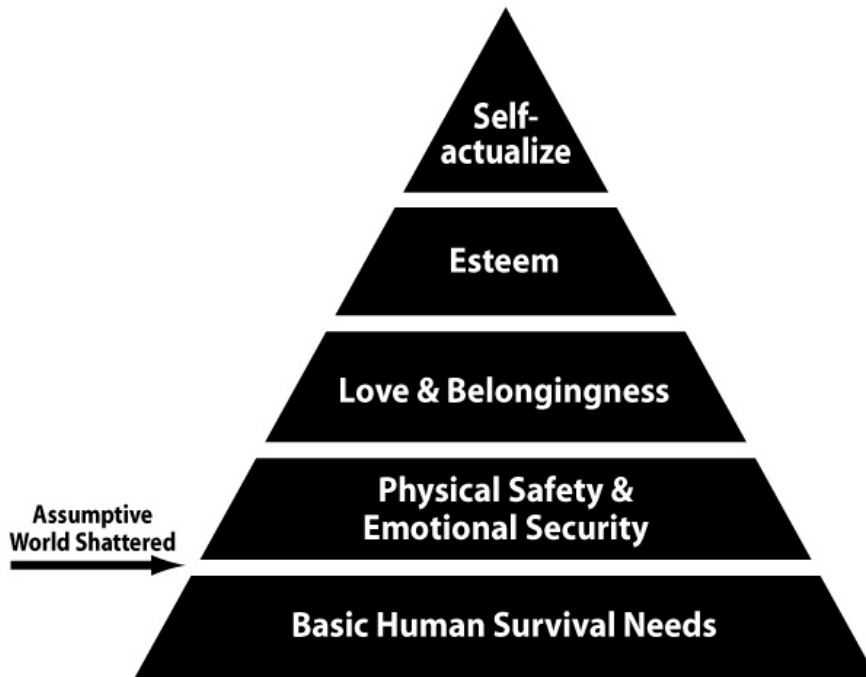
The impact on the gay and lesbian communities, “includes the social, cultural, political, sexual and spiritual aspects of community...the entire community reels under the impact of loss” (Nord, 1997).

Community events (Pride Day, Halloween, etc.), as well as individual anniversaries, provide the opportunity for ‘re-grief’ experiences.

Factors in AIDS- related Multiple Loss:

- **Quantitative:** Ongoing, continual and relentless
- **Qualitative:**
 - Disease process has a protracted nature
 - Disease process entails high levels of anxiety and uncertainty due to the episodic nature of health and sickness (the roller coaster)
 - Disease process characterized by horror, fear and sadness; due in part to grotesque symptomology
- **Social context:**
Community-wide trauma leaves no-one ‘untouched’ or in a position to help

The Challenge of Multiple Loss Within the Basic Hierarchy of Human Needs



The experience of multiple loss presents challenges to our need for:

- Physical safety and emotional security – a sense of orderliness in the world
- The familiarity of the activities of daily living – the taken-for-granted cognitive functioning
- A sense of love and belongingness
- Intellectual and spiritual growth
- Self-actualization

We can choose to increase our ability to get our needs met in each area.

Challenges In Adjusting to the Reality of Multiple Loss

- **Chronic Denial** – In order to remain functional: pervasive emotional shutdown and/or fervent hyperactivity. *“No big deal, shit happens, so what”*.
- **Depression** – “feelings of hopelessness, helplessness, sadness, cognitive impairment, somatic complaints, and problems falling asleep, staying asleep, and waking early; suicidal ideation, including thoughts about taking one’s life, plans for doing so, and actual attempts”. (Martin & Dean, 1993)

Reactive depression, not accompanied by a fall in self-esteem, may in some instances be a form of self-punishment related to survivor’s guilt.

- **Anhedonia** – the complete and pervasive absence of meaning. The experience of watching my life like it was a TV show; without being engaged, sexually, behaviourally, or interpersonally.
- **Powerlessness** – evoking feelings of inadequacy. Grief is often accompanied by feelings of shame -“I am flawed” and guilt - “I behaved wrongly”.
- **Suicidal and death thoughts** – related to:
 - Anxiety
 - Fear of Death
 - Bodily Mutilation
 - Separation
 - Fear of Loneliness
 - Isolation
 - Ignominy
 - Rejection
 - “I can’t take anymore”
- **Anxiety** – a normal accompaniment to terminal illness, “exacerbated (by) continual change and loss...as part of an unstoppable process” (Nord, 1997); accompanied by “Who will be next?”
- **Alcohol and Drug Abuse** – healthy grief resolution is impeded by substance abuse and it “perpetuates complicated mourning” (Rando, 1993). Martin (‘88) found a “significant dose-response relationship between the number of bereavements and recreational drug and sedative use”. Although emotional responses may be more accessible when drunk, the attribution to the substance “it was the booze talking, not me” does not allow for the integration of the mourning experience. It is like drinking salt water when thirsty; initial feelings of relief followed by increased difficulty.

- **Social Withdrawal** – a common response in single loss, in multiple loss there is no possibility of the need to withdraw to subside with time.
- **Diffuse Anger** – while a single loss response is accompanied by anger, multiple grief events bring multiple angers, including:
 - Anger that values and beliefs seem empty and unhelpful
 - Anger that losses are beyond any normal expectation
 - Anger at being left alone
 - Anger at family of choice or origin
 - Anger at those dying and deceased for being infected
 - Anger at medical personal and caregivers for being ineffectual
 - Anger at AIDS and opportunistic infection
 - Anger at society for ignoring and mistreating those with AIDS
 - Anger arising from personal helplessness
- **Survivor Guilt** – “Why not me?” may be accompanied by sorrow for our own survival (this does not need to be rational). Helplessness in the face of unrelenting loss, “there is nothing I can do” leads to a desire to make meaning of the experience, “there must be a *reason* I survived”.

The Shattering of the Assumptive World

Our assumptions form the basis for our security in the world and how we understand and make meaning of our experiences. We are largely unaware of how we base our reality on assumptions, as they form the background from which we operate in the world. For example, we assume that gravity is a constant, that the sun will rise and set and that there is some purpose to our existence. Prior to AIDS, a reasonable and unexamined assumption within the to-be-affected communities was “the people to whom I am attached will not be systematically and randomly eliminated by a protracted and disfiguring disease process within the next decade”.

Since the “individual self is interpersonal at its “very core”, multiple loss is a “threat to one’s very identity” (Uroda, 1977). Each loss is another blow to the self within a social network of meaning. The need to make meaning then becomes deeply felt.

Another common response to multiple loss is “chronic passivity” (Van der Kolk, 1989) coupled with a tendency to isolate. Survivors of AIDS related losses adopting this strategy may be willing to engage in the painful work of examining the impact of multiple loss when the accumulation becomes more unbearable than re-exposure to memory. Therapeutic work is difficult for us as survivors because emotions may be feared as the heralds of trauma. Living in the reality of an ongoing traumatic process brings into question the value of opening to an emotional response when a death surround characterizes our daily existence.

Learned helplessness as a response to lack of control.

A Survivor’s reality is that s/he is:

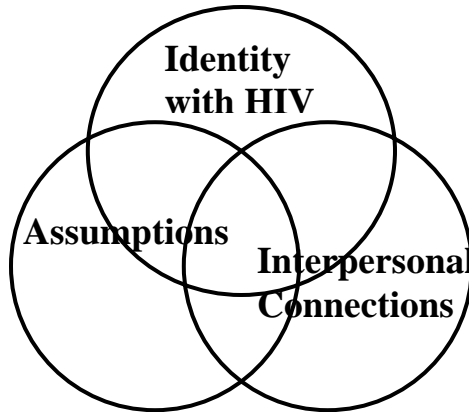
- Helpless to prevent the death of loved ones
- Helpless to eliminate the pain and demise of PHAs
- Helpless to prevent collective, community-wide losses
- Helpless to escape a world saturated with AIDS

Incompetence and defenselessness arising from these tangible areas promotes a *perception* of helplessness which may show up as:

- Chronic reactive depression
- Helplessness to maintain emotional balance
- Helplessness to respond capably to ongoing loss
- Helplessness to find motivation to develop and implement a future vision

AIDS-related Multiple Loss and the Disruption of Identity

A survivor's sense of self is forever altered as they continue to be challenged to live purposefully and deliberately. Identity disruption occurs at 3 levels:



1. Identification with HIV status, whether positive or negative, influences the self-concept.
2. Assumptions about the universe are shattered.
3. Interpersonal connections are disrupted as they occur in the context of a death surround.

Sexuality is altered in that it now includes the components of:

- **Physical threat** – of infection, reinfection and
- **Psychological threat** – of annihilation

Healing AIDS-related Multiple Loss: What can we do?

Identity disruption is both normal in multiple loss and profoundly alienating, forcing the question: “*Who am I now?*” The beginnings of the answer can come from an exploration of the impact of the losses.

“Where do I start?”

There is often one overshadowing death (lover/best friend) that indicates a starting point in grief work. Particularly if the relationship was conflicted or ambivalent, the need to grieve may present itself more forcefully.

Using the journey of Grief as a road map, allowing your road to wander and meander, and working the four tasks of grief while focussing on one significant loss will lead to developing the ability to process other losses. The process is like developing a new “personality sub-routine”. Conscious, focussed grief work, like the work of learning to drive a car, requires practice and determination. Eventually, it becomes almost unconscious – not requiring as much time energy and attention, freeing us up for other creative ways of being.

Working with Multiple Loss

The work of addressing the impact of multiple loss “*requires introspection and increased levels of self-awareness*” (Sprang and McNeil, 1995)

Normalizing: “The times are crazy, you are not”

The process of normalizing both:

- Recognizes that extreme responses are required for extreme circumstances, and
- Recognizes the abnormality of the circumstances.

This recognition honours the need to bear witness, which can help us:

- Stop feeling guilty about feeling guilty
- Stop feeling anxious about feeling anxious
- Liberate more creativity and spontaneity for the healing process
- Shift from a pathological identity to an empowered one
- Shift from being oppressed to being challenged
- Shift from victim to survivor

Constructing A Timeline

Typically after 2 or more significant deaths, survivors will adopt a strategy of refusing to mourn, which may include not attending funerals etc. (Nord, 1997). In order to begin the long-term commitment to uncovering the meaning of the losses, a timeline can help separate out the different losses. The timeline should include all losses including those that are intangible and global (e.g. community, sexuality, fun, safety) not just death events. This then invites the process of methodical storytelling.

Expressions of Recollections

Emotional responses are “generally constricted initially” (Sprang and McNeil, 1995). Inviting your own flow of expression, which dips in and out of the mundane and the intense, allows for expression without becoming overwhelmed.

“Disenfranchised grief is best dealt with in a social setting.”

(Nord, 1997)

Working in Groups:

- Validates losses
- Builds community
- Provides a setting to consistently ‘lean into’ the pain of grief
- Affords the certainty of being witnessed
- Helps in sharing feelings to receive support
- Counters alienation/isolation (others hear and supports)
- Lessens survivor guilt
- Aids in the search for meaning
- Fulfills a need for catharsis
- Fosters a sense of choice and control

Functional balance: (Between attaching and detaching)

- Requires ongoing self-monitoring
- Involves neither total immersion or total avoidance
- May include twisted humour as a healthy coping strategy

Bearing witness:

- Ensures the experience will never be forgotten
- May include writing books/articles, attending support groups, creating lasting memorials
- Prevents AIDS having the final victory of total eradication

Aspects of Closure

As human beings we invest energy in our attachments to people, places, experiences, beliefs and things. Whether positive or negative (an apartment I love, a job I hate), moving on from an attachment requires paying attention to what is being left behind. For example, if leaving a workplace there may be a card and/or party to mark the transition. Often this is the time when *appreciations* are shared and the card/party is a *ritual* element in the closure.

After moving on, a person may realize:

- ♦ “Oh, I never got to tell so and so that I *regretted*...”
- ♦ “I really *resented* the way they dealt with me when...”
- ♦ “I guess I never really told them how much I *gained* as a person in that job...”
- ♦ “I wish I had told them how happy I was to be *moving on* to this new position...”
- ♦ “What I didn’t like about that surprise party was that it felt just like the surprise party for my twenty-fifth birthday – when my ex showed up and caused a huge scene – his *ghost* was haunting me all night and I just couldn’t relax!”

Because these aspects are not spoken to, they remain as *unfinished business*, carry an emotional charge, and will need to be spoken of or attended to. It is not uncommon to hear someone speaking of their resentments towards a workplace situation, even years after they have left, because they did not have the opportunity to close well and name the resentments at the time. Unattended closures can then become more emotional baggage to carry around.

The ‘Aspects of Closure’, listed below, identify the areas that may carry an emotional charge associated with an ending. Typically, one aspect will be more present than others (appreciation, resentment etc.). Speaking to all aspects as fully as possible makes for an experience of closing which is as complete as possible. (*Adapted with permission: Susan Aaron, Psychodramatic Bodywork)

Gains & Achievements

- ♦ What I have gained/achieved as a result of this experience.

Appreciations

- ♦ What I appreciate about myself and/or others.

Unfinished Business

- ♦ Naming what is unfinished helps to leave it behind.

Regrets

- ♦ Any regrets I carry from this time.

Resentments

- ♦ What I resent about this experience.

Ghosts of Closures Past

- ♦ Other similar experiences/closures that are present for me now.

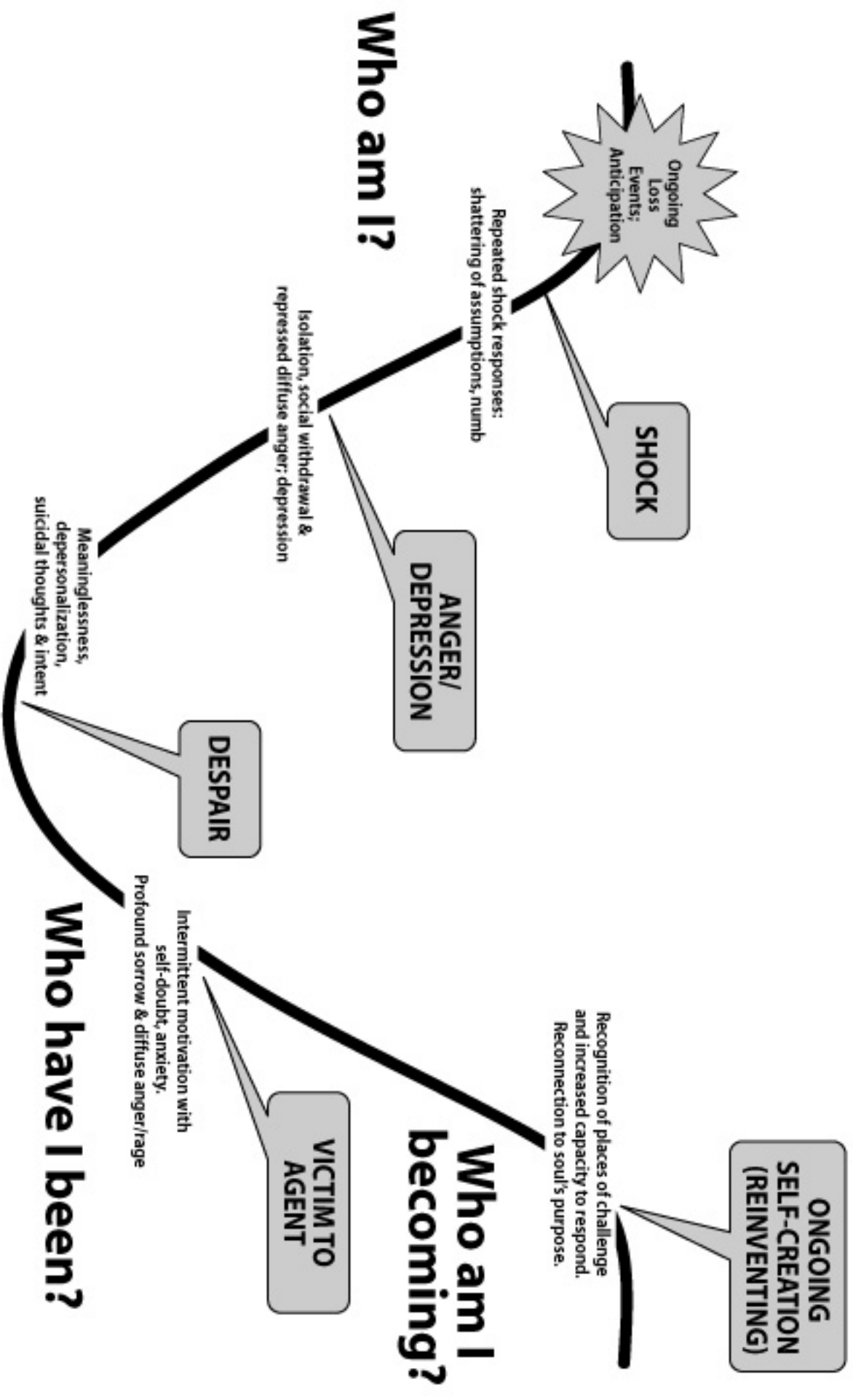
Moving on; what's next?

- ♦ As this experience is ending, I can name what is beginning, and what I will carry forward.

Ritual

- ♦ Any deliberate action which has meaning in relation to closing on the experience.

The Journey of AIDS-related Multiple Loss



Multiple Ongoing AIDS-related Loss & Community Devastation

Complexity of Losses

- Self
- Significant people, places, things, hopes, dreams (tangible and intangible)
- Community of Meaning
- Social/political context of stigma and marginalization

Loss of identity & assumptive world

Attaching

- Acknowledge difficulty in attaching

Anticipating Losses

- Normalize confusion
- Give language/help make "it" real (some 1-1, peer, professional support)
- symbols/metaphors/rituals

Ongoing Loss Events

- Shattering of assumptions
- Numb
- Flooding
- Disorientation

Single Loss

Loss/Death

Who am I?

Protest

Shock

Anger/Depression

- Social isolation
- Withdrawal
- Repressed diffuse anger

Searching & Yearning

- Meaninglessness, hopelessness
- Depersonalization
- Suicidal thoughts

Despair

- Full range of feelings
- Help express anger

"The Pit"

Tasks

1. Tell the story
2. Experience the pain
3. Make necessary adjustments
4. Able to reconcile/make meaning reorient towards new beginnings

Reinvestment

Who am I becoming?

Reorganization

Who have I been?

Victim to agent

- Intermittent motivation
- Self-doubt
- Anxiety
- Profound sorrow
- Diffuse anger/rage

- Explore what you believed to be true about yourself
- Support shift to agency

What Is Lost? What Is Left?

- Help reflect on survival discovery and growth to this point
- Identify **current** challenges and capacities

Ongoing Self-Creation

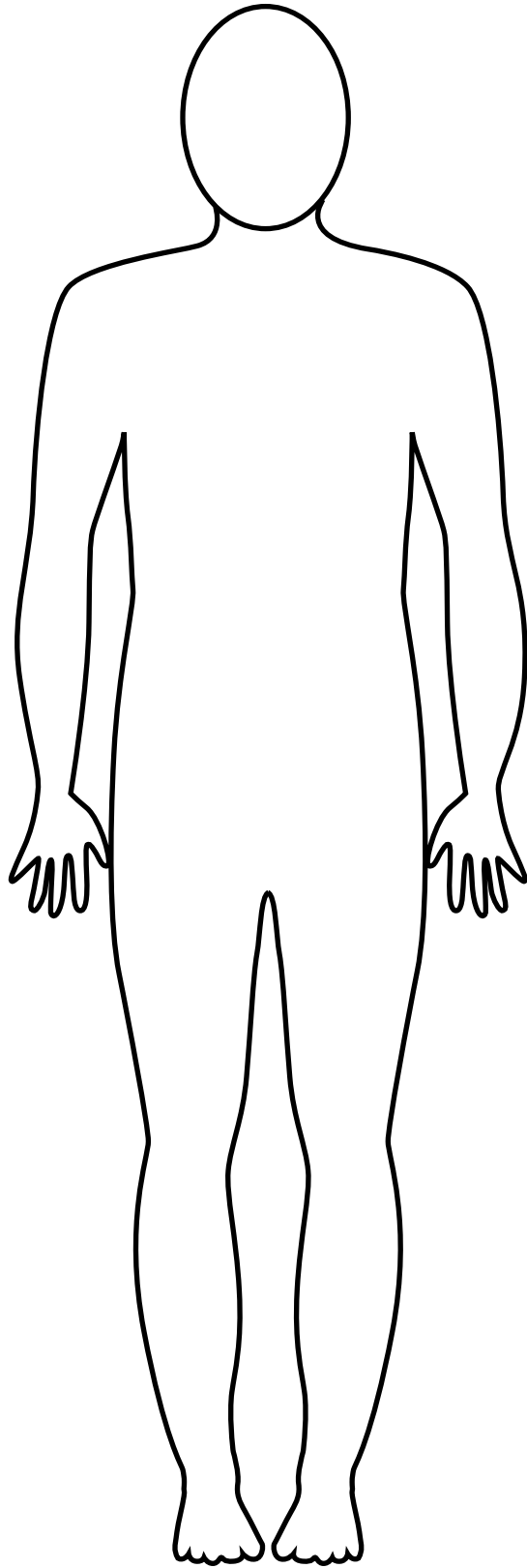
- Re-inventing self
- Recognition of places of challenge
- Increased capacity to respond

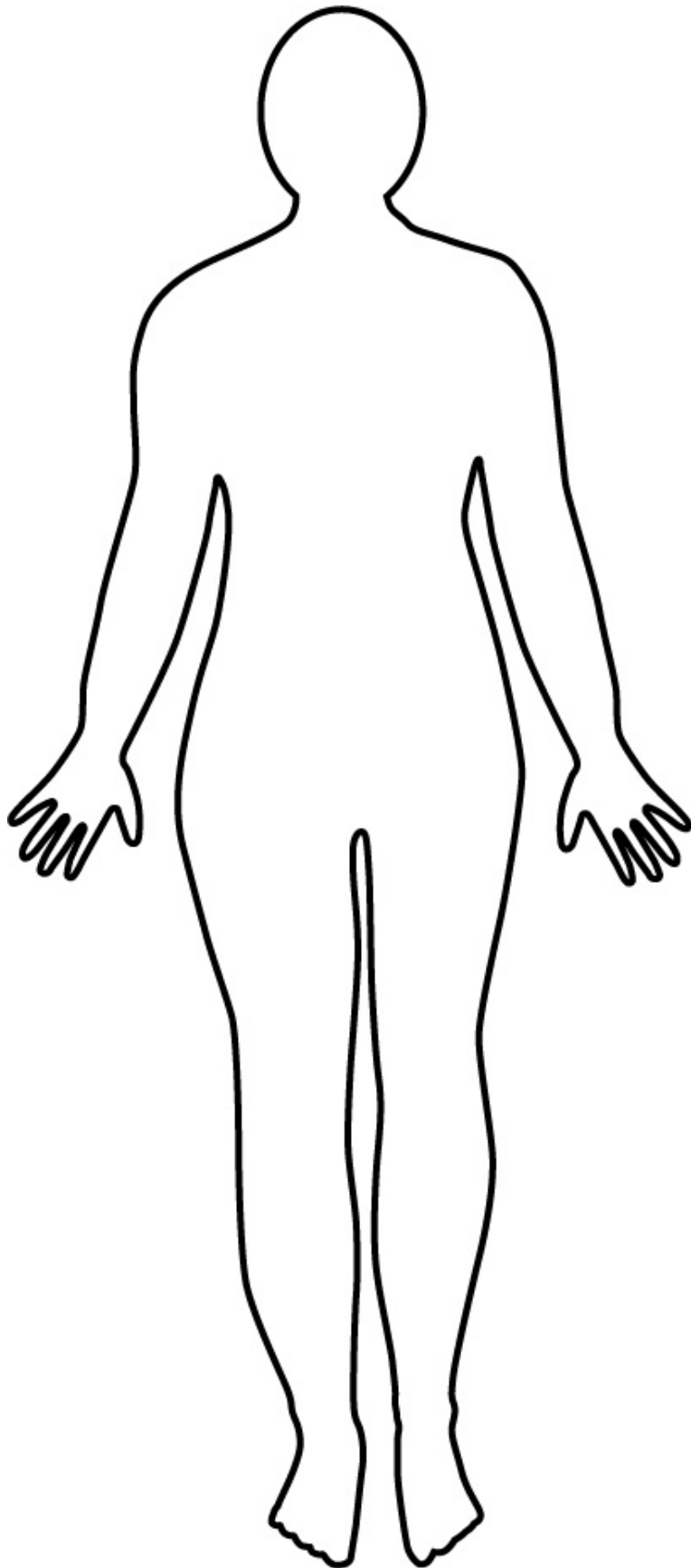
Transformation

- Reconnection to soul's purpose
- Meaningful/purposeful engagement in life
- Constructing a narrative that includes meaning of loss in new orientation to the world

What Is Possible?

- What has meaning for you?
- What is your soul's desire?





'SURVIVE & THRIVE' Sample Retreat AGENDA

Saturday

- ✧ **8:45 am Breakfast**
- ✧ **9:30 am – 11:00 am Introductions, Check-in & Group Guidelines**
- ✧ **11:15 am - 11:45 pm Loss Assessment Questionnaire**
- ✧ **11:45 am - 12:30 pm Presentation on AIDS-related Multiple Loss and Community Devastation**
- ✧ **12:30 pm – 1:30 pm Lunch**
- ✧ **1:30 pm – 4:00 pm Depicting the Impact of Multiple Loss: Theory and Body Collage Exercise**
- ✧ **4:00 pm – 4:30 pm Closing**

Sunday

- ✧ **8:45 am Breakfast**
- ✧ **9:30 am – 10:00 am Check-in**
- ✧ **10:30 am – 12:30 am Individual Presentations on the Impact of Multiple Loss and Identification of Central Challenge**
- ✧ **12:30 pm – 1:30 pm Lunch**
- ✧ **1:30 pm – 3:30 pm Individual Presentations on the Impact of Multiple Loss and Identification of Central Challenge**
- ✧ **3:45 pm - 4:30 pm Group De-briefing and Closing**

'Survive and Thrive'

A Workshop for people who have experienced AIDS-related multiple loss

The goals for the weekend workshops are:

- **To help increase awareness about the impact of multiple loss.**
- **To identify and develop personal coping strategies.**
- **To build skills to develop supports in your area.**
- **To help consolidate local follow-up efforts.**

Agenda Overview

Friday Evening: Dinner & Discussion

Saturday and Sunday: 'Survive and Thrive' Session

Where:

When:

Area Served:

For more information and to register contact:

OR

This weekend is arranged in partnership between

'Survive and Thrive'

**A Workshop for people who have experienced
AIDS-related multiple loss**

Friday, April 15 - Sunday, April 17, 2005

Participant Registration Form

- Registration is Free and includes:

Dinner Friday, Breakfast and Lunch on Saturday and Sunday, and full and partial subsidies for travel, accommodation and childcare for out-of-town participants.

Name & Agency: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Email: _____

Emergency Contact Name/Phone: _____

Dietary restrictions: _____

Travel plans/needs: _____

Since accommodation is based on double occupancy, please indicate if you have a roommate preference: _____

From the following list, please check any requests you may have in assigning you a room:

Smoking ___ Non Smoking ___ Alcohol Free ___ Substance Free ___

This Workshop is limited to 25 participants.
Registration will be a first-come, first-serve basis.

**Please email or fax completed registration forms by
to:**

@ or FAX#:

‘Survive and Thrive’ Retreat Planning Checklist

Area	Supporting Documents	Person(s) Responsible	Timelines	Other Information (Contact people, etc.)
<p>SET-UP: Formation of Retreat Planning Committee (RPC)</p> <ul style="list-style-type: none"> • Determine members and roles. • Share Planning Checklist and other relevant docs with members and agree on specific responsibilities (poss. through conf. call). 				
<p>1. Facility Booking</p> <ul style="list-style-type: none"> • Select possible facilities with reasonable room rates and appropriate meeting room 				
<ul style="list-style-type: none"> • Confirm date availability and get price quotations 				
<ul style="list-style-type: none"> • Circulate info to RPC 				
<ul style="list-style-type: none"> • Submit specifics for 				

event contract, including billing arrangements				
2. Publicity	Poster Template, Appendix H , Intervention Framework			
• Create local poster				
• Distribute to clients, volunteers and board members and RPC				
• Distribute to local and regional agencies and contacts				
3. Registration	Registration Form Template, Appendix H, Intervention Framework			
• Create local registration form and choose central registrar, identify on form.				
• Distribute e-copy to RPC				
• Create initial participant's list with numbers, regional distribution and connection & dist. to RPC				
• Set final reg. deadline, make final list and dist.				
• Set-up reg. table at event,				

check participants against list and provide with retreat packages.				
4. Hotel Booking	Intervention Framework, page 33 & Filled-in Registration Forms			
<ul style="list-style-type: none"> • Make preliminary rooming list and reserve with hotel including extra rooms based on final estimates. 				
<ul style="list-style-type: none"> • Submit final list by hotel deadline. 				
<ul style="list-style-type: none"> • Confirm arrivals of participants on first day and cancel rooms of no-shows to avoid charges. 				
5. Participant Travel Arrangements	Filled-in Registration Forms			
<ul style="list-style-type: none"> • Identify regional needs and modes of transport 				
<ul style="list-style-type: none"> • Communicate with participants to confirm modes and payment (pre-vs. on-site reimbursement) 				
<ul style="list-style-type: none"> • Arrange to have petty 				

cash and forms for travel re-imbursments, parking and meal per diems				
6. Menu Planning	Intervention Framework, page 33, & filled in Registration Forms			
<ul style="list-style-type: none"> • Make selections from facility catering menu, confirm timing of meals and circulate to RPC 				
<ul style="list-style-type: none"> • Review registration for food allergies, special needs and confirm menu 			At least 2 weeks prior to event	
<ul style="list-style-type: none"> • Confirm final numbers with catering dept. 			2-3 days prior to event	
<ul style="list-style-type: none"> • Attend to any on-site participant meal special needs. 			At event	
Other:				

Useful Resources

Books

- Doka, Kenneth J. 1989. *Disenfranchised Grief – Recognizing Hidden Sorrow*. New York. Lexington Books.
- Ennis, Frances. 1995. *One Day I was Fine...A Book about Grief and AIDS*. Newfoundland and Labrador AIDS Committee.
- Nord, David. 1997. *Multiple AIDS-Related Loss: A Handbook for Understanding and Surviving a Perpetual Fall*. Washington, DC. Taylor & Francis.
- Rando T.A. 1993. *Treatment of Complicated Mourning*. Champaign, Illinois. Research Press.
- Parkinson, Frank. 1993. *Post-Trauma Stress*. Tuscon. Fisher Books.
- Worden, J.W. 1982. *Grief Counselling and Grief Therapy: A handbook for the mental health practitioner*. New York. Springer.

Article Abstracts

Alterations in brain and immune function produced by mindfulness meditation.

Davidson RJ, Kabat-Zinn J, Schumacher J, Rosenkranz M, Muller D, Santorelli SF, Urbanowski F, Harrington A, Bonus K, Sheridan JF.
Psychosom Med. 2003 Jul-Aug;65(4):564-70.

Abstract

OBJECTIVE: The underlying changes in biological processes that are associated with reported changes in mental and physical health in response to meditation have not been systematically explored. We performed a randomized, controlled study on the effects on brain and immune function of a well-known and widely used 8-week clinical training program in mindfulness meditation applied in a work environment with healthy employees.

METHODS: We measured brain electrical activity before and immediately after, and then 4 months after an 8-week training program in mindfulness meditation. Twenty-five subjects were tested in the meditation group. A wait-list control group (N = 16) was tested at the same points in time as the meditators. At the end of the 8-week period, subjects in both groups were vaccinated with influenza vaccine.

RESULTS: We report for the first time significant increases in left-sided anterior activation, a pattern previously associated with positive affect, in the meditators

*'Survive & Thrive' Intervention Framework
AIDS Bereavement Project of Ontario*

compared with the nonmeditators. We also found significant increases in antibody titers to influenza vaccine among subjects in the meditation compared with those in the wait-list control group. Finally, the magnitude of increase in left-sided activation predicted the magnitude of antibody titer rise to the vaccine.

CONCLUSIONS: These findings demonstrate that a short program in mindfulness meditation produces demonstrable effects on brain and immune function. These findings suggest that meditation may change brain and immune function in positive ways and underscore the need for additional research.

Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders.

Miller JJ, Fletcher K, Kabat-Zinn J.

Gen Hosp Psychiatry. 1995 May;17(3):192-200.

Abstract

A previous study of 22 medical patients with DSM-III-R-defined anxiety disorders showed clinically and statistically significant improvements in subjective and objective symptoms of anxiety and panic following an 8-week outpatient physician-referred group stress reduction intervention based on mindfulness meditation. Twenty subjects demonstrated significant reductions in Hamilton and Beck Anxiety and Depression scores postintervention and at 3-month follow-up. In this study, 3-year follow-up data were obtained and analyzed on 18 of the original 22 subjects to probe long-term effects. Repeated measures analysis showed maintenance of the gains obtained in the original study on the Hamilton [$F(2,32) = 13.22$; $p < 0.001$] and Beck [$F(2,32) = 9.83$; $p < 0.001$] anxiety scales as well as on their respective depression scales, on the Hamilton panic score, the number and severity of panic attacks, and on the Mobility Index-Accompanied and the Fear Survey. A 3-year follow-up comparison of this cohort with a larger group of subjects from the intervention who had met criteria for screening for the original study suggests generalizability of the results obtained with the smaller, more intensively studied cohort. Ongoing compliance with the meditation practice was also demonstrated in the majority of subjects at 3 years. We conclude that an intensive but time-limited group stress reduction intervention based on mindfulness meditation can have long-term beneficial effects in the treatment of people diagnosed with anxiety disorders.

Website: Online Search Engine for health and medical related periodicals:

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>

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