

Trauma Therapy for Death Row Families

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Abstract

The family members of death row inmates undergo unique suffering that includes disenfranchised grief and intense psychological trauma. In Texas, where executions occur at a rate of one every two weeks, this class of trauma victims presumably is large: a fact that should generate public mental health concern. Yet, the class remains virtually unknown to the therapeutic community. Very little has been done to address the trauma healing needs of death row families. This theoretical paper proposes that structural therapy designed to re-engage attachment relationships and re-empower family members' innate resources to emotionally regulate each other may provide one of the most effective means to help this population survive trauma.

Key words: death penalty, capital punishment, torture, human rights, trauma, disenfranchised grief, ambiguous loss, PTSD, structural family therapy.

Trauma Therapy for Death Row Families

1. Introduction.

From 1982 until the end of 2009, the state of Texas has executed 447 people: for many years at a pace of about one person every two weeks (Texas Department of Criminal Justice, 2009). Currently, over 300 await execution. Each of the death sentenced and executed came from a family. Recent studies have documented the psychological distress experienced by the family members of death row inmates (Adcock, 2010; Beck, Britto, & Andrews, 2007; Beck & Britto, 2006; Beck & Jones, 2007; Beck, Blackwell, Leonard, & Mears, 2003; Byrd, 2000; Jones & Beck, 2006; King, 2003, 2006, 2007; Sharp, 2005; Vandiver, 1998; see also Radelet, Vandiver, & Berardo, 1983). The studies suggest that death sentences cause serious emotional and psychological damage in these families, identifying symptoms consistent with dysthymic disorder, Posttraumatic Stress Disorder (PTSD), complex PTSD, complicated and disenfranchised grief, guilt, and shame (Beck, Britto, & Andrews, 2007; Jones & Beck, 2006; Sharp, 2005). Concern even has been raised about intergenerational consequences of death sentencing (Beck & Jones, 2007). However, so far, the literature contains no therapies designed to address death row families' unique struggle with trauma.

This article proposes a theoretical structural family therapy to ameliorate the pain of death row families. A basic assumption of family therapy is that families have within themselves "unused possibilities" (Minuchin and Fishman, 1981) for emotional regulation that may be their best source of healing. The death penalty is a relational assault, threatening and then totally severing family ties (King, 2007). Therefore, family therapies that enhance intra-familial attachment relationships, through restructuring of the family and provision of tools for emotional

regulation, may provide the most hope for ameliorating the death row families' distress. The therapist's skilled shaping of the attachment relationships within and between the family's subsystems, combined with experiential training in dyadic emotional regulation (e.g., Fosha, 2001) and assistance with "meaning making," may best promote lasting relief in families suffering the trauma of a death sentence (Armour, 2003; Van Ecke, Chope & Emmelkamp, 2006).

2. Overview of the Literature.

The literature on death row families has been primarily descriptive and diagnostic. Depression is so frequently reported as to be a common denominator. For example, [(Jones and Beck, 2006)] found that, out of twenty-four death row family members, sixteen experienced depression for more than two years. Ten out of the eleven who were primary support persons for death sentenced inmates were depressed. Among these, "depression led to loss of jobs, home, and even life." Most studies also report social isolation, stigma, guilt, and prolonged and distorted grieving (inter alia, Jones & Beck, 2006; Sharp, 2005; King & Norgard, 1999; Smykla, 1987).

Most recently, Elizabeth Beck and colleagues have focused on death row families' experiences of "disenfranchised grief" and "nonfinite loss" to capture "the nature and intensity of the families' bereavement" (Jones & Beck, 2006 [p. 284]; Beck & Jones, 2007; Beck, Britto, & Andrews, 2007). "Disenfranchised grief," a concept developed by Kenneth Doka, "occurs when a loss cannot be openly acknowledged, publicly mourned, or socially supported" (Jones & Beck, 2006 [p. 285]; Doka, 1989). Community approval of an inmate's execution denies social support to the family members, causing them to feel isolated and ashamed (Beck, Britto & Andrews,

2007). Their resulting disenfranchised grief manifests “high levels of distress and disorganization” and resists healing (Jones & Beck, 2006 [p. 285]). “Nonfinite loss,” in turn, refers to losses “slowly manifested over time” ([p. 284]). Much like experiencing the slow demise of a terminally ill family member, the relatives of death row inmates find themselves entrapped between a present marred by frequent losses of hoped-for milestones and the dreaded future “appointed time” of execution. Sharp ([2005]) describe[d] death row family members as locked into what she call[ed] a BADD Cycle of disenfranchised grieving (bargaining, activity, disillusionment, and desperation).

The vocabulary of disenfranchised grieving accurately captures the experience of these families, and the interminable quality of nonfinite loss is an important addition to understanding. However, the experience of loss is not only suspended in time, but radically ambiguous, as death row families often navigate repeated appellate events that alternately bestow and dash hopes before execution finally occurs (Radelet, Vandiver & Berardo, 1983). Furthermore, grief categories are insufficient to capture the nature of the external stressor causing pathology and distress: homicide. Miller (2009) found that homicide survivor distress is proportional to the perceived intentionality of the killing. Death row families are forced to deal with not only intentionality, but elaborate, public, premeditation and planning. Trauma is a category that must be carefully considered when examining their experience and looking for solutions to their pain.

The death sentence, culminating in execution, exposes death row family members to at least two interacting kinds of trauma of great intensity and long duration: 1) Post Traumatic Stress Disorder (PTSD); and 2) “ambiguous loss.” Beck and her colleagues also found symptoms of PTSD in sixteen of the twenty-four family members in their study (Beck, Britto, & Andrews,

2007). They concluded that death row family members' trauma stems from their experience of social isolation coupled with the "overwhelming sense of powerlessness that is inherent in the experience of death row" ([p. 129]).

Pauline Boss coined "ambiguous loss" to describe a kind of *ongoing* trauma caused by a continuing external relational stressor (Boss, 2006). Ambiguous loss, more accurately than "nonfinite loss," captures the seemingly interminable survival/extinction emotional stress of death row family members. According to Boss, ambiguous loss occurs when a family member is "physically absent but psychologically present, or physically present but psychologically absent." Before and after execution, the inmate, imagined as terrified and isolated, takes on an imposing role in the psychological life of the family. Every prison visit with the actual inmate similarly is a struggle against the frightening future for psychological presence. The death sentence creates a limbo of chronic uncertainty, upsets the family's systemic processes, rearranges normal family relationships, prevents passage through the normal stages of grief, and undermines resilience. Violent death has been held to have four grief stages: 1) initial shock and alertness; 2) survivor search for the lost loved one; 3) disorganization and difficulty in functioning; and, finally, 4) mitigation, defined as "healthy adaptation to the reality of the death of the loved attachment object and an ability to reinvest in another" (Stevens-Guille, 1999 [p. 55]; Parkes, 1970). Ambiguous loss stands in the way of mitigation for death row family members.

Family members of death row inmates intensely identify with their missing death sentenced member. Frequently they report that "they feel like they are on death row with their loved one" (Jones & Beck, 2006 [p.296]). They often become enmeshed with the prisoner and

his own fear, losing awareness of their own psychological boundaries. In their experience of ambiguous loss, the physically absent prisoner becomes very present as the controlling member of their psychological family, bearing an imagined highly aroused affective state, and often remaining thus present for many years after the execution takes place. He is a “family ghost” that must be addressed in the course of therapy for a death row family (Minuchin and Fishman, 1981 [p. 57]).

3. Method

I am not a therapist, but a graduate student in counseling psychology and a Texas criminal defense attorney with years of experience representing death row inmates in their habeas corpus appeals and working with their families. Unless otherwise explicitly sourced, my opinions are formed from experiences in my law practice and the public accounts of family members given to the Texas After Violence Project (TAVP), a non-profit oral history organization that I founded. One purpose of TAVP is to provide materials that can be used in social science study of community violence and capital punishment. The organization itself takes no policy position on the death penalty; rather, it is designed to listen without judgment, promote dialogue, and make a record for history. Upon receiving final consent from narrators with adherence to Institutional Review Board guidelines, TAVP releases the stories for archiving and public access in the University of Texas library system. The judgments expressed herein are my own.

4. Death Sentence Trauma and the Natural Support System.

The death penalty is indistinguishable from torture in legal description and similar in affective consequences (Cerna, 1997; Vogelmann & Lewis, 1994). The United Nations Convention Against Torture defines “torture” as including any “act by which severe pain or

suffering, whether physical or mental, is intentionally inflicted on a person . . . punishing him for an act he . . . has committed” (United Nations Convention Against Torture, art. 1). *Death sentencing* unquestionably causes severe “mental” suffering “which cannot be relieved by developing more ‘humane’ methods of killing” (Vogelman & Lewis, [1994]). “From the moment the sentence is pronounced, the prisoner is forced to contemplate the prospect of being taken away to be put to death at an appointed time” (id., quoting Amnesty International, 1989 [p. 61]). The prisoner’s family members likewise are forced to contemplate this while, in a number of states (including Texas), from sentencing to execution, physical contact between prisoner and family also is prohibited (Byrd, 2000). The intense fear, helplessness, and horror observed in clinical assessment of PTSD is “common” in death row families (Beck, Britto, & Andrews, 2007 [p. 125]).

“The core experiences of psychological trauma are disempowerment and disconnection from others” (Herman, 1997 [p. 133]). Traumatic events demonstrate contempt for an individual’s dignity and autonomy, sending her the message that she is nothing, destroying her belief that she can be herself in relation to others (Herman, 1997). An execution is such an event, “not only depriv[ing] the prisoner of all vestiges of human dignity, [but] . . . ultimate[ly] desecrat[ing] the individual as a human being. It is the annihilation of the very essence of human dignity” (*Kindler v. Canada*, 1992 [p. 241]). It causes trauma in those with ties to the person under such assault, whether they are advocates, friends, or family members. For those attached to the defendant, executions can smash beliefs they may have had in a meaningful, safe, and fair world.

Post-Traumatic Stress is a process in which dysregulation caused by traumatic exposure

becomes hardwired into the brain's responses to stimuli (Van der Kolk, 2006). Healing trauma involves seeking methods that can assist sufferers to find the capacity to cognitively evaluate their emotions again. "[I]t is critical that they gain enough distance from their sensory imprints and trauma-related emotions so that they can observe and analyze these sensations and emotions without becoming hyperaroused or engaging in avoidance maneuvers" (Van der Kolk, 2003 [p. 187]). Once they are able to achieve such distance, they can viscerally (not just intellectually) discover that remembrance of traumatic events does not necessarily lead them to have overwhelming emotions and they can achieve competent self-regulation and self-soothing (Van der Kolk, 2006).

Van der Kolk (2003) has laid out three "critical steps" for treating PTSD: (1) *safety*: "After having been traumatized, [it] is critical that the victim re-establish contact with his or her natural support system"; (2) *anxiety management*: practical skills taught in therapy may include "deep muscle relaxation, breathing control, role playing, covert modeling, thought stopping, and guided self-dialogue"; and (3) *emotional processing*: this involves the victim learning to remember the traumatic event without feeling helpless, that is, learning to remember *without re-experiencing* the event and learning that the event had "a beginning, a middle, and an end" and "now belongs to . . . personal history" ([pp. 188-189]).

The theoretical structural therapy model that I propose attempts to apply Van der Kolk's "critical steps" of treatment to death row families. The model should enhance the potential of the natural support system of the family to nurture its own subsystems. It does that, first, by having the therapist attend to the nature and strength of the attachment relationships in each family subsystem, calculating which to support in which configurations (in order to avoid excluding any

members and to enhance the chances of the entire family's re-empowerment) and, then second, by having the therapist strategically meet with subsystems and experientially show those subsystems how to emotionally regulate themselves and to emotionally process their trauma, so that they can begin doing that on a self-sustaining basis within the family, creating a cycle of healing to replace the cycle of trauma.

5. Ambiguous Loss and the Family Ghost

It is my perception that death row families have a very potent "ghost" member. Minuchin and Fishman (1981) describe "families with a ghost" as follows:

A family which has experienced death or desertion may have problems reassigning the tasks of the missing member. . . . Problems in these families may be experienced by family members as issues of incomplete mourning. But if the therapist operates on this assumption, she may crystallize the family instead of helping them move toward a new organization. From the therapeutic point of view, this is a family in transition. Previous shapes are handicapping the development of new structures. ([p. 57])

The "family ghost" is common terminology in family therapy. Harry Stack Sullivan (1972) defined [] "family ghost[s]" as presences who are "exterior to sensual contact—effective by virtue only of the individual's faith in their past or present existence elsewhere" ([p. 47]). Carl Whitaker made "ghosts" real by bringing absent family members into therapy sessions (Haley & Hoffman, 1967).

Experiencing ambiguous loss, death row family members inevitably find themselves in an ongoing traumatic transition with a family ghost that can last many years. Their ghost is the *imagined* to-be-executed or executed inmate, specifically visualized or contemplated as being traumatized, or having been traumatized or killed. A subsystem between a death row family member and the ghost can become a kind of *pas de deux* family within a family, dangerously

enmeshed within itself and disengaged from the rest. Mothers frequently respond to the death penalty's destruction of their attachment relationship with their child by dissolving their boundaries. A Texas mother told TAVP how, when her son was given an execution date, she "successfully committed suicide, but the paramedics brought her back." Her son survived that date, but was executed shortly thereafter. I observed another Texas mother in an apparent state of catatonia days before her son's execution. She was in my office, with her head on a desk, completely unresponsive to any kind of stimulus from other family members who were trying to reach her. [She could have been dissociating or manifesting *tonic immobility*, a state in animals and humans elicited by extreme fear coupled with overwhelming physical restraint that prevents fight or flight. Tonic immobility is induced in lab animals by inverting them on their backs and restraining them until they stop struggling (Marx, Forsyth, Gallup, Fuse, & Lexington, 2008).] Reporters witnessing executions have described a characteristic wail let out by the inmates' mothers (Willett, 2000). Recently, a reporter described a mother weeping inconsolably, stamping her feet, and pressing her head against the unyielding viewing chamber glass while her son was killed (Turner, 2009).

Enmeshment with the ghost can be subtle yet potent. In a story given TAVP, the brother of a young man executed many years previously recounted numbness and memory loss that he had experienced since the execution, which was carried out on the eve of his own high school graduation. When it happened, everything became a "blur." At the funeral, he sat next to his grandfather without recognizing him. God, he said, stripped him of memories, "wipe[d] out everything for [him] like a disk clean-up on a laptop or something." Years later, he continued to feel somewhat distant from his family, which had always been a loving, functional family, even

during the years of his brother's imprisonment.

Starting when he was about ten years old, his parents traveled to death row weekly to see his brother. He had gone on many of those trips, and loved his brother deeply. But not infrequently, his father would walk into the house and mistakenly greet him by his brother's name. Because his parents were "always scared of getting another phone call," they treated him as though he were his brother, only kept under tighter rein. He understood that his parents' obsession with saving his brother robbed him of some of the attention and care they otherwise would have bestowed upon him. Nevertheless, at one point, he accused his father of not loving him.

Years after the execution, the young man still wore a custom-made t-shirt bearing a color photo of his brother and his parents on the front. The shirt represented the tight emotional bond he had with his brother. But he could recall virtually nothing of what his brother had told him during the many prison visits. Instead, he was possessed by his sensations of his brother in danger. He clearly remembered empathizing with his brother's emotional turmoil when an unlikely stay of execution had occurred:

If I was to tell you that at 1:45 we was going to take you to this place and strap you down and kill you, you think you'd be able to deal with that? You see what I'm saying? . . . And then they gave him a steak? So it was like, they took him down there, strapped him in, and was going to do everything to him, and then be like, 'Nah, we're not going to kill you today. Come back another day.

As the reprieve proved temporary and the family's initial euphoria turned to dread, he became angry at ongoing efforts to save his brother, whom he perceived to be subjected to many indignities on death row. What would his brother be saved for? More of the same maltreatment? Now he felt ashamed for a thought that had passed his mind then: "*Go ahead and kill him.*"

The young man continued to feel as though there was no one who could share his experience. “How can you address someone who just lost their brother to lethal injection? . . . You can’t even, you don’t even know what to say to that person.” He recognized that his own family or other families that similarly had gone through executions might understand him, but he observed, “they have a hard time dealing with it themselves, so how are you going to ask advice of them?” He described himself as being basically “inside the box,” which is remarkable, because this is exactly how he had seen his brother during visits. The visitation room on Texas’ death row contains a long row of slender, sterile, white metal cubicles (“boxes”), with steel mesh doors at the back for introduction and extraction of the inmate and a wall of thick glass on the front separating the inmate and his family members.

The young man evokes therapeutic concern because of the effect that the family ghost has had on his maturation and individuation process and on his continuing experiences of isolation and numbness. The traumatizing image of his brother in danger appears to have effected a block between him and his otherwise loving parents, enhancing ongoing trauma for all and inhibiting their capacity to be fully present and to emotionally regulate each other.

6. A Proposed Therapy for Death Sentence Trauma.

The daunting nature of the therapeutic work of restoration cannot be overstated. Death row families often already are victimized by economic poverty, racial discrimination, and some degree of dysfunction long before the crime leading them to experience death row occurs. The death sentence further disrupts the very attachment bonds that otherwise are the most critical resource for their trauma healing (Allen & Bloom, 1994). With otherwise intact families, I believe a therapist taking a family structural approach should try to accomplish several things:

(1) strategically form secure relationships with family members to help them experientially understand dyadic emotional regulation; (2) continuously map the family's subsystems; (3) move subsystems together, helping them discover and use their innate potential for mutual emotional regulation; (4) reassign or redefine the role of the family ghost in relation to all subsystems, including the family as a whole; and (5) help the family in its process of meaning making and pursuit of what matters.

(1) Strategic formation of secure relationships.

Van der Kolk's first critical step to trauma recovery is re-establishing contact with the natural support system, because secure attachment bonds are the best defense against "trauma induced pathology" (Johnson, 2002 [p. 25]). [Humans] are communal creatures who receive through the subconscious communication of [their] physiologies the key to [their] mutual thriving. Attachment is "the interactive regulation of synchrony between psychobiologically attuned organisms" (Schoore, 2003 [p. 64]). Secure contact with an attachment figure — a parent, child, sibling, spouse, lover, friend, teammate, fellow soldier, or colleague — is an innate survival mechanism. A secure attachment provides a safe base from which to explore the world as well as a haven where feelings of distress can be expressed in ways that elicit support. "The building blocks of secure bonds are emotional accessibility and responsiveness" (Johnson, 2002). A secure bond is the single most important treatment for trauma, because it literally "tranquilizes the nervous system" (Johnson, 2002 [p. 44], quoting Schoore, 1994).

The therapist needs to nurture her own secure attachment relationship with each participating individual family member in order to help each experience dyadic emotional regulation. Diana Fosha (2001) defines dyadic regulation as mutual coordination between family

members of their emotion-handling strategies:

Optimal dyadic regulation of emotion [means that] each partner is open and communicates to the other, who responds openly in turn. The partners remain engaged and oriented toward one another even when things get difficult. Mutual coordination does not mean perfect empathy and flawless mutual attunement. It means being motivated to maintain connection and communication even in the face of discord and difficulty without withdrawing into oneself and closing up or putting up a wall. ([p. 228])

The therapist joins the family as an extraordinary source of empathy and as an expert in sharing emotional insight. In each dyadic relationship the therapist forms a subsystem model that she hopes will be good for replication between and within the family's other subsystems. Her end goal is "eventually enabling each member to use each other and the family as a secure base" (Stevenson-Hinde, 2007 [p. 340]).

(2) Continuous mapping of family subsystems. The therapist continuously maps the family's kaleidoscopically relating subsystems because her process of joining each subsystem as an expert member of the family has to be dynamic, adjusting to developments within and between enmeshed or disengaged subsystems (Minuchin & Fishman, 1981). Traumatic events, and especially death sentences and executions, disengage family subsystems, because they dramatically increase each subsystem's sense of isolation and powerlessness. The relationship style of almost any particular subsystem likely will be one that is enmeshed with the family ghost. Until the ghost is reassigned and the family has reached a point of emotional stability, the map is going to show lines (broken or whole, but dominant) between every subsystem and the ghost (the missing family member perceived through the state's traumatizing actions).

(3) Moving subsystems to find optimal emotional regulation. While facilitating the family subsystems' general and specific understandings of the trauma and its effects, the therapist needs

mindfully to move the subsystems toward each other so as to help them uncover their own unused potential to optimally assist each other with emotional regulation. The therapist strategizes with regard to which subsystems are ready, which ones could have the greatest influence toward balancing and releasing the potentialities of the whole family subsystem or significant other parts, and so forth.

(4) Reassigning the ghost. The therapist helps the subsystems to become securely emotionally reattached vertically and horizontally with each other, according to appropriate family roles, instead of dysfunctionally bonded to the traumatic image of the missing family member and, in some cases, the event that disappeared him. The therapist must simultaneously assist the family to reintegrate the missing member in stable ways that, for example, may honor his or her memory (especially if injustice in addition to the execution is perceived), may involve attempted reconciliatory acts with the aggrieved family on the other side of the crime or the community, or may simply involve concerted effort to recall and recount the dignity of that individual and his or her benign roles in the family before the crime occurred. Emotionally reattached subsystems have to be liberated from the linkage with the traumatizing image of the executed family member that causes intra-familial walls.

(5) Assisting meaning making and the pursuit of that which matters. In addition to relocating the subsystems, the therapist needs to help the family reconstitute its previously nurturing and grounding schemas — its meaningful stories about its secure place in the world — by “incorporating new and adaptive cognitions” and by undertaking empowering actions (Allen & Bloom, 1994 [p. 426]). Armour (2003) notes “studies have shown that finding meaning occurs less often for persons dealing with violent death” ([p. 523]). She proposes placing meaning

creation within the context of “the intense pursuit of what matters,” a program of intense meaning generating ventures that enable survivors of homicide to “relearn the self” and “relearn the world” [(p. 525)]. The program has a couple of elements that may meet the needs of execution survivors: (1) fighting for what’s right; and (2) living in ways that give a purpose to the executed family member’s death. The incorporation of *doing* into meaning making engages the body as well as mind in the reconstitution of the self following the traumatic event. The essential meaning making must reconstitute the individual’s and family’s senses that they have achieved a position within the community that is beyond shame. Maercker and Muller (2004) found that an individual’s “self-perceived rejection by extended social environments (e.g., acquaintances, colleagues, local authorities)” could have a stronger association with PTSD symptoms than self-perceived rejection by family members [(p. 350)]. In a recent case on which I worked, survivors of the executed inmate posted his obituary in the local newspaper, recounting his many achievements and good deeds during his decades on death row. This possibly unprecedented act was a good first step toward their healing.

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