

The Burgess Award Lecture*

Ambiguous Loss Research, Theory, and Practice: Reflections After 9/11

This article contains an overview of three decades of research, theory development, and clinical application about ambiguous loss. Although the work includes both physical and psychological types of ambiguous loss, the focus is the aftermath of 9/11 (September 11, 2001), when the World Trade Center collapsed following terrorist attacks. On the basis of her previous work, the author was asked to design an intervention for families of the missing. She reflects on what she learned from this unexpected test and presents new propositions and hypotheses to stimulate further research and theory that is more inclusive of diversity. She suggests that scholars should focus more on universal family experience. Ambiguous loss is just one example. Encouraging researchers and practitioners to collaborate in theory development, she concludes that research-based theory is essential to inform interventions in unexpected times of terror, and in everyday life.

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The history of science reveals a wide diversity of questions asked, explanations sought, and methodologies employed in the common quest for knowledge... this diversity is in turn reflected in the kinds of knowledge acquired, and indeed in what counts as knowledge (Evelyn Fox Keller, 1985, p. 167).

In this article, I review and update three decades of research and theory development on *ambiguous loss* by describing the latest tests of the theory, what was learned, and what needs further research. Throughout this narrative, there is a subtext that science, and thus theory development, is a multifaceted, not monolithic, enterprise (Keller, 1985). The process requires collaboration between scientists and practitioners, and between researchers and the people we serve.

For me, the process began in 1973 at the University of Wisconsin—Madison. Already then, I was interested in both family research and family therapy as a way to better understand family processes. I began with clinical observation, moved to formal research and theory development, and then back again to clinical observation. In an endless circle, this process has continued to the present focusing alternately on families of the *physically missing* (e.g., lost soldiers, kidnapped children) and families of the *psychologically missing* (e.g., from Alzheimer's disease and other illnesses or conditions that rob the mind). Never was the theoretical work about ambiguous loss subjected to so rigorous a test as

in New York City after terrorists attacked the World Trade Center on September 11, 2001, hereafter referred to as 9/11 (Boss, 2002a, 2002b, in press; Boss, Beaulieu, Wieling, Turner, & LaCruz, 2003). Since then, upon invitation from the International Committee of the Red Cross, the work has been further tested with families of the nearly 4,000 still missing in Kosovo after ethnic cleansing in the late 1990s. Knowledge about ambiguous loss continues to be gathered worldwide from tragedies of disease, terrorism, and war, but in this article, the example of applying theory to inform practice is limited to the case of families of workers lost in the World Trade Center after the terrorist attacks of September 11, 2001 (9/11).

RESEARCH-BASED THEORY GUIDES PRACTICE

The day after September 11, 2001, a student in my family theory seminar some 20 years ago called urgently from New York City. Her husband, president of a large labor union of men and women who serviced the World Trade Center towers, wanted support for the families of his missing union workers—workers who, when the attack occurred, were washing outside tower windows, operating elevators, and cleaning rooms and hallways. Others were preparing food for the Windows on the World Restaurant on the top floor of the north tower. Many were immigrants, migrants, or refugees from the Caribbean islands, Africa, Puerto Rico, Mexico, Guyana, South America, and Russia. Most lived in the Bronx, Queens, or New Jersey, and all were proud to be employed in the world famous Twin Towers. As of September 12, nearly 100 were missing and their families were traumatized. Could I come to New York and help? I was reluctant, but I also believed that good theory should be useful theory. If I could not be of help now, what good were three decades of work on ambiguous loss? I could not refuse.

With two courageous graduate students, I flew to New York City on September 16, 2001. People all over the city were carrying photos of missing loved ones. At first, 6,000 were reported missing, but numbers shifted all year long as people turned up alive or remains were found that could be identified. At the one-year anniversary of 9/11 in 2002, the statistics had shifted, but they remained fundamentally ambiguous:

- Bodies found intact: 289.
- Body parts found: 19,858.

- Total number dead (presumed death certificate accepted, identifiable, or DNA verified): 2,819.
- Number of families who received no remains: 1,717.
- Ages of most of the dead and missing: 35 – 39.
- More men lost than women.
- Those lost were from 115 different nations.
- Estimated number of children who lost a parent: 3,051.
- Twenty percent of Americans knew someone hurt, killed, or missing in the attacks (Miller, 2002).

This was the largest scale ambiguous loss I had ever encountered. When I saw the devastation and helplessness in the faces of usually confident New Yorkers, I wondered whether I could really help. The view from a midwestern ivory tower allows for more confidence than a view from Ground Zero. My students and I huddled silently together as we stood near that terrible site, smoke burning our eyes, the stench unforgettable. Heavy machinery was tearing at the tangled steel like a fallen cathedral in a science fiction film. Nothing made sense. A bride and groom were heading toward the smoking rubble with photographer in tow, the bridal veil flying out behind them. Did they come to be near a parent or sibling lost in the pile? And then there were the thousands of dazed people roaming the sidewalks, holding up posters and photographs. “Have you seen him?” “Have you seen her?” In the midst of this chaos and raw emotion, the only rational guide for how to begin was theory. My assignment was clear: First, develop and implement an intervention for the families of the missing union workers, estimated at that time around 100, and second, train New York therapists to work with these families. We began with the latter.

Typically, therapists are trained to think that if they are doing their jobs right, clients will get over their grief and do so relatively quickly. Healthy people find closure. But resolution after loss is rarely that absolute, and especially not when a loved one vanishes without a trace. With no body to bury, the situation after 9/11 defied psychological closure, so therapists had to be trained to see a larger context—the external stressor of ambiguity—and to focus on family, community, and cultural strengths.

The New York therapists who volunteered for the Minnesota-New York Ambiguous Loss Project were psychologists, social workers, and

psychiatrists. Most were well trained in classic grief therapies and posttraumatic stress disorder (PTSD; American Psychiatric Association, 1994), but few had heard of ambiguous loss and how not finding a loved one can block the grief process and create symptoms similar to traumatization and complicated grief. Nearly all were accustomed to treating one person at a time and working only in office settings. Few were trained to work with extended families in community settings. Training workshops began, therefore, with theory, first about general systems processes (Buckley, 1967; von Bertalanffy, 1968), then about ambiguous loss and why it is so difficult to overcome. With a dialectical view of processes, both the individual and the family as a whole were assessed and treated. Therapists were receptive, and the information helped us to prepare for the families who represented 40 different cultures and religions. Because therapists did not know which of the vastly diverse families they would be assigned to, I offered them a general theoretical model and a set of general guidelines for family meetings (which were to occur the next day) with the assumption that these would allow for more inclusiveness of diversity than one uniform clinical strategy (for guidelines, see Boss, 1999, in press).

BACKGROUND OF THEORY DEVELOPMENT

In the training sessions after 9/11, there was rarely time for background history, but I add a brief review here to illustrate the multifaceted and multidisciplinary process of theory development that shaped the work on ambiguous loss. In 1972, while training with Carl Whitaker, MD and psychiatric residents at the University of Wisconsin, I observed a consistent pattern in the families treated in the family therapy clinic. Families were intact, but fathers seemed distant and absent. They were there, but not there. They continually asked why we needed them in the session because “children were a mother’s business.” Indeed, in the early 1970s, fathers were not expected to be part of childrearing, but children noticed and were distressed by the ambiguity. Based on clinical observations, I wrote a paper for a child development class entitled “Psychological Father Absence in Intact Families.” It became my first paper at the National Council on Family Relations (NCFR; Boss, 1972, 1986). Later, after studying theory development with sociologist Jerald Hage, I lifted

the construct of *psychological father absence* to a more general level so it could apply systemically to any family member or person who is “there, but not there.” Since 1975, I have called that theoretical construct *ambiguous loss*.

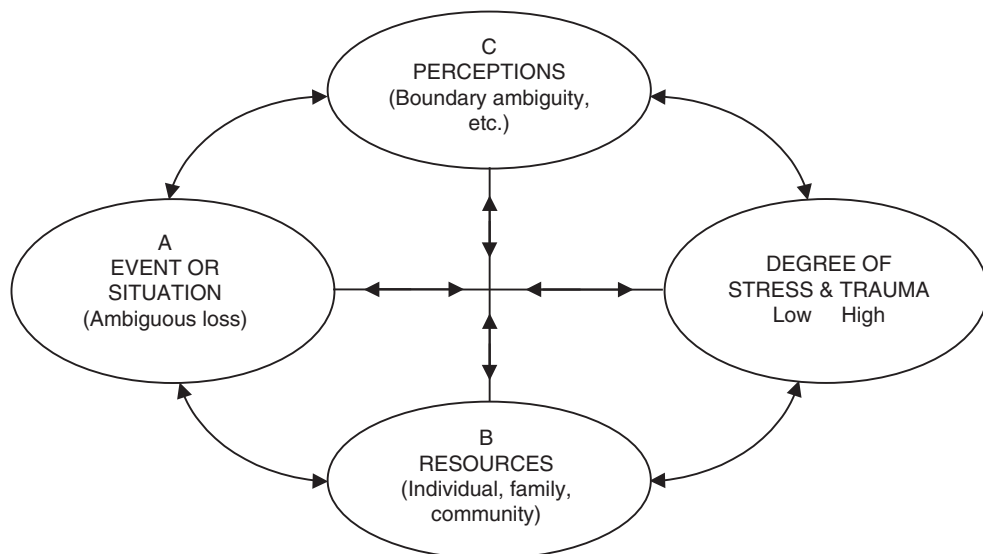
The shift to a more general level of theorizing broadened the opportunities for testing, and importantly, for inclusion of diverse populations and varied types of loss. The focus no longer was limited to father absence and normative family structure, but was now on the *psychological family*, and thus more subtle structural and perceptual processes of family interactions and transitions over time (Boss, 1980b). To understand how families remain resilient despite ambiguity and loss, individual and collective perceptions of a loved one’s absence or presence are needed. The psychological family in a person’s mind, and its degree of congruence with the collective family perception, was even more important for healing after loss than the family listed in the census taker’s notebook (Boss, 1999; Boss, Dahl, & Kaplan, 1996). Since 9/11, I hold this premise even more strongly.

THE THEORY OF AMBIGUOUS LOSS

The theoretical work about ambiguous loss grew out of my original interest in family stress. Elsewhere, I write in detail about how constructs are linked within the contextual model of family stress to manage stress, prevent crisis, and build resilience (Boss, 1987a, 1993a, 1993c, 2002c, in press; Boss & Mulligan, 2003; see Figure 1).

The basic theoretical premise is that ambiguous loss is the most stressful loss because it defies resolution and creates confused perceptions about who is in or out of a particular family. With a clear-cut loss, there is more clarity—a death certificate, mourning rituals, and the opportunity to honor and dispose remains. With ambiguous loss, none of these markers exists. The clarity needed for boundary maintenance (in the sociological sense) or closure (in the psychological sense) is unattainable. Ambiguous loss is a problem *structurally* when it leads to boundary ambiguity; for example, parenting roles are ignored, decisions are put on hold, daily tasks are undone, family members are ignored or cut off, and rituals and celebrations are canceled even though they are the glue of family life. Ambiguous loss is a problem *psychologically* when there are feelings of hopelessness that lead to depression and

Figure 1. Where Ambiguous Loss and Boundary Ambiguity Fit Into the Family Stress Model



passivity, and feelings of ambivalence that can lead to guilt, anxiety, and immobilization. The irresolvable situation tends to block cognition, block coping and stress management, and freeze the grief process (Boss, 1999). Symptoms are outcomes of the relentless stress from having to live with no answers, rather than from psychic or familial weakness. For clinicians trained in the medical model and researchers trained in mechanistic (vs. process) systems theory, this perspective provides a new lens.

Based on Figure 1, *ambiguous loss* (A factor) is defined as a situation of unclear loss resulting from not knowing whether a loved one is dead or alive, absent or present (Boss, 1999). How family members (individually and collectively) perceive the situation of ambiguous loss is called *boundary ambiguity* (C factor). Boundary ambiguity is a continuous variable ranging from high to low. High boundary ambiguity is a risk factor for individual and relational well-being, and is a barrier to a family's management of stress. It erodes resilience (Boss, 2002c, in press). From a *sociological* perspective, family boundaries are no longer maintainable, roles are confused, tasks remain undone, and the family is immobilized. From a *psychological* perspective, cognition is blocked by the ambiguity and lack of information, decisions are put on hold, and coping and griev-

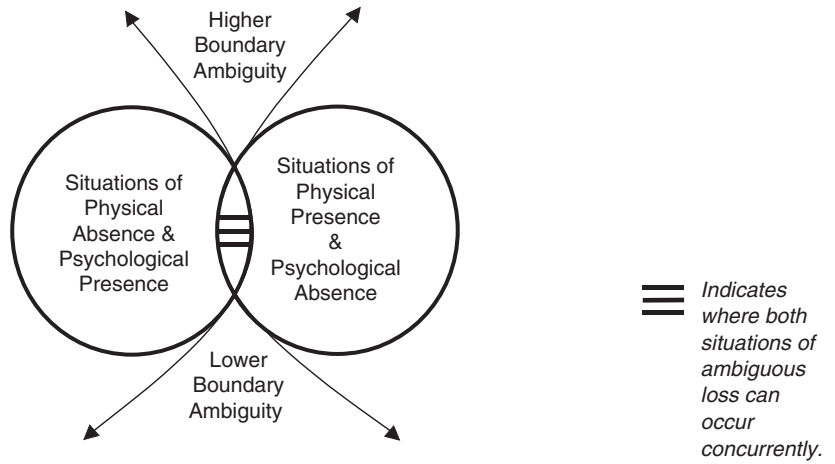
ing processes are frozen (Boss, 1999, 2002c, 2004).

Two situations of ambiguous loss have potential to cause high degrees of boundary ambiguity and negative outcomes. In the first, a family member is *physically absent, but kept psychologically present* because his or her status as dead or alive is unavailable. Without proof of death, family members do not know what to do, or how to think, so they deny the loss and continue to hope. Family processes freeze. In the second situation of ambiguous loss, a loved one is perceived as *physically present but psychologically absent*. In these situations, persons are emotionally and/or cognitively missing to the people who care about them and the system as a whole. Examples of this are dementia, depression, addictions, chronic mental illness, and homesickness (see Figure 2).

The two types of ambiguous loss frequently overlap for individuals and families. After 9/11, for example, a woman we worked with had a physically missing husband, and at the same time, a psychologically missing mother with Alzheimer's disease. With ambiguous losses of both types, she felt doubly confused and abandoned.

Note also that not all situations of ambiguous loss lead to high boundary ambiguity or other problems. Despite a missing family member, some families or family members perceive their

Figure 2. Catastrophic and Unexpected Types of Ambiguous Loss Situations, Which Cause Varying Degrees of Boundary Ambiguity



Catastrophic and Unexpected Situations	
<ul style="list-style-type: none"> • war (missing soldiers) • natural disasters (missing persons) • kidnapping, hostage-taking, terrorism • incarceration • desertion, mysterious disappearance • missing body (murder, plane crash, etc.) 	<ul style="list-style-type: none"> • Alzheimer’s disease and other dementias • chronic mental illness • addictions (alcohol, drugs, gambling, etc.) • depression • traumatic head injury, brain injury • coma, unconsciousness
More Common Situations	
<ul style="list-style-type: none"> • immigration, migration • adoption • divorce • work relocation • military deployment • young adults leaving home • elderly mate moving to a nursing home 	<ul style="list-style-type: none"> • homesickness (immigration/migration) • adoption • divorce, remarriage • preoccupation with work • obsession with computer games, Internet, TV

Note: Adapted from Boss, P. (2002). *Family stress management* (p. 100). Newbury Park, CA: Sage Publications.

systemic boundaries as clear even though it does not appear so to an outsider. After 9/11, for example, aunts and uncles were often viewed as parents. Longtime partners of missing workers perceived themselves as wives and then widows, challenging the officials in charge of family

remunerations. Culture and ethnicity play a major part in defining who family is and where family boundaries are placed.

Finally, note that in situations of ambiguous loss, the unit of analysis and intervention is twofold: the individual and the family as a

whole. That is, data and observations are needed to check the family's interaction patterns (rules, roles, and rituals, among others) and individual strengths and weaknesses. An individual may need treatment for symptoms such as somatic illness or suicidal ideation, while the family as a whole may need treatment for blocked interactions and frozen dynamics (Boss, in press). For both researchers and therapists, the full understanding of the impact of ambiguous loss must include both individual and family levels of assessment.

TESTING AND REFORMULATING

The first study of a situation of ambiguous loss with potential for high boundary ambiguity began in 1971 with families of U.S. soldiers missing in action in Vietnam and Laos (Boss, 1975, 1977, 1980a, 1980c). Subsequently, with colleagues, I studied families of missing children (Fravel & Boss, 1992), families with adolescents leaving home (Boss, Pearce-McCall, & Greenberg, 1987), émigrés uprooting (Boss, 1993c, 1996; Gates et al., 2000), and families in which someone was psychologically missing because of Alzheimer's disease or other chronic mental illnesses (Boss, 1993d; Boss, Caron, & Horbal, 1988; Boss, Caron, Horbal, & Mortimer, 1990; Boss & Couden, 2002; Caron, Boss, & Mortimer, 1999; Garwick, Detzner, & Boss, 1994; Kaplan & Boss, 1999). Theory development continued (Blackburn, Greenberg, & Boss, 1987; Boss, 1992, 1999; Boss & Greenberg, 1984; Boss & Kaplan, 2004) with writings on measurement (Boss, Greenberg, & Pearce-McCall, 1990; Mortimer, Boss, Caron, & Horbal, 1992), and application for specific populations (Boss, 1983a, 1983b, 1993b, 1993c, 2001, in press). Other researchers tested the theory with adoption, divorce, addiction, autism, miscarriage, stillborn babies, gay and lesbians with family-of-origin issues, foster care, adoption, incarceration, brain injury, immigration, and cultural loss (for review, see Carroll, Boss, & Buckmiller, 2003). Most recently, practitioners are using the theoretical work on ambiguous loss to better understand and strengthen family processes and resilience in the aftermath of terrorism and war to prevent the symptoms that so often follow: family violence, family break-ups, depression, and addictions.

THEORY TO PRACTICE: WORKING WITH FAMILIES

Family Meetings as Intervention

In collaboration, Minnesota and New York clinicians, union professionals, and family leaders organized and conducted family meetings as the major intervention for families of the missing (for details, see Boss et al., 2003). Families were self-defined and most often comprised several households, such as grandparents, aunts, and uncles, along with the spouse and children of the missing worker. After training volunteer therapists, our first goal was to provide a safe and familiar environment where families of the missing could meet in the community and talk together. The labor union hall was selected. The union provided food for the families and flowers for the tables because we all needed to see something beautiful. (The smoke from Ground Zero was visible from the window of the room in which we met.) Many families did not speak English, so we enlisted the help of clinicians from their own cultural communities. Spanish-speaking therapists from the Roberto Clemente Center were especially helpful.

We followed guidelines based on earlier theory development (Boss, 1999). In summary, we named the situation as one of ambiguous loss; normalized the stress, confusion, and ambivalence; set the stage for family members to listen to each other's perceptions and stories about the missing person; and helped families reconstruct roles, rules, and rituals. The long-term goal was for family members to find some meaning (other than self-blame) about the loss and the ambiguity. For many, at first, the meaning was that there was no meaning in this situation of loss.

The first family meetings moved slowly, but eventually family members began sharing with one another their perceptions of what happened. Some told stories; others speculated on their loved one's whereabouts. Still others told of seeing the missing person come up the sidewalk, of talking with him or her at night, or of seeing him or her in a crowd. We did not pathologize such reports. Families argued over whether to have a funeral without a body, and if so, how to do it. Therapists continually repeated, "It's all right if you don't all see it the same way now." Differing perceptions were normalized and tolerance was nurtured. We encouraged the continued

celebration of birthdays and holidays, and helped families to revise them without the missing person. Family secrets were discovered and discussed. For example, therapists helped a father practice how to tell his children living in another country that their mother was missing and likely dead. Adult-to-adult conversation in multiple family groups freed the children to play at the art table with their peers.

Out of respect for the families, translations for non-Spanish-speaking therapists were stopped, and instead, we doubled efforts to find and train Spanish-speaking therapists. With this critical shift, families felt more comfortable and understood more quickly that what they were feeling had a name, that it was not their fault, and that the ambiguity caused a normal ambivalence and understandable conflict. Knowing this allowed them to begin telling their own stories and interacting with other in their own languages. Early on, therapists normalized family members' feelings of anger, confusion, helplessness, and ambivalence, and after a few meetings, we saw families doing this for each other in multiple family groups. Many continued interacting back in their own neighborhoods.

The multiple family group meetings at the union hall continued monthly and then bimonthly throughout the year after 9/11. Returning families often brought along new families, saying, "They need to be here." A young mother and her children were brought in by friends because she found out her missing husband had another wife in another country, and feelings of betrayal and anger, along with grief, were immobilizing her. Families who had not yet told their children that the missing parent was likely dead also came. It was as if the returning families knew what was needed. Just before the one-year anniversary of the 9/11 attacks, parents with missing spouses asked to observe professional therapists talking with their children in a group setting so that they could learn how to talk more effectively about loss with them at home (Boss et al., 2003, in press). Bereaved parents, not accustomed to therapy, learned from observation how to talk about feelings of sadness and grief with their children. Many parents and children cried together for the first time. Other successes were noted after one year. Using their own initiative, surviving spouses arranged for English classes and job training in their neighborhoods. Several mothers decided to share apartments to save rent and child-care costs. Grandmothers, grandfathers,

aunts, and uncles rallied to help. But above all, widowed parents connected to each other and formed a community of action and new hope. (As of February 2004, the family meetings in the union hall continue, but are initiated by the families more than professionals, with focus primarily on family fun and social activities, including dance and bodywork.) I would not have predicted such healthy functioning so soon for what many might call *high-risk families*. Working with these New York labor union families has opened my eyes and given me new curiosity and insights about family resilience (Boss, in press).

The meetings continue periodically as of this writing, but now take a more community-based and often recreational tone. The cadre of resilient New York therapists who have worked on the ambiguous loss project from its chaotic inception after 9/11 have now written together (Boss et al., 2003), and continue supporting these union families when requested. One might say that, at some level, the therapists have become part of the community too.

REFLECTIONS ABOUT AMBIGUOUS LOSS SINCE 9/11

Periodic reflection is an important part of any ongoing theory development project, but it was imperative after so challenging a field test as New York after 9/11. What follows are 12 reflections about ambiguous loss that suggest new propositions and hypotheses for further study. (My recent work in Kosovo for the International Committee of the Red Cross substantiated these reflections.)

1. *Many professionals tend to consider family members who believe missing persons are still alive as irrational and pathological.*

Professionals seemed uncomfortable with having no way to clarify the ambiguity surrounding a loss. Many saw the failure to find closure as *their* professional failure, or as client resistance, so they often felt ineffective and demoralized. Many were impatient with families who kept hoping, even though it was important for sufferers to have someone listen patiently and non-judgmentally to their story. Indeed, accounts were horrendous and difficult to hear, but it was our job to listen empathetically, even if the story sounded irrational to us. In the social sense, a person's story of loss is not real, and thus not resolvable, until someone is willing to hear it.

Professionals learned quickly the difference between ordinary loss, which allows the grief process to proceed, and ambiguous loss, which does not. Training therapists to use a preventive approach to balance their medical models of PTSD and complicated grief helped therapists to become more patient and less pathologizing with families whose grief was blocked by the external culprit of ambiguity.

2. Parents, adolescents, and children tell us that hearing stories and telling stories about the missing person helps begin their healing process.

The narrative traditions we used in the family meetings merged ideas from European “talk therapy” with tribal traditions of storytelling. Given the diverse training and cultural beliefs of the therapists on our Minnesota-New York team, plus the immense diversity of families, we merged ideas from Sigmund Freud, Melanie Klein (1984), and Nelson Mandela (2002) to promote healing. That is, we combined ideas from European talking-cure traditions and object relations theory with indigenous tribal traditions of storytelling for healing trauma and loss. An important note is that this is not technical debriefing, per se, but simply storytelling in a familiar community setting.

We began the family meetings by encouraging the adults, teenagers, and children to share a story about their missing family member, and asked family members to listen to each other’s differing views. If destructive “no-talk” rules had begun to develop at home and children thought they could not talk about their missing parent or relative for fear of making a parent cry, storytelling seemed to break the impasse. Adults, too, had difficulty telling their story in the presence of their children for fear of making them cry. But in a group setting, it was easier for adults and children to find support and thus overcome reluctance to speak or express feelings. Teenagers, however, often preferred different ways of expression. For example, three adolescent girls whose father was missing did not tell stories, but offered to sing several songs about courage and overcoming loss. They sang a capella for the parents and children in the union hall, and observing from the sidelines, I saw that their vocalized story soothed the singers and listeners alike.

3. Most helpful is the grouping of multiple families together in their own familiar community setting, sitting in circles, so that they can hear

each other’s stories and form connections through common experience.

Multiple family meetings in the labor union hall proved to be highly supportive interventions in helping remaining parents and children regain their resilience. Community connections with others suffering from having a missing family member appeared to help parents and children move forward. Originally noncommunicative, the bereaved began to connect in the union hall. Those who arrived depressed or angry would only talk with peers who were experiencing the same kind of loss. “Your husband is missing, too? You’re alone now with a new baby?” Phone numbers were exchanged, and they made plans to meet back in their neighborhoods. Grandparents helped us in a myriad of ways, at the meetings and reinforcing our work back home. Children looked forward to future meetings and connections made with other children who had a missing parent. (Note: Multiple family meetings with the team of therapists still continue at this writing, but less frequently and at the families’ request. Needs now are vocational and recreational in addition to therapeutic.)

4. Ordinary people can understand the theory of ambiguous loss and are able to apply it on their own to better understand new situations.

When I first saw Mrs. C, it was one month after 9/11. Her husband was missing. She came to the family meeting with her adult children, their children, and her missing husband’s brother. Thirteen sat around their family’s table in the union hall. The family had decided to have a memorial service, but not having Mr. C’s body, they buried his guitar instead. They needed to bury something tangible. A year later, at the anniversary of 9/11, I saw Mrs. C again. She gestured for me to come over to her table. I did, and she told me in broken English, “Now I have another ambiguous loss.” I asked what it was, and in Spanish, she asked her daughter to translate: “My oldest daughter has now gone away from me. She never calls or comes to see me anymore. She said I was grieving more for this husband than I did for her father (who was my first husband), so she doesn’t want to see me anymore.” Mrs. C switched back to English and asked me, “Isn’t this another ambiguous loss?” I said, “Yes, you are right.”

Using theory as a guide, ordinary people such as Mrs. C can indeed identify and label new situations as ambiguous loss. Knowing what the problem is, they can ask for help before

permanent damage in family processes occurs. Recognizing the problem, Mrs. C was able to ask more concretely for help to alleviate a second ambiguous loss.

5. Ambiguous loss is not a problem for every family or family member. Some individuals and families manage to live with ambiguous loss without negative effects.

Reasons varied. First, although further research is needed, the outcome of situations of ambiguous loss appears to be influenced by attributions and belief systems. Some of the survivors believed that their loved one's being in the Twin Towers at the time of the attack was predestined. Many who believe this continue to trust in God's will to see them through their travail. Believing this, they appear to move forward despite the lack of information. Second, some survivors appeared to have high levels of tolerance for ambiguity because of inherent personality traits. They were resilient, knowing they had survived previous ambiguous losses (e.g., forced immigration), and thus could survive this one too. Third, some had a deep faith and trust that God or Allah would guide them through the unknown, thus the ambiguity surrounding their loss was less troubling. And fourth, the reason most relevant for the professionals who provide secular intervention across cultures was that those who appeared to be doing reasonably well even when a loved one was missing did so by *learning to hold two opposing ideas in their minds at the same time*. The two opposing ideas: "Our loved one is dead; maybe not."

The father of an electrician who worked in the World Trade Center said, "My son has been missing so long now—he's probably dead, but I feel he's here with me, and always will be." This father held two conflicting ideas in his mind at the same time. A young mother said 6 months after the attack, "I am moving forward now with my life—for the sake of the children—but I'm not ready to give up hope of finding him—his body." Such dialectical thinking is useful because it begins the healing process even while confusion persists. The only way out of the despair is to hang on to two opposing ideas: simultaneously "I must move on and organize life without my son, but at the same time, I can hope and remember." Incidentally, the father's son was never found. The young mother's husband was found, however, but only his torso. She told me this clarified that he was dead, and thus brought her solace.

6. Family's rituals and symbols are the core of family life and especially helpful in reconstructing family interactions when there is ambiguous loss. Early on, one of the most useful interventions was to help families discuss and reconstruct their usual rituals and family celebrations. For example, after 9/11, parents wondered through tears whether they should allow their children to go trick-or-treating for Halloween, and what to do for Thanksgiving. Although these were practical questions, they symbolized deep psychological and physical processes critical to family life. Our work followed the assumption of Ernest Burgess (1968): The family is a unity of interacting personalities. Thus, to preserve the family, interactions in the form of routines and rituals had to continue. Indeed, meaning arises in the process of interaction among people (Mead, 1964), so continuing family gatherings and celebrations, albeit revised, aided healing. Ritual in the presence of others is a powerful means to avoid family secrets, and thus effect change in families (Imber-Black, 1993; Imber-Black, Roberts, & Whiting, 2003). These theories about family interactions led us to value and help revise family rituals and celebrations so that families could continue to interact despite ambiguous loss.

Why are rituals essential in healing after loss? Symbols, ceremonies, and rituals instigated by trusted persons in a familiar community setting helped families by signaling permission to begin grieving even though they had no body to bury. Without some verification of death, families were afraid of being disloyal if they gave up looking. The mayor of New York City offered official "presumed death" certificates, giving permission to families to stop hoping and begin grieving. Fortunately, some religious leaders bent the rules to allow funerals without a body. Yet many families preferred to reject the presumed death certificates, opting for clear evidence from DNA tests on the nearly 17,000 recovered body parts. Others opted for a slower way of coping and integrating the loss by simply accepting the ambiguity as "the way life is." They did not seem to need or seek rituals of closure to ease their pain.

7. The stress of ambiguity appears to be greater and more debilitating for individuals and families oriented toward mastery and control.

People accustomed to having answers, being in control, being able to fix a situation, and having the means to solve problems appeared to be less

able to tolerate ambiguity. I found journalists, TV producers, executives, and yes, therapists, who were impatient with the still grief-stricken families, friends, and coworkers of the missing. They wanted closure. They wanted the door to sadness and loss shut, as if the grief process were over and done with. Perhaps the pain of ambiguity was too great for them to cope, so they ended it arbitrarily. Over and over I was asked, "Why can't they see there's no one alive anymore in that rubble?" That's the point! They were not able to *see* a body; they could not see their loved one as dead, transformed from what they were. Without such clear evidence, people kept hoping for some miracle. And now and then, someone did turn up alive—in the hospital or in a foreign country—just enough times to keep hundreds of families hoping.

It was difficult to understand why knowledgeable people had so little empathy for this more difficult kind of loss. It may be that the idea of ambiguity and the tolerance for it are foreign to those accustomed to having power, control, agency, and answers, whereas those less fortunate and less powerful—often refugees, migrants, immigrants—understood ambiguity as an integral part of their lives.

8. Naming the ambiguity as an external culprit diminishes self-blame and family shame.

After traumatic loss, individuals and families as a whole often blame themselves. "If only I had done this or done that. If only we had protected her more. If only . . ." Our therapeutic task after traumatic loss is to externalize the blame. One would think it was obvious after the 9/11 attacks that foreign terrorists were to blame, but many family members nevertheless were immobilized by guilt, shame, or anger at themselves. "We had a fight the last night he was alive." "I wasn't there to answer the phone when he called from the burning tower, and all he got was my voice mail." Naming the external ambiguity as the cause is helpful to reduce self-blame and family shame, but the next step is to increase tolerance for not ever having a clear answer.

9. Assessment and treatment for PTSD are insufficient and often inappropriate because PTSD differs conceptually and thus clinically from ambiguous loss.

Traditionally, therapy for PTSD (APA, 1994) is aimed at the individual and does not include family members (e.g., parent, child, mate, and extended family). It is nonsystemic, focused on

pathology and not strength and resilience. A PTSD therapist diagnoses and treats the specified symptomatology (DSM-IV) for an individual disorder. Although such treatment is needed in some cases after a traumatic experience, the PTSD approach does not address the patient's need to go home and resume life with mates and children. The PTSD approach also misses the ongoing agony of having a missing person in a family, and the potentially lasting effects from individual grief and family processes blocked by the ambiguity. Finally, the PTSD approach does not distinguish between the *situational* trauma and stress from ambiguous loss, and the *psychological* illness of PTSD. People with missing loved ones are immobilized in a quandary that even the most able would find debilitating. Ambiguous loss, then, is not an illness but a situation of stress that has the potential to debilitate.

10. What scholars label as "high-risk" families are doing surprisingly well after 9/11, perhaps because we have not considered their resilience strengthened by community, and their experience gained from overcoming previous ambiguous losses.

With support from extended family, church, and community ties, and in this case, from the labor union, to our surprise, families bounced back relatively quickly. They seemed to be doing better than higher income families with missing members, perhaps because the latter were more isolated (in suburban homes with acreage rather than in apartment buildings) and more accustomed to self-reliance and independence rather than community support and connection. Research is needed to verify this proposition. Perhaps the labor union families were accustomed to having group solidarity, grouping together to survive, or having their resilience tested and ready for the next crisis. Because many were immigrants or refugee families, they had already honed their coping skills and resilience to get to this country and make a home for themselves and their children. Whatever the explanation, this nonuniformed blue collar population so understudied for strengths (as opposed to deficits) presents an opportunity to investigate resilience in a new light.

11. Since 9/11, my greatest learning is that closure is a myth, yet highly touted by professionals who view closure after loss as a criterion of normalcy and evidence of their successful clinical work.

Clinicians must take another look at this all too convenient concept of closure. It is not feasible

when a loved one is missing. Without verification of death, families understandably flounder with confusion about roles, rules, rituals, and boundaries. Individuals are confused about identity, ambivalence, hope, and guilt. With ambiguous losses, the inability to find closure is normal because the external situation, not the individual or family, is pathological in its defiance of closure. This contextual view is apparently new and must be incorporated into training programs for clinicians and researchers (Boss, in press).

Although closure should not be expected or required when a family member has gone missing, I argue further that closure is never really possible, even with a clear-cut death. Closure is a myth valued by a culture intolerant of ambiguity. As researchers, therapists, and educators, we must shift our thinking on this point if we are serious about strengthening resilience in distressed families.

In the United States, there is a tendency to criticize and judge how people grieve their losses, especially if they take more time than we think they should. The cultural value is to get over it, find closure, and move on. Family scholars and practitioners now have the opportunity to influence others in tempering their impatience for grief and overeagerness for closure. Understanding this paradox helps: With ambiguous loss, the more we press for closure, the more families resist. The resistance may be ours because of our own need for certainty and closure.

12. *There appears to be a universal human need to bury one's dead.*

People seemed to need a body to bury even when common sense suggested that the missing person was dead. I saw this in New York after 9/11, and more recently in Kosovo, where thousands of family members are still missing from the ethnic cleansing in the late 1990s.

Worldwide, people continue to be kidnapped, mass graves exist, soldiers go missing; ferries sink, airplanes explode; submarines malfunction; and earthquakes, mudslides, and floods cover entire villages. Nearly always, family members go to great lengths to find the remains of their loved ones (Boss, 2002a, 2002b). Why do people do this? Why do they need a body to bury when it seems obvious that they are dead? From my observations, reasons vary:

First, the reason may be cultural. In U.S. culture, the valued and expected outcomes of loss are to find, fix, and solve. Accepting loss is discouraged.

As death is denied in our culture (Becker, 1973), so is ambiguous loss, but even more fiercely. People can say goodbye more easily when they see the evidence of a dead body and participate in group rituals of mourning and dispensing remains. This process of mourning breaks down the cultural denial of death and loss.

Second, a reason for needing a body to bury may be one of cognition and rationality. Without a body, people feel confused about the loss and are cognitively blocked. Without cognition or knowing what the problem is, they cannot begin to cope, they cannot grieve, and they cannot make decisions. Their assumption of the world as fair, comprehensible, and manageable is shattered by the mystery. Nothing makes sense, and they remain immobilized.

Third, the reason that people need a body to bury may depend on one's level of attachment (Bowlby, 2001). With a clear loss such as death, Safer, Bonanno, and Field (2001) found that the quality of attachment is confounded by the situational context and possible memory bias. In another study, Bonanno and colleagues (2002) found that people who exhibit little or no grief after loss are not cold, unfeeling, or lacking in attachment, but "...are capable of genuine resilience in the face of loss" (p. 23). These findings about attachment may be similar when there is no body to bury. Survivors tell me they feel cheated out of a chance to say goodbye and to bury and honor their loved ones in their own way. Paradoxically, having the body of a loved one appears to motivate detachment and letting go. The need to bury one's dead appears to be greatest when there is deep attachment, but this is a proposition that needs testing. Research should determine the linkage between adult attachment, resilience, and the resolution of grief from ambiguous loss.

Six months after the attack, the wife of a man still missing in the World Trade Center said, "I would be happy just to have a part of him to bury—even if it's just a finger nail." She believed he was dead, but she was stuck—angry because he was still missing, but even more so because she felt she had no part in his burial. When I last saw her, she said she received his heart and buried it in a full-sized coffin. It was impossible for her to let go of a beloved person without actively participating in some ritual of honor and farewell. These begin the process of *detachment*. Research should explore this apparently universal human process.

Fourth, a reason that people may need the body of a loved one to bury is that there are no supportive rituals without one. Families of the missing are left to fend for themselves. After 9/11, some church officials allowed families to bury empty coffins, musical instruments, bowling balls, or photographs, but for the most part, people were on their own. They should not have to be. Researchers, clinicians, and educators must study this area further to provide more guidance and support for such distressed families and their clergy.

I talked with several families who made decisions about their lost loved ones, but they were usually motivated by people of authority: clergy, the mayor, therapists, nurses, physicians, and family elders. Despite not having a body to bury, someone they respected had offered choices, patience, and symbols to help. The urn of ashes from Ground Zero was one example. Yet, differing perceptions persisted to complicate acceptance of such symbols. One young man said, "I choose to believe that part of my brother's body is in these ashes," but the wife of that same missing man did not. Their differing perceptions over remains caused conflict about burial rites, but were minimized at family meetings where such disagreements were talked about and normalized.

FUTURE DIRECTIONS

What is needed? First, more research is needed on the long-term effects of ambiguous loss on the resilient and the troubled. Anecdotal evidence suggests that families across cultures appear to manifest remarkably similar dynamics after ambiguous loss. Like the New York families, Argentinean families of the *desparecidos* (disappeared) manifested confusion in boundaries and roles (uncle/daddy), denial of facts, and guilt if one dared to give up hope (Sluzki, 1990). Like many children of war and the Holocaust, the children of pilots missing in action in the Vietnam War since the 1970s carry symptoms of unresolved grief and have frequent intrusive thoughts of their lost fathers decades later (Campbell & Demi, 2000). Yet, many have learned to tolerate the ambiguity and have gone on to live well despite missing family members. To understand the long-term effects of ambiguous loss, we must study resilient *and* symptomatic individuals.

Second, research is needed on the simultaneous occurrence of both types of ambiguous loss, especially regarding the prevention of unintended child neglect due to traumatic and unre-

solved grief. For example, in the aftermath of the terrorist attacks on the World Trade Center, the remaining parent was often so depressed and preoccupied with the missing mate that the children were simultaneously experiencing a physically missing parent and a psychologically missing parent. Several adolescents said that they felt as if they had lost both parents even though one was still there with them. Although the family meetings were helpful to interrupt such overlaps of ambiguous losses for the children of 9/11, more research is needed to test and shape interventions to support children and adults under the increased pressure.

Third, more cross-cultural studies are needed to identify *commonalities* and *differences* in families responding to ambiguous loss. Although diverse responses and unique coping strategies are documented, we must also identify the common responses if we are to help families distressed by trauma and loss. Blocked communication patterns may be one such example. Across cultures, I have observed that communication after ambiguous loss often becomes suppressed—with "no-talk rules" and family secrets (Imber-Black, 1993)—especially in families who are not treated for months or years after the family member went missing. The secret helps continue the denial of death. For example, 8 months after a father had gone missing in the World Trade Center, the mother still explained his absence to the children by saying he was working in another state. In another case, a father who could not face his wife's death had never told his 6-year-old why he suddenly insisted she call her aunt "Mommy." The child was confused even more because her playmates talked about her mother's death in her presence. More study is needed on skewed and repressed communication patterns as indicated by family secrets that maintain the denial of death.

Fourth, to better understand family resilience and how it is attained or eroded, I suggest more studies on situations of ambiguous loss, because it is the ultimate stress test for families. My experiences—from the 1970s with families of missing soldiers to the present with families of missing after 9/11 and in Kosovo—taught me that illustrations of resilience lie in unexpected places. For researchers, practitioners, and theorists to notice these strengths, we need to reconstruct our views of normalcy versus pathology, of family structure versus function, and of who is considered family—psychologically, not just physically.

Fifth, cross-cultural research is needed to verify clinical observations of what might cause some people to tolerate ambiguity more than others. As previously discussed, I have some hunches, but formal study is needed to enhance future interventions. In addition, research is needed to better understand when a loss is ambiguous and when it is not. Having a clear-cut death is not always the answer. Again, cultural beliefs and personality differences may account for differences.

Sixth, both individual family members and families as a whole must be studied to understand the systemic ripple effect of ambiguous loss. Using an implicit systems theory with a process rather than mechanistic view (Buckley, 1967), families as self-defined are treated as a unit even though the individual members are likely to experience the ambiguity and loss differently. Paying attention to systemic processes on multiple levels—individual, family, and community—is paramount because it is often a person's familiar connections that provide comfort in times of catastrophe and distress.

CONCLUDING THOUGHTS

My goal in this article has been to stimulate new interest in family theory building. Because of its timeliness, I focused on ambiguous loss from terrorism, but many less catastrophic situations occur in everyday family life. New scholars are needed to join this work on ambiguous loss, and more importantly, to discover more inclusive and useful family theories of a more general nature.

Rather than fixating on universal family *structure*, family scholars may make more progress in strengthening families and children by focusing on universal family *experience*. Regardless of cultural and religious beliefs and values, one of these commonalities is ambiguous loss, but what are some others? What experiences do couples and families share despite race, ethnicity, class, sexual orientation gender, and generation?

We do not have as a goal one grand theory to normalize all families, but I submit that family theory will be more useful locally, nationally, and internationally if we focus less on normative structure and more on events and situations common to all families. Loss is one such experience. It lies at the root of human pain and family conflict, and if complicated by ambiguity, has the potential to cause family and marital problems for generations. Why the topic of loss has

not received more attention from family researchers and theorists is mind boggling—except that I too have felt our cultural reluctance to face this topic. It is not comfortable to study loss because it is too close to our own inevitable experience.

I had mixed emotions after 9/11 in New York, and again in Kosovo, when I saw what I had previously predicted happen again and again—a sad success. As a researcher, I saw yet again depression and family conflict. Clinically I observed unresolved grief, ambivalence, guilt, relational conflict, and confused family boundaries. As if on cue, families of missing argued over what to do, differed in their perceptions of the lost person's status, canceled family rituals and routines, and were often so preoccupied with the lost person that family members still present were ignored. Children especially were affected. With theory as our guide, clinicians were alert, and could intervene early when negative symptoms first appeared. This helped to prevent long-term problems in family dynamics, which otherwise might remain for generations in families of the disappeared.

Parents missing from war, the Holocaust, ethnic cleansing, kidnapping, exterminations, and terrorism traumatize children worldwide. They grow up and start their own families with the scars of traumatic loss. In the United States, people still struggle with the aftermath of ambiguous loss suffered after the attempted annihilation or assimilation of Native American Indians, and the slavery of Africans brought to our shores. People on both sides of World War II are still struggling with the aftermath, as are children of those lost in the Holocaust, Cambodia, Rwanda, Kosovo, the Korean and Vietnam Wars, and more recently, the Gulf and Iraq Wars. In Central and South America, terrorists kidnap family members so often that the term *desparecido* (the disappeared) is now common vocabulary in Argentina, Brazil, Colombia, Chile, Panama, Peru, and Mexico. In the war-torn region of Kosovo, 4,000 families still search for their missing. Natural disasters add to the list of those who vanish without a trace. If we in the National Council on Family Relations are to remain the premier source of knowledge about family research, theory, and application, we must be ready to work with diverse families to regain resilience in diverse situations of trauma and loss. This will require multicultural collaboration between scientists and practitioners in a team approach aimed at building more general theory to guide interventions and prevent dysfunction.

Echoing Evelyn Fox Keller (1985), such work is not a monolithic enterprise. New ideas are often discovered on the borders between disciplines where collaborative work is more likely.

Since my work in New York after the terrorist attacks of 9/11, and more recently with families of the missing in Kosovo, I am convinced that theory is essential to guide our work if we as family scientists and practitioners are to help families in times of crisis. At the same time, I am aware that the value of family theories and teaching theory development is being questioned. This is alarming. Without sound theory, interventions lack sound guidelines. Without research-based theory in hand, we lack the understanding of complex family interactions and linkages, which, in times of crisis and terror, become chaotic and require immediate intervention. For me, theory links science and practice and stands ready to guide my thinking in emergencies and in everyday work with couples and families.

To create theory, we must build on knowledge gained from practice and science and use methods of discovery and methods of proof. In this article, I have reflected on recent field experience to update my theoretical work on ambiguous loss. Although I have reflected on diverse attributions and adaptations in families after 9/11, I have also pointed out commonalities and recurring themes in families of the missing across cultures. What I have learned is that there are multiple truths. Each of us has an approximation of truth within our reach, but each tests his or her idea in a different way. The scientist tests a hypothesis, the therapist tries an intervention, and the artist creates a narrative. The theorist must be aware of all three endeavors (Boss, 1987b).

Discovery happens not with the scientific method or formal theory building, but through openness to heeding one's senses and responding to one's intuition. We make ourselves more discovery prone by listening, being aware of our feelings, and recognizing apprehensions and emotions about what we think we already know to be true about families.

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