Chapter 1

Conceptualizing Death and Trauma: A Preliminary Endeavor

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DEATH AS A TRAUMATIC STRESS RISK FACTOR

Internationally, the overall death rate ranges from 18 per 1,000 (West Africa) to 6 per 1,000 (East Asia), with most countries around the 9–11 per 1,000 range (figures for 1989; Aiken, 1991). In the United States and Canada, 14%–18% of pregnancies end in the spontaneous death of the fetus (Neugebauer et al., 1992). Infant mortality ranges from a low of 4.8 per 1,000 live births in the most developed countries to 161 per 1,000 in the least developed countries (World Health Organization [WHO], 1995).

Death is not a rare event. Yet, by best estimates, posttraumatic stress disorder (PTSD), the hallmark traumatic stress disorder, is not common. Nearly everyone experiences the death of a loved one. About 55% of the people in the United States are exposed to an event that would qualify as an extreme stressor according to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychiatric Association [APA], 1994, p. 428). Yet, the estimated nonclinical population lifetime PTSD prevalence rate is only 7.8% (Kessler et al., 1995). What range of reactions might there be that could account for differences between exposure and the development of a disorder?

Posttraumatic Stress Disorder, Traumatic Stress, and Death

Until 1994, PTSD required experiencing of "an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone" (APA, 1987, p. 250). This formal medical diagnosis dominated our understanding of traumatic stress for nearly two decades. However, since most people experience the death of someone with whom they were close, death per se cannot be described as "outside the range of usual human experience." Some argue it is

unlikely that "ordinary" death could serve as a stressor that has the potential to produce PTSD (cf. Zisook & Schuchter, 1992). Others argue that while grief and trauma are not the same thing, the same event has the potential of producing either or both experiences (cf. Eth & Pynoos, 1985, 1994; Pynoos & Nader, 1988).

The original definitions of traumatic stress led to considerable wrangling about what events actually qualified as "traumatic" (APA, 1987). The *DSM-IV* definition of traumatic stress shifts the focus from a list of qualifying events to key elements of the event. Under the new criteria, a person must have "experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others" (APA, 1994, p. 426). Thus, death, either as reality or threat, is the pivotal aspect of the definition. The second element—"the person's response involved intense fear, helplessness, or horror" (APA, 1994, p. 426)—opens new understandings of death as a traumatic stressor.

The event-only perspective of traumatic stress has been abandoned. Traumatic stress is an interaction between the person and the event. Because of the bifold nature of the definition, it is possible for death, even if it is sudden or violent, to be traumatic or nontraumatic based on the response of the person who is experiencing the loss. By definition, if the experience is traumatic and leads to a diagnosable pathology, the individual must have reacted with intense fear, helplessness, or horror.

Many of the experiences reported by the bereaved are similar to those that are associated with stress reactions and PTSD. Those reports can include (a) recurrent and intrusive recollections; (b) recurrent distressing dreams, flashbacks, and other dissociative experiences; (c) psychological distress at exposure to symbols of the event or the deceased, including anniversary date distress; and (d) physiological manifestations such as difficulty with sleep, irritability, and difficulty concentrating (APA, 1987, 1994; Eth & Pynoos, 1985; Glick, Weiss, & Parkes, 1974; Jacobs, 1993; Nader, Pynoos, Fairbanks, & Frederick, 1990; Rando, 1992, 1994; Trice, 1988; Trolly, 1994; Turnbull, 1986). Burnette and colleagues (1994) surveyed 77 international experts in the field of thanatology. The consensus from this group was that, even in normal bereavement, it is common to observe yearning and the need to talk about the lost person. These behaviors are accompanied by intrusive thoughts about the lost person, as well as preoccupation and distress at reminders of the person. Clearly, many of these symptoms overlap with even the most strict definition of traumatic stress (APA, 1994). Yet, the question remains, Do these symptoms mean that the person has PTSD?

As stated elsewhere (Stamm, 1995; Stamm & Friedman, in press), traumatic stress can be envisioned as a part of the larger concept of stress, which can include, but is not limited to, the mental disorders of acute stress disorder and PTSD. I suggest that stressful experiences can be conceived as an individual's experience in relation to an event, such that elements of that event in combination with that specific individual create a situation whereby the experience itself is stress producing and one's beliefs—of faith in life, in others, in self—are disorga-

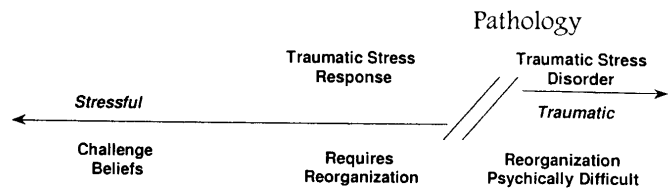

Figure 1.1 Conceptualization of traumatic stress.

nized, reFstructured, or at least challenged (Stamm, 1993). The key differentiation between a traumatically stressful experience and a stressful experience is the *demand* for reorientation (Stamm, 1995; Stamm, Catherall, Terry, & McCammon, 1995). Experience-induced reorientation is stressful but may or may not cause a diagnosable traumatic stress-related mental disorder.

In fact, it is unlikely that people would change at all without some stress to act as a motivator. Positive as well as negative changes can be stressful. This raises the question as to whether stress is a single continuum ranging from minor to extreme stress or whether traumatic stress is a categorically different experience. At present, there is insufficient scientific evidence to answer this question absolutely, but ongoing biological research holds promise (e.g., Friedman, Charney, & Deutch, 1995; Perry, 1993). Figure 1.1 (Stamm, 1995) suggests the nature of this theoretical assumption.

According to the conceptualization shown in Figure 1.1, death is a stressful experience that may or may not lead to a traumatic stress disorder. Death from extreme stressors such as disaster, war, starvation, or genocide is a potent risk factor for traumatic stress responses. These kinds of events seem to demand restructuring of one's belief system (Janoff-Bulman, 1992; McCann & Pearlman, 1990; Stamm, 1995). However, even the "timely" death of another leaves those who have experienced the irrevocable physical loss in a situation in which it is virtually impossible to continue life as if no change has occurred.

This does not mean that all death experiences lead to PTSD or even traumatic stress. Some would even argue that it is possible to experience the death of another without feelings of serious distress (cf. Wortman & Silver, 1989). But some restructuring is nearly always necessary. Following a death, at the very least, someone who was previously a part of the person's life is no longer physically present. For example, after the death of a parent, a bereaved woman remarked that she had to remind herself that her grocery purchases were no longer dictated by what she thought her sick mother might be able to eat. Although this was a simple accommodation—which the woman did not consider aversive—it was nonetheless an accommodation.

In summary, this chapter proposes that death is a stressful life experience that can produce a situation ripe for a traumatic stress response that *may or may not*

lead to a traumatic stress disorder. In addition, the assumption is made that stress reactions are not always ultimately injurious. Challenges to our sense of self and the world are catalysts to growth. They create opportunities for developmental enhancement unless the person-event interaction leaves the person with insufficient personal resources to meet the challenge. In this case, a pathology may develop.

This is, in fact, what the literature would suggest. For some, little or no accommodation is necessary (cf. Wortman & Silver, 1989), while others face a difficult and long-term process (cf. Corr, Martinson, & Dyer, 1985; Jacobs, 1993; Rando, 1992, 1994). Painful change is not inherently bad, and, in fact, it may ultimately bring positive maturity (Janoff-Bulman, 1992; Lazarus, 1966; Lazarus & Folkman, 1984; Stamm, 1995; Stamm, Varra, & Sandberg, 1993). Regardless of the course of the experience, death is a reality. At the very least, it signifies a change in the physical constitution of an individual's or family's psychosocial constellation (Turnbull, 1986).

Stressful Experience, Traumatic Stress Reaction, and Traumatic Stress Disorder

While no paper can ever address the full context of even a single experience, the point of this chapter is to create a window to the larger picture of death as a stressful experience and glance across the death and trauma literature. People live in a biopsychosocial context; stressful events are not isolated from the person who experiences them. The change from the *DSM-III-R* event-centered PTSD definition to the *DSM-IV* person-event interaction definition clearly recognized the importance of contextualizing stressful experiences. This chapter endeavors to raise the question of stressful experiences as an ecological, contextual issue so that we might learn to prevent the abortive growth process of PTSD and enhance the possibility of positive developmental growth in the face of the inviolate change of death.

The term *stressful experience* (Stamm, 1995; Stamm, Bieber, & Rudolph, 1996; Stamm, Varra, & Sandberg, 1993) recognizes this person-event interaction at the broadest and most encompassing level. Two other terms originated by Figley (1985, 1995) have been adapted for use here. The term *traumatic stress reaction* refers to "the natural and consequent behaviors and emotions ... [as] a set of conscious and unconscious actions and behaviors associated with dealing with the stressors" or memories of the experience (Figley, 1985, p. xix). An important underlying assumption made is that a traumatic stress reaction contains within it an element of event-induced demand for reorganization of one's belief system (Stamm, 1995). *Traumatic stress disorder* (Figley, 1985, 1995) indicates those stressful experiences that are so traumatically stressful and place such high demands on the person for change that the person's psychosocial resources are challenged sufficiently to create pathology (Stamm, 1995). Following the prevailing professional thought, pathology is defined as a diagnosable mental disorder according to criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or the International Classification of Diseases system.

Traumatic Stress Other than Acute Traumatic Stress Disorder and PTSD

Traumatic stress disorders may take a variety of forms, including PTSD, which has been the focus of great attention over the past two decades. As we have come to know it better, we are more able to see the other idioms of distress (e.g., Friedman & Jaranson, 1994; Friedman & Schnurr, 1995; Kessler et al., 1995; Stamm & Friedman, in press). There is a compelling and expanding literature on these other responses. Perhaps the most developed is dissociation (Kluft, 1988; Spiegel, 1991; Steinberg, 1997; Terr, 1991). Depression is frequently seen as comorbid with PTSD and often alone following a stressful event (Kessler et al., 1995). Physical diseases and somatization are gaining recognition as well (Friedman & Schnurr, 1995; Stamm & Friedman, in press).

IDENTIFYING THEORETICAL TOOLS ACROSS DEATH AND TRAUMA

According to Lifton (1967), death is the ultimate confrontation with one's own mortality. It is, in a sense, the best material for demanding change of one's beliefs. After one confronts the possibility of death, it is no longer possible to assume invulnerability and innocence. The person must either deny the reality of the experienced death or restructure his or her world to incorporate the experienced information that human life is finite. If denial or repression is not used to keep awareness of the death at bay, the death experience requires some reorganization of one's understanding of oneself as well as the manner in which one lives in the world.

There are many useful theories that can assist us in understanding death as a medium to challenge one's beliefs, perceptions, and expectations. To that end, three theoretical perspectives are reviewed briefly here: (a) world assumption theory (Janoff-Bulman, 1992), (b) constructivist self-development theory (McCann & Pearlman, 1990a), and (c) the dimensions of grief summarized by Jacobs (1993), Stroebe and Stroebe (1987), and Turnbull (1986). These three perspectives, along with practice and research, have informed the development of the quantitatively derived Structural Conceptualization of Stressful Experiences (SCSE), designed as a metatheoretical model to address the range of stress responses, from mildly challenging to traumatically stressful (Stamm, Bieber, & Rudolph, 1996; Stamm, Varra, & Sandberg, 1993).

World Assumption Theory

World assumption theory (Janoff-Bulman, 1992) is based in clinical experience and quantitative research with general populations and trauma victims. It pro-

poses that we have three fundamental assumptions about ourselves, the external world, and the interaction between the two. The assumptions are that (a) the world is benevolent, (b) the world is meaningful, and (c) the self is worthy (Janoff-Bulman, 1992). However, as one gains knowledge and accumulates experience, these assumptions seem naive and become increasingly illusory. Traumatic events accentuate this process. Ultimately, it becomes necessary to deny life experiences or to restructure one's assumptions along the lines of one's experiences. This requires cognitive reappraisal of the meaning of the negative event.

> Traumatic victimizations are unwanted and unchosen. Yet, the cognitive strategies used by trauma survivors attest to the possibility for some human choice even in the face of uncontrollable, unavoidable negative outcomes. These choices reside in the interpretations and reinterpretations, appraisals and reappraisals, and evaluations and reevaluations made of the traumatic experience and one's pain and suffering (Janoff-Bulman, 1992, p. 140).

Successful restructuring is a positive accomplishment. As Janoff-Bulman (1992) states, the individual "emerges somewhat sadder, but considerably wiser" (p. 175).

Constructivist Self-Development Theory

Constructivist self-development theory, a theory based in clinical experience with trauma victims and in quantitative research with trauma survivors, trauma therapists, and general population subjects, brings additional tools for understanding stressful experiences. According to this theory, one has at one's center the self, which is composed of three interrelated parts: (a) *frame of reference*, or one's overarching ways of experiencing self, others, and the world; (b) *self-capacities*, which allow one to regulate affect and maintain self-esteem; and (c) *ego resources*, which regulate interactions with the outside world (i.e., the basic cognitive schemas, both conscious and unconscious, that provide the means for interpreting experience) (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995).

The first part, frame of reference, comprises three aspects: *identity, world view*, and *spirituality*. Identity is the experience of self in various roles, including one's experience of one's body. World view includes the notions of causality, life philosophy, moral principles, and so forth, quantitatively operationalized as experience of autonomy and experience of connection (Pearlman, MacIan, Mas, Stamm, & Bieber, 1992; Stamm, Pearlman, & Bieber, 1996). Spirituality is one's inherent human capacity for an awareness of meaning and connection with something beyond oneself, an awareness of all aspects of life, hope, and relation to the nonmaterial (Newmann & Pearlman, 1995). Subordinate to frame of reference, the theory posits five basic psychological needs that are sensitive to disruption by stressful life experiences: (a) safety, (b) trust, (c) esteem, (d) control, and (e) intimacy (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995).

Trauma can disrupt any or all of these factors. Considering trauma from a constructivist developmental perspective, there are two posttrauma restructuring

alternatives. In the first alternative, an individual has developed, in some more or less mature form, all of the basic schemas before the traumatic experience. In this case, when disruption occurs, the healing process is rehabilitative, one of restoring the disrupted structure by incorporating the traumatic material. However, if trauma occurs very early in an individual's development, the healing process is habilitative. Habilitation requires developing basic factors that enable the person to experience satisfying relationships.

Dimensions of Normal Bereavement

This section enumerates a four-dimensional pattern of grief proposed by several authors (Jacobs, 1993, Stroebe & Stroebe, 1987; Turnbull, 1986). All of these works trace a common history to Parkes (Parkes, 1972, 1985; Parkes & Weiss, 1983) and to Bowlby's attachment theory (1969/1980). The terminology used is that introduced by Raphael (1983), continued by Stroebe and Stroebe (1987), and most recently used in Burnett et al. (1994). These authors define bereavement as reaction to the loss, while grief is the emotional response (sadness, anger, guilt, etc.) to loss.

While earlier work sometimes proposed grief as occurring in linear phases, Jacobs (1993) describes grief as involving related dimensions. Jacobs contends that there is only an illusion of independent phases because of the time course of the dimensions.

The first dimension is *numbness*, which is a feeling of disbelief usually starting immediately at the death and continuing for several days. The second dimension is *separation distress* (Raphael, 1983). During separation distress, there is a pervasive desire to be with the dead person accompanied by the awareness that this is not rationally possible. Separation distress typically occurs from a few days to several weeks postdeath and reaches a peak at about 3 weeks. During this phase, the bereaved person may believe that he or she has seen or heard the deceased. Some people may engage in avoidance in an attempt to ameliorate the pain of loss. Clinically, there is also searching and protest behavior, accompanied by anxious mood (Jacobs, 1993).

The third dimension, the *mourning process* (labeled despair by Stroebe & Stroebe, 1987), is usually intermingled with separation distress. This dimension contains the depressed mood and neurovegetative symptoms commonly associated with grief. People may also experience feelings of "unreality," as if they no longer exist in any familiar world (Turnbull, 1986). Many somatic symptoms accompany this stage, including increased viral illness, listlessness, insomnia, and exhaustion. According to Turnbull (1986), this is the point at which individuals must make the transition from the old life to a new life without the physical presence of the deceased. The final dimension is *recovery*, the time during which individuals find new patterns of interactions that do not depend on the lost loved one. The recovery phase is characterized by positive coping behaviors. Jacobs (1993) includes a fifth dimension, *traumatic distress*, which is characterized by intrusion and avoidance. This typically overlaps with numbness and/or

separation distress. Similar symptoms reported by Turnbull (1986) are not segregated and are assumed to be part of the process of numbness and separation distress.

Structural Conceptualization of Stressful Experiences

SCSE is a theoretical work blending theory, practice, and research to describe the range of experiences stressors; and "ordinary" events such as moving, divorce, or normal death, as well as events traditionally considered "traumatic," such as rape and natural disaster. The SCSE was designed to be applicable cross culturally but has yet to be tested in such a manner. To date, this factor analytic-theory has been verified in a typical college student sample, and data are being collected from other groups (Stamm, 1993; Stamm, Bieber, & Rudolph, 1996; Stamm, Varra, & Rudolph, 1996; Stamm, Varra, & Sandberg, 1993). Chapter 2 expands the theory and summarizes the empirical evidence on the similarities and differences between experiences of death and other stressful life experiences.

A stressful experience occurs *to* a person in the context of an event environment. The common human response to environmental input is simply to receive and catalogue the input unless it is contrary to one's general expectations for a given situation. When confronted with input that is, in a sense, "larger than us," the taking-in process is taxed. One possible explanation of how a person can be traumatically stressed would be that the person encounters an event with a force greater than him- or herself and some amount of unbalancing occurs. If the resources of the person match or surpass the event, the event is absorbed, and the individual's path continues much the same as it has been; equilibrium is present. In theory, the more massive the event in relation to the person, the greater the unbalancing that can potentially occur.

The SCSE attempts to understand this balance by examining the individual's perception of his or her psychosocial resources (*resources of the person*) and the individual's perception of the magnitude and character of the event (*magnitude of the event*). Because neither events nor people can be described out of the context of time and place, there is a third component of SCSE: distance, or one's perception of one's physical and psychological closeness to the event or the people involved.

Resources of the person consist of two basic structures. The first, *place-in-the-world*, describes an individual's perception of his or her worthiness and belonging in the environment and community. It is characterized by a feeling that one has a place in the world, being able to make positive contributions, finding comfort in one's beliefs, taking care of oneself, being supported by one's faith, and not feeling like one is absent or never gets a break. The second structure, *person-to-person*, describes an individual's understanding of others in relationship to him- or herself. It is characterized by an ability to adapt.

In the magnitude of the event component, the event itself is not the focus. What is the focus is a composite of elements of the event that, if present, could

make any event sufficiently novel for it to carry the potential to change the individual's life path in either a positive or negative direction. The first element is *abrogation-of-expected-reality*, the gap between what one believes will happen and what is happening or has happened. This includes common responses such as "The event seemed too horrible to believe" and "it was like someone changed the rules." On the positive side, people often appreciate life more and remember good times. The *finiteness* element is about death: the reality of death, the desire for death, believing someone has died, and life-after-death experiences. In the case of violent or sudden death, it incorporates the grotesque. It is not dreamlike in quality, nor does it seem to have any redemptive teaching aspects. Yet, it can incorporate aspects of being able to intervene in the death process.

The final element, *person in event*, deals with the person's perceptions of his or her thoughts, feelings, and actions during the event. This is the area where the most positive attributions, or the most guilt, can accumulate. Positively, people appreciate being able to help, being able to surpass their own expectations, and being proud of what they did to help. People can also develop a sense of community, of feeling close to others and part of the group. The positive attributions that follow—realizing what was important, appreciating being alive more, appreciating people and things more, and remembering the good times—offer fertile ground for developing positive postevent attributions. Negative feelings can include not trusting what one thought was true, wanting to get away, wanting to die, feeling alone, and even being the cause of the event.

The least is known about the third component, *distance*. This includes the duration of the event, time postevent, and one's perception of one's physical and psychological closeness to the event or people in the event. This last aspect, psychological closeness to the event, is theoretically appealing because it can account for stronger or weaker reactions to the event based on the importance of the event to the person. For example, a mother's reaction to the death of her child in a faraway war might be stronger than the reaction of those much closer to the war itself. By virtue of the mother's close relationship with the child, there was little psychological distance from the war (particularly with modern news reporting), even though there might be a great physical distance.

IDENTIFYING CONTEXTUAL RISK FACTORS

Preparation Time and the Event-Resource Balance

When death is sudden and/or unexpected, such as from war, accidents, suicide, crime, or disasters, there may be little time for those in the social support network of the deceased to prepare for the loss. (Social support is defined as the "existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us" [Sarason, Levine, Basham, & Sarason, 1983, p. 12].) In these cases, few resources may be available. This suddenness of loss may be exacerbated by disbelief if there is no body, as might be the case in a prenatal death or in a disaster or fire (see Chapter 4) (Hodgkinson, 1989; Rando,

1992, 1994; Smith & Borgers, 1989; Stevens-Guille, 1992). Zisook and Schuchter (1992) found differences on the Hopkins Symptom Check List when comparing sudden and unanticipated death with prolonged, anticipated death. Those who experienced the sudden, unexpected death of a loved one reported more depressive, anxiety, paniclike, and avoidant symptoms than those who had predeath preparation time.

However, having time to prepare for another's death is not, in and of itself, a fail-safe inoculation against experiencing a traumatic stress reaction. Prolonged death has its unique attendant difficulties. While there is an opportunity for the social system to engage in anticipatory grief (Friedman, 1967; Knight & Herter, 1974; Rando, 1984; Stroebe & Stroebe, 1987; van Dongen-Melman & Sanders-Woudstra, 1986), this time of preparation can create problems. For instance, complications arise in the decision-making process during the terminal phase of an individual's life. In addition, the uncertainty and lack of feelings of control associated with medical decisions and remissions may cause stress (cf. Seligman, 1975). For example, difficulties arise when a person who is expected to die is mourned but does not die (Easson, 1981; Knight & Herter, 1974; Koocher, 1984; Koocher & O'Malley, 1981; Meagher & Leff, 1990).

Certainly in first-world medicine, but also in other settings (Terry, 1995; Stamm & Stamm, 1995), the medical process itself may be potentially stress producing. Results from a controlled trial designed to improve care for dying patients have alerted us to the level of pain and distress these patients experience and question many standard first-world medical practices (Connors et al., 1995). For friends and family members, spending time with the dying person may mean viewing the person in a disfigured state (Green, 1990, 1994; Lavigne & Ryan, 1979; Shonkwiler, 1985). Moreover, some first-world modern medical treatments for terminal diseases, such as certain types of chemotherapy, may prolong life but may actually end up being the toxin from which the patient ultimately dies. At times, the quality of life that is sustained through aggressive and intrusive medical treatment is questionable, creating difficulties for those people in the social support system of the dying person in terms of making decisions that determine care (Foos-Graber, 1984; Meagher & Leff, 1990; Mindel, 1989; van Dongen-Melman & Sanders-Woudstra, 1986).

These and other experiences associated with the actual dying process may be converted into traumatic material that can fuel flashbacks, survivor guilt, the death imprint, nightmares, and concerns about personal safety (Birenbaum et al., 1990; Easson, 1981; Green, 1990, 1994; Janoff-Bulman, 1992; Hodgkinson, 1989; McCann & Pearlman, 1990a; Rando, 1992, 1994).

Potentially, it is even more difficult when choices made by the survivors either caused or are perceived to have caused the death. For example, in a city in the western United States, a child died as a result of the mother leaving the sleeping child in the family vehicle when she went to work. During the legal proceedings that followed the child's death, the death was ruled accidental; there had been confusion in the family's work schedule, and the mother thought the father had

taken the child to day care. Despite the court ruling, the family will probably have a difficult time with their feelings of responsibility for their child's death. Similar feelings of responsibility have been reported in relation to disasters (cf. McCaughey, 1986) and combat (cf. Shay, 1994).

Environmental Contextual Considerations

The contextual environment in which one lives can also exacerbate or ameliorate effects of the experience of grief and trauma. Cultural norms (de Jong & van Schaik, 1994; Fabrega & Nutini, 1994; Stamm & Stamm, 1995; Terry, 1995), war status (Garbarino, Kotenly, & Dubrow, 1991; Marsella, Bornemann, Ekblad, & Orley, 1994; Stamm, Stamm, & Weine, 1994; Weine, Farley, & Munczek, 1995), geography and government, available psychosocial and medical options (Terry, 1995), age or race, and the depth of one's social support system play a role in determining the amount of personal and interpersonal resources available to individuals and their social support systems at the time of a crisis (cf. Fabrega & Nutini, 1994; Stamm, 1997; Terry, 1995).

Research on schemas and stereotypes indicates that when people are confronted with ambiguity, they are more likely to use previously devised schemas and even stereotypes to reduce perceived ambiguity (cf. Hamilton, 1987; Taylor & Crocker, 1981). In some types of deaths where situational ambiguity is high—such as in war, murder, or prolonged death—there may be an increased risk for reliance on stereotyped behavior.

Another example of stereotyped responding can be seen in families in which prolonged deaths disrupt traditional family processes (Kramer, 1987). Family members may find it necessary to assume nontraditional roles. Sex-role stereotyping, however, may make it more difficult to accommodate the needed role flexibility and may thereby add to the family's stress risks. Eagley (1987) suggests that gender roles arise from division of labor. In egalitarian groups, role taking is tied to the group's current needs (Lerner, 1989); conversely, in groups that are highly sex stereotyped, it is likely that sex-role strain will become a salient characteristic of the overall stress of the group (Garnets & Pleck, 1979). Thus, system stress may increase if previous divisions are no longer functional because of a death-related change.

System stress is particularly pernicious when members need physical caretaking, such as with children or infirm members. System stress can be direct, through factors as simple as poorer nutrition and hygiene, or indirect, through the primary caretakers' own crises (Kehle & Parsons, 1988). For children especially, disruption of the parental/caretaker system is sufficient to cause a stress reaction or even a stress disorder (McCann & Pearlman, 1990a).

Many environment factors can affect the person-event balance. When addressing a person in context, it is important to consider the biological aspects, psychosocial aspects, and sociocultural aspects of the person. Any of these areas can enhance positively or negatively the risk factors for bereavement and grief.

DEATH AS AN EXTREME STRESSOR

Even if experiencing the death of another offers opportunities to derive positive, transpersonal meaning and purpose, most people experience some level of grief-related distress following the death of another. Nevertheless, most process the death in such a way that they can meaningfully continue their life.

Yet, the possibility of pathology developing from the death experience is real (Applebaum & Burns, 1991; Easson, 1981; Green, 1990; Green, Wilson, & Lindy, 1987; Horowitz et al., 1992; Hodgkinson, 1989; Jacobs, 1993; Kastenbaum, 1969; Parkes, 1985; Rando, 1992, 1994; Raphael, 1983; Rosen, 1995; Stroebe & Stroebe, 1987). Parkes (1985) identifies four areas of potential difficulties: (a) the type of death, (b) the characteristics of the relationship between the bereaved and the lost loved one, (c) the characteristics of the survivor, and (d) social conditions. Kastenbaum (1969) as well as Neugebauer and colleagues (1992) warns that multiple deaths can cause bereavement overload.

Moreover, death by means of an extreme stressor such as murder, disaster, or war can enhance the probability of the development of pathological grief (see Chapter 4) (Eth & Pynoos, 1985), thereby making the early diagnosis and treatment of a traumatic stress response of critical importance. When pathological restructuring of one's beliefs occurs, the traumatic aspects of the loss experience become the point around which one's entire life revolves, and one's world view is thus shaped by the traumatic experience (Herman, 1992; Janoff-Bulman, 1992; McCann & Pearlman, 1990a, 1990b; Pearlman & Saakvitne, 1995; E. Rosen, 1989; H. Rosen, 1985).

According to Pynoos and Nader (1988), when one experiences a life threat or witnesses injury to another, PTSD can develop. From this perspective, if experiencing the loss of another through death brings concomitant fears of threat to one's life, pathological bereavement in the form of PTSD is not only possible, but the risk increases. As previously noted, others, including McCann and Pearlman (1990a), Lifton (1967), and Janoff-Bulman (1992), consider loss and threat to one's life as a possible precursor to stress disorders. Moreover, the very definition of PTSD (APA, 1994) calls for, in part, the perception of death or threat of death accompanied by feelings of helplessness and fear.

Green (1990, 1994) possibly makes the clearest statement of the idea of loss or threat to one's life as a precursor to traumatic stress disorders. In her article reviewing the traumatic stress literature, Green (1994) lists seven stressor dimensions that have been identified as possible precursors to PTSD. Death is a possible part of each of the seven dimensions.

Threat to life or bodily integrity is obviously related to the perception of death. This threat may come from natural or human-made disasters, from fires, transportation disasters, war, or crime. Basic reactions to these types of threats have been outlined among children (Pynoos & Nader, 1990), adults (Hodgkinson, 1989), and even families of murder victims (see Chapter 4) (Stevens-Guille, 1992; Redmund, 1992).

A second dimension outlined by Green (1990, 1994) is the experience of seeing another person disfigured, mutilated, or dead. The original cause of the disfigurement does not seem to be as important as the exposure to the grotesque element. In fact, according to some (Lavigne & Ryan, 1979; Shonkwiler, 1985), it is even possible for disfigurement from medical treatment to cause long-term stress reactions. When violent sudden loss is accompanied by seeing the person in a disfigured state, there seems to be a particularly great risk for the death imprint (cf. Hodgkinson, 1989; Lifton, 1967). According to the *DSM-IV* (APA, 1994), witnessing a dead person or being placed at risk for death may be a precursor to the requisite reaction that involves intense fear, horror, or helplessness.

While somewhat less directly related to death than seeing or handling dead bodies, experiencing physical harm or injury can also lead to pathology (Green, 1990, 1994). This dimension may have a subclass that deals with the intention of the harm. Green (1990, 1994) argues that the deliberateness of the harm may be a mitigating factor in the stressor. For example, being the recipient of harm caused with intent would be perceived as more stressful than if the harm was caused accidentally. The harm does not have to be visible to serve as a potential traumatic stressor. Simply learning of exposure to a noxious agent can serve as a dimensional precursor to traumatic stress (Green, 1990, 1994).

The final dimension discussed by Green (1990, 1994) is causing death or severe harm to another. This harm could be intentional or even job related, such as in fulfilling the role of a soldier. In fact, society does condone causing harm or the death of others in the context of war. However, even when there is societal approval, pathological complications can arise (Breslau & Davis, 1989; Hobfoll et al., 1991). When the death of another is accidental, as discussed in the case of the mother who accidentally caused the death of her child, a person can become a victim as well as the agent of the stressor event.

Responses to stressor experiences can be evoked at a primary level or at a secondary level, such as through witnessing the act, or vicariously by being told of the act (Albeck, 1994; Danieli, 1985; Figley, 1995; Green, 1991; McCann & Pearlman, 1990b; Rosenheck & Nathan, 1985; Stamm, 1995; Stamm, Bieber, & Rudolph, 1996). For example, a loved one could be diagnosed HIV positive, which serves as the original stressor. Two types of potentially traumatic stresses are present here. The person with AIDS experiences primary stress prior to his or her death. Those in the social support system of the AIDS patient may experience their own struggle at a secondary level. After the loved one dies, the social support system has the primary stress of the death comingled with the previous stress of a secondary nature.

Ultimately, pathological grief and traumatic stress disorders can arise in the context of bereavement. In fact, PTSD, under the current understanding, cannot occur without the existence of either actual or threatened death (APA, 1994). People are at particular risk for developing pathologies when the death involves elements of the grotesque, violence, or suddenness. This is negatively enhanced by the survivor's perception of helplessness, fear, or horror. These are the kinds of

experiences that seem to most challenge our beliefs in the goodness and rightness of the world and thus leave us most unsettled.

CONCLUSION

While treatment recommendations are beyond the scope of this chapter, at the very least, it seems important for caregivers to be attentive to the variability of bereavement. Looking across the death and trauma literature, it is becoming increasingly clear that we must be attentive to the potential negative effects of pathological bereavement and do all that we can to enhance the positive outcome of bereavement.

Normal bereavement, stress, and traumatic stress all require some element of restructuring of an individual's belief system. This restructuring seems to focus around one's faith in life, one's understanding of others, and one's understanding of oneself (Herman, 1992; Janoff-Bulman, 1992; McCann & Pearlman, 1990a, 1990b; Stamm, 1995a, 1995b).

We do know that pathological grief occurs (cf. Jacobs, 1993; Rando, 1992, 1994; Raphael & Martinek, 1997). For most, though, normal bereavement occurs. Normal bereavement moves from a state of numbness in which restructuring is not an applicable concept, through a time of mourning and separation distress—perhaps recognition of the need for restructuring—to a state of recovery involving successful restructuring. It is in this final stage that people use positive coping behaviors to construct a new and different but positive world (Jacobs, 1993; Stroebe & Stroebe, 1987; Turnbull, 1986). This new world is one that honors the place of the lost person but is constructed with new patterns of interactions that are not dependent on the physical existence of the lost loved one.

Thus, the normal course of bereavement culminates in a positively restructured world (Gilberg, 1994; Janoff-Bulman, 1992; Turnbull, 1986; Lifton, 1993; Hodgkinson, 1989; Rando, 1984; Stamm, 1995). It is important to be aware that this normal bereavement process can be truncated or shunted by inattention to the risk factors for traumatic stress reactions. Conversely, inattention to the important aspects of normal grief and bereavement in a person struggling with traumatic stress can increase the potential risk for both a traumatic stress disorder and the development of pathological grief. By remembering that these two human phenomena are closely linked yet distinguishable by terror, perhaps we will be better able to walk the path toward positive restructuring, both in our patients' lives and in our own.

> Man by suffering shall learn.
> So the heart of him, again
> Aching with remembered pain,
> Bleeds and sleepeth not, until
> Wisdom comes against his will.
>
> (Aeschylus, *Agamemnon*)

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