Chapter 2

Empirical Perspectives on Contextualizing Death and Trauma

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DEATH AS A TRAUMATIC STRESS RISK FACTOR

Death is a significant risk factor for traumatic stress reactions. Violent or sudden death is particularly associated with negative psychological outcomes.

War and Poverty

Some environments carry particularly high risks, most notably poverty and war. Death by poverty-related disease and war is the most important focus of public health (World Health Organization [WHO], 1995). People in the least developed (poorest) countries have a life expectancy of about 43 years, as compared with 78 years in the most developed (richest) countries (WHO, 1995). Each years, 12.2 million children under 5 years of age die in developing countries (WHO, 1995). In some areas of the world, it is impossible to find a person whose immediate family is untouched by the sudden violent death of a loved one. Many suffer posttraumatic stress disorder (PTSD) and other psychiatric disorders as a result (Friedman & Jaranson, 1994; Marsella, Friedman, Gerrity, & Scurfield, 1996).

There were an estimated 60 wars being fought in 1997 (The War Page, 1997), all of which were likely to bring negative psychiatric consequences to at least some of the people involved. Consider some of the wars that have occurred since the development of the field of traumatic stress (Figley, 1985). During the 1980–1992 civil war in El Salvador, 75,000 people died, an average of more than 6,000 per year. Many of the victims were "disappeared," or dismembered. These deaths, combined with combatlike living environment, left mourning families without access to the usual rituals associated with the death of a significant other. For some, this continues unresolved (Aron, 1988; Aron, Corne, Fursland, & Zelwer, 1991; Bowen, Carscadden, Beighle, & Fleming, 1992; Tierra Blanca, 1994). The crisis of apartheid in urban areas of South Africa is well documented (Gilbert, 1996;

Simpson, 1993a, 1993b; Tyson, 1983). Less well known is the "unofficial war," brewing since the early 1980s, that erupted in Kwazulu-Natal in 1987. Political killings, which peaked at 311 in March 1994, have shown a steady rate of decline, dropping from an average of about 60 to 20 killings per month during 1996. The recovery of this rural province, with an unemployment rate of 58%, depends on poverty relief, personal development, employment, and community development (Higson-Smith, 1997)

In Liberia, a country of 2.3 million people, 150,000 people died from massacres and malnutrition between 1990 and 1994 (Fouke, 1991; Kramer, 1995; Monrovia, 1994), and the war and death continue at an alarming rate (Bracken, Giller, & Ssekiwanuka, 1996; Save the Children, 1996), although there are signs of reconciliation. Sadly, many of the soldiers are children, which puts at increased risk the very people who would be the first generation of nonwarring people (Personal communication, David Samalou, July 1997).

Under the Pol Pot regime in Cambodia (1970–1975), nearly 10% of the country's 9 million people died, and another million died during reorganization. From 1979 to 1990, an additional 100,00 died (Garbarino, Kostelny, & Dubrow, 1991). The negative psychological effects on the living have been pervasive and long lasting (Rozee & Van Boemel, 1989; Carlson & Rosser-Hogan, 1993; Sack et al., 1994, 1995).

At least 200,000 have died and 27,000 are missing as a result of the genocide in Bosnia-Herzegovina. Moreover, the overall war in the former Yugoslavia has involved the entire population, not just soldiers (Institute for Global Communications, 1997; Weine & Laub, 1995; Stamm, Stamm, & Weine, 1994; Weine, Becker et al., 1995; Weine, Farley, & Munczek, 1995). Official estimates report 140,000 dead or missing Bosnian Muslims; the actual figure may be as high as 200,000 (Cigar, 1995). This war has had profound negative psychological effects, particularly on children (Herceg, Melamed, & Pregrad, 1996) and even relief workers (Smith, Agger, Danieli, & Weisaeth, 1996).

Non-War-Related Death

The sweep of war can be overwhelming. The consequences of the terror and genocide that can accompany war are powerful. But what about those who live in relatively politically stable areas? What is death like for these people? Without political consequences, can death be an extreme stressor? Outside of warring areas, how common is death? Perhaps more common than most realize. Consider the relatively privileged population of United States college students. In one study of 281 college students with an average age of 20 years, 49% had experienced the death of a parent, sibling, or close friend (Segal & Figley, 1988). In another study of 1,081 college students with an average age of 21 years, 23% reported a death experience as their most stressful life experience. Of the 1,830 stressful life experiences reported by these 1,081 people, 427 (23%) were death related (see Chapter 1) (Stamm, Bieber, & Rudolph, 1996). Clearly, the death of a significant other is not uncommon, even among those who are generally assumed to be insulated from death by affluence and young age.

Included in the preceding numbers are a certain percentage, as yet unclear, of deaths that were sudden and/or violent. These deaths, like those that result from the devastation of war or profound poverty, are significant risk factors for the development of traumatic stress-related disorders (e.g., Doka, 1996; Figley, Bride, & Mazza, 1997; Rando, 1992, 1994). Hodgkinson and colleagues (1995) found that those who were bereaved by disaster or other sudden death reported significantly more general psychological symptoms, denial, intrusion, and avoidance than those who expected their bereavement.

Suicide seems to be a very potent risk factor. The risk of suicide may be compounded with other known risk factors for traumatic stress, such as sexual assault and child abuse (Brand, King, Olson, Ghaziuddin, & Naylor, 1996; Davidson, Hughes, George, & Blazer, 1996; Farber, Herbert, & Reviere, 1996), disaster (Warheit, Zimmerman, Khoury, Vega, & Gill, 1996), being in combat (Farberow, Kang, & Bullman, 1990), or a chronic, life-threatening illness (Elliot, Pages, Russo, Wilson, & Roy-Byrne, 1996; Suris, Parera, & Puig, 1996). In addition, the loved ones of suicide victims are at risk for experiencing guilt, anxiety, depression, and posttraumatic stress disorder following the suicide (Brent, Moritz, Bridge, Perper, & Canobbio, 1996; Miles & Demi, 1992).

IDENTIFYING THEORETICAL TOOLS ACROSS DEATH AND TRAUMA

Identifying Factors in the Stressor Event: The Structural Assessment of Stressful Experiences Study (SASE)

What is it that makes an event stressful? What makes it terrifying to a person? Does death always contain these factors, or are there differences in the intensity of the stress related to death? The following is a description of a study that attempted to separate out the various elements of the stressor event and how it relates to the death of a loved one.

Recognizing that the stressful experience occurs *to* a person in the context of an event, the Structural Conceptualization of Stressful Experiences (SCSE) is conceived as a function of 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 part of the SCSE. This third part is *distance*, or one's perception of one's physical and psychological closeness to the event or people in the event. Unfortunately, to date, the theory has been verified only in a typical college student sample, although there are other studies in planning. While the cross-cultural generalizability of the theory is not known, the SCSE was designed to be adaptable cross culturally.

Six universal factors have been quantitatively verified in the SCSE (Stamm, Bieber, & Rudolph, 1996). (The term *universal* is not a sociocultural term. As it is used here, it is a statistical term that refers to structures that have been identified, and can be reliably reproduced, across all of the subjects in a data set. For example, for a structure to be universal to males and females in the study, it would have to appear reliably in the male and female segments of the data set. If it appeared reliably only in the male segment, it would be specific to males only. Similarly, if a structure were reproducible across all of the different classes of stressor events in the data set, it would be universal to the data set. If it appeared only in one segment of the data set, for example only among those who experienced death, it would be specific to that group.) In theory, assuming an appropriate cultural match between the reference group and the target group, a universal factor is one that can be applied regardless of the victim's sex or even the kind (class) or magnitude of the stressful experience. (Chapter 1 describes the theory of SCSE in more detail.) Briefly, two universal factors exist in regard to the resources of the person: (a) the person's conception of his or her place in the world and (b) the person's conception of others in his or her world. Three universal event magnitude factors have been identified: (a) the abrogation of one's expected reality; (b) an understanding of the finiteness of human life through experiences of death; and (c) the perception of one's thoughts, feelings, and actions during the event. One distance structure, proximity, has been identified and is described as perceived psychological and physical proximity to the event and people in the event.

The SCSE also contains specific factors applying only to a particular group. Sex-related and event-related specific factors have been identified.

Two specific factors are uniquely associated with death. The first of these two specific structures—resources of the person—refers to a paradox between the public and private experience of grief. This structure involves the social pressure that can ignore an individual's feelings and rush a person who has lost a friend or loved one "to get on with life." The other structure is associated with the event itself and is characterized by the actual details of the death and surrounding events, including the consequences of the death for the participant (e.g., if the decedent was a parent, did the child have to move to another home?).

Traumatic Versus Normal Bereavement

Raphael and Martinek (1997) noted that traumatic stress and bereavement have been confused unnecessarily by the fact that Lindemann did not separate traumatic exposure from bereavement in his original conceptualization of grief. They point out that many of those in Lindemann's study of grief were severely traumatized by their experiences. Raphael and Martinek argue that the difference between normal bereavement and traumatic bereavement can be understood in terms of *intrusion* and *avoidance*. They argue that that reexperiencing (intrusion) is present for both traumatic and normal bereavement. The difference lies in the dimension of avoidance. People experiencing normal bereavement do not

avoid intrusive thoughts. In fact, such thoughts may be sought after as welcomed memories of the lost person. Those who have experienced traumatic bereavement will have intrusive images and avoidant behavior associated with the fear of threat/danger in their experiences.

If we need to learn to separate traumatic stress from loss, then it is important to examine the range of experiences that occurs and determine where death in general and traumatic death specifically fit in comparison with other stressful experiences. Is traumatic death worse than rape? How does death compare with problems in living? Are there some types of death that are more stressful than others? Are there differences based on male and female perspectives?

Looking back across the previous parts of this chapter, it would seem imperative to test these differences across different cultures and stressors. Unfortunately, cross-cultural testing is a protracted and expensive process. The study described subsequently addressed the questions raised in a college student population. The study sample was large ($n = 1{,}177$). Unfortunately, it suffered from the same limitations as many studies, examining young, White, intelligent, relatively privileged people. However, it did allow a relatively easily accessed first step toward understanding the dynamics of how death, particularly violent and "untimely" death, compares with other stressors.

CONTEMPLATING CONTEXTUAL RISK FACTORS

Comparing Death-Related Stressful Experiences With Other Stressful Experiences

To understand the context in which death-related trauma can occur, it is important to understand how death compares with other stressful experiences. The study described here compared death with both extreme (accidents/disasters and sexual assault) and ordinary (problems in living) stressors. The results reported were drawn from a database of college students in three regions of the United States: the Northeast ($n = 36$), the Intermountain West ($n = 1{,}081$), and the Pacific Northwest ($n = 51$). The appropriate institutional review boards approved the research, and all subjects were treated in accord with the ethical guidelines of the American Psychological Association. Subjects were provided with national and local information about free and low-cost mental health resources, and some received course credit for their participation.

The subjects' mean age was 21.3 years ($SD = 4.2$), and they reported an average of 13.1 years of schooling ($SD = 1.4$). There were 518 men (44%) and 658 women (56%). The largest racial group was Caucasian (85%), followed by Hispanic (3%), Black (2%), and Oriental and American Indian (each 1%). Of the 87% who reported a religious preference, 79% were Christian, and 5.5% were Atheist. Jewish, Muslim, Eastern, and pagan/occult each accounted for 1% or less. On average, men reported the importance of spiritual and religious beliefs as 5.9 ($SD = 3.2$), with women at 6.8 ($SD = 2.9$), on a scale ranging from *not at all important* (0) to *very important* (10).

Table 2.1 Distribution of Most Stressful Life Experiences

	Bad things (accident/ disaster, etc.)	Death	Problems in living	Sexual assault	Uncodable
Men	100	127	231	8	46
Women	101	172	302	52	38

Data were collected via the Impact of Events Scale (Horowitz, Wilner, & Alverez, 1979) and the SASE (Stamm, Bieber, & Rudolph, 1996; Stamm, Varra, & Rudolph, 1996). The SASE considers stressful to traumatically stressful experiences and asks about both positive and negative reactions to an event. It includes a variety of subscales designed to measure the full range of reactions to stressful experiences. The reliabilities of the scales reported here (as measured by Tucker's coefficient of congruence) range from .72 to .96 (test-retest: .72 to .82).

There are scales that apply to all of the people in the study as well as scales that are unique to male or female subjects and scales that are unique to particular types of events. The scales that apply across genders and events are discussed to show relative differences across study participants. Scales specific to male and female subjects as well as to death as a stressor are also described (as statistics are presented). The SASE was designed to measure not pathology but the range of positive and negative responses possible following stressful events. Thus, there are no established cutoff scores for pathology; scores can be understood in relation to each other. Broadly, larger positive scores are interpreted as more reported awareness and positive response to the topic of the scale. All data were analyzed via SPSS in a Sex × Event analysis of variance followed by Bonferroni-adjusted post hoc tests.

Classification of Stressful Experiences

The protocol outlined in Stamm, Varra, and Rudolph (1996) was used to classify subjects' experiences into five categories of stressful experiences based on a content analysis of 1,177 people's self-selected most stressful life experiences (see Table 2.1).

Two exploratory, post hoc subdivisions of the death category were used. Data from the SASE were analyzed by suicidal death ($n = 28$) and nonsuicidal death ($n = 204$; largely nonviolent deaths due to old age) (see Table 2.2).

As a means of examining the small group of "untimely" deaths, data were categorized into three groups: (a) violent, (b) accident or disaster, and (c) illness (see Table 2.3). Because of the small sample size, data were compared only on the Impact of Event Scale, which has only 15 items (the SASE includes nearly 200 items).

Table 2.2 Distribution of Suicide Versus Nonsuicidal Deaths

	Suicide	Nonsuicide
Men	9	90
Women	19	114

Table 2.3 Distribution of "Nonnormal" Deaths

	Violent (self- or other inflicted)	Accident/ disaster	Illness
Men	17	24	6
Women	16	14	25

Psychosocial Resources

The study subjects were not different in terms of the way they reported their beliefs concerning their understandings of others in relation to themselves (Person to Person scale) or their understanding of themselves in relation to others and their place in the world (Place in the World scale). It appears that the general psychosocial resources available to these people were not different either in type or in magnitude across the five classes of stressful experiences.

The way women who had experienced death ($M = 31.6$) adapted was not different from those who had experienced accidents/disasters ($M = 31.4$), problems in living ($M = 32.1$), or emotional support provision ($M = 34.9$). However, all of these women reported making significantly fewer accommodations to the stressor than did those women who had been sexually assaulted ($M = 36.6$) (Feminine Situational Adaptation scale), $F(4, 547) = 3.88$, $p < .01$. This suggests that, at least in female adaptation, death is more similar to the other classes of stressful experiences than it is to sexual assault.

Male and female subjects were not different in the aspect of using personal resources to cope with the public and private aspects of death-related loss. They responded similarly to what has been reported in the clinical literature as "putting up a brave front in public" (Public Coping/Private Pain scale) while feeling empty inside (Rando, 1984; Turnbull, 1986).

Magnitude of the Event

Interestingly, the scale that addresses the actual aspects of death, the reality of death, desire for death, believing someone has died, and life-after-death expe-

riences (Details of Death scale) was experienced as similar by all of the study subjects. Death is death, it would seem, regardless of one's experiences.

However, it does seem that the experience of death brings about differential perceptions in other areas. For example, in terms of the shattering of one's assumptions about life (Abrogation of Expected Reality scale), death ($M = -209.6$) is more like accidents and disasters ($M = -198.6$) and sexual assault ($M = -236.2$) than the group of everyday stressful events encountered as problems in living ($M = -186.4$), $F(4, 889) = 13.2$, $p < .01$.

Understanding of the finality of death, as measured by the Finiteness scale, seemed to be similar across the different classes of stressful experiences. However, there was a difference in the way male and female subjects reported their perceptions of the finiteness of death. Women ($M = 39.2$) reported a stronger understanding of the finality of death than men ($M = 33.5$), $F(1, 889) = 9.93$, $p < .01$. Moreover, when a post hoc analysis was done comparing the differences between death by suicide ($M = 27.7$) and death by a more "normal" process ($M = 40.7$), awareness of the finality of death was perceived in a more negative light for suicide than for "normal" death, $F(2, 292) = 5.0$, $p < .01$, and more positively by women ($M = 40.0$) than by men ($M = 32.8$) $F(1, 292) = 5.7$, $p = .02$.

In regard to an individual's perception of his or her thoughts, feelings, and beliefs (Person in Event scale) during a stressful experience, it would seem that believing that one is able to help provides more opportunities for positive appraisals. Those who had experienced death ($M = 58.8$) were more likely to have positive appraisals of their behavior during the event than those who had experienced accidents/disasters ($M = 42.0$), sexual assault ($M = 11.9$), or even problems in living ($M = 37.5$), $F(4, 889) = 21.79$, $p < .01$. There were no significant differences between those who experienced suicide and nonsuicidal deaths.

There are two sex-specific subscales in the event section of the SASE. The Protection within the Collective scale, a female scale, is characterized by feeling victimized by people or circumstances yet being protected by membership in a community. The magnitude of protection was statistically different from all of the other stressors and highest for those women who were in the death category, $F(4, 534) = 22.8$, $p < .01$. This suggests again that, for women, positive appraisal may be obtained from being with—and a part of—others.

In sum, people seem to be operating with similar schemas, or belief factors, about their psychosocial resources and about the experience of potentially stressful events. When comparing the magnitude of disruption on these schemas as a result of different categories of stressful experiences, those who experience death are generally more like those who have experienced traditionally defined traumatic stressor events than they are like those who experience problems in daily living. However, very broadly, experiencing the death of another does seem to offer peculiar opportunities for deriving positive, transpersonal meaning and purpose from the stressor experience.

Table 2.4 Impact of Events Scale Intrusion and Avoidance Subscales Across Types of Death

	Violence				Accident/disaster				Illness			
	Men		Women		Men		Women		Men		Women	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Intrusion	3.4	1.6	2.2	1.7	2.3	1.6	2.8	1.7	1.6	1.8	2.3	1.7
Avoidance	2.7	1.5	2.2	1.5	1.7	1.3	2.4	1.4	1.6	1.4	1.7	1.4

Impact of Events Scale

Data on the Impact of Events Scale are particularly interesting given the previously discussed theoretical distinction made by Raphael and Martinek (1997). Specifically, Raphael and Martinek suggest that reexperiencing (intrusion) is present for both traumatic bereavement and normal bereavement but that they differ profoundly on the dimension of avoidance. As mentioned earlier, people experiencing normal bereavement will not avoid intrusive thoughts, and they may seek such thoughts as welcomed memories of the lost person. Those who have experienced traumatic bereavement will have intrusive images and avoidant behavior associated with the fear of threat or danger in their experiences. Thus, the expectation is that all who experience death will respond similarly to the intrusion scale but that those who experience death associated with an extreme event will endorse more avoidance items than those who experience more "normal" death.

As in previous sections of this chapter, the first analysis compared those who experienced death and those who experienced the other stressors (bad things, problems in living, and sexual assault), and a similar pattern emerged. There were no statistical differences by sex or among the four groups on the intrusion scale. However, on the avoidance scale, $F(3, 1015) = 12.34$, $p < .001$, those who were sexually assaulted were the most avoidant ($M = 2.6$) and were significantly different from all others. Those who had experienced death ($M = 1.9$) were also significantly different from the other groups (i.e, lower than the sexual assault group and higher than the bad things [1.6] and problems in living [1.7] groups). This begs the question as to whether the distinction between traumatic death, with intrusion and avoidance, and normal death, with intrusion and no avoidance, is buried in the results.

As a means of addressing this question, the death sample was further subdivided. Unfortunately, it was only possible to extract complete Impact of Events Scale data on 89 people. Even so, the data support the hypothesis that people with bereavements that are likely to be traumatic have similar scores on intrusion but higher scores on avoidance than those who are "normally" bereaved. As predicted by the theory, people did not differ by sex or intrusion (see Table 2.4). There was a significant difference between the groups on avoidance, $F(2, 83) = 3.33$,

$p = .04$. Post hoc tests (joint Bonferroni) indicated that violent death was different from death by either accident or illness. However, death by accident/disaster was not different from death by illness.

CONCLUSION

Violent death is a potent risk factor for the development of traumatic stress disorders. When the violent death occurs because of war or war-related poverty, particularly in the context of genocidal war, there is a very high potential for the development of a stress response that may linger for many years. Death of a violent or sudden nature that is not war related can also be a potent risk factor for development of traumatic stress responses. This is particularly true for suicide and homicide. In the case of the former, guilt over not preventing the death can linger for many years. In the latter, anger at the person causing the death, supported by the ongoing complications of the legal process, can fuel the traumatic stress.

Even among relatively privileged United States college students, death can have far-reaching effects. For college women, accommodating death was more like accommodating disasters, accidents, and problems in living than like accommodating sexual assault. Both men and women endorsed feeling differently in private than they acted in public (often dubbed "putting up a brave front"). The actual aspects of understanding death and its finiteness were similar across different classes of stressors, but women seemed to be stronger in their understanding of death than men. Death by suicide was perceived more negatively than nonsuicidal death. Again, women reported being clearer about the implications of the finality of the death than men.

One of the most interesting differences between death and other stressor classes was that those who experienced death were more likely to have positive appraisals of their actions during the event than those who experienced accidents/disasters, sexual assault, or even problems in living. A possible reason is that people find more opportunities to help at the time of the death of another than with other stressors and thus have more "redemptive" opportunities. While it is impossible to determine whether it reflects a cultural gender bias, a reporting bias, or a reflection of gender differences, women are more likely to report positive feelings than men.

It is important that the nature of death be more closely differentiated. The data from the Impact of Events Scale suggest that memories of the dead arise in the minds of most people. What seems to be different is the amount of energy spent removing those memories. Those who experience violent deaths are more likely to try to avoid reminders than those who experience the loss of another by illness or old age.

Looking across the range of stressors reported here, the people who are most likely to make positive reappraisals after stressful life experiences are those who have death-related stressful experiences. This is hopeful. Even though most people do not spend a great deal of time thinking about death, death as a concept—in

and of itself—does not break the social contract of expected reality. Violent, unexpected death does break this contract. It would seem that the key lies in supporting people's ability to participate meaningfully in the death process even in the face of abject fear.

To this we've come: that men withhold the world from men.
No ships nor shore for him who drowns at sea.
No home nor grave for him who dies on land.
To this we've come: that man be born a stranger upon God's earth,
That he be chosen without a chance for choice,
That he be hunted without the hope of refuge.

Is there one, any one behind those doors to whom the heart can still be explained?...
What shall I tell you to make you understand?
My child is dead. John's mother is dying, My own life is in danger...
Look at my eyes, they are afraid to sleep.
I ask you for your help and all you give me is papers.
What will your papers do?
They cannot stop the clock
They are too thin an armor against a bullet....

Oh, that day will come, I know.
When our hearts aflame will burn your paper chains
That day, neither ink nor seal shall cage our souls!
That day will come, that day will come!

(Magda's Aria, from
The Consul by Gian Carlo Menotti)

REFERENCES

Aron, A. (1988). Refugees without sanctuary: Salvadorans in the United States. In A. Aron (Ed.), *Flight, exile, and return: Mental health and the refugee*. San Francisco: Committee for Health Rights in Central America.

Aron, A., Corne, S., Fursland, A., & Zelwer, B. (1991). The gender-specific terror of El Salvador and Guatemala: Post-traumatic stress disorder in Central American refugee women. *Women's Studies International Forum, 14*, 37–47.

Bowen, D. J., Carscadden, L., Beighle, K., & Fleming, I. (1992). Post-traumatic stress disorder among Salvadoran women: Empirical evidence and description of treatment. In E. Cole, O. M. Espin, E. D. Rothblum (Eds.), *Refugee women and their mental health: Shattered societies, shattered lives*. New York: Harrington Park Press.

Bracken, P. J., Giller, J. E., & Ssekiwanuka, J. K. (1996). The rehabilitation of child soldiers: Defining needs and appropriate responses. *Medicine, Conflict and Survival, 12*, 114–125.

Brand, E. F., King, C. A., Olson, E., Ghaziuddin, N., & Naylor, M. (1996). Depressed adolesents with a history of sexual abuse: Diagnostic comorbidity and suicidality. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 34–41.

Brent, D. A., Moritz, G., Bridge, J., Perper, J. A., & Canobbio, R. (1996). Long-term impact of exposure to suicide: A three year controlled follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 646–653.

Carlson, E. B., & Rosser-Hogan, R. (1993). Mental health status of Cambodian refugees ten years after leaving their homes. *American Journal of Orthopsychiatry, 63*, 223–231.

Cigar, N. (1995). *Genocide in Bosnia: The policy of "ethnic cleansing."* College Station: Texas A&M Press.

Davidson, J. R. T., Hughes, D. C., George, L. K., & Blazer, D. G. (1996). The association of sexual assault and attempted suicide within the community. *Archives of General Psychiatry, 53*, 550–555.

Doka, K. J. (1996). *Living with grief after sudden loss: Suicide, homicide, accident, heart attack, or stroke*. Washington, DC: Hospice Foundation of America.

Elliot, A. J., Pages, K. P., Russo, J., Wilson, L. G., & Roy-Byrne, P. P. (1996). A profile of medically serious suicide attempts. *Journal of Clinical Psychiatry, 57*, 567–571.

Farber, E. W., Herbert, S. E., & Reviere, S. L. (1996). Childhood abuse and suicidality in obstetrics patients in a hospital-based urban prenatal clinic. *General Hospital Psychiatry, 18*, 56–60.

Farberow, N. L., Kang, H. K., & Bullman, T. A. (1990). Major depression or uncomplicated bereavement?: A follow-up of youth exposed to suicide. *Journal of the American Academy of Adolescent Psychiatry, 33*, 231–239.

Figley, C. R. (Ed.). (1985). *Trauma and its wake: Vol. 1*. New York: Brunner/Mazel.

Figley, C. R., Bride, B. E., & Mazza, N. (Eds.). (1997). *Death and trauma: The traumatology of grieving*. Philadelphia: Taylor & Francis.

Fouke, C. J. (1991). Churches bring relief to devastated Liberia. *Christian Century, 108*, 853–859.

Friedman, M. J., & Jaranson, J. M. (1994). The applicability of the posttraumatic stress disorder concept to refugees. In A. J. Marsella, T. Bornemann, S. Ekblad, & J. Orley (Eds.), *Amidst peril and pain: The mental health and well-being of the world's refugees*. Washington, DC: American Psychological Association.

Garbarino, J., Kostelny, K., & Dubrow, N. (1991). *No place to be a child: Growing up in a war zone*. Lexington, MA: D.C. Heath.

Gilbert, L. (1996). Urban violence and health: South Africa 1995. *Social Science and Medicine, 43*, 873–886.

Herceg, M. S., Melamed, B. G., & Pregrad, J. (1996). Effects of war on refugee and non-refugee children from Croatia and Bosnia-Herzegovina. *Croatian Medical Journal, 37*, 111–114.

Higson-Smith, C. (1997). *Background to Kwazulu-Natal, South Africa* [On-line]. Available: http://www.goecities.com/HotSprings/Spa/3028/webdoc1.htm.

Hodgkinson, P. E., Joseph, S. A., Yule, W., & Williams, R. M. (1995). Measuring grief after sudden, violent death: Zeebruggee bereaved at 30 months. *Personality and Individual Differences, 18*, 805–808.

Horowitz, M. J., Wilner, N., & Alverez, W. (1979). Impact of Events Scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209–218.

Kramer, R. (1995). *Liberia: A casualty of the Cold War's end* [On-line]. Available: www.africanews.org/usaf/liberia.html.

Miles, M. S., & Demi, A. S. (1992). A comparison of guilt in bereaved parents whose children died by suicide, accident, or chronic disease. *Omega, 24*, 203–215.

Monrovia. (1994, March 19). *Syracuse Post-Standard* A-1.

Nader, K., Pynoos, R. S., Fairbanks, L., & Frederick, C. J. (1990). Childhood PTSD reactions one year after a sniper attack. *American Journal of Psychiatry, 147*, 1526–1530.

Rando, T. A. (1984). *Grief, death and dying*. Champaign, IL: Research Press.

Rando, T. A. (1992). The increasing prevalence of complicated mourning: The onslaught is just beginning. *Omega, 26*, 43–59.

Rando, T. A. (1994). Complications in mourning traumatic death. In I. Corless, B. Germino, & M. Pitmann (Eds.), *Dying, death and bereavement: Theoretical perspectives and other ways of knowing*. Boston: Jones & Bartlett.

Raphael, B., & Martinek, N. (1997). Assessing traumatic bereavement and posttraumatic stress disorder. In J. P. Wilson & T. M. Keane (Eds.) *Assessing psychological trauma and PTSD* (pp. 373–395). New York: Guilford.

Rozee, P. D., & Van Boemel, G. B. (1989). The psychological effects of war trauma and abuse on older Cambodian refugee women. *Women and Therapy, 8*, 23–50.

Sack, W. H., Clarke, G. N., Kinney, R., Belestos, G., Him, C., & Seeley, J. R. (1995). The Khmer adolescent project: II. Functional capacities in two generations of Cambodian refugees. *Journal of Nervous and Mental Disease, 183*, 177–181.

Sack, W. H., McSharry, S., Clarke, G. N., Kinney, R., Seeley, J. R., & Lewinsohn, P. (1994). The Khmer adolescent project: I. Epidemiologic findings in two generations of Cambodian refugees. *Journal of Nervous and Mental Disease, 182*, 387–395.

Save the Children. (1996). *Calls for action to end liberian refugee misery* [On-line]. Available: oneworld.org/scf/press/may14.html.

Segal, S. A., & Figley, C. R. (1988). Stressful events. *Hospital and Community Psychiatry, 39*, 998.

Simpson, M. A. (1993a). Bitter waters: Effects on children of the stresses of unrest and oppression. In J. P. Wilson, & B. Raphael (Eds.), *International handbook of traumatic stress syndromes*. New York: Plenum.

Simpson, M. A. (1993b). Traumatic stress and the bruising of the soul: The effects of torture and coercive interrogation. In J. P. Wilson, & B. Raphael (Eds.), *International handbook of traumatic stress syndromes*. New York: Plenum.

Smith, B., Agger, I., Danieli, Y., & Weisaeth, L. (1996). Health activities across traumatized populations: Emotional responses of international humanitarian aid workers: The contribution of non-governmental organizations. In Y. Danieli, N. S. Rodley, & L. Weisaeth (Eds.), *International responses to traumatic stress: Humanitarian, human rights, justice, peace and development contributions, collaborative actions and future initiatives*. Amityville, NY: Baywood.

Stamm, B. H., Bieber, S. L., & Rudolph, J. M. (1996). Review of stressful experiences content analysis coding scheme. In B. H. Stamm (Ed.), *Measurement of trauma, stress and adaptation* (pp. 333–348). Lutherville, MD: Sidran Press.

Stamm, B. H., Stamm, H. E., & Weine, S. (1994). *Genocide and communal identity: Shoshone Indians and Bosnian Muslims*. Paper presented at the 10th Annual Conference of the International Society for Traumatic Stress Studies, Chicago, IL.

Stamm, B. H., Varra, E. M., & Rudolph, J. M. (1996). Psychometric review of Stressful Events Content Analysis Coding Scheme (SECACS). In B. H. Stamm (Ed.), *Measurement of trauma, stress and adaptation*. Lutherville, MD: Sidran Press.

Suris, J., Parere, N., & Puig, C. (1996). Chronic illness and emotional distress in adolescents. *Journal of Adolescent Health, 19*, 153–156.

The War Page. (1997). *1997 has about 60 wars in progress* [On-line]. Available: www/aloha.net/fritzbee/pagesix.htm#61.

Tierra Blanca. (1994, March 19). *Syracuse Post-Standard* C-1.

Turnbull, R. (1986). The stages of grief. In R. Turnbull (Ed.), *Terminal care*. Washington, DC: Hemisphere.

Tyson, G. A. (1983). Stress and detention. *South African Medical Journal, 64*, 858–859.

Warheit, G. J., Zimmerman, R. S., Khoury, E. L., Vega, W. A., & Gil, A. G. (1996). Disaster related stresses, depressive signs and symptoms, and suicidal ideation among a multi-racial/ethnic sample of adolescents: A longitudinal analysis. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 37*, 435–444.

Weine, S., Becker, D., McGlashan, T., Vojvoda, D., Hartmen, S., & Robbins, J. (1995). The psychiatric consequences of "ethnic cleansing:" Clinical assessments and testimony of Bosnian refugees recently resettled in America. *American Journal of Psychiatry, 152*, 536–542.

Weine, S. M., Farley, M., & Munczek, D. (1995). *Trauma research as intervention in human rights violations: Prostitution, disappearance and genocide.* Paper presented at the 11th Annual Meeting of the International Society for Traumatic Stress Studies, Boston, MA.

Weine, S. M., & Laub, D. (1995). Narrative constructions of historical realities in testimony with Bosnian survivors of "ethnic cleansing". *Psychiatry, 58*, 246–260.

World Health Organization. (1995). *World Health Report 1995—Executive summary* [On-line]. Available: http://www.who.org/programmes/whr/.back/xsum95_e.htm.