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The Traumatization of Grief? A Conceptual Framework for Understanding the Trauma-Bereavement Interface

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Abstract: Scientific opinion differs on whether pathological (or complicated, traumatic) grief is an entity distinct from post-traumatic stress disorder. Some argue that it is different, and for the creation of a new category of pathological grief for the DSM system, while others consider bereavement and associated grief reactions to fall within the category of traumatic life events, for which the existing system would offer adequate classification. Although investigators have begun to explore similarities and differences in the trauma and bereavement domains, there is still confusion and lack of consensus about definitions and basic concepts. A conceptual framework, suggested here, may help bring clarity to the area. Our analysis shows that the lack of consensus about the nature of reactions and disorders of bereavement is due to concentration on different parts of the framework. Furthermore, the lack of differentiation between traumatic and non-traumatic bereavement has caused neglect of the unique features of non-traumatic grief reactions. These components need further exploration, especially since extension of DSM classification is currently under consideration.

Introduction

It is important to establish how the two research fields of bereavement and trauma should be defined and conceptualized in relationship to each other. Should the phenomena be considered as separate entities, or should bereavement, being an extremely stressful life event, be included and analyzed among the broader range of devastating experiences that make up the category of traumatic life events? The decision taken on this issue has important consequences. For one thing, it affects judgements about the nature and categorization of pathological responses to trauma or bereavement. It also affects such matters as operationalization and selection of appropriate measurement instruments. Not least, the viewpoint taken will influence the choice of theoretical approach. Conversely, as it happens, the theoretical viewpoint taken by the researcher influences opinion whether bereavement phenomena should be considered as a separate, subsumed, or overlapping category, in relationship to those of trauma.

In fact, examination of research on bereavement and trauma across the decades shows systematic shifts in scientific thinking on this issue. The earliest work of bereavement failed to consider trauma. To trace this briefly: although Freud was interested in the impact of traumatic events on psychological functioning, this was not the subject of discussion in his classic article on bereavement, "Mourning and melancholia" (1). Rather, in this paper, which was to become the major landmark in the early history of scientific understanding of bereavement, he addressed the distinction between normal grief (translated as "mourning," see 2) and clinical

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depression ("melancholia"). Quite separately (although also of interest to Freud) attempts to understand traumatic experience were conducted in the context of the First World War, with cases of "shell shock" providing psychiatrists with good reason for scientific investigation. This early lack of direct comparison between the phenomena of trauma and bereavement continued through the 1940s with Lindemann's (3) similarly influential contribution "Symptomatology and management of acute grief." Many of Lindemann's respondents were survivors of a nightclub fire, which claimed lives. Although Lindemann described reactions as acute grief, it is evident that some survivors were traumatized as well as bereaved (cf. 4, discussed in 5) — and yet, no differentiation of these two influences on symptomatology was made by Lindemann.

The research fields developed along fairly separate lines throughout much of the Twentieth Century. Within the bereavement field, momentum grew with the work of Parkes (6) describing the specific consequences of loss of a loved one in adult life, while work on trauma fell within the more general study of psychosocial stress (7-9). Within the latter field, Horowitz (10) formulated his concept of the "stress response syndrome." Within this original framework, bereavement would be an event no different from other traumatic or stressful ones. These rather independent trends continued in both theoretical and empirical domains until recently. Effectively, with few exceptions (e.g., 11, 12), bereavement researchers have worked independently of the theoretical and empirical input of trauma researchers, and vice versa. However, as we shall see below, during the last decade this was superceded by the emergence of different sets of opinions, some researchers emphasizing the interrelatedness and overlap, others the independence and distinguishing features of the phenomena. Much of the discussion has been fuelled by claims about the status of pathological grief as a distinct versus incorporated (in other categories) diagnostic disorder, in classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM, 13).

It is important to note that, although the literature uses very different terms for "non-normal" reactions to bereavement, including traumatic grief, or complicated grief, throughout this manuscript we will use the term "pathological grief" to signify the non-normality of, or complications in, the grieving process as a response to bereavement. We will make clear how other researchers define and use the various terms in the specific discussions of their work that follow.

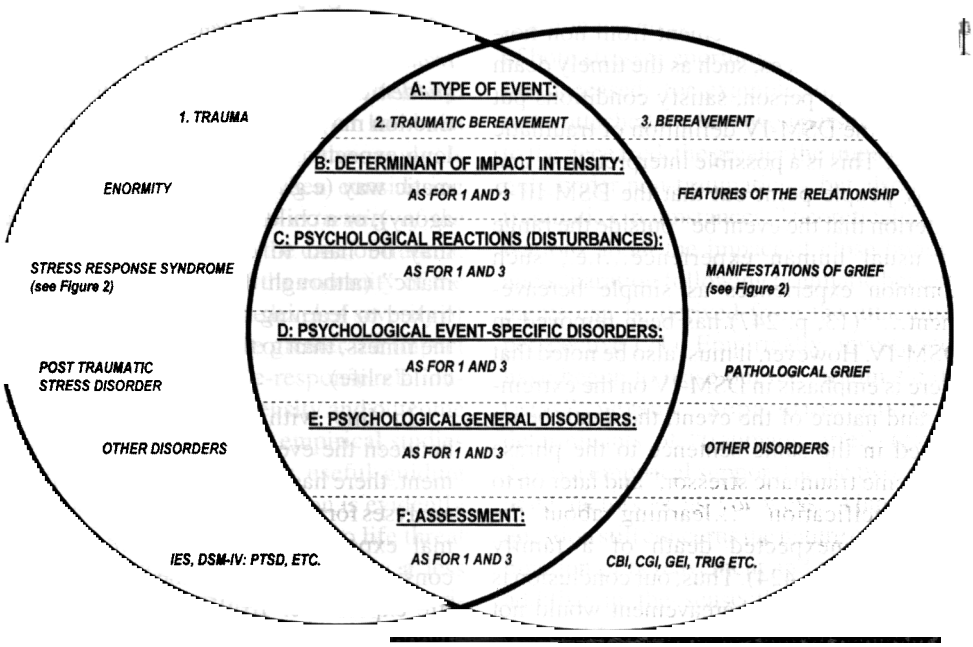
Given the importance both for conceptual understanding and for the purposes of assessment, a review of contemporary views on the phenomena and manifestations of bereavement and trauma appears timely. To this end, we develop a conceptual framework to explore the interface of psychological reactions to trauma and bereavement. Several levels of analysis need to be differentiated within this framework. The two domains, trauma and bereavement, need first to be defined and specified, and their potential overlap versus distinction systematically mapped out. Then, the manifestations associated with these stressors need examination, with respect to normal reactions and more complicated ones. As we shall see, there have been discrepancies between scholars in the ways that they have conceptualized and assessed traumatic bereavement, Post-Traumatic Stress Disorder (PTSD) and pathological grief, leading to diverse classification and diagnostic criteria. We examine the arguments on which these are based. In conclusion, we suggest the need for further differentiation of traumatic and non-traumatic bereavement and concentration on the phenomena associated with non-traumatic bereavement as normal reactio

to the death of a significant person. Separating the manifestations in this way will result in better understanding of phenomena at the interface of trauma and bereavement.

Trauma and Bereavement: A Conceptual Framework

The extent of overlap of the two environmental stressors, trauma and bereavement, can be depicted in a diagram (see Figure 1). This diagram separates out the definition of the phenomena per se, that is, the types of event (Category A), from the scientific analyses of the manifestations associated with the two events (Categories B-F). Fundamental to our conceptualization is the view that the phenomenology of reactions to bereavement is influenced by the type of event that has taken place. Thus, we need to start with understanding of the mode of death and type of bereavement, and examine phenomenology in relation to these. Scientists have used different criteria on which to base their evaluations of the intensity of the impact of the two types of events (Category B). Likewise, they have subdivided the reactions associated with each event into psychological (and physical) reactions to loss that we designate "disturbances" (on the understanding that bereavement leads to upheaval) said to be "normal" (Category C), versus event-specific psychological disorders which, for our purpose, we designate "pathological" (Category D). It is important to consider the occurrence of general disorders, which may either be directly associated with the occurrence of the life event (i.e., causally) or which may simply co-occur (i.e., comorbidity, non-causal) (Category E). Finally, how have investigators gone about assessing reactions, both "normal" and pathological (Category F)? We discuss each of these categories next.

Figure 1. *The Interface of Trauma and Bereaveme*



A. Types of events. What *type of event* is said to comprise a trauma, on the one hand, or a bereavement on the other? In common usage, traumatic events are typically conceptualized as those that entail the personal experience of drastic, horrendous, unpleasant, shocking events. Examples range from manmade events such as concentration camp internment and violence (war experiences, rape, robbery, murder) to natural disasters such as floods, hurricanes or volcanic eruptions. Following this generally-accepted conceptualization, traumatic events are taken by us to be those which are violent and untimely in nature. The experience of a trauma can, but does not necessarily, lead to the development of disordered symptomatology. The widely used DSM-IV states that disordered symptomatology occurs "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury...or learning about unexpected or violent death...or threat of death or injury experienced by a family member or other close associate" (13, p. 424). Could bereavement from non-horrific circumstances, such as the timely death of an elderly person, satisfy conditions put forth in the DSM-IV definition of traumatic events? This is a possible interpretation, and many people point out that the DSM-III-R criterion that the event be "outside the range of usual human experience...i.e., such common experiences as simple bereavement..." (13, p. 247) has been removed in DSM-IV. However, it must also be noted that there is emphasis in DSM-IV on the extremity and nature of the event, the death being linked in the same sentence to the phrase "extreme traumatic stressor," and later on to the specification "...learning about the sudden, unexpected death of a family member..." (p. 424). Thus, our conclusion is that *non-traumatic* bereavement would not be included in this category.

Overlap between trauma and bereave
ment (and the complications o
bereavement) already becomes apparent
since according to the description above, th
traumatic experience leading to the develop
ment of disordered symptomatology can b
the experience of the death of a close perso
But, just as trauma is more inclusive tha
bereavement, so is bereavement more inclu
sive than the limits defined by the category
extreme traumatic stressors. It is noteworth
that some investigators of the interfa
between bereavement and trauma refer
bereavement as "loss" (e.g., 14, 15), but v
prefer "bereavement" because the term
more specific, and because "trauma" al
frequently includes losses (e.g., loss of
limb). Bereavement refers to the situation
a person who has recently experienced t
loss of someone significant through that p
son's death (e.g., death of one's partn
parent or child). This is not always a tr
matic occurrence. Fundamental to
conceptualization is the exclusion of th
bereavements from the "traumatic berea
ment" category that are *not outside the ra*
of usual human experience, are *not extrem*
traumatic types of stressor, and are
sudden and unexpected. In reality, the
tinction may sometimes be hard to make
long-expected death may occur in a t
matic way (e.g., the dying person suffe
agony), or a child's death, however grad
may be hard to categorize as "non-t
matic" (although the trauma may be n
linked to learning of the terminal natur
the illness, than to the peaceful ending o
child's life).

In line with these basic differe
between the events of trauma and bere
ment, there has been a tendency in scie
analyses for trauma to be viewed as an ab
mal experience, whereas bereaveme
considered to fall within the range of no
life experience. To illustrate, accordi
Jacobs (16): "...trauma is not universa

inevitable like bereavement" (p. 356). This perceived difference in relative "normality" of the two types of events has had far-reaching implications, to be discussed below.

In conclusion, Figure 1 underlines the fact that traumatic events can occur without bereavement, and vice versa. They can thus be considered distinct phenomena in some cases. But there are also events that are both, creating the third category of "traumatic bereavements" (or as important to consider: traumas that include bereavement). Important for subsequent discussion is our definition of traumatic bereavement as one in which the death occurred in highly impactful circumstances, those that are not a universal, inevitable part of normal life. It refers then to the nature of the event, and not to the personal reaction — closely though these may be related. As we will argue later, personal reactions to non-traumatically occurring bereavements may also involve high distress, disturbance, and sometimes disorder. But, according to our formulation, the nature of these reactions is likely to be different from those following traumatic bereavements.

B. Determinants of impact intensity. While the pattern depicted so far has been relatively straightforward, the analysis becomes more complex when considering factors that determine the *extremity of the impact* of the stressor. In the case of trauma, this has much to do with the enormity of the event (e.g., the greater the level of severity of exposure to stressors, the greater the impact on the individual). A dose-response relationship between stressor intensity and outcome has usually been found in empirical studies (cf. 17). Although this is a useful guiding principle, further quantification is evidently needed. For example, exposure to life threat without physical damage is usually a less enormous event than one where there is serious physical damage.

Like trauma, in the case of bereavement, it is possible to argue that enormity of the event is a strong determinant of impact intensity. However, for bereavement, the intensity of the reaction relates more to features of the relationship, including the closeness and type of the relationship to the deceased person (e.g., attachment, dependency). Thus, rather than using the term "enormity," the central feature relating to intensity of bereavement reaction can best be defined in terms of features of the relationship. Again, we must recognize that further specification is in order (features of a relationship such as "closeness" and "type" cover many factors, including conflict in the relationship and/or insecure attachment of the bereaved), discussion of which is beyond the scope of this article. Rubin (18), Klass, Silverman and Nickman (19) and Sanders (20) provide theoretical and empirical analyses of the nature and impact of relationship and continuing affectional bond to the deceased, from which taxonomies of relationship features could be derived.

Again, in traumatic bereavements the reaction would be expected to be a function of both stressor enormity and relationship to the deceased: for example, the closer and more attached the bereaved person had been to the deceased, the greater the impact — not only under non-traumatic — but also under traumatic circumstances. Theoretically, derivations about the impact of close bonding and separation following traumatic bereavements can be derived from the attachment perspective (21). Empirically, investigators have begun to tease out the "traumatic distress" versus "separation distress" determinants of "traumatic grief" (cf. 22, 23), but empirical support for the two as separate factors is as yet weak. Thus, a key question still concerns the nature of this combination of bereavement and trauma — is it additive in the sense that symptoms just cumulate, or interactive/incremental, in the

sense that there is intensification of the symptoms common to both? Nader (24) presents strong arguments for the latter interpretation. For example, thoughts of the deceased may lead to traumatic recollection, or traumatic aspects of the death may complicate issues of bereavement. We return to consider this key point in further detail below.

It is already apparent that the analysis of the phenomena associated with trauma and with bereavement has theoretical underpinnings (see 25 for more detailed discussion). It is beyond the scope of this paper to discuss the relationship of such theory-building as cause or consequence of the mapping out of typologies in Figure 1, but we need to be aware that our conceptual analysis is influenced by theoretical interpretation. It is also important to note at the outset that, whereas some consider bereavements to be "traumatic" because they are highly impactful (due, for example, to the closeness to or dependency on the deceased), in our framework, a bereaved person would be "traumatized" only if the events surrounding death occurred traumatically. This does not mean that non-traumatically-occurring deaths cannot be enormously impactful. It means that reactions are likely to incorporate different phenomena and manifestations, depending on whether the death was or was not a traumatic event. It also does not exclude other factors (than the mode of death) from the determinants of impact in bereavement (reason for death; personality of the person lost / of the survivor; complications in the relationship, etc.).

It is important to note that researchers in the specific fields of bereavement and trauma have been seeking to identify "objective" criteria to determine a person's (psychological) reaction to a stressor (e.g., closeness, exposure to stressor, physical damage). By contrast, in the field of emotion research in general, given that people respond very differently to what seems to be "objectively" the same types of event researchers agree that a person's reaction to an emotion-eliciting stimulus represents a multi-faceted reaction to the *personal meaning the emotion-eliciting situation holds for the individual* (e.g., 26-28). This aspect of personal meaning has not yet received much attention in the reaction to trauma and/or bereavement.

In conclusion, scientific analysis of determinants of impact of trauma versus bereavement has focused on different indices (enormity versus relationship), which reflect fundamental differences in the nature of these stressors. As we shall see below these correspond to differences in the nature of reactions and disorders of normal psychological functioning associated with the two events.

C. Psychological reactions (disturbance)

Bereavement, like trauma, precipitates *psychological disturbance*, in the sense of upset and arousal, in most individuals, which would be classified as "normal" reaction. However, patterns of response differ following the two life events (see Table 1 for overview of typical reactions and symptoms; cf. 2, 10; for more detailed comparisons, see 24, 29, 30).

Normal reactions following a trauma event have been described as a "stress response syndrome," a dominant feature which has been described as intrusion versus avoidance (10, 31). By contrast, the reaction to bereavement — grief — is said to incorporate a broad range of emotional, cognitive and behavioral manifestations (cf. 6, 25). In each case, symptomatology typically diminishes over time, although there may be long-lasting effects. There is recognition in the literature that both types of symptomatology (stress response syndrome and grief) are likely to be present following trauma bereavement and that the former reac

may interfere with the latter (see 32, 33). In this context, Raphael and Martinek (29) speak of the "double psychological burden" (p. 383) of dealing with both these psychological processes. There may be intensification and overlap of symptoms, for example, reminiscent thoughts versus horrendous recollections; grief work versus trauma intrusion; continued bond/identification versus anger and rage at the event's occurrence (cf. 24).

Table *Psychological Reactions to Trauma and Bereavement*

Trauma	**Bereavement**
Intrusive symptomatology	Affective
• Hypervigilance	• Depression, despair, dejection
• Startle reactions	• Anxiety, fears, dreads
• Illusions	• Guilt, self-blame, self-accusation
• Repetitive thoughts	• Anger, hostility, irritability
• Overgeneralization of associations	• Anhedonia — loss of pleasure
• Inability to otherwise concentrate	• Loneliness
• Thought disruption	• Yearning, longing, pining
• Labile or explosive states of mind	Behavioral
• Sleep and dream disturbance	• Agitation, tenseness, restlessness
• Symptoms of flight/fight readiness	• Fatigue/overactivity
• Searching behavior	• Searching
Denial/avoidance symptomatology	• Weeping, sobbing, crying
• Daze	• Social withdrawal
• Selective inattention	Cognitive
• Amnesia	• Preoccupation with thoughts of deceased
• Inability to visualize memories	• Lowered self-esteem
• Thought inflexibility	• Self-reproach
• Fantasies counteracting reality	• Helplessness, hopelessness
• Numbness, detachment	• Sense of unreality
Overcontrol, inc. avoidances	• Retardation of thought, memory, concentration
Sleep disturbances (too much/too little)	**Physiological/somatic**
Tension-inhibition responses of ANS	• Loss of appetite
Frantic overactivity	• Sleep disturbances
Withdrawal	• Energy loss, exhaustion
	• Somatic complaints
	• Physical complaints similar to deceased
	• Changes in drug intake
	• Susceptibility to illness, disease

ıe symptoms listed in Table 1 are categoed in different ways, the stress response ıdrome list according to intrusion-avoid:e, the grief manifestations according to affective, cognitive and behavioral/physiological symptoms. Nevertheless, closer examination suggests much overlap, for example, both lists include such reactions as

intrusion of memories, dream and sleep disturbance, concentration problems and anxiety. Commonality is to be expected, of course, on the grounds alone that the grief symptoms list includes reactions to traumatic bereavement (the list having been compiled for bereavements in general). Simpson (30) emphasized that clinically significant distress and impairment in functioning are common to both normal grief and stress response syndromes, and of similar duration. Other common features to non-bereavement trauma and non-traumatic bereavement he identified as guilt and shame, self-destructive impulses, hostility to others, lasting changes in value systems and beliefs, and a lasting search for meaning.

But are there, in fact, *distinguishing* features between the two? Raphael and Martinek (29) have tried, on the basis of available evidence (more is needed, they say) to identify the differences in typologies. According to these investigators, intrusions, memories and preoccupations differ between the two types of events on the basis of content. In trauma this is the scene of the event, in bereavement it is the lost person. Likewise, in the former, anxiety is associated with the experienced threat, and to reminders, in the latter anxiety is specifically separation anxiety with respect to the deceased person (cf. 29). Unique to grief, however, is yearning and pining. Sadness is usually present in grief, but not so typical of traumatic reactions. Trauma survivors are more avoidant of affects and reminders, and more withdrawing from others. Bereaved persons rather tend to seek out reminders and talk to others about their experience. Arousal is associated with both types of event, but the orientation is different. Kleber and Brom (34) summarize some of the focal differences succinctly:

"In grief, the adaptation to a situation without a loved one plays an important role. A partner, confidant, and source of support has fallen away. The environment ha changed drastically. The effects and th coping process are less focused on the ever of the death, but more on the loss of the love one and the building of a new life. Sadnes and depression are therefore the emotion more strongly in the foreground after a los while anxieties play a less important ro than in other traumatic events" (p. 124).

In conclusion, the classification of ps chological reactions consequent to traur experience or bereavement (Table 1) diff with respect to generality and level abstractness of the categories. Likewise, t grief list focuses on symptomatology alor whereas the trauma list is more inclusi covering symptoms, the coping process a phases (trauma). When this is taken into co sideration, there is much overlap in reactio to traumatic events and bereavement. Nev theless, we have pinpointed an import difference in reactions associated with exclusive categories non-bereavem trauma and non-trauma bereavement: in latter, reactions are focused around the on ing affectional bond to the deceased pers whereas in the former, anxieties associa with the traumatic occurrence itself are c cal.

D. Psychological disorders (life event cific). Traumas and bereaveme precipitate *psychological disorders* in s (by no means all) individuals. Popula studies have indicated that, on average, a a quarter of individuals who are expose an extreme stressor go on to develop a blown PTSD syndrome (cf. 17). In re years, much attention has been given t development of PTSD as a trauma-spe disorder, since its introduction into the l system in 1980 (cf. 35). It is importa remember that other anxiety disorders also been closely linked to the occurren traumatic experiences — high anxiety l common following trauma exposure

and possibly being even the most prominent category of disorders following traumatic experience (cf. 14). Parkes (36) noted that, following the plethora of research in connection with the establishment of PTSD, PTSD was often, mistakenly, taken to be the commonest consequence of psychological trauma. Thus, it is important to consider other consequences than PTSD (see below).

Bereavement-specific complications occur following this life event, just as they do for trauma, for grief itself may take a complicated course. Like PTSD, pathological grief can be a long-lasting disorder in many of the individuals who suffer from it (estimates for its occurrence typically ranging from 10-15%). Well-established are three categories of pathological grief, namely, inhibited grief (i.e., absent or minimal), delayed grief (characterized by late onset, and intense) and prolonged, chronic grief (cf. 5, 6). These types of pathological grief are not considered to follow traumatic bereavements alone, but that they may follow the non-traumatic loss of a close person.

In contrast to the trauma-specific category PTSD, pathological grief has not been classified in the DSM system (13) as a diagnostic category, but a "condition that may be a focus for clinical attention" (so-called "V-codes"). Attempts to change this state of affairs, to include pathological grief as a distinct diagnostic disorder, are currently being made (for a review, see 37).

We noted above that there may be interference and added burden when an individual has to deal with an experience that is both traumatic and a bereavement. At this interface, then, complications in the grieving process would be expected. It is for this group of individuals that **some** investigators have recently suggested a separate diagnostic category although, as we shall see, it is sometimes unclear whether complications following non-traumatic bereavements should also be included.

In conclusion, although both trauma and bereavement have specific pathologies associated with them, the status of PTSD and pathological grief in diagnostic systems such as the DSM is not equivalent, the former being a separate diagnostic category, the latter not. This unequal treatment may be due to the fact that we commonly think of trauma as beyond the range of normal human experience, whereas bereavement is considered a normal part of human experience. The question arises, then, whether "pathological grief" should be created as a category, whether it should be designated as "traumatic grief" among stress disorders, or whether it merits classification at all.

E. Psychological disorders (general). Other conditions may be present following traumas and bereavements. Not only is comorbidity with the event-specific disorders described above frequent (simple co-occurrence), but the events may bring about an increase in the risk of other disorders (38), their manifestations being "directly associated with" psychological trauma and traumatic stress in general (cf. 14). In particular, as noted above, traumatized individuals often develop other anxiety disorders. These lists, compiled from various research sources (e.g., 39, 40) — if not completely inclusive of all DSM categories — are still too general to be very useful. Needed is further specification on the basis of empirical research.

Bereavement too places the individual at high risk for different types of psychiatric disorder, including Major Depressive Disorder, anxiety disorders, and substance abuse. A direct association of bereavement with these disorders has been reported (e.g., 41, for depression). However, although investigators have begun to examine the relationship of types of bereavement with disorders (e.g., 42-44), it is still not yet clear how precisely the disorders are associated

between normal grief manifestations and PTSD criteria, leading him to the conclusion that there was no justification for excluding normal bereavement from the category of traumatic life stressors.

Bereavement and trauma as two separate sets of phenomena. By contrast, Raphael and Martinek's (29; see also 58) conceptualization focuses on the two sets of phenomena associated with traumatic experiences, on the one hand, and bereavement, on the other. They describe these in terms of specific, frequently contrasting core reactions (cognitive processes; affective reactions; avoidance phenomena; arousal phenomena; reactive processes including facial expression). They argue that the phenomena differ in important ways. Raphael and Martinek (29, p. 392) state that trauma may lead to traumatic stress reaction and perhaps the development of PTSD, while loss of a loved one leads to grief and perhaps chronic grief disorder. According to this view, types of symptoms may be similar, but their content is different. Importantly, aspects of the reaction may be diametrically opposed, for example, the memory of disfiguration in a death by accident may "interfere" with the tendency to dwell on the deceased's appearance. Fundamental to Raphael and Martinek's (29) position is that these two different sets of phenomena interact in "traumatic bereavement." The survivor would be expected to experience both types of reactions, either together or alternately.

Pynoos and Nader (59) examined traumatic and grief reactions among children exposed to a sniper attack at a school. Severity of exposure was highly associated with PTSD symptoms, whereas closeness to the killed children predicted grief reactions. These investigators also argued that loss (bereavement, in our terms) and trauma interact to intensify the symptoms common to both: "When loss and trauma collide, they create an experience — traumatic bereave ment — that is more than merely the sum o its parts" (24, p. 173). This, then, is also sim lar to Raphael and Martinek's notion th symptomatology is exacerbated. It seen fair to say that these investigators rega bereavement (grief) and trauma (traun reactions) as different human experienc even when precipitated by a single event (s also 60).

Traumatic bereavement: the intersecti of bereavement and trauma. Several inve tigators have focused on the intersecti between trauma and bereavement (that is, the overlap in the circles of Figure 1) f which, they argue, a distinct diagnostic ca gory of "traumatic grief" needs to be creat (e.g., 14, 15). Rando (14) described tra matic bereavement as "one variation complicated mourning," contending that a differences between uncomplicated acu grief and traumatic stress responses are p marily in content and degree, and n necessarily in underlying, dynamic p cesses. Along similar lines, Green (1 argued for more exploration of the overlap trauma and bereavement, noting th "...while there are clearly some differen in reactions to bereavement and trauma, a the process of recovery from them, the t areas may not be as distinct as we have b treating them" (p. 14). She recommen focus within the area of "unnatural" or tr matic death, to provide both conceptual a empirical linking of the fields. In her viev is the mode of death that makes a berea ment more or less traumatic. Thus, the fo is clearly on the section of interface, and on complications within the sphere of n traumatic bereavement.

Pathological grief following non-tr matic and traumatic bereavement. Hig influential among recent formulations h been the contributions of two teams of

searchers, guided by Horowitz, and by Jacobs and Prigerson (for a comparison of the two sets of criteria, see 5, p. 20-21). Jacobs and Prigerson's conceptualization of "traumatic grief" (e.g., 5, 16, 53) appears to cover both traumatic and non-traumatic bereavement experiences, (the total right hand circle of Figure 1), focusing on the intensity and symptomatology of distress. For instance, Jacobs (16) argued that "...it is possible to conceptualize trauma and loss as separate experiences and distinct processes...each experience is distinctive and potentially leads to a unique type of clinical complication." He went on to add, though: "However, in some ways loss and trauma resemble each other... These similarities establish common ground for both loss and trauma that argues for their inclusion together as stress-related disorders" (p. 356).

This line of reasoning has been developed in their most recent publications (e.g., 53, 61). They argue for the establishment of a distinct clinical entity, that is, one that is separate from PTSD (and from other disorders), to be designated "Traumatic Grief" (for diagnostic criteria, see 5, p. 28, Table 1; 53, Table 1). Traumatic Grief refers to pathological grief, a unified syndrome distinct from bereavement-related depression and anxiety, and distinct, too, from normal reactions to bereavement. It is *not* specific to traumatic bereavement, the relevant criterion being that the person has "experienced the death of a significant other." The taxonomic principles underlying the diagnostic category were derived from clinical descriptions of people who had experienced not only traumatic but also non-traumatic types of bereavements. In line with this, the symptoms were conceptualized as falling into two categories, separation distress (relating to the missing of the deceased) and traumatic distress (feelings of shock, dissociation, etc.).

Following the conceptual framework outlined above, there would be good reason to argue that these so-called "dual elements" (53, p. 4) in one diagnostic category are conceptually distinguishable and should be specifically, separately defined in relationship, first, to traumatic bereavement experience (traumatic distress) and second, to non-traumatic bereavement experience (separation distress). Prigerson and Jacobs (53) also show that there is unity among the proposed "traumatic grief" symptoms and conclude that a single category is appropriate.

There is no restriction to traumatic bereavement in Horowitz et al.'s (55) formulation, the person having experienced "Bereavement (the loss of a spouse, other relative, or intimate partner)..." and diagnostic criteria consisting of intrusive and avoidant symptomatology specifically about the relationship with the deceased person (see 55, p. 909, Appendix 1). Thus, like Jacobs and Prigerson (53) these researchers do not separate the types of complication that might be associated more particularly with non-traumatic from those associated with traumatic types of bereavement. Furthermore, following the above reasoning, it is not clear why a new category, rather than an extension of PTSD event criteria, is needed.

Pathological grief following non-traumatic bereavement. Conspicuously absent from classification proposals has been an independent consideration of complications associated with non-traumatic bereavement. As we have just seen, the major investigators have included these within the broader category defined as "complicated" or "traumatic" grief. A rare exception was an earlier formulation by Jacobs (16, p. 363-369, appendix) who developed criteria for delayed/absent, inhibited/distorted and chronic grief, following the formulations of, for example, Parkes and Weiss (62) and Raphael. These have been superceded by Jacobs' creation with Prigerson of the cate-

gory "traumatic grief," and may, Jacobs (5) argued, reappear as subtypes of traumatic grief following further investigation.

In our view, this is a critical omission. Many of the complications of bereavement have nothing to do with the fact that death was traumatic, but rather with the nature of the relationship with the deceased person. Separate consideration of these types of complication is essential.

Concluding Remarks

A conceptual framework has been suggested to clarify the relationship of the phenomena and manifestations associated with trauma and with bereavement. Particular attention was paid to the lack of differentiation between the two types of events and the various classifications of associated pathological symptomatology. The proposed framework allowed us to pinpoint an important shortcoming of the literature. Non-traumatic and traumatic bereavement may bring about a unique pattern of pathology which, in some cases, may require clinical treatment. The question arises, however, whether we need a diagnostic category for pathological grief. Given the important theoretical and clinical implications of this question, more research is urgently needed to document whether or not pathological grief qualitatively and / or quantitatively differs from reactions to trauma, such as PTSD, or normal reactions to bereavement (i.e., normal grief). By the same token, the interface of trauma and bereavement warrants empirical research to determine how and to what extent traumatic bereavement differs from trauma and from bereavement alone (cf. 37). With these questions left unanswered, it is clear that much work still needs to be done to pinpoint the exact differences and similarities between (1) trauma, bereavement and traumatic bereavement and (2) stress reactions and PTSD, on the one hand, and normal and pathological grief, on the other. When investigating these questions, extra attenti should be paid to the theoretical and practic implications of creating a new DSM catego for grief, because an essentially norm (though harrowing) reaction to the death o significant person will become placed in t realm of psychopathologies.

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