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Trauma and Grief: A Comparative Analysis

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The expression in the English language "to come to grief" is synonymous with "to meet with disaster." One could infer, then, that bereavement is to be considered a disaster—a traumatic event. In fact, the studies of bereavement and trauma share a common origin in the seminal work of Sigmund Freud. It can be said that Freud's (1917) contribution "Mourning and Melancholia," providing, as it did, the first theoretical analysis of distinctions between normal and complicated forms of grieving, has shaped the development of the scientific study of bereavement up to the present day. Likewise, the evolution of his ideas about the relationship of traumatic events to the development of hysterical symptoms, most notably in his volume with Breuer *Studies in Hysteria* (Breuer & Freud, 1895/1937) and in his later work, influenced by World War I experiences with war victims, are still of relevance to trauma research (see Kleber & Brom, 1992).

It is even more curious to note that Freud's interest in the phenomena of both trauma and bereavement was stimulated to a very large extent by one single case, that of Anna O, a patient of Breuer. This young woman had been ill, suffering from symptoms that were hard to diagnose, for quite some time before the death of her father. She had seen him only rarely during her illness, and she apparently idolized him. His death, as Breuer described, was "the most severe psychic trauma which could have happened to her" (Breuer & Freud, 1895/1937, p. 17).

There are, then, good reasons to argue that the early origins of the fields of both bereavement and trauma are not only to be found in the work of one scholar, but in a single case study. Anna O. was utterly grief-stricken and, according to Freud's detailed analysis of this case, deeply traumatized as a consequence of the loss of her beloved father. There was no question, it seems, in Freud's mind, that loss was coupled with reactions relating to both grief and trauma.

Yet, despite this common history, which persisted through the 1940s, with Lindemann's (1944) classic analysis of symptomatology following traumatic bereavement, scientific investigations of bereavement and trauma have developed into relatively independent disciplines and have been treated differently with respect to scientific analysis. As will be elaborated below, trauma has been examined in the context of pathology, whereas bereavement has been treated as a normal human experience.

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There are good reasons to argue that bereavement should be viewed within a general framework of stress response syndromes, that is, to study bereavement as a trauma. After all, bereavement represents a major stressful life event in most people's lives. Nevertheless, the question arises whether this approach provides an adequate explanation of ways of coping with bereavement. In order to evaluate this, one first needs to describe commonalities and distinctions between the phenomena of trauma and bereavement, to identify respective patterns of reactions, and to examine the contribution of theoretical formulations provided by each area. Examination is made of these three aspects—the phenomena, the manifestations, and the respective theoretical approaches—in this chapter. This should enable assessment of how each field can profit from knowledge acquired in the other discipline. The focal theme of this chapter is thus to explore ways that models of grief and trauma may grow through knowledge acquired in the other field.

The work of Mardi Horowitz on trauma (e.g. 1983, 1986) is distinctive not only as a major contribution to trauma research itself, but also as offering potential for application to the analysis of bereavement phenomena. Furthermore, examination of the *Diagnostic and Statistical Manual* (DSM-IV; American Psychiatric Association [APA], 1994) criteria for the disorder known as Post Traumatic Stress Disorder (PTSD) shows the influence of this particular perspective. This chapter's treatment of the trauma field, given the space limitations, will therefore focus on this theory. With respect to bereavement, a brief overview of traditional theorizing is first given in order to provide the necessary background to understanding our own approach, namely, the dual process model of coping with loss (Stroebe & Schut, 1995). This model is an extension of traditional approaches, which were found wanting in explanatory power.

There is a more general interest underlying the theme of this paper. Researchers must be aware and concerned about the possibility that the scientific process itself may have an impact on societal interpretation—in the case of trauma and of bereavement, by defining a phenomenon as either pathological or normal. Perhaps by bringing together the two scientific disciplines that analyse these related phenomena in such very different ways, we can reduce such polarization and provide more accurate representations of the two types of stressors and their psychological effects. One might say that we are using our two fields to make a comparative case study for reflection on the nature and consequences of the scientific endeavor itself.

THE PHENOMENA: TRAUMA AND BEREAVEMENT

First, the basics: how do we define the two life events, trauma and bereavement, and their accompanying symptomatologies, and what are the commonalities and distinctions between them?

Trauma

Trauma entails the personal experience of drastic, horrendous, unpleasant, shocking events. Examples of traumatic experiences range from war to natural disasters

such as hurricanes or floods, to man-made atrocities such as concentration camp internment, to violence, including assault on oneself or one's loved ones.

Trauma can, but does not necessarily, lead to the development of characteristic disordered symptomatology, most commonly known as PTSD, a disorder which is included in both of the widely used classification systems, DSM-IV (APA, 1994) and the International Classification of Diseases (ICD-10; World Health Organization, 1994). The *essential feature of the experience* leading to the development of characteristic disordered symptomatology is described as "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*" (APA, 1994, p. 424).

Bereavement

A bereavement can be defined as the situation of an individual who has recently experienced the loss of someone significant through that person's death. Some examples, as for trauma, come easily to mind: death of one's child, parent, spouse, sibling, or other person with whom one had a close, meaningful relationship. Others are less obvious, for example, in cases where a person suffers a loss that cannot be openly acknowledged, publicly mourned, or socially supported, such as in nontraditional love relationships (see Doka, 1989).

In contrast to PTSD, "bereavement" (i.e., the death of a loved one) is not classified in DSM-IV (APA, 1994) as a condition meriting recognition as a diagnostic category, but among "conditions that may be a focus for clinical attention" (so-called "V-codes"). It seems likely that this is a consequence of the general tendency to view bereavement as normal human experience. Nevertheless, there is strong pressure to create a category of pathological grief. It is beyond the scope of this chapter to go into this complex issue (see Horowitz, Bonanno, & Holen, 1993; Stroebe, van Son, Stroebe, Kleber, Schut, & van den Bout, unpublished manuscript).

Trauma and Bereavement: Commonalities and Distinctions

What is the extent of overlap versus distinctiveness of the two phenomena? First we need to consider the nature of the two types of stressors. The first commonality is obvious: both trauma and bereavement are environmental stressors which have been shown to precipitate psychological disturbance in most and disorder in some individuals. The second derives from overlap of the two stressors: some bereavements (deaths) are traumatic, as in the case of a daughter raped and murdered. Some traumas are (also) bereavements: one's family wiped out in the holocaust.

Nevertheless, trauma and bereavement can be distinct phenomena. It is possible to experience trauma without bereavement: all members of a family survive an armed gun raid; and bereavement without trauma: the peaceful, expected death of a loved one who gradually slips away.

Second, distinctions in types of definition can be identified. It is noteworthy that trauma is typically defined in terms of the extremity of the life event; the

enormity of the event itself is seen as critical to the degree of impact/outcome. To illustrate, it was formerly described, in DSM III-R (APA, 1980, p. 247), as an event "outside the range of usual human experiences (i.e., outside the range of such common experiences as simple bereavement . . .)". Bereavement, on the other hand, the "usual human experience" of the loss of a loved person, is defined in terms of the nature and closeness of the lost relationship, in addition to the extremity of the life event (sudden, traumatic bereavements are frequently considered to be the worst type). It will become evident that this makes an essential difference when the theoretical approaches to the two types of events are compared. We turn now to an examination of respective psychological reactions.

STRESS RESPONSE SYNDROMES AND GRIEF MANIFESTATIONS

The terms trauma and bereavement refer to life events, following which individuals may become "traumatized" or "grief-stricken," in everyday language (specialists are cautious in their usage of such words). Both states incorporate psychological and/or physical patterns of reactions that prototypically (not inevitably) occur following the event, but which subside with time, and do not constitute, necessarily, negative health outcomes. These are referred to, respectively, as stress response syndromes (Horowitz, 1986) and manifestations of grief (Stroebe & Stroebe, 1987; Stroebe & Schut, 1994). These are outlined next.

Stress Response Syndromes

Even normal manifestations following the experience of a traumatic event have been described as a "syndrome," and here Horowitz has been influential. In fact, knowledge about normal patterns of response largely derives from work on PTSD.

As mentioned above, the difference between normal and disordered reactions to trauma lies in the intensity and frequency rather than the type of reactions that occur: researchers regard them as lying on a continuum (van den Bout, Kleber, & Brom, 1991; Kleber & Brom, 1992, p. 190). For manifestations to become classified as a disorder they have to be more extreme: PTSD lasts much longer and gets blocked or aggravated. It is important to note that other pathological responses to traumatic events are possible (e.g., depressive reactions, anxiety disorders, dissociative reactions, and brief psychotic episodes).

Antithetical reactions of intrusion and denial are perhaps the most distinctive feature of trauma reactions to have been identified in contemporary scientific analyses. Horowitz (1986), on the one hand, identified *intrusion*, that is, compulsive reexperiencing of feelings and ideas to do with the event (sleep and dream disturbance, startle reactions, preoccupations, hypervigilance, inability to otherwise concentrate, searching behavior, review, and pangs of emotion). On the other hand, *avoidance* co-occurs, that is, denial and avoidance (including symptoms such as daze, evidence of disavowal, amnesia, selective inattention, frantic overactivity, inability to visualize memories, and numbing). These extreme deflections to "too much" or "too little" conscious experience may, according to Horowitz (Horowitz et al., 1993), either be simultaneous manifestations or may show a sequence of phases, a conception which, though not always occurring, is basic to his model of coping.

It is probably true to say that Horowitz (see, e.g., 1986) sees the symptomatology of intrusion and denial as at the essence of psychological reactions following a traumatic event. However, also characteristic of PTSD responses are anxiety-provoking ideas, worry over loss of control, new phobias plus fear of repetition of the traumatic event, chronic tension, and hypervigilance (Horowitz, 1986).

Grief Reactions

While Horowitz's approach to the identification of stress response symptomatology was through study of the minority of victims who suffer from PTSD, our analysis of the consequences of bereavement has been derived, for the most part, from nonclinical populations (cf. Stroebe & Stroebe, 1987). According to this, manifestations are dominated by negative affect, but also cover a wide range of *emotional, cognitive, behavioral, and physiological reactions* (these to some extent overlap). Affective manifestations include depressed mood, anxiety, guilt feelings, anger, anhedonia, and loneliness. Behavioral manifestations include agitation, fatigue, searching, crying, and social withdrawal. Cognitive manifestations include preoccupation with the deceased, lowered self-esteem, hopelessness, and retardation of thought and memory. Finally, physiological/somatic manifestations include loss of appetite, sleep disturbances, somatic complaints, and susceptibility to illness and disease. Not all of these symptoms appear in every bereaved person, nor at any one time across the duration of bereavement.

Included among the disorders for which bereaved people are at heightened risk are depression, anxiety disorders, somatic complaints, and infections (cf. Parkes, 1972/1996; Stroebe, Stroebe, & Hansson, 1993). DSM-IV (APA, 1994) states that as part of their reaction to loss, "some grieving individuals present with symptoms characteristic of a Major Depressive Episode" (p. 684), and yet, there are differences. Symptoms not characteristic of "normal" grief that also differentiate from a major depressive disorder were listed as: "(1) guilt about things other than actions taken by the survivor at the time of death; (2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; (3) morbid preoccupation with worthlessness; (4) marked psychomotor retardation; (5) prolonged and marked functional impairment; and (6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person" (APA, 1994, pp. 684–685).

There is further evidence from recent empirical work that indicates the need for a distinct category of complicated grief. Prigerson has identified a set of symptoms that are distinguishable from bereavement-related depression, and which are associated with enduring functional impairments (see, e.g., Prigerson et al., 1995). Symptoms of complicated grief included searching, yearning, preoccupation with thoughts of the deceased, crying, disbelief regarding the death, and lack of acceptance of the death. In Prigerson et al.'s (1995) analyses, the symptoms have much to do with the lost relationship and attachment to the deceased, but less with trauma symptomatology.

Despite such advances in understanding, it is nevertheless difficult to define

"pathological grief." As a general guideline, one can say that pathological grief is a deviation from the (cultural) norm in the time course or intensity of specific or general symptoms of grief (cf. Stroebe & Schut, 1994). The deviation may occur with respect to the *timing* of specific or general symptomatology. There may be a blocking of certain thoughts and/or feelings; the bereaved person may also get stuck or "locked" with respect to one single aspect (e.g., guilt); something may have "gone wrong" in recovery; or there may be a "standing still" in the grief process.

Commonalities and Distinctions between Traumatic Stress and Grief Responses

Manifestations. At first inspection, reactions following the two types of event look very different, and clearly, there are differences due to the very nature of each event: one cannot yearn for the deceased if there is no deceased. But one can yearn for a lost livelihood, or the use of one's limbs after spinal injury. There is also considerable overlap. Were we to apply Horowitz's categorization to nontraumatically bereaved persons, we would find much that would be an accurate description, and the same would be the case in applying the grief symptomatology categorization to nonbereavement trauma victims.

Furthermore, resemblance between reactions to the two events has been empirically shown. In a study conducted in the Netherlands, an evaluation was made of the proportion of conjugally bereaved persons who experienced post traumatic stress symptomatology. In this two-year longitudinal study, 50% of a bereaved sample met the criteria for PTSD at one of four data collection points, whereas 9% did so at all four points (Schut, de Keijser, van den Bout, & Dijkhuis, 1991).

Nevertheless, in each field, specific symptomatologies have been identified which reflect the scientific interpretation of each life event. In the trauma area, general patterns of symptoms (cognitions, memories, etc.) have been identified in relationship to the *stressfulness of the traumatic event itself and its aftermath.* Focus is on anxiety reactions. Bereavement research has concentrated on specific symptomatology due to *loss of an attachment figure.* Symptomatology (most centrally, depression) relates not only to the death event itself, but to life with the deceased. Trauma research has much to learn by considering aspects to do with the lost relationship, when this co-occurs, and bereavement has to include analysis of stressful components that are integral to bereavement.

Intrusion-avoidance as symptom versus process. An important difference in the scientific analyses of trauma and bereavement phenomena is that Horowitz analyzes intrusion-avoidance processes as *symptomatic* of traumatic reactions, whereas in the bereavement area, they have been regarded as *coping strategies*, and even as *coping styles.*

A fundamental difference has to do with the degree of *personal control* over intrusion-avoidance symptomatology that is experienced within the two types of loss. This concept, central to Horowitz's (1986) model of coping with trauma, and also of relevance to analyses of bereavement phenomena, will be discussed below.

Comparative extremity of the impact of traumas and bereavements. Since Holmes and Rahe (1967) put loss of a loved one at the top of the list of stressful life events, bereavement has been repeatedly cited as the worst that can happen to one. Yet, as we saw, trauma and not bereavement is the life stressor that so far merits recognition as the precipitator of mental disorder in standard diagnostic classification manuals. Although one may be tempted to conclude that trauma, by its very definition, is generally more horrendous and impactful than bereavement, such conclusions must be drawn with great caution. In our view, discussion of the comparative severity of the impact of events in this context is not very fruitful.

Determinants of adjustment to trauma and bereavement. Just as both "bereavement" and "trauma" cover a myriad of different types of events, which impact variously on outcome, so, in both cases, do a number of scientifically identified additional factors act as determinants, including placement within other life events, the social and physical environmental context, the person's pre-existing personality structure and style(s) of coping (cf. Horowitz et al., 1993; Stroebe, Stroebe, & Hansson, 1993), to say nothing of trying to capture the fundamental but elusive "meaning of loss" factor, which is so intricately bound up with measures of adjustment that assessment is almost precluded.

Detrimental health consequences following trauma and bereavement. Both types of events have been shown quite conclusively to be associated with detrimental consequences to both psychological and physical health, and even with mortality (e.g., the early studies by Eitinger & Strom (1973) documenting excessive morbidity and mortality among Norwegian concentration camp survivors and Parkes (1972/1996) similarly, for bereaved husbands and wives). Recent reviews of outcome studies confirm these early results (see, e.g., Stroebe, Stroebe, & Hansson, 1993; Wilson & Raphael, 1993).

Treatment of traumatic stress and grief reactions. In cases where traumatic stress and grief reactions co-occur following exposure to a life event that is simultaneously traumatic and a bereavement, experts are of the opinion that it is *indeed necessary to deal with the traumatic component, which may block grief, before grieving for the lost person can be facilitated* (Raphael, Middleton, Martinek, & Misso, 1993). Nevertheless, in our view, there are unique components to bereavement adjustment that lead to different types of complication and that may also need specific intervention. Bereavement cannot simply be understood as a (less intense) traumatic event.

Pathology. Discussion of DSM categorization of the two phenomena (APA, 1994) indicated that there are also clear differences in views about what comprises pathology in each area. Reactions to traumatic life events are measured in terms of intensity of symptoms, reactions to bereavement (in addition) according to different types of complications. These bereavement complications have been linked to different types of attachment (Parkes, 1991). Although some researchers disagree (e.g., van den Bout et al., 1991), in our view pathological grief does not simply differ from normal grief in terms of intensity and duration of the symptoms. This, then, is in contrast to the type of complications assumed to follow traumatic events. However, each field has neglected the complications identified in the other. Given the overlap in the life experiences, this needs to be amended in both fields. Discussion of the theoretical models will make this clearer.

MODELS OF COPING

Stressor Life Events

Central to Horowitz's (1986) cognitive model is the analysis of regulatory control processes (active warding off or reexperiencing of aspects of the traumatic event) that occur if the situation (the trauma) cannot be altered. When this happens, ". . . the inner models or schemata must be revised so that they conform to the new reality" (Horowitz, 1979, p. 244). In the course of this processing, information (about the traumatic event) is regulated and reinterpreted. Beliefs and images about the self and others are reexamined, and new information is sought. Shifts in meanings and revision of the schemata take place. Associated emotions are repeatedly reduced or activated. Kleber and Brom (1992, p. 139) have succinctly described how these control processes operate:

> *Control processes work in such a way that the continuous representation of the event is inhibited or accelerated. Optimal control delays the intrusion and yields tolerable dosages of the new information and the emotions. This leads to an optimal alternation between denial and intrusion. . . . Thus completion can occur; inner models can adapt to reality.*

Following this model, too much control (denial or avoidance) prevents processing; with too little control (too much intrusion) one succumbs to continual rehearsal of the traumatic experience and excessive, fearful emotions.

Horowitz's observations (1986, p. 86) led him to view these stress response tendencies of intrusion and denial as occurring *in temporal phase*, which may overlap, vary in sequence, and be subject to individual differences. Abstracting a general stress response tendency, he described the following cognitive and emotional sequence: there is a phase of initial realization that a stressful event has occurred, often with a sharply accelerated expression of reactive emotion. This is followed by a phase of denial and numbness, which is succeeded by a mixed phase of denial and intrusive repetition in thought, emotion, and/or behavior. Then comes a phase of further ideational and emotional processing, working through, and acceptance (or stable defensive distortion), with a loss of either the denial or the peremptory recollection of the stress event. At the different phases, intense or prolonged experiences may become symptomatic with the following manifestations: overwhelmed reaction, panic or exhaustion, extreme avoidance, flooded states, psychosomatic responses, and character distortions (see Horowitz, 1986, p. 86 for a detailed account).

Those are the most relevant tenets of Horowitz's model with respect to the comparison with bereavement models. Next we describe what has been done in the latter field and begin to compare the two approaches.

Bereavement

Traditional models of coping with grief. As in trauma research, models of coping with bereavement grew out of the psychoanalytic tradition. Central to traditional formulations has been the concept of "grief work." According to major theorists such as Freud (1917), Lindemann (1944), Parkes (1972/1996), Bowlby (1980), Raphael (Raphael & Nunn, 1988), in order to come to terms with the death of a loved one, one has to confront and work through the loss.

Thus, while Horowitz's model postulated "working through" as a phase of coping with trauma that succeeded intrusion and denial, in traditional analyses of coping with grief, this is not a phasal reaction but a strategy of coping that is associated with eventual recovery and adjustment. Also, in trauma research, denial processes have been recognized as necessary components, rather than impediments.

Also fundamental to traditional approaches to coping with bereavement have been conceptualizations of the grieving process in terms of *phases* or *tasks* (cf. Bowlby, 1980; Worden, 1982/1991). Again, the contrast with Horowitz's phasal conceptualization is evident. Formulations vary slightly from one researcher to another, but they typically postulate the following phases of grief (cf. Bowlby, 1980): (1) shock, associated with numbness and denial; (2) yearning and protest, as realization of the loss develops; (3) despair, accompanied by somatic and emotional upset and social withdrawal; (4) gradual recovery, marked by increased well-being and acceptance of loss. It is important to note that these should not be taken to imply a set, fixed, clear-cut, or prescriptive sequence.

Task models differ from the above in that there is more scope for variation both across time and between individuals, and in that more consideration is given to the griever as agentic in the recovery process (cf. Worden, 1982/1991). The tasks are: (1) accepting the reality of loss; (2) experiencing the pain of grief; (3) adjusting to an environment without the deceased; (4) and "relocating" the deceased emotionally and moving on with life.

So here, in contrast to Horowitz's model, denial is an initial reaction, not conceived of as periodically returning or fluctuating with intrusion. Apart from this, there is much similarity, including the symptomatology of fear, sadness, and rage (outcry) in the early stages of each coping process.

Shortcomings of traditional models of coping with bereavement. We had a number of reasons to be dissatisfied with these traditional models of grief (Stroebe & Stroebe, 1991; Stroebe & Schut, 1995). In brief, these included the fact that: (1) they did not seem to be supported by our empirical results, neither in Germany nor here in the Netherlands; (2) they did not seem to reflect cross-cultural or historical differences in ways of coping with loss; (3) conceptualizations of "grief work" were indistinguishable from rumination processes or general negative affect.

Most important here, however, was the fact that denial processes were accorded a function in coming to terms with loss *only*, as noted above, in the initial phase, when reality is too painful and some dosage of realization necessary. Otherwise, emphasis has most certainly been on the dysfunctional consequences of denial, avoidance, suppression, and repression. This did not seem to reflect what was actually happening to bereaved people. Following analysis of our own data sets (Stroebe, Stroebe, & Schut, 1993; Stroebe & Stroebe, 1991), the analysis of denial processes that seemed to be needed was actually, in retrospect, more similar to Horowitz's formulation than to those of traditional grief models. In our view, analysis of coping with bereavement needed to include a finer-grained analysis of approach

versus avoidance of thoughts and feelings connected with the loss of a loved one.

Rather than looking, as Horowitz did, primarily on the level of cognitive processing, we were initially guided by individual and subgroup differences that we observed between bereaved people, along what one might call the dimension of working through versus not working through grief. On the one hand, some people seemed to adopt a way of coping with grief by confronting it and going over details of the experience. On the other hand, some people seemed to avoid memories, distract themselves, and keep busy with other things, in an apparent effort to move on to new relationships and, it seemed, to try to put their loss behind them.

However, this was not the only shortcoming. Traditionally, following leads from both psychodynamic and attachment theory, focus has been on the tie or bond with the deceased, and on the lost relationship. Yet the bereavement experience incorporates much more than this. If we take a stress theory perspective, along the lines of Lazarus and Folkman (1984), it becomes clear that bereavement encompasses *secondary* stresses that need confrontation and that also impact on the course of adjustment and determine the ways that a person copes.

To summarize, it seemed to us that what was needed was not only (1) a more precise analysis of processes of coping with loss, but (2) a broadening of the perspective to include analysis of the differential tasks of grieving, not only those necessitated by the loss of the loved relationship directly, but also those that lead toward coping with the changes in the surrounding world consequent to the loss. With respect to the former interest, there is common ground between our theory and that of Horowitz for the trauma area, and there are possibilities for further integration of his cognitive, information-processing approach into our analysis. With respect to the latter, our differential task analysis may have something to offer the trauma field, as the following example illustrates. Consider items on the Impact of Event Scale, developed by Horowitz and his colleagues as a self-report instrument to measure the essential characteristics (intrusion-avoidance symptomatology) associated with stress disorders (Horowitz, Wilner, Kaltreider, & Alvarez, 1980). In the instructions and questionnaire items, reference is made throughout to "it," the traumatic event. Using this scale as a measure of approach-avoidance in bereavement is problematic: what is "it"? Adaptation necessitates specification of "the loved person" versus "circumstances surrounding the loss" or "the death event" or, also quite importantly, "the consequences of loss." The original scale also takes no account of confrontation-avoidance of current life stressors, from dealing with to avoiding financial trouble consequent to loss, to facing up to, versus retreat from, a society where one is the odd man (person) out.

Development of the dual process model of coping with loss. What evolved from these two types of concerns, on the one hand with coping phenomena, on the other with stressor definition, was our dual process model of coping with loss. It becomes evident that, in some ways, this model owes much to both the attachment approach, with its emphasis on the lost relationship, and stress theory, with its concentration on the demands imposed by stressful life events, and the resources that individuals bring to bear on such situations in order to cope. (See Figure 1.) The model, which is still at the stage of development and undergoing further empirical examination, was formulated in the context of marital/partner bereavement. It may have potential application to other types of bereavement and loss, but, again, further research is necessary before such generalizations are made.

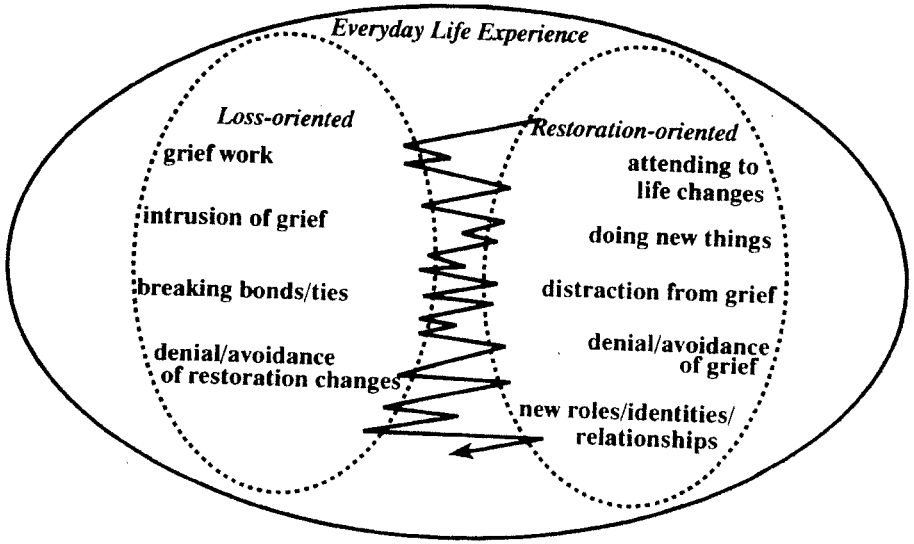

Figure 1. A Dual Process Model for Coping with Loss.

Loss- and Restoration-Oriented Coping

This model incorporates two processes related to approach versus avoidance of grief, and approach versus avoidance of secondary stressors, which we call *loss-orientation* and *restoration-orientation*. So here already, our model differs from that of Horowitz: we have postulated two types of stressors that necessitate cognitive processing. The consequence is the possibility that *selective attention* occurs: rather than intrusion or avoidance of "it," in attending to the one, one avoids the other.

Loss-orientation. By loss-orientation we mean that a person is concentrating on, dealing with, and processing some aspect of the loss experience. Grief work falls within this dimension, as do rumination and yearning for the deceased, just thinking or talking about him or her, looking at photos, and imagining how he or she would react. Facing up to loss or crying over the death would also be part of this process. Confrontation with one's emotional reactions to the loss of the loved person and focusing on the personal meaning of what has happened are central features of loss orientation. There can also be a resistance to change (to restoration), reflected in a clinging to the past. It may be hard to accept that the old roles and routines have gone forever, and nostalgia may predominate.

In loss-orientation, it is, then, the lost relationship that is the focus of attention.

In our view, this aspect is what attachment theorists such as Bowlby (1980) have focused on.

Restoration-orientation. By contrast, the process less familiar, and certainly less explicit, in bereavement research and counselling, is that of restoration-orientation. When a loved one dies, not only do we grieve for him or her, we also have to adjust to substantial changes that are secondary consequences of loss. In the case of spousal bereavement, these may include attending to tasks that the deceased had previously undertaken, such as finances or the cooking. In focusing on these, one is not (or not directly) focusing on the emotional impact of the loss of the loved one. It incorporates learning to do things alone—learning to go places as a single person, not as part of a couple (and this, perhaps more than anything, may force confrontation again with the fact of loss). It means establishing new routines, fulfilling new roles, developing a new identity, and adjusting to an environment without the deceased; these are the things that we mean by "restoration." Perhaps stress/trauma perspectives have more to offer with respect to analysis of this type of orientation.

A number of points need to be made clear. (1) For most people, whatever the positive or negative consequences of either strategy, it is necessary to do both, that is, to cope with loss and with restoration concerns, since there have been massive changes within both spheres, following the death of a loved one. (2) The model accommodates individual differences: people differ in their patterns of coping on the loss-restoration dimension. For Horowitz, personality factors contribute to the magnitude of PTSD *symptomatology* (whether one does or does not develop the disorder), whereas for us, individual differences can be seen to impact on the *coping process* directly. The most obvious example is sex differences, where men are more restoration- and women more loss-oriented (Stroebe, Schut, & Stroebe, 1995). (3) The model is not limited to intrapersonal processes, as Horowitz's is; it enables analysis of interpersonal variables in facilitation versus hindrance of the grieving process. If, for example, one bereaved person is loss-oriented and a second is restoration-oriented, there may only be facilitation to the extent that oscillation is promoted. This would be concordant. Other concordant and discordant patterns can be derived. (4) In claiming that there is restoration-orientation, we are not simply assuming an absence of grief. It necessitates an attention to other *additional* tasks that are a consequence of having to adapt to change. In this respect, our model is compatible with Worden's (1982/1991) task model. (5) Although the tasks of restoration are not directly linked with emotional adjustment to loss of the loved person, the two are, of course, closely related: even as they necessitate distraction from grief, they bring about reminders of it, which may then lead to what we call *oscillation*.

The Process of Oscillation

Critical to the formulation is the notion of *oscillation*. Bereaved people typically move between loss- and restoration-oriented coping. At times, they will be confronted by their loss; at others, they will avoid memories, be distracted, or seek relief by concentrating on other things.

This is not, in contrast to Horowitz's or the traditional grief models, a phasal

model. However, the model easily incorporates a *time perspective* with regard to oscillation. There is typically more loss-orientation in the early days of bereavement, with a move toward more restoration-orientation as time goes on.

Why should there be this oscillation, this need for approach-avoidance of the two orientations? Horowitz, as we saw, regarded intrusion-denial processes as *regulatory*: controlling confrontation with the stressor. He listed impediments versus facilitators to working through stress which acted as controls on the flow of ideas. Our analysis, in contrast, has concentrated on processes that regulate oscillation itself, or reasons why there is shifting from one orientation to the other, for example, habituation, forgetting, distraction, or exhaustion (see Stroebe & Schut, 1995). For example, it may be necessary to habituate to loss through repeated exposure and confrontation, but on the other hand, it may be necessary to allow for forgetting, since there is a tendency for reactions to become weakened over time, if left inactivated (cf. Kruglanski, 1993).

Coping and Pathology/Health Consequences

This brings us to the issue of the impact on health of the way that one copes. For Horowitz, the impact on health is almost synonymous with one type of disturbance of coping, that is, of involuntary, highly intense, intrusion-avoidance. It is indicative that Horowitz (Horowitz et al., 1993) sees pathological grief as a potential diagnostic disorder that could be included within PTSD stressor criteria. Our model, on the other hand, accommodates different types of pathological grief, in relationship to different ways of coping.

The principle of oscillation postulates that there needs to be movement between the two orientations. This is critical to "normal grieving," and one could speculate that this pattern is associated with secure attachment styles (see Parkes & Weiss, 1983; Parkes, 1991 for application of attachment theory to bereavement). We would argue that complications or pathology would occur if either (1) oscillation does not occur (and maybe this is easier when there is no trauma—the demands of the situation may be critically different here), or (2) there is (involuntary) disturbance within this process (which may happen when a bereavement is also a trauma).

(1) Oscillation could be said to not occur if there is relentless, obsessive rumination. Chronic grief would be exemplary of this type of pathology. In terms of the model, chronic grievers would be entirely, or very predominantly, "loss-oriented" in their coping. It is a matter for empirical verification whether these will be related to insecure styles of attachment and associated with dependent relationships.

At the other extreme, there can be very marked avoidance. There may be persistent suppression (or even a less voluntary repression) of memories and denial of the painful impact of death. One can see parallels here with the syndromes of "inhibited" or "delayed" grief (cf. Lindemann, 1944; Parkes & Weiss, 1983). Again, one would propose that these patterns are related to avoidant attachment styles, associated with compulsive self-reliance.

(2) In identifying disturbance of oscillation as a form of pathology (turbulence), we are talking about the type of disturbed processes that Horowitz identified: disturbed intrusion-avoidance. Following this, such disturbance could be regarded as only one of three types of complication.

CONCLUSIONS

Patterns of resemblance versus distinction between the phenomena of trauma and bereavement, their symptomatology, and their scientific interpretation have been discussed. There is clear overlap between the two phenomena, such that there are good reasons to analyze grief within the scientific study of traumatic stress reactions and to explore the relevance of theoretical approaches to bereavement for more general application to the trauma field. Nevertheless, we have identified limitations in adopting a general trauma framework for the study of grief. Examination of the symptomatologies of grief and traumatic reactions shows considerable differences in typologies. It became clear that reactions to bereavement covered a different, broader range of manifestations than those that have been described following traumatic losses. Furthermore, it was argued that most trauma research emphasizes pathological rather than normal reactions. The latter approach is important for, after all, a large majority of bereaved people, although suffering intensely, do not have complicated reactions, generally adjusting in time to their changed situation. It is noteworthy that this is also the case following traumatic experiences. Overall, the percentage of individuals who suffer PTSD following exposure to a traumatic life experience is estimated at only 25% (Kleber & Brom, 1989).

Furthermore, in viewing phenomena from a "pathological" stance, trauma research has concentrated on one type of complication, namely, extreme intensity and/or duration of avoidance and intrusion. In the case of bereavement, additional complications have been identified, for example, chronic or delayed grief. When a trauma has included a lost relationship, it would be useful to incorporate analyses such as we have described for the bereavement research field.

Finally, we noted that trauma research does not distinguish different components in the nature of the stressor itself. Yet we argued, in the case of bereavement, that adjustment not only requires coming to terms with the loss of the loved one, but also dealing with secondary stressors, such as the need to develop new roles and a new identity. This influences the coping process. This conceptualization also marks a departure from traditional models of adjustment to bereavement, which, in our view, have failed to provide explanations of such dual components. These two coping orientations were described in *The Dual Process Model of Coping with Loss* (Stroebe & Schut, 1995). Our conclusion is that, although the scientific analysis of grief and grieving can profit from incorporation of scientific understanding of traumatic events in general, such a stressor-specific model is necessary to understand the phenomena associated with bereavement. Just as traditional theories of bereavement lack explanatory power, so, in our view, does the most influential model of trauma. Only part of the complex psychological process of adjustment to bereavement can be understood through the framework provided by models of coping with traumatic experiences such as that of Horowitz (1986). Nevertheless, we are well aware that our own conceptualization needs further refinement and empirical confirmation.

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II

LOSSES WITHIN CLOSE RELATIONSHIPS