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TRAJECTORIES OF GRIEVING

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The death of a close relative or friend is almost always painful and disturbing. Yet, it has become increasingly obvious that not everybody reacts to such losses in the same way. A small subset of bereaved individuals, usually 10% to 15%, suffer chronic distress and depression for years after the loss. Others experience acute distress and depression from which they recover only gradually over a period of 1 or 2 years. However, many and sometimes the majority of bereaved individuals exhibit only short-lived grief reactions and manage to maintain a relatively stable trajectory of healthy functioning or resilience throughout bereavement (Bonanno, 2004; Bonanno & Kaltman, 2001). Understanding these divergent patterns and the factors that predict their occurrence has become an important area of bereavement inquiry. In this chapter, we briefly discuss the historical background on the subject and then review several recent studies of bereavement outcome trajectories. We focus on findings from prospective studies that challenge traditional ideas about bereavement. These studies illustrate the importance of examining the full spectrum of bereavement outcome patterns.

A BRIEF LOOK AT THE HISTORICAL BACKGROUND

The earliest taxonomies of individual differences in grief reaction were based primarily on clinical observation or on data sets based on psychiatric samples. It is not surprising that the earliest models of bereavement outcome focused primarily on the distinction between normal and abnormal or pathological forms of grieving. Using these models, bereavement scholars pondered the question of what constitutes a normal grief course. They also focused attention on the possible role played by avoidant or defensive processes in delaying the onset of grief.

One of the earliest comparative descriptions of normal and pathological forms of grieving came from Parkes's (1965) groundbreaking study of bereaved psychiatric patients. Parkes distinguished three types of pathological grief reaction: (a) *chronic grief*, (b) *inhibited grief*, and (c) *delayed grief*. Bowlby (1980) later echoed Parkes's taxonomy to propose "disordered forms of mourning" that could be arrayed along a single conceptual dimension. Anchoring one end of the continuum was *chronic mourning*. At the other end, Bowlby placed the *prolonged absence of conscious grieving* (p. 138). He maintained that individuals who show an absence of conscious grieving "may appear to be coping splendidly" (p. 153) but are often tense and short tempered, with tears just below the surface. Bowlby believed that physical symptoms, such as headaches and heart palpitations, were also common in this group. He indicated that sooner or later many people who consciously avoid grieving become depressed, often in response to a subsequent, more minor loss.

On the basis of the evidence available at the time, Raphael (1983) also proposed a number of "morbid or pathological patterns of grief" (p. 59). These included chronic, unresolved grief reactions as well as the absence of grief, in which "the grieving affects or mourning process may be totally absent, partially suppressed, or inhibited" (p. 60). Like Bowlby (1980), she noted that some bereaved people seem to cope remarkably well and often carry on as if nothing had happened. Although she acknowledged that such responses "may be seen as evidence of strength and coping by many" (p. 205), she too argued that in most cases they were actually markers of psychopathology.

In 1984, the Institute of Medicine released a report summarizing the state-of-the-art knowledge about bereavement. The report concluded that the death of a loved one produced a "near universal occurrence of intense emotional distress . . . with features similar in nature and intensity to those of clinical depression" (Osterweis, Solomon, & Green, 1984, p. 18). The report also concluded that absent grief was a pathological form of mourning that "represents some form of personality pathology" and that "persons who show no evidence of having begun grieving" should receive "professional help" (Osterweis et al., 1984, p. 65). Several years later, Middleton, Moylan, Raphael, Burnett, and Martinek (1993) surveyed an international sample of researchers,

theorists, and clinicians working in the field of bereavement. A compelling majority of these experts endorsed the idea that absent grief was a pathological grief reaction that usually stemmed from denial or inhibition of the normal grief reaction. This response was almost always viewed as maladaptive in the long run.

Is this really the case, however? When people experience relatively mild or short-lived grief reactions, should this be considered atypical or pathological? In 1989, Wortman and Silver noted that there was no convincing empirical evidence to support this assertion. More recently, Bonanno and colleagues (e.g., Bonanno, 2004, 2005; Bonanno, Znoj, Siddique, & Horowitz, 1999) have argued that many bereaved people show a clear resilience in the face of loss. At the other end of the spectrum, one might also question whether psychopathology observed during bereavement should always be interpreted as an abnormal grief reaction. Might not at least some of the chronic dysfunction be attributed to an enduring emotional disturbance that predates the loss?

THE CRUCIAL IMPORTANCE OF PROSPECTIVE RESEARCH

The most straightforward way to examine these questions and to adjudicate among these various perspectives is to conduct prospective research using community-based samples. This involves identifying a relatively large sample of respondents who are not anticipating a pending loss well before the death of a loved one, and then following those who have suffered a loss for an extended period of time during bereavement. Studies of this nature are rare, for obvious reasons. A design of this type is both expensive and time consuming; however, there are two reasons why this type of prospective approach is crucial.

The first reason is that it is not possible to detect some grief trajectories without accurate information about preloss functioning. For example, at least some individuals who experience depression, or what appears to be grief-related pathology following the loss, may have been depressed prior to the loss. As we discuss in more detail later in this chapter, such individuals may be more accurately viewed as suffering from chronic depression rather than chronic grief. Still another possibility, only recently considered in the bereavement literature, is that some people might actually experience improvements in their psychological well-being after the death. This possibility contrasts markedly with the traditional view that loss typically involves prolonged suffering and distress. However, there are almost certainly circumstances in which the death of a loved one will come as a relief. For example, it may mark the end of a long and arduous period of suffering or exposure to chronic stress (Bodnar & Kiecolt-Glaser, 1994; A. Horowitz, 1985; Schulz et al., 2003; Wheaton, 1990). In such circumstances, a person may

have experienced heightened distress or depression prior to the loss and then marked improvement after the death. Although people who show this pattern may be indistinguishable from other resilient bereaved people following the loss, it would be important to distinguish among these groups and explore the ways in which they may differ.

A second reason is that without prospective data, it is difficult to adjudicate among competing views about why bereaved people may not evidence pronounced grief. Moreover, the absence of prospective data complicates efforts to identify the factors that might explain divergent reactions to loss. We noted earlier that bereavement theorists have historically viewed the absence of pronounced grief reactions as a relatively rare and pathological form of inhibited grieving. Such a reaction has traditionally been regarded as indicative of denial or inhibition. The alternative is that such reactions indicate resilience on the part of the bereaved survivor. However, it is difficult to tease these explanations apart after the loss has occurred.

A number of studies have documented that mild or absent grief reactions are not rare but tend to occur as often as, and sometimes more often than, any other response to loss (for reviews, see Bonanno, 2004, 2005; Bonanno & Kaltman, 1999, 2001; Wortman & Boerner, 2006; Wortman & Silver, 2001). Also, several studies have directly examined the question of whether mild grief reactions eventually might give way to delayed grief. To date, however, convincing evidence of delayed grief has not been reported. For example, Middleton, Burnett, Raphael, and Martinek (1996) interviewed bereaved spouses, bereaved adult children, and bereaved parents about their grief experiences at repeated intervals beginning within 1 month of the loss and extending to 13 months postloss. Despite their conviction that delayed grief was a genuine clinical phenomenon, Middleton et al. concluded that "no evidence was found for the pattern of response which might be expected for delayed grief" (p. 169). A similar conclusion was apparent in an even longer term study conducted by Bonanno and Field (2001). Conjugally bereaved individuals were assessed over a 5-year period using multiple outcome measures. Although a few cases of delayed grief were observed, these were captured only on isolated measures, suggesting random measurement error. None of the participants evidenced delayed symptom elevations consistently across the different outcome measures, and when a psychometrically more reliable, weighted composite measure was used, not a single participant evidenced delayed grief.

In sum, past research indicates that minimal or absent grief reactions are very prevalent, whereas delayed grief reactions are quite rare. Despite these findings, however, the view that absent grief portends subsequent difficulties is still prevalent among clinicians (see Wortman & Boerner, 2006, for a review).

The only convincing way to adjudicate among these views is to conduct prospective bereavement research beginning well before the loss has occurred

and continuing for several months following the loss. The absence of grief has been regarded as an indication that the person was never that attached to the deceased (e.g., M. J. Horowitz, 1990), perhaps because of a general tendency to remain emotionally cold or distant. Alternatively, people who fail to evidence pronounced grieving may have been involved in marriages that were unsatisfying or characterized by a high degree of conflict (M. J. Horowitz, 1990; Rando, 1993), thus obviating the need for grief (Raphael, 1983). In contrast, if mild grief reactions reflect a genuine resilience, then people who show this pattern following the loss should have normal or nonconflictual relationships prior to the loss. These examples illustrate the importance of identifying the different trajectories of functioning from before to after the death of a loved one. Until recently, there was relatively little systematic research using such a design.

THE CHANGING LIVES OF OLDER COUPLES STUDY

In the mid-1980s, a large-scale prospective study on widowhood in late life, called the Changing Lives of Older Couples Study (CLOC), was initiated by Camille Wortman in collaboration with Ronald Kessler and James House. The CLOC team was able to recruit and interview a baseline sample of 1,532 older married people from the Detroit, Michigan, metropolitan area. Participants who lost a spouse during that time were identified using state death records and invited to participate in subsequent interviews at 6 and 18 months after the loss. This procedure resulted in a sample of 205 people who had been interviewed an average of 3 years prior to the death of their spouse and at 6, 18, and 48 months postloss. The study included a thorough and comprehensive preloss assessment of many variables, including the quality of the marriage, social support, personality, and views of the world. After the spouse's death, the investigators repeated many of these assessments. They also made a careful assessment of grief and a number of related constructs, including indications of continuing attachment and indicators of working through the loss (e.g., frequency of thoughts and conversations about the deceased).

Several years ago, we, along with other colleagues (Bonanno et al., 2002) used the CLOC data to identify the most common or prototypical trajectories of adjustment to loss. To do this, we used a method that involved calculating change scores across time. The first step in this approach was to categorize participants as having either low or high levels of baseline depression, or depression prior to the loss based on the normative range of depression scores observed in other studies. The next step involved categorizing change from before the loss to 6 months postloss. A *grief reaction* was defined as an increase in depression from pre- to postloss that exceeds the standard normal range

of variation (i.e., the standard deviation) for each group. If a person with a low prebereavement depression score showed only a minor increase in depression following the loss, one that fell within the normal variation (i.e., less than 1 standard deviation), then this person was classified as not having a substantial grief reaction. This approach also allowed us to identify people who had high prebereavement depression and improved by at least 1 standard deviation during bereavement. This same step was then repeated for comparisons between prebereavement and 18-month depression scores.

The next step was to identify the most prevalent patterns or trajectories that emerged from these data. We (Bonanno et al., 2002) classified participants as either changing, staying the same, or improving from prebereavement to 6 months of bereavement and as changing, staying the same, or improving from prebereavement to 18 months of bereavement. Using these categories, we found five distinct trajectories that cover the outcome patterns of most of the participants: (a) *common grief or recovery* (11%, low preloss depression and high postloss depression at 6 months that improved at 18 months), (b) *stable low distress or resilience* (46%, low pre- and postloss depression at 6 and 18 months), (c) *depression followed by improvement* (10%, high preloss depression and low postloss depression at 6 and 18 months), (d) *chronic grief* (16%, low preloss depression and high postloss depression at 6 and 18 months), and (e) *chronic depression* (8%, high preloss depression that persists at 6 and 18 months postloss).

Finally, Bonanno et al. (2002) examined differences across these trajectories for a number of prebereavement predictor variables as well as for a number of variables measured during bereavement, including markers of more grief-specific symptoms (e.g., yearning) and variables indicative of the extent to which participants processed or avoided the loss.

RESILIENCE TO LOSS

The most compelling finding to emerge from this analysis was that more than half of the participants exhibited low depression throughout bereavement (Bonanno et al., 2002). There were in fact two separate trajectories that culminated in a stable low depression response during bereavement. One trajectory seemed to represent a genuine form of resilience. Participants showing this pattern comprised close to half the CLOC sample (46%). They had little or no depression at any point in the study (i.e., both prior to the death of their spouses and at 6 months and 18 months of bereavement), and they exhibited relatively few symptoms of grief during bereavement. The second trajectory resulting in a low depression outcome during bereavement was smaller, comprising 11% of the CLOC sample. These individuals were highly depressed prior to the death of their spouses but had improved to stable low

levels of depression at both time points after the spouse's death, and they also exhibited relatively few grief symptoms during bereavement.

Bonanno et al. (2002) also examined several alternative approaches to define the trajectories, and each produced more or less the same basic results. For example, cluster analyses yielded results strikingly similar to the trajectories just reported. Using either a four- or five-cluster solution, a cluster representing stable low depression throughout the study (resilience) was evident in 49% of the sample. We also used an alternative approach to define change over time based on the standard error of measurement (see Devilly & Foa, 2001, for more detail on this approach), and the proportion evidencing resilience was even higher: 58%. Together, these results provide strong convergent support for the robustness of these patterns.

GENUINE RESILIENCE ACROSS TIME

An important issue that could be addressed in the CLOC study was whether people who showed the stable low depression–low grief profile were actually resilient or were perhaps evidencing a more superficial adjustment. These data could also address the possibility that resilience was nothing more than the absence of attachment to the spouse.

One factor that argues against the low depression–low grief profile as a form of superficial adjustment is that so many participants exhibited this pattern. Another important factor was that almost all participants in this group reported having experienced at least some initial suffering and distress in the early months of bereavement. Although data were not available immediately following their loss, the 6-month interviews did include several questions in which bereaved participants were asked to make retrospective assessments of their early reactions to the loss. About 75% of those who showed a resilient outcome trajectory reported experiencing intense yearning (painful waves of missing the spouse) as well as pangs of intense grief in the earliest months of bereavement. Shortly after the death, the painful reality of the loss had occupied the thoughts of virtually all participants, including the resilient people. All but 1 of the respondents who showed the resilient trajectory reported that shortly after the loss, they experienced intrusive thoughts about the loss that they could not get out of their minds. They also indicated that they found themselves *ruminating*, or going over and over what had happened.

A key to how resilient people managed to cope so well with the death of their spouse despite the painful nature of their grief was suggested by several findings from a follow-up study (Bonanno, Wortman, & Nesse, 2004). First, the resilient people were better able than other participants to gain comfort from talking about or thinking about the spouse; for example, they were more likely than other bereaved people to report that thinking about and talking

about their deceased spouse made them feel happy or at peace. They also had low scores on avoidance and distraction, suggesting that their lack of distress indicated good adjustment rather than defensive denial. Resilient bereaved people also reported the fewest regrets about their behavior with the spouse or about things they may have done or failed to do when the spouse was still alive. Finally, resilient individuals were less likely to try to make sense of or find meaning in the spouse's death.

These findings indicate that close to half of the bereaved persons in the CLOC sample exhibited what appeared to be a resilient outcome trajectory. They experienced relatively little depression prior to the death of their spouse, and although they evidenced some cognitive and emotional upheaval immediately following the loss, they had relatively little or no depression and few grief symptoms throughout bereavement. Furthermore, compared with other groups, they seemed to be less troubled by the loss, were not preoccupied with the logic or meaning of the death, and were better able to hold on to positive and comforting memories of the spouse.

The fact that the CLOC data included prebereavement assessments meant that it was possible to examine the additional criticism that ostensibly resilient individuals had simply never been strongly attached to their spouses or that they were superficial or cold and unfeeling people. Recall that the initial baseline or prebereavement interviews in the CLOC study were conducted an average of 3 years prior to the spouse's death. This lengthy interval prior to the loss is important because it means that the data were not likely to have been contaminated by the anticipation of the impending death. Another prospective study (Bonanno, Moskowitz, Papa, & Folkman, 2005) had shown that the likelihood of such anticipatory reactions is dramatically reduced when assessments are obtained 8 months or longer before the death occurs. This interval provided a reasonable assurance that the participants' responses generally reflected their normal lives and relationships with their spouses and were relatively unconfounded with anticipatory grief reactions.

Examination of the prebereavement measures showed no evidence that people with stable low depression and low grief were in any way unhealthy or dysfunctional. Prior to the spouse's death, this group did not have conflicted or low-quality marital relations with the spouse; neither were they ambivalent about or excessively dependent on the spouse, They did not evidence extreme scores on any of the personality measures included in the study, such as extraversion or emotional stability.

Of particular importance to the debate about the type of person who would not exhibit a pronounced grief reaction is that the interviewer's ratings of resilient individuals in the prebereavement interviews did not distinguish them from other participants; for example, they were rated about the same as other participants in the degree to which they appeared to be comfortable or

socially skillful during the interview and as expressing warmth when interacting with other people.

Finally, the resilient participants scored relatively higher than other participants on several preloss measures, which is suggestive of resilience-promoting factors that would better prepare them for coping with the impeding loss. For example, resilient individuals reported relatively higher levels of instrumental support and scored higher than other participants on questionnaire measures of belief in a just world and acceptance of death.

IMPROVEMENT DURING BEREAVEMENT

As we discussed earlier, there was clear evidence for a second type of resilience during bereavement: a pattern of poor functioning and adjustment prior to the loss followed by markedly improved psychological health after the spouse's death. Although this was a smaller group than the more straightforward resilient group, this pattern nonetheless captured 11% of the sample (13% in the cluster analyses). Furthermore, the improved group maintained relatively low levels of depression and relatively few grief symptoms across several years of bereavement (we discuss further follow-up on this group at 48 months of bereavement later in this chapter).

In contrast to the stable low depression, or genuinely resilient group, the improved participants were highly depressed prior to the loss. They also had the poorest quality marriages compared with all other participants. They made the least positive and most negative evaluations of their spouses and marriages, and they scored higher on a measure of ambivalence toward the spouse in the prebereavement interviews. It is noteworthy that in addition to their marital difficulties, virtually all the participants in this group had been contending with a seriously ill spouse at the time of the prebereavement interviews. This was an elderly sample, and illness among the spouses was not uncommon. However, no other group was so clearly characterized by spousal illness as the improved group.

Given this difficult situation, it should not be surprising that the improved group also showed a relatively unfavorable psychological profile on other prebereavement measures. They scored high on measures of emotional instability (neuroticism), introspection, and perceived personal injustice. The items that comprised the measure of perceived personal injustice included statements such as "When I look back on what has happened to me, I feel cheated," "I don't seem to get what should be coming to me," and "Other people always seem to get the breaks." Despite this conspicuously unfavorable prebereavement profile, the improved group dropped to relatively low levels of depression and reported relatively low levels of grief symptoms during bereavement. Like the resilient group, the improved participants were also relatively

less likely to search for meaning in the loss. Given the difficulties they had experienced prior to the death of their spouses, it is tempting to assume that people could improve this much only by relying heavily on denial or distraction during bereavement. However, again like the resilient group, the improved participants had relatively low scores on a set of questionnaire items that tapped the use of avoidance or distraction.

There were also some key differences between the improved and resilient groups. For example, the improved participants reported thinking about and talking about the loss less frequently. In contrast to the resilient group, who reported the greatest ability to gain comfort from thinking about or talking about the spouse during bereavement, the improved group reported the lowest levels of comfort from memories of the spouse. It is noteworthy, however, that the improved group also exhibited marked increases in the ability to find comfort from thinking or talking about the spouse—they were the only group of participants in the CLOC study to do so—and by 18 months of bereavement they had increased so much in this regard that they were no longer distinct from the resilient group on this variable.

Finally, and of particular note, participants in the improved group were fully aware of the remarkable progress they had made. This group scored higher than any other group on a scale designed to measure the perception of pride in coping ability. The scale included questions such as "During the past month, did you feel amazed at your strength?" and "Did you feel proud of how well you were managing?" The improved group was also more likely than other participants in the CLOC study to report becoming more confident and a stronger person as a result of dealing with the loss of their spouses.

RESILIENCE AND IMPROVED FUNCTIONING IN OTHER STUDIES

Several other recent studies provide convergent evidence for the resilience and depressed–improved patterns identified in the CLOC study. In a study of older adult caregivers, for example, 42.5% of the sample of caregivers had low levels of depression both before and after their partners' death (Zhang, Mitchell, Bambauer, Jones, & Prigerson, in press). Caregiver studies have also provided further evidence for the depressed–improved pattern (e.g., Schulz et al., 2003; for a more detailed review, see chap. 13, this volume).

Both of the resilient and depressed–improved patterns were observed in a prospective study of gay men (Bonanno, Moskowitz, et al., 2005) that used data from the University of California San Francisco Coping Project (Folkman, Chesney, & Christopher-Richards, 1994). Not only was this sample considerably younger (mean age 36 years) than the CLOC sample, but it was also composed exclusively of gay men in committed long-term relationships.

Moreover, all of the men who eventually experienced bereavement had been providing care for a partner who was dying of AIDS, and in some cases both partners in the relationship had tested positive for HIV. If that were not stressful enough, the data for this study were originally collected in San Francisco in the late 1980s and early 1990s, before the advent of antiretroviral medication that dramatically prolongs the lives of people with AIDS. Hence, at that time, being HIV positive (HIV+) generally meant that one had relatively little time left to live.

It is not surprising that on the whole, the sample evidenced high levels of depression, with close to half of the bereaved sample showing elevated depression many months before the eventual death of their partners (Bonanno, Moskowitz, et al., 2005). Nonetheless, it was still possible to map changes across time from prebereavement to postbereavement. Of course, the high levels of depression meant that there would be considerably fewer participants showing the stable low depression pattern. In fact, 9% of the sample showed a depressed–improved pattern, and 27% of the sample had stable low depression or resilience from pre- to postloss. This proportion of resilience was lower than in the CLOC Study; however, if one considers that half of the sample was depressed well before the loss, in actuality this means that about half of the sample that was not depressed before the loss was resilient during bereavement. Also, consistent with other studies (Bonanno, 2004), both the resilient and depressed–improved groups had the highest levels of positive affect during bereavement.

A further analysis using the *normative comparison approach* (Kazdin, 2003) also revealed a level of resilience comparable to that observed in other bereavement studies. Simply put, normative comparisons define health and dysfunction in relative terms using the mean and standard deviation for a comparable group of participants or in relation to established norms for the specified outcome measure (e.g., Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002). In this case, Bonanno, Moskowitz, et al. (2005) compared the level of depression in bereaved HIV+ caregivers with a matched sample HIV+ gay men who were not bereaved or caregiving. Exactly half of the HIV+ bereaved sample had a level of depression that was not statistically different than the HIV+ nonbereaved sample. In other words, although they were depressed, their depression was not uncharacteristic of men dealing with the stress of being HIV+ at the time of the study.

CHRONIC GRIEF AND CHRONIC DEPRESSION

The use of prospective data makes it possible to explore several important issues about chronic grief reactions. In past studies, it has often been shown that bereaved people with prior depression or other psychopathology were more

likely to experience severe grief reactions during bereavement (e.g., Zisook & Shuchter, 1991). Unfortunately, evidence for this association has relied exclusively on retrospective measures of prebereavement depression that were obtained after the loss had already occurred (e.g., Nuss & Zubenko, 1992; Parkes & Weiss, 1983; Zisook & Shuchter, 1991). However, depressed people often show memory biases toward depressive affective states (e.g., Clark & Teasdale, 1982; Elliot & Greene, 1992), overestimating both the number of previous symptoms of depression (Zimmerman & Coryell, 1986) and their intensity (Schrader, Davis, Stefanovic, & Christie, 1990). Thus, bereaved individuals suffering from chronic grief reactions are also likely to overestimate their prior emotional difficulties. In fact, a 5-year study of bereaved people's memory for previous grief following the death of a spouse (Safer, Bonanno, & Field, 2001) readily demonstrated this bias.

An untested alternative explanation for the link between depression during bereavement and prior depression is that some bereaved people had been depressed prior to the loss and simply remained depressed during bereavement. In this case, the symptoms these individuals exhibited during bereavement would be at least partially due to ongoing difficulties rather than representing a specific reaction to the recent loss.

Addressing this question using the CLOC data produced some striking findings. Chronically elevated depressive symptoms during bereavement were evidenced by 23.4% of the sample (Bonanno et al., 2002); however, these participants formed two distinct trajectories. One trajectory, comprising 15.6% of the sample, suggested an unambiguous chronic grief reaction. These participants manifested low levels of depression prior to the loss but then showed elevated depression at 6 and 18 months of bereavement. A second, smaller group, comprising 7.8% of the sample, had markedly elevated depression prior to bereavement and then showed only a slight increase and remained depressed during bereavement. Both groups had higher levels of grief-specific symptoms (e.g., yearning) measured at 6 and 18 months of bereavement compared with all other participants, and they did not differ from each other in their level of grief symptoms. However, as we discuss shortly, additional data suggested that one of these trajectories represented a relative "pure" chronic grief reaction, whereas the other pattern was more representative of a preexisting chronic depression.

Distinguishing these patterns made it possible to address several core assumptions in the bereavement literature. One of the more widely held assumptions, for example, was that chronic grief arises as a result of a dysfunctional or problematic relationship. Chronic grief following the death of a spouse has been linked with conflict in the conjugal relationship (Parkes & Weiss, 1983; Stroebe & Stroebe, 1993) and with intense ambivalence toward the spouse (e.g., Bowlby, 1980; Parkes & Weiss, 1983); however, there is also a well-established link between marital conflict and depression as it occurs more

generally, independent of a loss (Beach, Smith, & Fincham, 1994; Weissman, 1987). Thus, it may be that the observed link between previous marital conflict and chronic grief reactions is not so much a product of unresolved grief, as has been traditionally assumed, but rather a manifestation of an ongoing depressive syndrome that predates the loss.

The trajectory results clearly argued in favor of the latter: People who evidenced the pure chronic grief trajectory did not report extremely conflicted marriages and did not evidence exceedingly high levels of ambivalence about the spouse or marriage when these factors were measured prior to the spouse's death. Chronically grieving individuals scored about the same as resilient individuals on these variables. We noted earlier that it was actually the depressed group, followed by improvement group, that had the most conflicted marriages prior to bereavement. The group that showed a chronic depression pattern from pre- to postbereavement also had high levels of marital conflict and ambivalence prior to the loss. In other words, marital conflict was seen primarily in people with elevated prebereavement depression, which by definition was not a characteristic of the chronic grief trajectory. Furthermore, because only some of the people with elevated prebereavement depression remained depressed during bereavement, while others showed improved adjustment during bereavement, marital conflict by itself did not seem to play a causal role in producing grief reactions.

A related assumption, also common in the bereavement literature, is that chronic grief results from excessive dependency (Lopata, 1979; Osterweis et al., 1984; Parkes & Weiss, 1983; Raphael, 1983), either as a general characteristic of the bereaved person's personality (Prigerson et al., 1997; Sable, 1989) or in its more specific form as a primary feature of the lost conjugal relationship, as for example in Raphael's (1983) notion of a "pathological dependence" on the partner (p. 208). However, just as we saw a general association between marital conflict and depression independent of loss, there is also clear evidence for a general association between interpersonal dependency and depressive symptoms independent of loss (Hokanson & Butler, 1992; Stader & Hokanson, 1998). In other words, people who exhibit both elevated depression during bereavement and interpersonal dependency may be struggling with ongoing difficulties that predate the loss.

In this case, the CLOC data were consistent with at least some aspects of traditional bereavement theory. People who evidenced the pure chronic grief reaction had high levels of personal dependency and dependency on the relationship prior to the death of their spouses. Thus, among people who were not depressed prior to the loss, dependency was an important predictor of grief reactions.

A third important finding was that people who were not depressed prior to the loss but then showed chronic grief were more likely than any other group to have had a healthy spouse, and less likely to have provided health

care for the spouse, in the years prior to the spouse's death. One might surmise that people in this group would have been less likely to anticipate that their spouse would die in just a few short years. These people also lost a spouse who may have been a more vital companion than respondents in the other conditions.

Together, these findings suggest that during bereavement, the chronic grief group was struggling primarily with the loss of a beloved and vital spouse on whom they were also dependent. In addition, because the spouses of these participants were typically healthy in the years prior to their death, this struggle was most likely exacerbated by a lack of anticipation or psychological preparation for the loss. In contrast, the prebereavement characteristics of people who showed a chronic depression trajectory suggested that whatever negative reactions they might have had to the spouse's death were layered upon an already-considerable number of ongoing psychological difficulties.

The importance of distinguishing *chronic grief* and *chronic depression* was even more evident in Bonanno, Moskowitz, et al.'s (2005) prospective study of bereaved gay men. In this case, because of the highly stressed nature of the sample, the pattern of elevated pre- and postbereavement depression was even more apparent. In fact, fully half of the men in that study who showed clinically elevated depression during bereavement had also shown clinically elevated depression many months prior to bereavement.

FOLLOWING THE CHANGING LIVES OF OLDER COUPLES SAMPLE INTO THE 4TH YEAR OF BEREAVEMENT

Understanding how bereaved people heal in the long term is one of the most important and least well-understood research questions with regard to grief (Jacobs, 1993). Thus, it is vital to determine how bereaved persons across the different outcome trajectories ultimately adjust to their loss. Building on the prior work described earlier, we further extended the five grief trajectories from the CLOC study to 48 months postloss (Boerner, Wortman, & Bonanno, 2005). For these analyses, we used the data of the 92 bereaved elders who had one preloss assessment and three postloss assessments.

One major question of interest was whether the resilient respondents stay resilient and the depressed–improved respondents remain improved in the long term, 4 years after the loss of their spouse. We predicted that the resilient group would continue to do well at 48 months postloss, meaning that they would show neither delayed grief nor evidence a lack of cognitive and emotional involvement with the deceased (Boerner et al., 2005). We also suspected that the depressed–improved group might do less well than the resilient group at 48 months compared with at 18 months because they had previously shown characteristics (e.g., emotional instability in the prebereavement

assessments) that might potentially reemerge at a later date. We expected depression to remain low for the group that showed the common grief or recovery pattern because distress levels in this group had already abated by the time of the 18-month follow-up. We further investigated whether chronic grievers and chronically depressed respondents would remain distressed up to 48 months postloss. We expected that although factors such as losing a beloved, healthy spouse may have resulted in more persistent grief, chronic grievers would show at least some improvement from Month 18 to Month 48. In contrast, because the chronically depressed respondents showed a relatively stable pattern of depression that was present even before the loss, it seemed likely that something besides the loss was contributing to their depression. Therefore, we expected that their depression would remain high longer than in the other groups.

The results supported the prediction that respondents in both the resilient group and the common grief group would continue to do well at 48 months postloss and lent some support to our reasoning that the depressed–improved group may develop adjustment problems over time (Boerner et al., 2005). There was no indication of an ongoing pattern of avoiding thinking about the deceased or the loss among either the resilient or the depressed–improved groups. Rather, respondents in these groups appeared to be able to think about the deceased in a way that was comforting rather than upsetting to them. These findings add to the growing body of evidence challenging the notion of delayed grief as a likely consequence of the failure to become intensely distressed following the loss of a loved one. However, the evidence for a continuously positive adjustment was not as consistent for the depressed–improved group compared with the resilient group; in fact, the depressed–improved group had significantly higher levels of both grief symptoms and depression at 48 months postloss than the resilient group. Hence, the possibility of delayed problems among individuals who show improvement following their loved one's death needs to be further explored.

The differential findings regarding the chronic grief group and chronically depressed group also underscore the need to further refine the criteria that are used to identify individuals who may be at risk for long-term problems. The chronic grief group exhibited a clear turn toward better adjustment. They showed significant reductions in both grief symptoms and depression from 18 to 48 months, and at the 48-month point they had significantly less grief and depression than the chronically depressed group. In contrast, the chronically depressed group clearly demonstrated long-term problems, with little indication of improvement between Month 18 and Month 48. This group not only showed the poorest adjustment 4 years after the loss, but they also struggled more than other participants with questions about meaning. Perhaps these respondents were prone to ruminate about their situation (Nolen-Hoeksema, Parker, & Larson, 1994), and searching for meaning of the loss was part of

this more general rumination tendency. Alternately, such a tendency may lie at the core of the depression and explain its toxicity.

CONCLUSION

During the past 10 years, researchers have become increasingly aware that there are divergent reactions to loss. In the majority of studies, however, investigators have assessed grief and depression following the loss and aggregated the data across respondents. Although such data provide information about how grief, on average, changes over time, they obscure the full range of grief reactions.

For the past 50 years, clinicians have described a variety of responses to loss. They have identified and discussed several forms of disordered mourning, including absent grief, chronic grief, and delayed grief. However, few efforts have been made to study these responses empirically. It is widely assumed that recovery from a major loss takes time and that there is something wrong with people who show absent grief or who recover too quickly. In our past theoretical and empirical work, we have suggested that absent grief may indicate resilience. Until recently, however, the lack of prospective data has made it difficult to adjudicate among these completing views or to identify the antecedent factors that might help explain divergent reactions to loss. In the research we have described in this chapter, we relied primarily on data from the CLOC Study (for more detailed descriptions, see Bonanno et al., 2002; Carr, Nesse, & Wortman, 2006) as well as several other prospective and comparative studies (e.g., Bonanno, Moskowitz, et al., 2005). These findings present a dramatic challenge to prevailing assumptions about absent and chronic grief and suggest that many of these assumptions may stem at least in part from confusion between these different patterns. In future research it will be important to further clarify the implications of the results presented here. For example, a number of studies have begun to document the prevalence of the resilient outcome pattern among other extremely adverse stressors, such as urban terrorist attacks (Bonanno, Galea, Bucciarelli, & Vhalhov, 2006) and treatment for breast cancer (Deshields, Tibbs, Fan, & Taylor, 2006). Given the prevalence of the resilient pattern among the diverse samples reported in this chapter, it would also be useful to examine resilience in the context of other types of loss, such as divorce or job loss.

It also will be important to learn more about how resilient individuals are able to assimilate major losses (Bonanno, 2004, 2005). Our initial research suggests that worldviews may be important, but more could be learned about how such views are evoked and why they appear to serve a protective function. In our more recent studies we have also begun to examine the social consequences of resilience, asking friends and associates to rate individuals who

demonstrate resilience. It would be intriguing to conduct additional studies to explore the social ramifications of a resilient style (e.g., Bonanno, Rennicke, & Dekel, 2005). One important issue concerns whether there may be costs associated with a resilient style in one's intimate relationships. Resilient people have an outlook on life that may make them less vulnerable to outside stressors but also less attentive to others' concerns, which could have a negative impact on close relationships. Resilient people may also receive negative reactions from others if they appear to recover too quickly from a loss. Others may interpret such a reaction as indication of aloofness or indifference, particularly if it occurs shortly after the loss. Alternatively, others may react more favorably to a resilient person because it is easier for them to be with someone who is less distressed.

Findings from the CLOC study, as well as other recent studies, make it clear that the absence of grief is not an appropriate rationale for clinical intervention. Despite statements from several influential clinicians recommending treatment for individuals who fail to evidence grief, this view has received no empirical support from our research or the findings of others.

As a number of investigators have indicated (e.g., Jordan & Neimeyer, 2003; Mancini, Pressman, & Bonanno, 2006), standard clinical interventions for grief have been shown to be surprisingly ineffective. This may be because in the past, researchers have not been aware of the distinction between chronic grief and chronic depression. It is possible that different types of intervention may be effective for individuals with chronic grief versus chronic depression. For example, those with chronic grief may benefit from therapeutic approaches that facilitate insight into the loss and foster the construction of meaning. In contrast, chronically depressed individuals may benefit more from a focus on enduring issues that may be implicated in the depression, including the absence of supportive relationships, poor coping skills, and poor emotional self-regulation. More research is needed to substantiate these claims.

In our judgment, the majority of grief researchers are open to the idea that there are divergent ways of reacting to the death of a loved one and have a keen interest in learning more about the antecedents and consequences of this variability. It would be interesting to learn more about the current prevailing beliefs about the grieving process held by clinicians and laypersons. It has been more than a decade since Middleton et al. (1993) published their important article surveying clinicians about their beliefs concerning grief. At that time, 65% of respondents endorsed the belief that absent grief typically stems from denial or inhibition and that such a response is generally maladaptive in the long run. What results would emerge if such a survey were conducted today? How do physicians, clergy, and other health care providers react when people deviate from what is believed to be normal grief? Many laypersons still believe that people typically show intense distress following the loss and that this distress decreases over time. This suggests that support

providers may respond to the bereaved in ways that are unhelpful if they exhibit too much or too little distress. Moreover, the bereaved themselves may find it disturbing when their reactions are different from what they expected, and this could contribute to the distress they are experiencing. Taken together, the findings we have reviewed here suggest that it would be useful to provide information about so-called normal grieving to health care providers, to support providers, and to the bereaved themselves.

REFERENCES

Beach, S. R., Smith, D. A., & Fincham, F. D. (1994). Marital interventions for depression: Empirical foundation and future prospects. *Applied and Preventative Psychology, 3*, 233–250.

Bodnar, J. C., & Kiecolt-Glaser, J. K. (1994). Caregiver depression after bereavement: Chronic stress isn't over when it's over. *Psychology and Aging, 9*, 372–380.

Boerner, K., Wortman, C. B., & Bonanno, G. A. (2005). Resilient or at risk?: A four-year study of older adults who initially showed high or low distress following conjugal loss. *Journal of Gerontology: Psychological Science, 60B*, P67–P73.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events. *American Psychologist, 59*, 20–28.

Bonanno, G. A. (2005). Resilience in the face of potential trauma. *Current Directions in Psychological Science, 14*, 135–138.

Bonanno, G. A., & Field, N. P. (2001). Evaluating the delayed grief hypothesis across 5 years of bereavement. *American Behavioral Scientist, 44*, 798–816.

Bonanno, G. A., Galea, S., Bucciarelli, A., & Vhalhov, D. (2006). Psychological resilience after disaster: New York City in the aftermath of the September 11th terrorist attack. *Psychological Science, 17*, 181–186.

Bonanno, G. A., & Kaltman, S. (1999). Toward an integrative perspective on bereavement. *Psychological Bulletin, 125*, 760–776.

Bonanno, G. A., & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology Review, 20*, 1–30.

Bonanno, G. A., Moskowitz, J. T., Papa, A., & Folkman, S. (2005). Resilience to loss in bereaved spouses, bereaved parents, and bereaved gay men. *Journal of Personality and Social Psychology, 88*, 827–843.

Bonanno, G. A., Rennicke, C., & Dekel, S. (2005). Self-enhancement among high-exposure survivors of the September 11th terrorist attack: Resilience or social maladjustment? *Journal of Personality and Social Psychology, 88*, 984–998.

Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., et al. (2002). Resilience to loss and chronic grief: A prospective study from pre-loss to 18 months post-loss. *Journal of Personality and Social Psychology, 83*, 1150–1164.

Bonanno, G. A., Wortman, C. B., & Nesse, R. M. (2004). Prospective patterns of resilience and maladjustment during widowhood. *Psychology and Aging, 19*, 260–271.

Bonanno, G. A., Znoj, H. J., Siddique, H., & Horowitz, M. J. (1999). Verbal-autonomic response dissociation and adaptation to midlife conjugal loss: A follow-up at 25 months. *Cognitive Therapy and Research, 23*, 605–624.

Bowlby, J. (1980). *Attachment and loss: Vol. 3. Sadness and depression*. New York: Basic Books.

Carr, D., Nesse, R., & Wortman, C. B. (2006). Spousal bereavement in late life. New York: Springer Publishing.

Clark, D. M., & Teasdale, J. D. (1982). Diurnal variation in clinical depression and accessibility of positive and negative experiences. *Journal of Abnormal Psychology, 91*, 87–95.

Deshields, T., Tibbs, T., Fan, M. Y., & Taylor, M. (2006). Differences in patterns of depression after treatment for breast cancer. *Psycho-Oncology, 15*, 398–406.

Devilly, G. J., & Foa, E. B. (2001). The investigation of exposure and cognitive therapy: Comment on Tarrier et al. (1999). *Journal of Consulting and Clinical Psychology*, 69, 114–116.

Elliot, C. L., & Greene, B. L. (1992). Clinical depression and implicit memory. *Journal of Abnormal Psychology, 101*, 572–574.

Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting and Clinical Psychology, 70*, 1022–1028.

Folkman, S., Chesney, M. A., & Christopher-Richards, A. (1994). Stress and coping in caregiving partners of men with AIDS. *Psychiatric Clinics of North America, 17*, 35–53.

Hokanson, J. E., & Butler, A. C. (1992). Cluster analysis of depressed college students' social behaviors. *Journal of Personality and Social Psychology, 62*, 273–280.

Horowitz, A. (1985). Sons and daughters as caregivers to older parents: Differences in role performance and consequences. *The Gerontologist, 25*, 612–617.

Horowitz, M. J. (1990). A model of mourning: Change in schemas of self and other. *Journal of the American Psychoanalytic Association, 38*, 297–324.

Jacobs, S. (1993). *Pathologic grief: Maladaptation to loss*. Washington, DC: American Psychiatric Press.

Jordan, J. R., & Neimeyer, R. A. (2003). Does grief counseling work? *Death Studies, 27*, 765–786.

Kazdin, A. (2003). *Research design in clinical psychology* (4th ed.). Boston: Allyn & Bacon.

Lopata, H. Z. (1979). *Women as widows: Support systems*. New York: Elsevier.

Mancini, A. D., Pressman, D. L., & Bonanno, G. A. (2006). Clinical interventions with the bereaved. In D. Carr, R. Nesse, & C. B. Wortman (Eds.), *Spousal bereavement in late life* (pp. 255–278). New York: Springer Publishing Company.

Middleton, W., Burnett, P., Raphael, B., & Martinek, N. (1996). The bereavement response: A cluster analysis. *British Journal of Psychiatry, 169*, 167–171.

Middleton, W., Moylan, A., Raphael, B., Burnett, P., & Martinek, N. (1993). An international perspective on bereavement related concepts. *Australian and New Zealand Journal of Psychiatry, 27*, 457–463.

Nolen-Hoeksema, S., Parker, L. E., & Larson, J. (1994). Ruminative coping with depressed mood following loss. *Journal of Personality and Social Psychology, 67*, 92–104.

Nuss, W. S., & Zubenko, G. S. (1992). Correlates of persistent depressive symptoms in widows. *American Journal of Psychiatry, 149*, 346–351.

Osterweis, M., Solomon, F., & Green, F. (Eds.). (1984). *Bereavement: Reactions, consequences, and care*. Washington, DC: National Academy Press.

Parkes, C. M. (1965). Bereavement and mental illness. *British Journal of Medical Psychology, 38*, 1–26.

Parkes, C. M., & Weiss, R. S. (1983). *Recovery from bereavement*. New York: Basic Books.

Prigerson, H. G., Shear, M. K., Bierhals, A. J., Pilkonis, P. A., Wolfson, L., Hall, M., et al. (1997). Case histories of traumatic grief. *Omega: The Journal of Death and Dying, 35*, 9–24.

Rando, T. A. (1993). *Treatment of complicated mourning*. Champaign, IL: Research Press.

Raphael, B. (1983). *The anatomy of bereavement*. New York: Basic Books.

Sable, P. (1989). Attachment, anxiety, and loss of a husband. *American Journal of Orthopsychiatry, 59*, 550–556.

Safer, M. A., Bonanno, G. A., & Field, N. P. (2001). It was never that bad: Biased recall of grief and long-term adjustment to the death of a spouse. *Memory, 9*, 195–204.

Schrader, G., Davis, A., Stefanovic, S., & Christie, P. (1990). The recollection of affect. *Psychological Medicine, 20*, 105–109.

Schulz, R., Mendelsohn, A. B., Haley, W. E., Mahoney, D., Allen, R. S., Zhang, S., et al. (2003). End of life care and the effects of bereavement among family caregivers of persons with dementia. *New England Journal of Medicine, 349*, 1891–1892.

Stader, S. R., & Hokanson, J. E. (1998). Psychosocial antecedents of depressive symptoms: An evaluation using daily experiences methodology. *Journal of Abnormal Psychology, 107*, 17–26.

Stroebe, W., & Stroebe, M. S. (1993). Determinants of adjustment to bereavement in younger widows and widowers. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement* (pp. 208–226). New York: Cambridge University Press.

Weissman, M. M. (1987). Advances in psychiatric epidemiology: Rates and risk for major depression. *American Journal of Public Health, 77*, 445–451.

Wheaton, B. (1990). Life transitions, role histories, and mental health. *American Sociological Review, 55*, 209–223.

Wortman, C. B., & Boerner, K. (2006). Beyond the myths of coping with loss: Prevailing assumptions versus scientific evidence. In H. S. Friedman & R. C. Silver (Eds.), *Foundations of health psychology* (pp. 285–324). Oxford, England: Oxford University Press.

Wortman, C. B., & Silver, R. C. (1989). The myth of coping with loss. *Journal of Consulting and Clinical, 57*, 349–357.

Wortman, C. B., & Silver, R. C. (2001). The myths of coping with loss revisited. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 405–430). Washington, DC: American Psychological Association.

Zhang, B., Mitchell, S. L., Bambauer, K. Z., Jones, R., & Prigerson, H. G. (in press). Depressive symptom trajectories and associated risks among bereaved Alzheimer's disease caregivers. *American Journal of Geriatric Psychiatry*.

Zimmerman, M., & Coryell, W. (1986). Reliability of follow-up assessments of depressed inpatients. *Archives of General Psychology, 43*, 468–470.

Zisook, S., & Shuchter, S. R. (1991). Depression through the first year after the death of a spouse. *American Journal of Psychiatry, 148*, 1346–1352.