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THE MYTHS OF COPING WITH LOSS REVISITED

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In a well-publicized legal case in Arizona, John Henry Knapp was convicted of the murder of his two young daughters, who died in a fire that destroyed their one-bedroom trailer. The principal evidence offered against Knapp was that immediately after the fire, he was outwardly calm and talkative and showed no overt display of distress. He was ultimately sentenced to death and remained in prison for 13 years. At that point, new evidence emerged about the origin of the fire that exonerated Knapp, and he was released (Brill, 1983).

As this example illustrates, societal beliefs about the grieving process can exert a powerful influence on how bereaved individuals are treated. For the past two decades, we have attempted to address the following question: Are there certain beliefs or assumptions about how people should react to the loss of a loved one that are prevalent in Western culture? To determine whether such assumptions exist, we reviewed a number of theoretical models of reactions to loss, such as Freud's (1917/1957) grief work perspective and Bowlby's (1980) early attachment model of grief (see also Bonanno & Kaltman, 1999). We also examined books and articles written by and for clinicians and other health care providers that describe how

bereaved individuals typically respond following a loss and what reactions are considered to be "normal." Finally, we reviewed books and articles written by and for bereaved individuals themselves (Silver & Wortman, 1980; Wortman & Silver, 1987, 1989).

Drawing from this material, we have maintained that in the United States today, there are strong and powerful assumptions about how people should react to the loss of a loved one. In previous papers, we have identified and discussed several different assumptions that are prevalent in Western culture (Silver & Wortman, 1980; Wortman & Silver, 1987, 1989, 1992; Wortman, Silver, & Kessler, 1993). First is that following a loss, individuals will go through a period of intense distress. Positive emotions are implicitly assumed to be absent during this period. Second it is assumed that failure to experience such distress is indicative of a problem. Third it is believed that successful adjustment to the loss requires that individuals confront and "work through" their feelings. Fourth, continued attachment to the person who died has generally been viewed as pathological, and the necessity of breaking down the attachment to the loved one is often considered to be a key component of the mourning process. Fifth, it is assumed that within a year or two, people will recover from the loss and return to earlier levels of functioning.

We maintain that it is extremely important to articulate assumptions about the grieving process that may be implicit in Western culture, and to subject these assumptions to careful scientific scrutiny. If it is generally assumed that the coping process should unfold in a particular way, bereaved individuals who do not conform to these expectations may receive harsh treatment, as was the case for Knapp. If counseling for bereaved individuals is based on erroneous assumptions, it may ultimately prove unhelpful. Friends and family members may have difficulty offering appropriate forms of support to a bereaved person if they are misinformed about the grieving process. Finally, those who have encountered a loss may be confused and distressed by their own responses if they have misconceptions about how they are supposed to react.

In our earlier papers (Silver & Wortman, 1980; Wortman & Silver, 1987, 1989) we carried out a systematic evaluation of the aforementioned assumptions, focusing on the best scientific evidence available at the time of our reviews. Because beliefs concerning the grieving process are firmly entrenched in our culture, we anticipated that they would be supported by the empirical data. Although the data were not always consistent, and although some of the assumptions had not been heavily researched, our review provided virtually no support for any of the assumptions we examined. For this reason, we came to label them "myths of coping with loss."

Some of our colleagues praised us for challenging the validity of prevailing assumptions and calling attention to the absence of empirical sup-

port for them (e.g., Bonanno & Kaltman, 1999; Fraley & Shaver, 1999). In contrast, others were more critical of our efforts. Some questioned our operational definitions of certain constructs (e.g., Fraley & Shaver, 1999) or our interpretations of specific studies (e.g., M. Stroebe, van den Bout, & Schut, 1994). Others maintained that we overstated the degree to which researchers and clinicians believe the myths we identified (e.g., Parkes, 1998; M. Stroebe et al., 1994). Such scrutiny of our position is not surprising when one considers that in many cases, treatment practices are based on the validity of these assumptions. For example, many current treatments are specifically designed to help individuals "work through" their loss or break down their attachment to the deceased (see, e.g., Worden, 1991). If assumptions about the importance of these processes are shown to lack support, some of the most widely used treatment approaches in the field could be questioned.

Now that nearly a decade has passed and new research has been completed, we felt it would be worthwhile to revisit the so-called myths of coping that we identified earlier. In this chapter, we draw from a series of recent, methodologically rigorous studies to reevaluate assumptions about the grieving process that we identified earlier. We then explore the implications of our review for subsequent research on, and interventions for, bereaved individuals.

NEW RESEARCH EVIDENCE PERTAINING TO THE "MYTHS OF COPING"

In the past decade, many new studies relevant to the myths of coping have been conducted (see Bonanno & Kaltman, 1999, for a review). Some new cross-sectional studies have examined the reactions of bereaved individuals from a few months to several decades after the loss (e.g., Wortman, Kessler, Bolger, House, & Carnelley, 1999). Others have begun assessing bereaved individuals within the first few months after the death and have continued assessments at various points thereafter (see, e.g., Bonanno, Keltner, Holen, & Horowitz, 1995; Murphy, 1997). Still others have focused on individuals whose spouse or partner is ill, and assessed relevant variables before, and at various intervals after, the death (e.g., Folkman, Chesney, Collette, Boccellari, & Cooke, 1996; Nolen-Hoeksema, McBride, & Larson, 1997). Finally, some followed large community samples across time and studied those who became bereaved between measurement periods (see, e.g., Carnelley, Wortman, & Kessler, 1999; Harlow, Goldberg, & Comstock, 1991; Mendes de Leon, Kasl, & Jacobs, 1994).

As was the case years ago, most bereavement studies focus on the loss of a spouse. However, there have been some new and important studies on reactions to the loss of a child (e.g., Murphy, 1997) or parent (Silverman,

Nickman, & Worden, 1992), as well as studies that have compared reactions to various types of familial loss (e.g., Cleiren, 1993; Cleiren, Diekstra, Kerkhof, & van der Wal, 1994). In most investigations, the group being studied is heterogeneous with respect to cause of death. However, some have focused on specific kinds of losses, such as parents whose children experienced a sudden, violent death (Murphy, 1997) or gay male caregivers whose partner died of AIDS (Folkman et al., 1996). A few studies have compared two or more groups of respondents who died under different circumstances (e.g., natural causes, accident, or suicide; see Cleiren, 1993; Cleiren et al., 1994).

Because of the number of excellent studies that have appeared in the past decade, we are now able to put the myths of coping to a rigorous test. These new studies include a wider variety of bereaved samples and research designs, and a greater number of operational definitions of key constructs. Thus we are now able to consider whether these myths hold true across various kinds of bereavement and deaths that occur under various conditions.

The Expectation of Intense Distress

As we discussed in earlier papers (Wortman & Silver, 1987, 1989), when a major loss is experienced, it is assumed that the normal way to react is with intense distress or with depression. As we previously noted, many of the most prevalent theories in the area of loss, such as classic psychoanalytic models (e.g., Freud, 1917/1957) and Bowlby's (1980) attachment model, are based on the assumption that at some point, individuals will confront the reality of their loss and experience a period of depression. Of course, no theorists took the extreme position that all individuals who experienced a loss would go through a full major depression. However, it was generally believed that most people experienced "intense emotional distress . . . with features similar in nature and intensity to those of clinical depression" (Osterweis, Solomon, & Green, 1984, p. 18). This view is still very much in evidence today. For example, Sanders (1999) has maintained that once the bereaved individual has come to grips with the loss, he or she will go through a phase of grief that "can be one of the most frightening periods in the grief process because it seems so like clinical depression" (p. 78).

The studies reviewed in our original papers indicated that, depending on the sample and the assessment procedure used, from about 20 to 35% of people who lost a spouse experienced depression in the first few months after the death (cf. Wortman & Silver, 1989). Very similar results have emerged from subsequent studies of conjugal loss. For example, in a prospective study of individuals over the age of 65 who became widowed

following a large baseline survey, 37.5% reported high depressive symptomatology during the first year of bereavement (Mendes de Leon et al., 1994; see Bonanno et al., 1995; and Bruce, Kim, Leaf, & Jacobs, 1990, for similar findings).

Two recent studies have found somewhat higher rates of depression following the loss of a loved one. In their study of caregivers of gay men who died of AIDS, Folkman et al. (1996) reported that 1 month after the loss, 75 to 80% of the respondents were evidencing clinically significant levels of depression. Similarly, in her study on the sudden, traumatic death of a child, Murphy (1997) reported that four months postdeath, more than 80% of the mothers and more than 60% of the fathers rated themselves as highly distressed. Murphy's scores are comparable to those obtained in our study of reactions to the loss of an infant to SIDS, where approximately 70% were classified as depressed at the initial assessment three weeks after the death (Wortman & Silver, 1987). It is interesting to note that both Folkman and Murphy emphasized that, despite the severity of the stressor their respondents were facing and the short period of time that had passed, a "significant minority" of respondents reported low levels of depressive mood or did not rate themselves as highly distressed.

When we have presented these data, colleagues have sometimes pointed out that those respondents who do not exhibit pathological or major depression may still be evidencing significant but less intense levels of depression. The aforementioned studies do not really speak to this issue, because they do not include measures of mild or subsyndromal depression. However, a prospective study of conjugally bereaved individuals over age 45 conducted by Bruce et al. (1990) did include a measure of dysphoria as well as depression. Dysphoria was defined as two weeks or more of feeling "sad, blue, depressed or when you lost all interest and pleasure in things you usually cared about or enjoyed." About 60% of the respondents had experienced dysphoria, but a significant minority (almost 40%) did not go through even a two-week period of sadness following their loss. Even more striking results have been reported by Zisook, Paulus, Shuchter, and Judd (1997) in their study of elderly widows and widowers. Research participants' ratings on symptom inventories were used to classify them into *DSM-IV* categories of major depression, minor depression, subsyndromal depression (endorsing any two symptoms from the *DSM-IV* symptom list), and no depression (endorsing one or no items reflecting depression). Two months after bereavement, 20% were classified as showing major depression, 20% were classified as exhibiting minor depression, 11% were classified as evidencing subsyndromal depression, and 49% were classified as evidencing no depression. These studies provide compelling evidence that following the loss of a spouse, a substantial minority of respondents show few signs of sadness. Comparable findings have been reported by Cleiren

(1993) in his study of how adults react to the loss of a spouse, child, sibling, or parent.

In our original articles, we noted that many people not only exhibited less distress than anticipated but actually experience positive emotions far more frequently than might have been expected. At three weeks following the loss of a baby to SIDS, parents reported experiencing positive emotions such as happiness as frequently as they experienced negative feelings (Wortman & Silver, 1987). Similar findings have been obtained in more recent studies. When caregivers of men who died of AIDS were asked to talk about their experiences and then emotions were coded from the dialogue, about 80% evidenced positive emotions and only 61% of respondents showed negative emotions (Stein, Folkman, Trabasso, & Christopher-Richards, 1997; see also Folkman, 1997). Comparable findings were obtained by Bonanno and Keltner (1997), who coded facial expressions of conjugally bereaved respondents while they were describing their relationship with the deceased. Videotapes of interviews were coded for the presence of genuine or "Duchenne" laughs or smiles, which involve movements in the muscles around the eyes. Not only was positive emotion exhibited by the majority of participants, but its presence was correlated with reduced grief 14 and 25 months postloss (see also chapter 22, this volume). These studies suggest that it is indeed normal to experience positive emotions following a major loss.

Viewing the Failure to Experience Distress as Problematic

Historically, the absence of grief following bereavement has been viewed as an indication that the grieving process was abnormal or "pathologic" (e.g., Deutsch, 1937; Marris, 1958; Osterweis et al., 1984). As M. Stroebe, Hansson, and Stroebe (1993) have indicated, however, there are many possible reasons why an individual may not exhibit intense distress following loss that would not necessarily be considered pathological (e.g., early adjustment following an expected loss, perhaps coupled with relief following an end to suffering). Nonetheless, available evidence suggests that most practicing clinicians continue to maintain either explicitly or implicitly that there is something wrong with individuals who do not exhibit grief or depression. In a survey of researchers and clinicians in the field of loss (Middleton, Moylan, Raphael, Burnett, & Martinek, 1993), respondents were asked to indicate whether certain variants of the grieving process occur, and if so, to describe their features. A majority (65%) agreed that "absent grief" exists, that it typically occurs as a result of intrapsychic causes such as denial or inhibition, and that it is generally maladaptive in the long run. This is because it is assumed that if grief is not expressed, a "delayed grief reaction" will surface at some point in the future or health problems will subsequently emerge (Worden, 1991).

In our earlier papers, we reviewed a number of studies that indicated that a delayed grief reaction is very rare. New studies support this conclusion. For example, in a study that followed the conjugally bereaved for five years, Bonanno and his associates reported that virtually no participants showed a delayed grief reaction (Bonanno et al., 1995; Bonanno & Field, in press; Bonanno, Znoj, Siddique, & Horowitz, 1999). A small number of respondents did report increased somatic complaints at later points in time, although these complaints were not related to frequency of visits to medical professionals (see also Middleton, Burnett, Raphael, & Martinek, 1996). Nonetheless, in the previously described survey by Middleton et al. (1993), a substantial majority (76.6%) of researchers and clinicians indicated that delayed grief does occur.

"Absent grief" has also been viewed as evidence for a character weakness in the survivor. For example, Horowitz (1990) has suggested that among those who show little overt grief are "narcissistic personalities" who "may be too developmentally immature to have an adult type of relationship and so cannot exhibit an adult type of mourning at its loss" (p. 301). Although such a view is often espoused in the clinical literature, it has not, to our knowledge, been put to an empirical test.

A prospective longitudinal study by Wheaton (1990) has helped to clarify one important reason why some bereaved individuals may not exhibit intense distress following loss. In a provocative analysis, Wheaton (1990) argued that for some people, the death of a loved one may represent the end of a chronically stressful situation, such as a bad marriage or heavy caregiving responsibilities. In fact, he demonstrated that when the marriage is viewed as a chronic stressor, mental health actually increases following the death of a spouse.

In sum, research continues to support our original conclusion that the failure to experience grief appears not to portend subsequent difficulties.

The Importance of "Working Through" The Loss

It is widely assumed in Western culture that to adapt successfully to a major loss, a person must "work through" what has happened. M. Stroebe (1992) has defined working through as "a cognitive process of confronting a loss, of going over the events before and at the time of the death, of focusing on memories and working towards detachment from the deceased" (p. 20). Although there is some debate about exactly what it means to "work through" a loss, most grief theorists agree that it requires an active, ongoing effort to come to terms with the death (Rando, 1993; M. Stroebe, 1992). Attempts to deny its implications, or avoid feelings or thoughts about it, are ultimately regarded as unproductive. Grief work has also been described as having an "obsessional" quality, in which the bereaved person repeatedly reviews thoughts about the loved one and his or her death

(Sanders, 1999). This process is seen as being invariably painful, but it is believed that the pain must be confronted and experienced (see, e.g., Rando, 1993; Worden, 1991).

In our original papers, we were unable to locate any studies designed specifically to test the value of "working through" the loss. However, we reported some data from our own research on SIDS loss that we felt was relevant to this concept. We identified items thought to reflect parents' active attempts to make sense of and process the death, including searching for an answer for why the baby had died, thinking of ways the death could have been avoided, and being preoccupied with thoughts about the loss. The more parents engaged in these activities at three weeks after their loss, the more distressed they were 18 months later. In her review of the literature on "working through," M. Stroebe (1992) was critical of our interpretation, suggesting that what we had termed "working through" probably was, at least in part, an indication of rumination. Stroebe acknowledged, however, that shortly after a loss, it may be difficult to tell when a bereaved person's review of thoughts and feelings about a loved one represents rumination and when it represents "working through" (cf. Nolen-Hoeksema et al., 1997).

During the past decade, a number of new studies have appeared in the literature regarding the value of working through a loss. These studies have assessed one or more constructs that seem relevant to the process of working through, including thinking about one's relationship with the loved one (Nolen-Hoeksema et al., 1997); expressing high distress on self-report measures of emotion (Cleiren, 1993); verbally expressing negative feelings or showing negative facial expressions (Bonanno & Keltner, 1997); confronting thoughts and reminders of the loss versus avoiding reminders and using distraction (M. Stroebe & Stroebe, 1991); disclosing or expressing one's thoughts and feelings to others (Lepore, Silver, Wortman, & Wayment, 1996); and expressing one's feelings through writing about the loss (Pennebaker, Mayne, & Francis, 1997).

When "working through" is defined in these ways, there is little indication that bereaved individuals who show evidence of "working through" their loss ultimately cope better than those who do not. In a study of gay men who lost a partner to AIDS, Nolen-Hoeksema et al. (1997) found that those who thought about their life without the partner, and how they had changed as a result of the loss, showed positive morale shortly after the death, but showed more persistent depression over the 12 months following the loss. Evidencing high self-reported distress shortly after the loss has consistently been shown to be a powerful predictor of poor grief resolution (see, e.g., Cleiren, 1993; or see M. Stroebe, 1992, for a review). Bonanno and Keltner (1997) found that those who expressed negative feelings or manifested negative facial expressions in an interview showed higher interviewer-rated grief 14 months postloss, even when initial

levels of grief were controlled. In a study designed specifically to compare those who used avoidant versus more confrontative coping styles in dealing with conjugal loss, Bonanno et al. (1995; in press) asked bereaved individuals to speak about their lost loved one and then complete scales indicating what they were experiencing. Physiological data assessing their cardiovascular reactivity were simultaneously collected. Those who evidenced emotional avoidance (i.e., little emotion relative to their physiological scores) showed low levels of interviewer-rated grief throughout the two-year study. There was no relationship between initial emotional avoidance and the delayed emergence of grief symptoms. Although respondents with an avoidant style did show higher levels of somatic complaints at six months postloss, these symptoms did not persist beyond the six-month assessment and were unrelated to medical visits.

Results in all of the aforementioned studies run directly counter to what the "working through" hypothesis would predict. There are a few studies that provide support for the value of "working through" a loss under some conditions or on some measures but not others. M. Stroebe and Stroebe (1991) found that 18 months following the loss of a spouse, there were no differences between widows who confronted their loss (i.e., did not avoid reminders and disclosed their feelings to others) and those who did not. In fact, widowers who confronted their grief showed lower depression scores over time. One study focusing on disclosure of feelings found that talking about the loss of an infant to SIDS resulted in lower subsequent rates of depression if people in the social environment were supportive of emotional disclosures but higher rates of depression if they reacted negatively to emotional disclosures (Lepore et al., 1996). Finally, writing about a trauma resulted in fewer health visits than writing about a trivial event (Pennebaker, 1997; Pennebaker et al., 1997). Those who demonstrated this effect showed an increase in the use of causal and insight words, suggesting successful "working through." However, writing about trauma had no effect on self-reported psychological distress. Finally, there are two studies suggesting that certain kinds of emotional avoidance may be detrimental in coping with the loss of a loved one. Nolen-Hoeksema and Larson (1999) and Rubin (1996) have reported that avoiding loss through increased reliance on alcohol or substance abuse is associated with prolonged distress.

All of the previously reviewed studies focused on bereaved respondents recruited from the general population. What about individuals who participate in grief counseling or grief therapy? It is widely accepted that such treatments can facilitate the process of "working through" a loss, and indeed some treatments are specifically designed to confront feelings about the deceased gradually (Mawson, Marks, Ramm, & Stern, 1981; Volkan, 1981). Although a review of the grief treatment literature is beyond the scope of this chapter, a recent meta-analysis of studies on grief therapy

raises serious questions about the efficacy of bereavement interventions. Fortner and Neimeyer (cited in Neimeyer, 2000) located all scientifically adequate outcome evaluations of grief therapy published between 1975, when the first such studies appeared, and 1998. Of these 23 studies, grief therapy was provided by professional therapists in 19 of them and by nonprofessionals in the remainder. The analysis revealed a significant but small effect size (.15). This means that the average participant in grief therapy was better off than only 55% of bereaved persons who received no treatment for anxiety or depression. It is interesting to note that these investigators found that 38% of those who received grief counseling showed deterioration as a result of their treatment. According to Neimeyer (2000), this rate is many times higher than the 5% rate typically shown in psychotherapy for various problems. Treatment outcome was found to be completely unrelated to the length of treatment, to the level of training of the therapist, and to the type of treatment approach (individual, family, or group). Better outcomes were achieved by clients for whom more time had passed since the loss. The results revealed that when normal grievers were offered counseling, this resulted in no positive effect and a 50% probability of deterioration. In studies dealing with grief following a sudden, traumatic death or chronic grief, a reliable positive effect was found (d = .38), and the potential for deterioration was substantially lower (17%) than for normal grievers.

Why are these treatment effects so modest, even for traumatic or chronic grief reactions? According to Neimeyer (2000), grief therapy studies typically offer treatments that are not based on well-delineated conceptual models and are often not described in any detail. When it is described, "it tends to be based on suspiciously simplistic models, such as stage theories of grieving that have been largely repudiated by contemporary theorists and researchers" (Neimeyer, 2000, p. 8). As Foa and Meadows (1997) have indicated, there have been major advances in what is regarded as a methodologically sound treatment study over the past decade. As a result, methods that were acceptable, or even common in earlier studies, are no longer considered scientifically rigorous today. Parameters of a methodologically rigorous study include such features as reliable and valid measures, clearly defined treatment programs that are manualized and replicable, and random assignment of research participants to various treatment and control conditions (see Foa & Meadows, 1997, for a more complete list of parameters that a treatment study must include to meet the "gold standard" of treatment outcome studies today).

Although we have not encountered many such studies in the field of bereavement, there are outstanding research programs on treatment for rape victims that can be interpreted as showing that "working through" the implications of a traumatic event can be beneficial (Foa & Rothbaum, 1997; Resick & Schnicke, 1992). These authors have each developed brief

but remarkably effective treatments for rape victims based on having them repeatedly reexperience the event within the context of individual therapy. They then perform in vivo exposure "homework" in which they confront avoided places and things. Frank, Prigerson, Shear, and Reynolds (1997) have recently adapted Foa and Rothbaum's approach to people suffering from intense or prolonged grief, and preliminary results appear highly encouraging.

In summary, this review indicates that there are several different ways of working through versus avoiding the thoughts and feelings associated with a loss. As Archer (1999) has noted, at this point we have little empirical data regarding how these approaches to grieving are related to one another, and little evidence that the "confrontative" strategies are associated with better outcomes than the "avoidant" ones. In fact, confrontative strategies such as thinking about one's relationship with the loved one or how the death occurred often portend subsequent difficulties. Avoidant coping strategies may predict or facilitate subsequent adjustment as long as they do not take maladaptive forms such as enhanced use of alcohol or drugs. When one moves from bereavement studies on the general population to treatment studies, the evidence in favor of working through does not improve. Although most treatments are designed to facilitate working through, a recent review suggests that as a whole, such treatments are rarely effective, but conceptual and methodological problems make many bereavement studies difficult to interpret. Two conceptually grounded and methodologically rigorous treatment programs on rape suggest that therapy can indeed help people work through a trauma. We believe these programs hold great promise for application to bereaved individuals.

The Necessity of Breaking Down Attachments

An important element in working through loss involves dealing with one's attachment to the lost loved one. Historically, Freud (1917/1957) and other psychoanalytic writers emphasized the importance of breaking down the affective bonds to the deceased. According to this view, grief work is completed only when the bereaved person withdraws energy from the deceased person and has freed him- or herself from attachment to an unavailable individual. This view continued to be influential for many years, with its advocates maintaining that if attachments are not broken down, the bereaved person will be unable to invest energy in new relationships and pursuits (see, e.g., Rando, 1984; Raphael, 1983).

These views about the importance of breaking down attachments were not shared by Bowlby (1980). As Fraley and Shaver (1999) pointed out in an insightful analysis, Bowlby maintained in his later writings that continuing attachments to the deceased, such as sensing his or her presence or talking with him or her, can provide an important sense of continuity

and facilitate adaptation to the loss (see also chapter 4, this volume). A similar view has been advocated recently by Klass, Silverman, and Nickman (1996). Although they were trained to expect grief resolution to be accompanied by breaking down attachments to the lost loved one, these investigators reported that this is not what they observed in their research or their clinical interviews with bereaved individuals. Instead, their work suggested that it is common for bereaved individuals to remain connected to the deceased and that these connections "provided solace, comfort, and support, and eased the transition from the past to the future" (p. xvii).[1]

When our earlier papers were written, the prevailing view among clinicians was that breaking down attachments was indeed essential for mourning (see, e.g., Rando, 1984; Raphael, 1983; Worden, 1982). Therefore, we were surprised to find several well-controlled studies suggesting that continued and persistent attachments to the deceased were very common (see, e.g., Parkes & Weiss, 1983; Rees, 1971). Parkes and Weiss (1983) speculated that forms of attachment such as sensing the presence of the deceased facilitated recovery. At that time, however, there was little empirical data linking attachment to the deceased to subsequent adjustment.

Recent studies continue to provide evidence that continued attachments to the deceased are quite common. For example, Zisook and Shuchter (1993) reported that 13 months after a spouse's death, 63% of respondents agreed that they feel their spouse is with them at times, 47% felt that he or she is watching out for them, and 34% talked with their spouse regularly. Similarly, in their study of how children cope with the loss of a parent, Silverman and Nickman (1996) reported that four months after the death, it was common for children to maintain an active and apparently beneficial tie to the deceased. The clear majority of children (74%) located their parents in heaven, and most viewed the parent as watching out for them. It was also common for children to reach out to the deceased to maintain a connection, with almost 60% talking with him or her and 43% indicating that they received an answer. Types of connections identified in other new studies include incorporation of virtues of the deceased into one's own character (Normand, Silverman, & Nickman, 1996), using the deceased as a role model, turning to the deceased for guidance regarding a particular problem, and reflecting on the death to clarify one's current values (Marwit & Klass, 1996).

These types of continued connections with the deceased can be viewed as comforting to bereaved individuals. Nonetheless, as Fraley and Shaver (1999) have emphasized, many of these same studies have reported

[1]Klass et al. (1996) contrasted their view that continued attachment can be beneficial with Freud and Bowlby's views that such attachments are indicative of pathology. Fraley and Shaver (1999) maintained, however, that Klass et al. have failed to recognize Bowlby's opinion regarding the value of attachments, as reflected in his later writings, and that it is actually almost identical to the view they espouse.

that among a significant minority of survivors, ongoing connections with the deceased were not always comforting. For example, 57% of the children in the study by Silverman and Nickman (1996) indicated that they were "scared" by the idea that their parents could watch them from heaven. In fact, some children regarded their deceased parent as a ghost "whose presence was frightening, unpredictable, and out of their control" (Normand et al., 1996, p. 88; see also Tyson-Rawson, 1996).

The literature is clear in suggesting that it is indeed common for individuals to maintain an attachment to the deceased, that this link can be perceived as comforting or frightening, and that there are many different forms that this attachment may take. What is less clear, however, is whether there is a relationship between specific attachment behaviors and subsequent resolution of grief. In the only study we could locate on this issue, interviewers rated the extent to which bereaved respondents manifested four different kinds of attachment six months following loss, and subsequently asked them to engage in a monologue role play with their deceased spouse (Field, Nichols, Holen, & Horowitz, 1999). This exercise has been found to be a powerful vehicle for confronting bereaved individuals with the reality of their loss. Results indicated that bereaved individuals who sought comfort through memories of their loved ones experienced less distress in the monologue. However, those who tended to hang on to possessions, or sought comfort through contact with the deceased's belongings, showed greater distress during it. The investigators also examined the relationship between attachment behaviors and grief symptomology and resolution over time. They found that those bereaved individuals who hung on to the deceased's possessions, or attempted to gain comfort through contact with the possessions, evidenced higher grief-specific symptoms over a two-year period, and less of a decrease in grief symptoms over time. These findings suggest that whether continuing attachment with the deceased is adaptive or maladaptive may depend on the form that this attachment takes. Many forms of attachment identified in earlier studies, such as adopting virtues of the deceased, were not examined in this study, and thus no information is available about their adaptive value.

The Expectation of Recovery

Once they have completed the process of "working through" the loss, it is generally believed that bereaved individuals will achieve a state of recovery where they can encounter reminders without pain and they can return to normal levels of functioning. Those who fail to recover after an "appropriate" amount of time are often viewed as displaying "chronic grief" (see, e.g., Jacobs, 1993), which is widely regarded as an indication of "pathological mourning" (Middleton et al., 1993). Although Lindemann (1944) originally maintained that, with appropriate psychiatric intervention, it was

usually possible to resolve a grief reaction in four to six weeks, many have suggested that this view was overly optimistic (see, e.g., Rando, 1993). In fact, Worden (1991) wrote that he would be suspicious "of any full resolution that takes under a year, and for many, two years is not too long" (p. 18). However, there are many textbooks as well as articles in the popular press that suggest that after approximately one year, individuals who lose a spouse should be "back to normal" (see Wortman et al., 1999, for a more detailed discussion).

Moreover, within a relatively brief period of time, individuals are expected to be able to remember the deceased and confront reminders of the loss without intense emotional pain (Parkes & Weiss, 1983; Rando, 1993). Many people continue to view recovery as the endpoint of the bereavement process and still evaluate bereaved people by judging whether they are taking "too long" to reach this endpoint. However, it appears that views of the recovery process are beginning to change (Silverman & Klass, 1996). Rando (1993) has pointed out that terms like "resolution" and "recovery" are not applicable to most losses because they imply a type of once-and-for-all closure that typically does not occur. Similarly, Miller and Omarzu (1998) emphasized that many are gradually acknowledging that bereaved individuals may never return to their preloss state. In fact, they maintain that this may not even be an optimal goal. They suggest that rather than expecting a return to the status quo, bereavement researchers should remain open to the notion that people may continue to negotiate and process their loss for many years.

In individual studies, the question of whether a bereaved person has "recovered" from the loss has been approached in several different ways. In cross-sectional studies, investigators have attempted to determine whether those who have been bereaved for many years show fewer symptoms of grief or distress than those bereaved more recently (see, e.g., Barrett & Schneweis, 1980). In longitudinal studies beginning before the loved one has died, recovery has been defined as a return to the baseline level of depression (e.g., Harlow et al., 1991); those who become depressed following the first interview and remain depressed over time are viewed as exhibiting "chronic grief" and as not recovering. In studies that have included a control group of married individuals who do not become bereaved, recovery has been defined as the length of time it takes bereaved individuals to reach the depression score of married individuals (e.g., Bruce et al., 1990). In each of these kinds of studies, recovery has also been conceptualized by examining whether or when bereaved respondents score below a cut-off designed to reflect a particular symptom or diagnosis—usually depression, which is considered the cardinal symptom of grief.

Although cross-sectional studies are generally viewed as less valuable in studying the grieving process than longitudinal ones (Wortman, Sheedy, Gluhoski, & Kessler, 1992), they are uniquely valuable in examining the

issue of long-term recovery. There are virtually no longitudinal studies that have followed individuals more than a few years after the loss, but cross-sectional studies can provide information about how respondents are doing several years or decades later. For example, Lehman, Wortman, and Williams (1987) study on the long-term impact of losing a spouse or child in a motor vehicle accident four to seven years after loss found that the majority of respondents had painful memories about their loved one in the previous month. In one cross-sectional investigation, Barrett and Schneweis (1980) interviewed a large representative sample of elderly people who had lost their spouses; respondents were divided at the median (8.5 years) by length of bereavement. Results revealed no significant differences on the vast majority of measures included in the study, such as happiness and loneliness.

Long-term cross-sectional data on recovery are also available from Rubin's (1996) study of two groups of bereaved parents in Israel: one who lost their sons 4 years earlier in the Lebanon war and another who lost their sons 13 years earlier in the Yom Kippur war. In both cases, bereaved parents were compared with control parents who had not lost their sons on a wide range of measures, and there were demonstrable differences between the bereaved and nonbereaved parents. Moreover, these effects were apparent for at least a decade. For example, the bereaved parents were more anxious than the nonbereaved parents, and the passage of time did not affect this outcome. Time also failed to differentiate between the two bereaved groups on other important measures, including preoccupation with the loss and somatic symptoms.

Wortman et al. (1999) conducted a study involving a nationally representative sample of approximately 800 conjugally bereaved individuals who lost their spouses anywhere from 1 to 60 years before data collection. The study included several dependent measures designed to clarify the recovery process, such as the frequency of memories and conversations about the deceased and whether these were perceived as painful. Results of this study indicate that the process of adjustment continues for many years. Individuals initially reported that they experienced painful feelings when they thought or talked about their spouses, but the frequency of such painful feelings appeared to decline over time. Nonetheless, it took respondents nearly 40 years to reach a point at which they experienced such negative feelings "rarely." For most respondents, such negative thoughts never seem to fade completely. Similarly slow declines were found for so-called anniversary reactions—experiencing particular occasions when the sadness and loneliness that they experienced right after the death returned to them.

Moreover the difference in depression scores between widowed and married respondents remained significant as long as 15 years after the loss, and it took the widowed respondents more than 30 years to reach the level of depression of married respondents. The difference in life satisfaction

between married and control respondents was significant as long as 7.5 years following the loss, and it took respondents more than 15 years to reach the level of life satisfaction of married respondents.

The results obtained in these cross-sectional studies are supported in an elegant cotwin longitudinal study of response to widowhood conducted by Lichtenstein, Gatz, Pedersen, Berg, and McClearn (1996). More than 2000 Swedish twins participated in a survey every three years for 12 years. Those who lost a spouse between any two intervals were classified as bereaved. Rates of depression were high in both the short-term bereaved (less than 5 years; 51%) and the long-term bereaved individuals (on average 13 years for men and 17 for women; 37%). They were also quite high in the to-be-bereaved condition (married at one interview but bereaved by a subsequent interview; 41%). All were significantly higher than those of the married respondents. When these analyses were repeated comparing bereaved respondents with their cotwin control, it was found that those bereaved fewer than five years reported more depressive symptoms, more loneliness, and less life satisfaction than their twin. Among the long-term bereaved respondents, women were significantly more lonely, less satisfied, and tended to be more depressed than their cotwin control. Long-term bereaved men were also found to be significantly more lonely than their cotwin control, although there were no significant differences in life satisfaction or depression.

An interesting finding to emerge from this study was that when married respondents were compared with to-be-widowed respondents, the latter group was found to have an elevated depression score. This finding has important implications for interpreting other longitudinal studies on bereavement. Some studies have claimed that the effects of widowhood were resolved in a year because by that time, the depression scores had returned to baseline (see, e.g., Harlow et al., 1991). The Lichtenstein et al. (1996) study demonstrates, however, that many bereaved individuals become depressed before the death, either because of anticipatory grief, caregiver burden, or other unknown reasons. These results suggest that those planning future studies should obtain a baseline interview at least a couple of years before the widowhood experience.

Taken together, these data suggest that although some symptoms lessen over time, many bereaved individuals continue to experience distressing symptoms, painful memories, and impaired quality of life for several years following their loss.

CONCLUSION

In our earlier papers, we maintained that some of the most widely held and influential assumptions about the process of coping with the loss of a loved one were not supported, and were often contradicted, by the

available data. In this paper, we have reviewed numerous studies that provide strong support for our original conclusions. We have presented clear evidence that a large minority of respondents fail to experience even mild depression following the loss of a spouse, child, parent, or sibling. Respondents in such studies fail to show delayed grief, or health problems as long as 25 months following the loss, although we cannot rule out the possibility that such problems will eventually emerge. In direct contradiction to the idea that it is necessary to pass through a period of depression, the expression of negative emotion in the first few months following a loss has repeatedly been shown to portend subsequent difficulties. Expression of positive emotions, in contrast, has been associated with less severe and long-lasting symptoms. These findings have emerged whether emotions are assessed through self-report, coded from narratives, or coded from facial expressions. Similarly, many studies have tested the "working through" hypothesis, defining the construct in various ways, and none has found clear support for the hypothesis that people who actively confront their thoughts and feelings about the loss show better long-term adjustment than those who use avoidant strategies. Grief treatments, which are generally expected to help people resolve their grief, have been found to be surprisingly ineffective and sometimes counterproductive. Numerous studies show that continuing attachment to the deceased is normal, although whether attachment is beneficial may depend on the form that it takes. There is also clear evidence to suggest that a substantial percentage of people experience distressing symptoms for many years following an important loss.

Given the striking absence of empirical support for the aforementioned ideas, it is important to ask whether they are still influential in the bereavement field today. As we noted earlier, some of these assumptions are in a state of transition, such as the view that it is important to break down ties to the deceased, which has recently been challenged by researchers and clinicians (Klass et al., 1996). These challenges have led to exciting and important new studies examining whether particular kinds of attachments are beneficial. The same is true for the assumptions about recovery. As researchers and clinicians are beginning to think about the recovery process in new ways, they note that people may not return to their preloss state. The coping task may not be to return to previous levels of functioning but to negotiate a meaningful life without the deceased. It is also likely that bereaved individuals experience important and enduring changes as a result of their loss. These changes may be negative, such as a permanent shift in the ability to regulate anxiety (Rubin, 1996), as well as positive, such as enhanced feelings of competence and self-esteem (Wortman et al., 1999; and see Updegraff & Taylor, in press, for a more detailed discussion of positive and negative changes following stressful life events).

We would maintain that assumptions about the importance of going through a period of distress, and of working through the loss, however, are

still extremely influential. In what is arguably the most widely used book on grief counseling, Worden (1991) stated that "there are certain tasks of mourning that must be accomplished for equilibrium to be reestablished and for the process of mourning to be completed" (p. 10). One of these tasks is to acknowledge and work through the pain of the loss. Worden argued that "it is impossible to lose someone you have been deeply attached to without experiencing some level of pain" (p. 13). He also warns that if this task is not adequately completed, "therapy may be needed later on" (p. 14). The views of Worden and others have given rise to a veritable industry of professional grief counselors. The major tenet on which their work is based is that "you have to feel it in order to heal it" (Labi, 1999, p. 70).

The notion of working through grief is also the most important feature of a treatment called Critical Incident Stress Debriefing. Originally developed by Jeffrey Mitchell, then a paramedic, to help soldiers in World War II deal with the traumas of war, this procedure is widely used today throughout the world following disasters and traumatic incidents. In Littleton, Colorado, for example, counselors spent 1500 hours talking to students in the first week after the April 20, 1999, shooting in which 15 died (Labi, 1999). As Theodore Fineberg, a New York-based psychologist who flew to Littleton as part of a team sent by the National Association of School Psychologists, explained, "Debriefing is a therapeutic opportunity to get people to open up, to ask questions and unburden the psychic pain they are carrying around" (Labi, 1999, p. 69). Nonetheless, the empirical evidence in support of Critical Incident Debriefing Therapy is sorely lacking: In a recent meta-analysis of six controlled studies examining the impact of this procedure, two produced positive results, two produced negative findings, and two showed no differences (Rose & Bisson, 1998).

Overall, our review suggests a number of intriguing implications for continued research and clinical work. It would be useful to clarify *why* some people show little distress shortly after their loss (and also fail to show delayed grief reaction). There are many possible ways of understanding such a reaction. It could signal relief if the relationship had been stressful or if the bereaved person was involved in caregiving responsibilities before death. It could reflect a lack of attachment to the loved one, as many clinicians have claimed. It could also be indicative of an avoidant coping style, or stoicism, that is working effectively. Alternatively, it could indicate that the bereaved person was able to incorporate the loss into his or her existing view of the world—for example, viewing the loss as God's will and believing that the deceased is in a better place, or believing that bad things happen and there is nothing one can do about them (Wortman & Silver, 1992; and see Janoff-Bulman, 1992, for a fuller discussion of the role of world views in response to loss). Given the many reasons why people may fail to show distress following a major loss, our review raises

serious questions regarding the widespread belief among clinicians that such individuals need to "work through" the loss. In fact, the previously discussed meta-analysis by Neimeyer (2000) suggests that among individuals who are not highly distressed, a grief-focused intervention can lead to a worse outcome than no intervention at all.

What about those individuals who show intense or prolonged distress following the death of a loved one? Is such a reaction indicative of the loss of a great love, perhaps coupled with strong dependence on the spouse who has died? Or is such a reaction merely a reflection of previous psychopathology on the part of the surviving spouse? It is hoped that prospective studies assessing bereaved individuals before the death and following them for a period of time afterward will help to unravel this mystery.

The studies reviewed provide no evidence to suggest that people who attempt to confront and process the loss do better than those who do not. But this does not mean that focusing on the death or expressing negative feelings necessarily causes a worse outcome than blocking or avoiding such thoughts and feelings. It is important to identify the factors that may lead some people to express negative feelings after a death. First, people may be more likely to express negative feelings if they experience more negative feelings. People may suffer more following a loss for many reasons, including the closeness of the attachment to the deceased (Cleiren, 1993), the manner of death, and the extent to which the death shatters previously held beliefs about themselves or their world (Janoff-Bulman, 1992). Certain deaths may not only cause more suffering but may raise more existential questions. Hence, certain types of loss, such as the death of a child because of a drunk driver, may be more difficult to work through than the death of a beloved but elderly spouse.

Given a loss that is difficult to work through, how should people be encouraged to deal with their grief? We suspect that many people who have experienced a particularly traumatic loss may not know how to process grief on their own and an unsupportive, constraining social network may even make matters worse (see Lepore et al., 1996). If they think about the loss and its implications, what determines whether they will move forward or whether they will become "stuck" in their grief (Holman & Silver, 1998), continuing a process of painful rumination with little progress? As M. Stroebe (1992) has suggested, individual coping styles may be important, with some people developing "approaching" or "avoidant" styles that work well for them. The ability to tolerate affect may also be important (cf. McCann & Pearlman, 1990). Those who become flooded with painful affect when they think about the loss may not be able to stay with their feelings long enough to gain insight. Individuals with more well-developed coping capacities and resources for self-soothing may be more able to process the event in manageable chunks, moving back and forth between approach and avoidant strategies to regroup. Unfortunately,

no studies on working through have included such constructs as coping styles, self-capacities, or the impact of the loss on world views.

In our judgment, working through is an area in dire need of further investigation. More basic research is needed to examine the role played by such components of working through as thinking about the loss, talking, crying, writing, and distraction. We also need more information about the conditions under which particular types of working through are likely to facilitate coming to terms with the loss. It is hoped that such research will provide a solid basis on which to develop effective interventions for bereaved individuals. Given the large number of bereaved individuals who suffer significant distress following the loss, we believe it is remarkable that no standardized treatments for grief have been developed, tested, and found to be effective. This should be an important societal goal, because many experts in the area have emphasized that helping a client work through a loss requires consummate training, and that those who push too hard and too fast may do more harm than good (Pearlman & Saakvitne, 1995; Rando, 1993). Fortunately, as we described earlier, bereavement researchers have begun to adapt treatments from the trauma literature, based on an exposure model to bereaved individuals (Frank et al., 1997). Of course, development of effective treatments will not resolve the problem, because only a small percentage of those who experience major mental health problems following bereavement seek professional help (Jacobs, 1993). As health care providers, it behooves us to develop and evaluate specific tools that bereaved people can use on their own to assist in "working through" the loss. Participating in guided writing programs, keeping diaries, completing workbooks, and interacting with other bereaved persons on the Internet are but a few examples.

In closing, we believe that it is important to identify beliefs about coping with loss that are widely held in the culture and to subject them to careful empirical scrutiny. There is evidence that the research community is revising its views on these issues (e.g., M. Stroebe et al., 1994). However, we believe that these myths are still prevalent among clinicians and among the general public. It is our hope that this review will encourage further research on how to facilitate resolution of grief among those who seek counseling following their loss and also among those who are suffering but not receiving professional help. We also hope that the profound variability that exists in Western culture in response to loss will ultimately come to be acknowledged, so that bereaved individuals will be met consistently with compassion by those whom they encounter.

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