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Prospective Patterns of Resilience and Maladjustment During Widowhood

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Using prospective longitudinal data on an older sample beginning prior to the death of a spouse, G. A. Bonanno et al. (2002) distinguished 5 unique trajectories of bereavement outcome: common grief, chronic grief, chronic depression, depression followed by improvement, and resilience. These trajectories having been identified, the aims of the current study were to examine differences in how respondents in each group reacted to and processed the loss. Specific hypotheses were tested regarding differences in coping, meaning making, context, and representations of the lost relationship. Results suggest that chronic grief stems from the upheaval surrounding the loss of a healthy spouse, whereas chronic depression results from more enduring emotional difficulties that are exacerbated by the loss. Both the resilient and the depressed–improved groups showed remarkably healthy profiles and relatively little evidence of either struggling with or denying/avoiding the loss.

The death of a spouse can be a painful and sometimes debilitating experience. However, bereaved individuals differ markedly in how much and how long they grieve (Bonanno & Kaltman, 1999, 2001; Wortman & Silver, 1989, 2001). Comparisons across bereavement studies have revealed three basic patterns of outcome: common or time-limited disruptions in functioning (e.g., elevated depression, cognitive disorganization, health problems) lasting from several months to 1 to 2 years, chronic disruptions in functioning lasting several years or longer, and the relative absence of depression and other disruptions in functioning (for a review, see Bonanno & Kaltman, 2001).

These patterns suggest potentially important implications for understanding the experiences of older bereaved adults. However, there remain a number of central but as yet unresolved questions. For example, because older bereaved adults generally experience less intense and less enduring grief symptoms (Lichtenstein, Gatz, Pedersen, Berg, & McClean, 1996; Nolen-Hoeksema & Ahrens, 2002; Sherbourne, Meredith, Rogers, & Ware, 1992; Zisook, Shuchter, Sledge, & Mulvihill, 1993), they may exhibit chronic grief reactions less often and the absence of grief reactions more often compared with younger bereaved adults.

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Perhaps an even more important issue is that because the vast majority of bereavement research is conducted after the loved one's death, making it difficult to accurately estimate preloss functioning (Safer, Bonanno, & Field, 2001), the basic outcome trajectories typically observed during bereavement may not capture the full range of grief outcomes. For example, at least some individuals experiencing prolonged depression during bereavement may have been depressed prior to the loss and thus may be more accurately viewed as suffering from chronic depression rather than chronic grief. Among those showing an absence of grief, it is not clear whether such a reaction is indicative of denial or inhibition, lack of attachment, or resilience in the face of loss (Bonanno, Papa, & O'Neill, 2001). Alternatively, some individuals showing absent grief may have had a spouse with prolonged, serious illness or a highly stressful marriage and thus experience marked reductions in depression after the spouse's death (Bodnar & Kiecolt-Glaser, 1994; Cohen & Eisdorfer, 1988; A. Horowitz, 1985; Wheaton, 1990).

In an effort to account for these possibilities, our research team recently examined depressive symptoms using longitudinal, prospective data from the Changing Lives of Older Couples (CLOC) study (Bonanno et al., 2002). Specifically, we tracked depressive symptoms in older adults beginning on average 3 years prior to the death of a spouse and again 6 and 18 months after the spouse's death. This approach revealed a more differentiated set of outcome patterns that both challenge core ideas in the bereavement literature and suggest a number of potentially important implications for the quality of life among older survivors.

A primary finding to emerge from this study was that large numbers of bereaved individuals appeared to be capable of genuine resilience in the face of loss. Nearly half of the sample (45.6%) showed low levels of depression at prebereavement and at 6 and 18 months following bereavement. These individuals also exhibited low levels of other grief symptoms (e.g., yearning). This pattern

was far more prevalent than the so-called typical or normal grief pattern (an increase in distress following the loss, which abates over time), shown by only 10.7% of respondents, or a delayed grief pattern, which, as in previous studies (e.g., Bonanno & Field, 2001; Middleton, Burnett, Raphael, & Martinek, 1996), was virtually nonexistent in this sample.

Clinical theorists have widely assumed that the absence of distress following the death of a spouse is a form of denial or inhibition of the normal grieving process (Bowlby, 1980; Middleton, Moylan, Raphael, Burnett, & Martinek, 1993; Rando, 1992; Worden, 1991). Much in the clinical literature suggests that people who have not begun to grieve should benefit from clinical intervention aimed at helping them work through hidden, unresolved grief feelings (Bowlby, 1980; Deutsch, 1937; Jacobs, 1993; Lazare, 1989; Rando, 1993; Worden, 1991). Investigators have also suggested that conjugally bereaved individuals who fail to show overt grief reactions are either cold and distant people or only superficially attached to their spouse (Fraley & Shaver, 1999; Horowitz, 1990; Rando, 1988, 1993), therefore obviating a grief reaction (Raphael, 1983).

In contrast to this view, the prebereavement data provided no evidence that these individuals were actually maladjusted, emotionally cold and distant, or not emotionally attached to their spouses. In addition, they had relatively high scores on several prebereavement measures suggestive of resilience to loss (e.g., acceptance of death, belief in a just world, instrumental support). Together, these findings are consistent with a growing body of empirical evidence suggesting that bereaved individuals who experience little or no overt disruptions in functioning and who evidence a capacity for positive emotional experiences are exhibiting a healthy resilience to loss (Bauer & Bonanno, 2001; Neimeyer, & Levitt, 2001; for a more specific discussion of the resilience construct, see Bonanno, 2004). Moreover, these findings are concordant with the suggestion that resilient individuals who exhibit little distress in response to loss are highly unlikely to require or benefit from grief counseling (Bonanno et al., 2001).

Another important implication of this study was that chronic grief appeared to be qualitatively different from chronic depression. According to the prospective data, 15.6% of the sample showed a chronic grief trajectory (a dramatic increase in depression following the loss that remained elevated throughout bereavement), whereas another 7.8% of the sample evidenced a trajectory that more closely resembled chronic depression (e.g., elevated depression prior to the loss that remained elevated during bereavement). What's more, many of the variables hypothesized in the literature as antecedents of chronic grief (e.g., quality of the marriage, coping resources) failed to distinguish the chronic grief group from other individuals with low preloss depression but were instead associated with elevated preloss depression. However, one factor that clearly distinguished the chronic grief group from other bereaved individuals who were not depressed prior to the loss was excessive dependency, both in general and in the relationship with the spouse. In addition, whereas caregiving and caregiver strain have emerged as important predictors of grief outcome in older samples (Schulz et al., 2001), the chronic grief trajectory was associated with a greater likelihood at prebereavement of having a healthy spouse and, in instances when the spouse was ill, with reduced likelihood of experiencing high caregiver strain. Further, in contrast to suggested links between intensive caregiving and chronic depression (e.g., Robinson-Whelen, Tadia, MacCallum, McGuire, & Kiecolt-Glaser, 2001; Schulz et al., 2001), the chronic depression trajectory was unrelated to caregiving or to caregiver strain.

Finally, another implication of this study was that some bereaved individuals actually improved (i.e., had reduced depression and distress) following the death of their spouse. A subgroup of participants (10.2%) was highly depressed prior to the loss but by the 6th month of bereavement had shown a dramatic decrease in depression. In fact, they manifested less depression than all groups except the resilient group and remained low in depression throughout the 18 months of the study. Like the resilient group, this depressed–improved group also showed few grief symptoms at 6 or 18 months postloss. One possible explanation for these findings is that the improved group's reduction in depression reflects an inhibition of grief (Jacobs, 1993; Rando, 1992). In contrast to their resilient counterparts, prior to the loss the depressed–improved respondents were more negative and ambivalent about their marriages, were highly introspective and emotionally unstable, and believed strongly that the world was particularly unjust to them. Alternatively, for the improved group the spouses' death may have represented the end of a chronic stressor rather than a stressor per se (Wheaton, 1990). Depressed–improved individuals had low levels of instrumental support available to them prior to the loss, and although they did not experience greater caregiving strain than other respondents, they were more likely to have had spouses who were ill. Thus, these individuals were involved in an unrewarding marriage to someone who, because of his or her illness, may have required help or support, and the death may have relieved them from a challenging set of responsibilities and demands. Still a third alternative is that because they tended to have had an ill spouse, improved participants may have gone through much of the grieving process before the spouse died (Stroebe & Stroebe, 1993).

The Current Study

Although these trajectories suggest many potentially important insights about the bereavement experiences of older adults, differences across the trajectories in the ways people actually react to and process the experience of loss have not yet been examined. The current study was conducted to address this deficit. In our previous study, we examined how the grief outcome trajectories differed along prebereavement variables selected from each of four fundamental components of bereavement identified by Bonanno and Kaltman (1999). These components pertained to coping, meaning, context, and representation of the spouse and marriage. In the current study, as we discuss in greater detail below, we examined variables from these same four components, measured at 6 and 18 months after the spouse's death.

Analyses of group differences in coping with bereavement will help to more fully illuminate how these processes inform older bereaved adults' adjustment. If we are correct in assuming that individuals exhibiting chronic grief are more clearly reacting to the death of their spouse whereas a chronically depressed trajectory is best understood as evidence of more enduring emotional difficulties, then chronic grievers should score higher on grief-specific types of coping (e.g., processing the loss) than chronically depressed individuals. Similarly, if our assumptions about resilient individuals are correct, then these individuals should show little

evidence of intensive grief processing or of defensive denial. We had less straightforward predictions regarding coping processes among the depressed–improved participants but rather expected these data to help adjudicate among competing hypotheses suggested in the literature. If this group is genuinely improved and not likely to benefit from intervention, then, like the resilient individuals, they should exhibit reduced grief processing and grief avoidance relative to other groups. If, however, the depressed–improved participants are not fully resolved about their loss, their scores on these variables should be higher than the resilient individuals and more in the range of the chronic or common grief groups.

A second, related component of bereavement that should illuminate important differences between the outcome patterns is the degree to which different groups searched for and/or found meaning during bereavement. Previous research suggests that resilient individuals would tend to not search for meaning whereas chronically grieved individuals would tend to search for but not find meaning (Davis, Wortman, Lehman, & Silver, 2000). A related aspect of meaning pertains to the extent to which people might find some benefit in otherwise undesirable events (Davis & Nolen-Hoeksema, 2001). Benefit finding during bereavement has been shown to predict positive adjustment, and this association became stronger over time (Davis, Nolen-Hoeksema, & Larson, 1998). However, benefit finding in this study was inversely correlated with age (Davis et al., 1998), and it is as yet unclear whether or how this process may be operative among older bereaved adults. In the current study, we expected perceived benefits (e.g., increased self-confidence) to be relevant primarily for the depressed–improved group. Finally, we examined perceived difficulties associated with widowhood (e.g., increase difficulty with daily chores). Perceived difficulties in daily living generally become more pronounced among older adults, a group for whom instrumental deficits tend to loom more prominently (Rzetelny, 1986). We were particularly interested in exploring whether perceptions of such difficulties might distinguish chronic grief from chronic depression.

A third component is the context in which the loss occurs. In our previous study, we examined prebereavement supports and caregiving. In the current study, we examined the availability of supportive resources during bereavement. Bereavement-related adjustment in older adults has been linked to perceived social support (e.g., Norris & Murrell, 1990). However, exactly how this relationship works in older adults is still unclear (Murrell, Norris, & Chipley, 1992). A structural perspective suggests a main effect of support on well-being, regardless of the presence or absence of stressor events, whereas from a functional perspective the perception of support is more relevant to and consequently interacts with the active coping efforts that operate during stressful life events (Cohen & Wills, 1985). It is possible the processes operate both separately and in parallel (House, Landis, & Umberson, 1988). However, in the only study we know of that explicitly compared the effects of social support among bereaved and nonbereaved samples, only a main effect of support was evidenced (Stroebe, Stroebe, Abakoumkin, & Schut, 1996). In the current study we investigated this question by examining group differences in supportive resources at prebereavement and 6 and 18 months postloss. In our previous study (Bonanno et al., 2002) of prebereavement social and instrumental support, only instrumental support produced significant findings, with resilient individuals scoring highest on this variable. If supportive resources are operative primarily as structural (main effect) processes, then the prebereavement group findings should remain constant from pre- to postbereavement. If supportive resources are functional (i.e., buffering), then during bereavement the worsened (chronic grief) group should perceive decreased support and the improved group should perceive greater support.

A fourth set of variables we examined pertained to participants' changing representation of the spouse and marriage during bereavement. We compared ratings of marital adjustment obtained before the spouse's death with retrospective ratings of marital adjustment made at 6 and 18 months of bereavement. Our previous study (Bonanno et al., 2002) showed that at prebereavement, depressed–improved individuals had poorer quality marriages than resilient individuals and that chronically depressed individuals had poorer quality marriages than chronic grievers. Whether these perceptions remain constant or change during bereavement should help illuminate how bereaved individuals' memories of their spouses interact with the course of their grief reaction (Bonanno & Kaltman, 1999). It was also of interest to examine possible group differences in idealization of the lost marriage. There is some evidence that idealization after loss occurs in both younger and older bereaved adults (Futterman, Gallagher, Thompson, & Lovett, 1990; Lopata, 1979; Parkes & Weiss, 1983). However, it is not yet known how pervasive such a positive bias may be, or whether it is associated primarily with more severe (Futterman et al., 1990; Lieberman, 1979) or less severe (Bonanno, Notarius, Gunzerath, Keltner, & Horowitz, 1998; Stern, Williams, & Prados, 1951) grief reactions.

Finally, in complement to these variables and to further explore the bereavement process, we included several questions to examine whether individuals showing an absence of grief had ever experienced grief-related distress (e.g., yearning, intrusions) after the loss but prior to the first (6 months postloss) interview. We anticipated that even resilient individuals would report experiencing at least some distress early in bereavement (Bonanno, 2004).

Method

Participants

Bereaved participants' data were obtained as part of the CLOC study, a prospective study of a two-stage area probability sample of 1,532 married individuals from the Detroit Standardized Metropolitan Statistical Area. The CLOC study was a comprehensive, prospective, and multidisciplinary investigation of conjugal bereavement in later life. The study was designed to broaden the knowledge base about this life stressor and to help clarify the mechanisms through which bereavement influences subsequent physical and mental health. Major aims were to identify those psychosocial resources that predict resilience in the face of spousal loss and to assess the role of various coping resources in preventing or reversing declines in heath among the bereaved. To be eligible to participate in the CLOC study, respondents had to be English speaking, married, and reside in a household where the husband was age 65 or older. All respondents were noninstitutionalized and capable of participating in a 2-hr home interview. Interviews were conducted by staff from the Institute for Social Research's Survey Research Center. All interviewers were mature women with considerable training and expertise in conducting face-to-face interviews. Where possible, interview questions were based on short forms of standard measures that had been validated in separate studies or pilot work that preceded the CLOC study. Abbreviated forms were used to minimize the duration of the

interview. Approximately 65% of the respondents contacted for an interview participated, a response rate consistent with that of other Detroit-area studies. Baseline interviews were conducted from June 1987 through April 1988.

Participants from the CLOC study who subsequently lost a spouse were identified using daily obituaries in three Detroit-area newspapers and monthly death-record tapes provided by the state of Michigan. The National Death Index (NDI) was used to confirm deaths and obtain causes of death. Widowed respondents were invited to participate in follow-up interviews at 6 and 18 months after the spouses' death. Of the 319 respondents who lost a spouse during the CLOC study, 86% (n = 276) participated in at least one follow-up interview and 64% (n = 205) participated in both follow-up interviews. The primary reasons for nonparticipation were participant ill health or death at follow-up (42%), participant refusal (38%), or study conclusion before the follow-up interview could take place (20%). Participants who completed and those who did not complete the study did not differ significantly in preloss depression ($p >$ .15). Analyses in the present study were based on the 185 widowed persons (161 women and 24 men) reported in Bonanno et al. (2002). These participants' average age at 6 months postloss was 69 (SD = 6.7) years.

Defining the Core Patterns of Bereavement

The bereavement outcome patterns were identical to those reported in Bonanno et al. (2002). These patterns were defined using longitudinal data on a brief, nine-item version of the Center for Epidemiologic Studies Depression (CES–D) scale (Kohut, Berkman, Evans, & Cornoni-Huntley, 1993) obtained an average of 3 years prior to the spouses' death (M = 36.7 months, SD = 16.6 months) and at approximately 6 and 18 months after the spouses' death. A three-step procedure was followed. First, participants were categorized as having either high or low preloss depression, using the 80th percentile as a cutoff for high depression. Second, two change scores were calculated for each participant by comparing CES–D scores at preloss with those at 6-month follow-up and at 18-month follow-up. A change score was categorized as a *grief reaction* if depression increased relative to preloss by one standard deviation or greater; as *improved functioning* if depression decreased by greater than one standard deviation; or as *no change* if depression scores remained constant or increased or decreased by less than one standard deviation. To accommodate the possibility that participants with extremely high or extremely low preloss depression scores might show decreased or increased depression during bereavement in part because of regression to the mean, change was defined separately for the high and low preloss depression groups, using the standard deviation of each group. In addition, because preloss depression scores tended to cluster around the sample mean, a grief reaction was assigned only when depression scores during bereavement increased to greater than the 50th percentile for the larger sample. In a third step, the two change scores were combined to create eight possible bereavement outcome patterns.

Only patterns exhibited by at least 5% of the sample were used in Bonanno et al. (2002) and in the present study. These patterns encompassed 185 participants, or 90.2% of the sample. The *common grief* pattern (n = 22, 10.7%) was assigned to low preloss depression participants who had a grief reaction at 6 months but whose depression score at 18 months postloss were not different from their preloss level of depression. The *resilient* pattern (n = 94, 45.9%) was assigned to low preloss depression participants who showed no change at either 6 or 18 months of bereavement. The *chronic grief* pattern (n = 32, 15.6%) was assigned to low preloss depression participants who showed grief reactions at both 6 and 18 months of bereavement. The *chronic depression* pattern (n = 16, 7.8%) was assigned to high preloss depression participants who showed no change at either 6 or 18 months of bereavement. Finally, the *depressed–improved* pattern (n = 21, 10.2%) was assigned to participants who scored high in depression prior to the loss but low in depression at both 6 and 18 months of bereavement. Mean depression scores for each group from prebereavement to 18 months postloss are graphed in Figure 1 (for more detailed information on the creation of these patterns or the rationale for the procedures used, see Bonanno et al., 2002).

Coping Variables

After the 6- and 18-month interviews, we obtained interviewer ratings of *how well the participant was coping* with the loss of his or her spouse (4-point scale: 1 = *not coping well*; 4 = *coping very well*). *Coping pride* was measured by averaging the participant's responses to two questions (α = .57): "During the past month, did you feel amazed at your strength?" and "During the past month, did you feel proud of how well you were managing?" (4-point scale: 1 = *never*; 4 = *often*). *Thinking and talking about the loss* were each measured using a single question: "During the past month, how often have you had thoughts or memories of your husband/wife?" and "During the past month, how often did you actually talk about your husband/wife or his/her death with anyone?" (6-point scale: 1 = *never*; 2 = *less than once a week*; 3 = *once a week*; 4 = *two or three times a week*; 5 = *daily or almost daily*; 6 = *several times a day*). *Avoidance/distraction* was measured by averaging four items (α = .60): "During the past month, have you tried to keep busy so that you would be less likely to dwell on your husband/wife or his/her death?" (4-point scale: 1 = *never*; 4 = *often*); "I try not to think about what happened" (4-point scale: 1 = *not at all true*; 4 = *very true*); "To cope with these feelings, how much have you gotten out of the house—for example, gone somewhere by taking a walk or a drive?" and "How much have you kept busy or tried to get involved in some activity?" (4-point scale: 1 = *not at all*; 4 = *a lot*).

Meaning of the Loss

Searching for meaning and *finding meaning* were each measured by a single question: "During the past month, have you found yourself searching to make sense of or find some meaning in your husband/wife's death?" (4-point scale: 1 = *never*; 4 = *often*) and "Have you made any sense of or found any meaning in your husband/wife's death?" (1–4 scale: 1 = *no*; 4 = *a great deal*). Because the relationship of searching for meaning to adjustment may depend on whether meaning is found (Davis et al., 2000), we also combined these questions and assigned participants to one of three categories: not searching for meaning; searching for but not finding meaning; or searching for and finding meaning. *Perceived benefits of widowhood* were measured by averaging two items (α = .64): "As a result of having to manage without my husband/wife, I have become more confi-

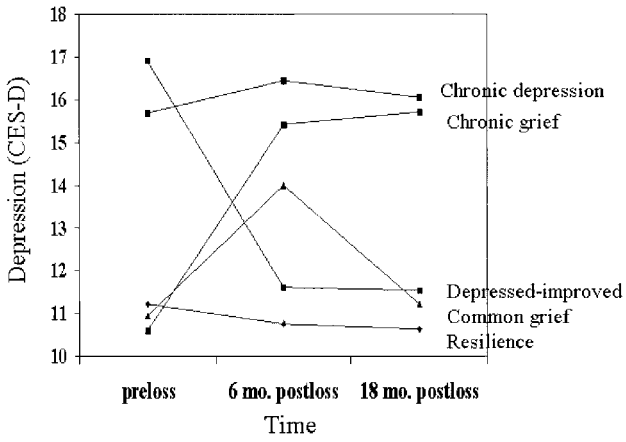

Figure 1. Patterns of depression, as measured by Center for Epidemiologic Studies Depression (CES–D) scores from preloss to 18 months (mo.) postloss (N = 185).

dent" and "I am a stronger person as a result of dealing with the loss of my husband/wife" (4-pont scale: 1 = *not at all true*; 4 = *very true*). *Perceived difficulties of widowhood* were measured by averaging three items (α = .62): "During the past month, have you experienced problems keeping up with things around the house, such as cleaning, paying bills, doing laundry or otherwise maintaining your home or car?"; "During the past month, have you been bothered by having to handle such things as your husband/wife's estate, arranging for credit or dealing with insurance companies or agencies (such as Blue Cross or Social Security)?"; and "During the past month, have you been troubled by having to make major decisions without your husband/wife, such as deciding whether or not to make major purchases or to move?" (4-point scale: 1 = *never*; 4 = *often*).

Context of the Loss

Perceived support from friends and relatives was measured by averaging two questions (α = .71): "On the whole, how much do your friends and relatives make you feel loved and cared for?" and "How much are your friends and relatives willing to listen when you need to talk about your worries or problems?" (4-point scale: 1 = *not at all*; 4 = *a great deal*). *Perceived support from children* was measured by averaging two questions (α = .70): "How much do your children make you feel loved and cared for?" and "How much are they willing to listen when you need to talk about your worries or problems?" (4-point scale: 1 = *not at all*; 4 = *a great deal*). *Instrumental support* from family and friends (other than spouse or child) was measured by averaging three questions (α = .68): "If you needed extra help with general housework or home maintenance, how much could you count on friends or family members to help you?"; "If you needed extra money, how much could count on someone, other than a lending institution, to lend or give you money?"; and "If you were ill, how much could you count on someone to make sure you are taken care of?" (4-point scale: 1 = *not at all*; 4 = *a great deal*).

Representations of the Spouse and Marriage

Comfort from positive memories of spouse was measured by averaging two items (α = .90): "Did thoughts or memories of your deceased husband/wife make you feel happy or at peace during the past month?" and "Has talking about him/her made you feel happy or at peace during the past month?" (4-point scale: 1 = *never*; 4 = *often*). *Regrets about relationship with spouse* were measured by averaging two items (α = .62): "During the past month, have you had any regrets about anything that happened between your husband/wife while he/she was alive?" and "During the past month, have you had any regrets about things you did or failed to do while he/she was alive?" (4-point scale: 1 = *never*; 4 = *often*). *Perceptions of marital adjustment* were measured at preloss and retrospectively at 6 and 18 months of bereavement by averaging three questions (reversed keyed; α = .62): "How much do/did you feel your spouse makes/made too many demands on you (before he/she became very ill)?" (5-point scale: 1 = *great deal*; 5 = *not at all*); "My spouse does/did not treat me as well as I deserve/deserved to be treated" (4-point scale: 1 = *very true*; 4 = *not at all true*); and "(Before he/she became very ill) how often would you say you and your spouse typically have/had unpleasant disagreements or conflicts?" (5-point scale: 1 = *more than once a week*; 5 = *never*).[1]

Grief-Related Reactions Prior to the 6-Month Interview

At the 6-month point in bereavement, participants were asked whether they had experienced the following symptoms at the time of the 6-month interview and, if not, at any point after the spouse's death but prior to the 6-month interview: yearning (painful waves of missing spouse), intense emotional pangs (feelings of intense pain or grief), intrusive thoughts (couldn't get thoughts of spouse out of your mind), or rumination (going over and over what happened).

Results

To minimize Type I error, we first conducted multivariate analyses for the effects of bereavement group on four sets of dependent measures (coping, meaning, context, and relationship variables). Significant multivariate effects were followed up with separate repeated measures univariate analyses for the effects of bereavement group and time. Significant univariate effects for bereavement group were followed-up further by pairwise comparisons across groups. In reporting these analyses, we focused particular attention on comparisons (a) between resilient and depressed–improved individuals and (b) between common grievers, chronic grievers, and chronically depressed individuals.

Coping

A multivariate analysis of variance (MANOVA) for interviewer ratings of participant's coping, self-reported coping pride, thinking and talking about the loss, and avoidance/distraction revealed significant effects of bereavement group at both 6 months, $F(20, 556) = 2.20$, $p < .01$, and 18 months, $F(20, 664) = 3.69$, $p < .001$. Follow-up univariate analyses (see Table 1) are described below.

Interviewer ratings of participants' coping showed only a main effect for bereavement group. Pairwise comparisons indicated that collapsing across time, the resilient, depressed–improved, and common grief groups did not differ from each other and that each of these groups was rated as coping better than chronic grievers or chronically depressed individuals. Chronic grievers and chronically depressed individuals did not differ significantly.

Coping pride increased significantly from 6 to 18 months postloss and evidenced a main effect of bereavement group. Depressed–improved individuals had the highest overall coping pride and chronic grievers the lowest. Pairwise comparisons showed that depressed–improved individuals had greater overall coping pride than the chronic grief, chronic depression, and resilient groups. Chronic grievers in turn had lower overall coping pride than all groups except the chronically depressed group.

Thinking and talking about the loss each decreased significantly from 6 to 18 months postloss, and each variable produced significant interactions between bereavement group and time. As can be seen in Figure 2, thinking about the loss at 6 months was greatest among the chronic grief group and lowest among the depressed–improved group. Pairwise comparisons revealed that chronic grievers thought significantly more about the loss at 6 months than the depressed–improved, resilient, and chronic depression groups. Analyses of change scores from 6 to 18 months showed significant

[1] Although it is widely agreed that alphas of at least .70 indicate adequate internal consistency, scale reliability generally increases with the number of items used to create the scale (Kline, 1999). The reliability of a scale is most seriously in question when the scale is composed of many items but exhibits weak internal consistency (Nunnally, 1978). The reliability of scales with relatively few items, as is the case in the present study, is more difficult to interpret. Nunnally (1978) provided a formula for calculating the number of items from the same item pool as the original scale that would have to be added to a scale to reach a specified alpha value. Applying this formula to the scales in the present study indicated that all scales in the study would have alpha values of over .70 if we were to add one or two similarly worded items.

Table 1
Mean (and Standard Deviation) Group and Time Differences in Coping Variables

Variable	Resilient	Depressed–improved	Common grief	Chronic grief	Chronic depression	Time	Group	Time × Group
Coping rating								
6 months	3.71 (0.54)	3.71 (0.61)	3.50 (0.76)	3.12 (0.83)	3.07 (1.00)	2.05	13.01***	2.35†
18 months	3.82 (0.39)	3.64 (0.74)	3.57 (0.76)	2.88 (0.83)	2.71 (1.07)			
Coping pride								
6 months	3.03 (0.79)	3.18 (0.80)	3.09 (0.73)	2.79 (0.76)	2.57 (0.92)	5.17*	4.43**	1.06
18 months	3.22 (0.73)	3.70 (0.99)	3.29 (0.59)	2.69 (1.42)	2.96 (1.06)			
Think about loss								
6 months	5.34 (0.99)	5.25 (0.85)	5.50 (0.62)	5.71 (0.53)	5.33 (1.05)	12.32***	2.05†	2.51*
18 months	4.90 (1.04)	5.05 (0.98)	4.72 (1.07)	5.39 (0.80)	5.53 (0.52)			
Talk about loss								
6 months	3.44 (1.36)	2.95 (1.27)	3.89 (1.18)	4.00 (1.18)	3.00 (1.31)	9.24**	1.10	2.92*
18 months	2.93 (1.34)	3.05 (1.19)	3.11 (1.37)	3.06 (1.06)	3.20 (1.70)			
Avoidance/distraction								
6 months	2.07 (0.48)	2.09 (0.59)	2.28 (0.41)	2.28 (0.47)	2.35 (0.51)	12.15***	4.87***	0.49
18 months	1.85 (0.51)	1.79 (0.46)	2.06 (0.50)	2.21 (0.54)	2.18 (0.54)			

† $p < .10$ (marginally significant). * $p < .05$. ** $p < .01$. *** $p < .001$.

decline in thinking about the loss for the chronic grief, common grief, and resilient groups but not the depressed–improved or chronic depression groups. Pairwise comparisons at 18 months indicated that the chronic grief and chronic depression groups thought more about the loss than the resilient and common grief groups. The depressed–improved group was at an intermediate level not significantly different from other groups.

As can be seen in Figure 3, talking about the loss at 6 months was greatest among the chronic and common grief groups and lowest among the depressed–improved and chronically depressed groups. Pairwise comparisons confirmed that these differences were significant. Resilient individuals were at an intermediate level not significantly different from any group except chronic grievers. Analyses of change scores from 6 to 18 months showed significant decline in talking for the chronic grief, common grief, and resilient groups, but not the depressed–improved or chronic depression groups. No group differences were significant at 18 months.

Avoidance/distraction decreased significantly from 6 to 18 months postloss and evidenced a main effect of bereavement group. Resilient and depressed–improved individuals had the lowest overall scores on this measure. Pairwise comparisons showed that resilient and depressed–improved individuals did not differ significantly, and both groups had lower avoidance/distraction than the chronic grief and chronic depression groups. Resilient individuals also had lower avoidance/distraction than common grievers.

Meaning of the Loss

A MANOVA for searching for meaning, perceived benefits, and perceived difficulties of widowhood revealed significant effects of bereavement group at both 6 months, $F(12, 516) = 3.02$, $p < .001$, and 18 months, $F(12, 501) = 2.51$, $p < .01$. Follow-up univariate analyses (see Table 2) are described below.

Searching for and finding meaning. Searching for meaning decreased significantly from 6 to 18 months postloss and also

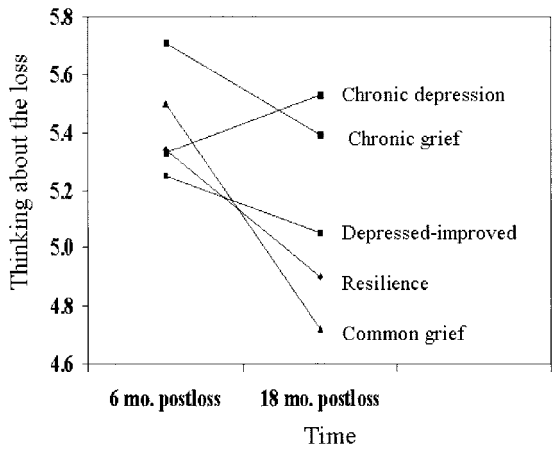

Figure 2. Group differences in thinking about the loss at 6 and 18 months (mo.) of bereavement.

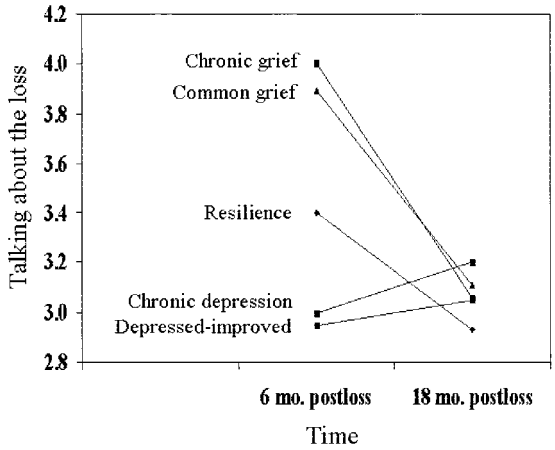

Figure 3. Group differences in talking about the loss at 6 and 18 months (mo.) of bereavement.

Table 2
Mean (and Standard Deviation) Group and Time Differences in Meaning Variables

Variable	Resilient	Depressed–improved	Common grief	Chronic grief	Chronic depression	Time	Group	Time × Group
Search meaning								
6 months	1.33 (0.73)	1.65 (0.89)	1.89 (1.23)	1.87 (1.19)	2.20 (1.37)	3.95*	5.03***	1.32
18 months	1.34 (0.72)	1.50 (0.95)	1.67 (1.03)	2.00 (1.18)	1.67 (1.05)			
Finding meaning								
6 months	2.10 (1.19)	1.85 (1.09)	1.89 (1.08)	2.06 (1.17)	1.80 (1.15)	0.03	0.53	0.47
18 months	2.13 (1.20)	2.10 (1.21)	1.94 (0.94)	1.83 (0.98)	1.80 (1.45)			
Perceived benefits								
6 months	2.85 (1.03)	3.18 (0.96)	3.17 (0.87)	2.52 (0.84)	2.54 (0.98)	5.03*	2.42*	0.61
18 months	3.16 (0.99)	3.28 (0.97)	3.31 (0.77)	2.86 (0.94)	2.57 (0.84)			
Perceived difficulties								
6 months	1.60 (0.73)	1.62 (0.74)	1.80 (0.91)	1.90 (0.89)	2.48 (0.93)	18.74***	3.17*	2.61*
18 months	1.51 (0.59)	1.50 (0.63)	1.56 (0.66)	1.44 (0.55)	1.83 (0.84)			

* $p < .05$. *** $p < .001$.

differed significantly by bereavement group. Pairwise comparisons indicated that resilient individuals searched for meaning less than all other groups except depressed–improved individuals. No other pairwise differences were significant ($p < .05$). The finding meaning variable did not show any significant effects.

We also examined the combination of searching for and finding meaning in a categorical variable. At 6 months postloss, two thirds of the participants reported not searching for meaning ($n = 123$, 71%), and the remaining participants were split between those who searched for but did not find meaning ($n = 25$, 14%) and those who searched for and found meaning ($n = 26$, 15%). These proportions were almost identical at 18 months postloss (did not search: $n = 126$, 72%; searched but did not find meaning, $n = 25$, 14%; searched for and found meaning, $n = 23$, 13%).

The distribution of these meaning categories within the bereavement outcome groups showed marginally significant contingency at 6 months, $\chi^2(8, N = 185) = 14.54$, $p = .07$, and 18 months, $\chi^2(8, N = 185) = 13.77$, $p = .09$. There were several noteworthy cells with significant nonchance distributions. At 6 months postloss, although 71% of the sample did not search for meaning, the proportion who did not search for meaning was significantly greater among resilient individuals (81%), adjusted residual (AR; Haberman, 1978) = 3.2, $p < .01$, and significantly smaller among chronic grievers (55%), AR = −2.1, $p < .05$. Additionally, 14% of the sample searched for and did not find meaning at 6 months, and the proportion who searched for but did not find meaning was significantly smaller among resilient individuals (7%), AR = −3.1, $p < .01$. At 18 months postloss, 72% of the sample again did not search for meaning, and the proportion was again significantly greater among resilient individuals (80%), AR = 2.4, $p < .05$, and again significantly smaller among chronic grievers (55%), AR = −2.5, $p < .05$. Interestingly, whereas 13% of the sample searched for and found meaning at 18 months, the proportion who searched and found meaning was significantly greater among chronic grievers (29%), AR = 2.9, $p < .05$.

Perceived benefits and difficulties of widowhood. Perceived benefits of widowhood increased significantly from 6 to 18 months postloss and evidenced a main effect of bereavement group. Pairwise comparisons showed that depressed–improved and common grief groups had significantly higher perceived benefit scores than the chronic grief and chronic depression groups. Resilient individuals had intermediate scores on this variable and were not significantly different from any other group.

Perceived difficulties of widowhood decreased significantly from 6 to 18 months postloss and evidenced a main effect of bereavement group and a significant Time × Bereavement Group interaction. Pairwise comparisons showed only that chronically depressed individuals reported significantly greater perceived difficulties in widowhood than all other groups. The interaction effect was largely due to the significant decrease in perceived difficulties among the chronic depression, $t(13) = 2.49$, $p < .05$, and chronic grief, $t(30) = 3.44$, $p < .01$, groups. No other groups showed significant change over time.

Context of the Loss

A MANOVA for the three support variables (support from friends and relatives, support from children, and instrumental support) failed to reveal a significant group effect at either 6 months postloss, $F(12, 474) = 0.85$, $p = .59$, or 18 months postloss, $F(12, 474) = 1.35$, $p = .18$. No further analyses of these variables were conducted.

Representation of the Spouse and Marriage

A MANOVA for comfort from positive memories of spouse and regrets about the relationship with spouse revealed significant main effects of bereavement group at both 6 months, $F(8, 338) = 2.34$, $p < .05$, and 18 months, $F(8, 342) = 2.08$, $p < .05$. Follow-up univariate analyses (see Table 3) are described below.

Comfort from positive memories of the spouse. Comfort from positive memories of the spouse showed no overall time effect but was significantly differentiated by bereavement group and by the interaction of bereavement group and time. Resilient individuals reported the greatest comfort from positive memories of the spouse and chronically depressed individuals the lowest. Pairwise comparisons confirmed that these two groups differed significantly. No other group differences were significant.

A graph of the interaction of bereavement group and time (see Figure 4) suggested that this effect was largely due to depressed–improved participants reporting greater comfort from positive memories and common grievers less comfort over time. Follow-up

Table 3
Mean (and Standard Deviation) Group and Time Differences in Representations of the Spouse and Marriage

Variable	Resilient	Depressed–improved	Common grief	Chronic grief	Chronic depression	Time	Group	Time × Group
Positive memories								
6 months	3.12 (0.86)	2.60 (0.75)	3.16 (0.75)	2.92 (0.86)	2.47 (0.94)	0.42	2.47*	3.66**
18 months	3.10 (0.86)	3.02 (0.87)	2.61 (1.09)	2.82 (0.87)	2.63 (0.94)			
Regrets regarding spouse								
6 months	1.51 (0.77)	1.50 (0.83)	1.39 (0.72)	1.74 (0.76)	1.90 (0.95)	2.82†	2.91*	1.77
18 months	1.44 (0.72)	1.70 (1.12)	1.67 (0.82)	2.17 (1.67)	1.83 (0.77)			
Marital adjustment								
Preloss	3.69 (0.79)	3.25 (1.13)	3.71 (0.74)	3.78 (0.67)	3.56 (0.91)	8.11***	2.09†	0.76
6 months	4.06 (0.80)	3.83 (0.71)	4.22 (0.40)	4.19 (0.44)	2.29 (0.52)			
18 months	4.06 (0.69)	3.73 (0.74)	4.18 (0.57)	4.16 (0.52)	4.31 (0.24)			

† $p < .10$ (marginally significant). * $p < .05$. ** $p < .01$. *** $p < .001$.

analyses confirmed this impression. An analysis of simple effects was significant for bereavement group at 6 months postloss, $F(4, 179) = 3.52$, $p < .01$. Pairwise comparisons revealed that at 6 months, resilient individuals and common grievers reported the greatest comfort from positive memories and were significantly higher than depressed–improved and chronically depressed individuals, who reported the least comfort from positive memories. Paired *t* tests for change in comfort from positive memories over time were significant only for the depressed–improved individuals, whose scores increased over time, $t(20) = 3.08$, $p < .01$, and the common grief group, whose scores decreased over time, $t(21) = -2.32$, $p < .05$. The simple effect for bereavement group at 18 months was marginally significant, $F(4, 179) = 2.11$, $p < .10$. Pairwise comparisons revealed that at 18 months the resilient and depressed–improved individuals were no longer significantly different and that the resilient group now had significantly greater comfort from positive memories than the common grief group.

Regrets about the relationship with the spouse. Regrets about relationship with spouse evidenced a marginally significant increase from 6 to 18 months postloss and a significant main effect of bereavement group. Resilient individuals had the fewest regrets overall, and chronic grievers had the most. Pairwise comparisons showed a significant difference only between these two groups.

Pre- and postloss measures of marital adjustment. Prebereavement marital adjustment ratings were moderately correlated with retrospective marital adjustment ratings at 6 months postloss ($r = .45$, $p < .001$) and 18 months postloss ($r = .43$, $p < .001$). However, the 6- and 18-month retrospective ratings were highly correlated ($r = .79$, $p < .001$). A repeated measures analysis of variance evidenced a significant main effect of time and a marginally significant main effect of bereavement group. The time effect appears to be due to a general idealization of the lost relationship during bereavement (see Figure 5). Compared with the overall level of marital adjustment reported at prebereavement ($M = 3.64$, $SD = 0.63$), retrospective ratings of marital adjustment were significantly greater (i.e., idealized) at 6 months postloss ($M = 4.08$, $SD = 0.70$), $t(174) = 7.16$, $p < .001$; showed little change from 6 to 18 months postloss, $t(175) = 5.18$, $p = .61$; and, thus, remained higher than prebereavement at 18 months postloss ($M = 4.07$, $SD = 0.64$), $t(166) = 6.89$, $p < .001$. Pairwise comparisons across bereavement groups indicated that depressed–improved individuals overall had lower marital adjustment ratings than all other groups, including resilient individuals. No other group comparisons were significant, and the interaction between the group and time effect did not approach significance.

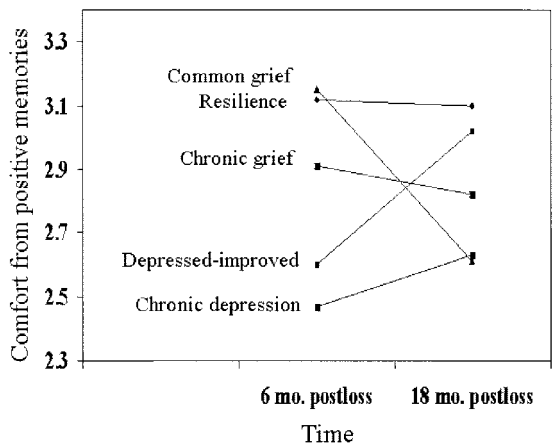

Figure 4. Group differences in comfort from positive memories of the spouse at 6 and 18 months (mo.) of bereavement.

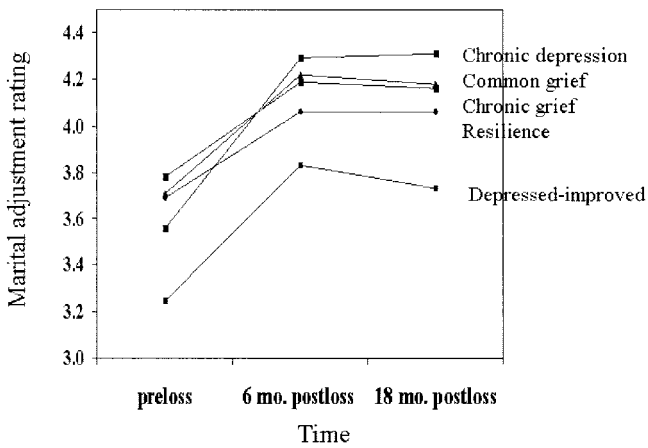

Figure 5. Group differences in perceived/remembered marital adjustment at 6 and 18 months (mo.) of bereavement.

Grief Reactions Prior to the 6-Month Interview

Participants' retrospective reports of grief symptoms (yearning, emotional pangs, intrusions, and rumination) after the loss but prior to the 6-month interview were assigned to one of three categories: (a) currently experiencing the symptom; (b) not currently experiencing the symptom but experienced the symptom at some point after the spouse's death; or (c) never experienced the symptom. Group differences along these categories were significant for yearning, $\chi^2(8, N = 185) = 16.56$, $p < .05$, and emotional pangs, $\chi^2(8, N = 185) = 37.01$, $p < .001$. For the entire sample, 69.4% and 60.3% reported current yearning and emotional pangs at the 6-month point, respectively, whereas only 14.8% and 18.5% respectively reported never having yearned or experienced emotional pangs during bereavement. Compared with these proportions, resilient individuals were more likely to report never yearning (23.4%), AR = 3.4, $p < .01$, and never having emotional pangs (25.5%), AR = 2.5, $p < .05$. In contrast, the chronic grief group was more likely to report current yearning (87.1%), AR = 2.3, $p < .05$, and current emotional pangs (80.6%), AR = 2.5, $p < .05$. Although group differences for the intrusions and rumination variables did not approach significance ($ps > .15$), it is worth noting that only 1 participant in the entire sample reported never having intrusions or rumination at any point in the first 6 months of bereavement.

Discussion

In a recent article, our research team was able to distinguish between chronic grief reactions and preexisting chronic depression, and between a genuine resilience to loss and potentially more problematic forms of absent grief (Bonanno et al., 2002). Having established these trajectories, our primary aim in the current study was to examine how they differed in variables pertaining to grief reaction and procession of the loss at 6 and 18 months of bereavement.

More than half of the sample (56.1%) showed the so-called absent grief or low-distress pattern following the loss. Most of these individuals (45.9% of the sample) evidenced stable low depression throughout the study. On the basis of the healthy profile these individuals exhibited on various prebereavement measures, we argued that they were genuinely resilient to loss and highly unlikely to require or to benefit from grief counseling. The results of the current study provide compelling support for this argument. Although they had been married an average of 44 years (SD = 13.4) and prior to the loss rated their marriages as generally satisfying, resilient respondents scored relatively low on variables measuring thinking and talking about the loss and searching for meaning in the loss. They also had low scores on avoidance/distraction, suggesting that their lack of distress is indicative of good adjustment rather than defensive denial. Finally, the resilient group scored relatively high on comfort from positive memories of the deceased, a finding that clearly argues against the view that they were not strongly attached to their spouses.

It is also worth nothing that although many resilient individuals reported never yearning (23.4%) or having emotional pangs (25.5%), the majority *did* report experiencing at least some yearning and emotional pangs during the first 6 months of bereavement, and virtually all respondents reported at least some grief-related intrusion and rumination. Thus, even resilient individuals are not spared from at least some initial distressing thoughts and emotions related to the death of their spouse (Bonanno, 2004).

The remaining group who showed low symptom levels (10.2% of the sample) evidenced a pattern that has received little attention from previous bereavement theorists: depression prior to the loss followed by marked improvement after the spouse's death. Of the various explanations we considered for this pattern, the results offered the clearest support for the view that the spouse's death was experienced as the end of a chronic stressor. Depressed–improved respondents had been in relatively unsatisfying marriages, and for most the spouse was ill prior to his or her death. Yet the depressed–improved group exhibited an unambiguously healthy profile during bereavement. Indeed, they were not statistically distinct from the resilient group on most of the measures we examined. Like the resilient group, they showed relatively little grief, searching for meaning, or processing the loss and had low avoidance/distraction scores; the latter finding indicates that like the resilient group, the depressed–improved group's healthy profile was not likely due to denial or inhibition of grief, as does the fact that depressed–improved respondents reported at least occasional grief symptoms in the early months of bereavement.

Although all groups showed idealization in their ratings of the lost spouse and marriage, the depressed–improved group consistently rated their spouse and marriage as less satisfying across the course of the study. They also scored high on perceived benefits of widowhood and higher than all other groups, including the resilient group, on coping pride, suggesting that even they were surprised by how well they did. Finally, although the depressed–improved respondents reported little ability to find comfort from positive memories of the spouse at the 6-month point in bereavement, they were the only group to increase significantly on this measure over the course of bereavement, and by the 18-month point, they had levels as high as resilient individuals. On the whole these findings clearly suggest that the depressed–improved group is coping well and not in need of clinical intervention.

Two final groups identified in our earlier study include a chronic grief group, who became depressed following the loss and remained depressed, and a chronic depression group, who were depressed prior to and remained highly depressed during bereavement. The current study revealed many striking similarities in the ways these groups experienced bereavement. However, despite the similarities, these groups also exhibited key differences. These differences were consistent with our assumption that the high level of distress exhibited by the chronic grief group was due primarily to the cognitive and emotional upheaval surrounding the loss of a healthy spouse, whereas chronically depressed individuals' distress was more likely due to enduring emotional difficulties that may have been exacerbated by the loss.

Although many participants reported that they did not search for meaning in their loss at either 6 or 18 months of bereavement, the chronic grief group was the most likely to report searching for meaning at each time point. In contrast, chronic depression was unrelated to searching for meaning. Similarly, the chronic grief group was most likely to report current yearning and emotional pangs at 6 months postloss, whereas chronic depression was not different from other trajectories on these variables. In addition, at 6 months postloss the chronic grief group reported thinking about and talking about the loss more often than did chronically de-

pressed individuals. Chronic grievers also decreased significantly in the degree that they thought about and talked about the loss from 6 to 18 months of bereavement (whereas for chronically depressed individuals these variables were not influenced by time), and they were significantly more likely to report finding meaning at 18 months postloss relative to other participants, a pattern consistent with active engagement with the emotional aspects of bereavement.

Together, these findings suggest that interventions with individuals who were not depressed prior to the loss but exhibit relatively acute and enduring grief reactions should focus on fostering the processing and the construction of new meanings around the loss (Neimeyer, 2000, 2001). In contrast, our findings also suggest that among respondents with enduring depression, interventions should perhaps focus on bolstering these individuals' self-esteem and assisting them in dealing with the day-to-day strains associated with widowhood. Consistent with this latter implication, chronically depressed individuals scored higher than all other groups, including the chronic grief group, on a scale to measure the perceived difficulties brought about by widowhood (e.g., cleaning, paying bills).

Although the current study benefits from a number of strengths, there are several important limitations that must be acknowledged. First, the data were gathered exclusively from self-report and interview measures. Given the considerable methodological hurdles inherent in this type of design (e.g., it was necessary to recruit and follow over 1,500 participants in order to generate a sample of 205 bereaved individuals with pre- and postloss data), self-report and interview measures provide a practical and financially viable method. Nonetheless, in future studies that attempt to distinguish patterns of resilience and maladjustment, it will be imperative to include more elaborate indices of reacting to and processing of the loss (e.g., peer ratings or behavioral measures). Second, the first interview following the loss was conducted 6 months after the death had occurred. We did question respondents at this time about whether they had ever experienced symptoms of grief at earlier points in bereavement. However, earlier and more frequent assessments would have provided more reliable data about the early bereavement experiences of the resilient and depressed–improved groups. Third, the outcome patterns were analyzed only through 18 months of bereavement. Although bereavement studies have rarely collected data beyond 2 years postloss, measures of longer term functioning might further illuminate how different the patterns of grieving outcome inform the bereavement experience.

Within the context of these limitations, the results of the current study suggest several important clinical implications. First, it appears that regardless of their prebereavement functioning, when bereaved individuals exhibit relatively little grief, distress, or depression following the death of their spouse, there is a strong probability that they are actually coping well with their loss and not likely to require professional intervention. According to traditional bereavement theory, adjustment following a major loss is facilitated by coping resources, such as emotional stability or instrumental support, or by working through the loss. It is interesting that following the loss of their spouse, the depressed–improved respondents showed considerable evidence of resilience despite an absence of coping resources and despite showing little indication of working through the loss. These results suggest that clinical bereavement theory needs to better accommodate the idea that there are alternative pathways through which one may emerge from the death of a spouse, evidencing good mental health (Bonanno, 2004).

In this same vein, our findings suggest that in future studies of bereavement, it would be desirable to focus more attention on the contextual features of the loss. Whereas longitudinal analyses of perceived supportive resources in the current study did not reveal significant effects, recent research indicates the usefulness of examining other related support variables, such as actual support (rather than perceived support; Bolger, Zuckerman, & Kessler, 2000) or the provision of support to others (Brown, Nesse, Vinokur, & Smith, 2003), the latter proving to be particularly important for older adults. Prior research has also indicated that some losses may be more devastating than others, depending on the nature and type of relationship and how the loss came about. Finally, although researchers and clinicians have rarely considered the possibility that under some circumstances the death of a loved one can actually result in improvements in the survivor's mental health and functioning, it remains crucial to continue exploring the impact of spousal illness and caregiving on bereavement, as well as other features of the relationship that may create chronic strain, such as whether the spouse is abusive or alcoholic.

Our findings also suggest that of the individuals who exhibit chronically elevated symptoms and distress after the death of their spouse, some will likely benefit most from focusing specifically on processing the loss (e.g., the meaning of the loss). In contrast, others will likely benefit most from dealing with the more pragmatic issues of low self-esteem and coping with the strains of meeting life's daily demands (Zisook & Shuchter, 2001). One challenge this distinction raises for future bereavement research and theory is how these different trajectories, which we have labeled chronic grief and chronic depression, may be identified during bereavement. The simplest means of distinguishing these groups, of course, is to use actual prebereavement data on depression. This is rarely possible in bereavement research but is sometimes possible in clinical settings, where clients may have been in treatment prior to the loss or where previous clinical records may be available. Although we have cautioned about the dangers of measuring prebereavement depression retrospectively by participant self-report, it is possible that alternative sources of information on prebereavement functioning may prove useful, such as ratings of a participant's functioning from close friends or family members.

Taken together, these findings suggest that many of the assumptions that have guided interventions with the bereaved may need to be reevaluated. It is widely assumed that absent grief is indicative of underacknowledged problems related to the loss. Yet, although respondents in our resilient and depressed–improved groups scored very low on depression and grief during bereavement, they showed every indication that they were coping well with the loss. It is widely assumed that individuals must work through the loss. Yet both the resilient and depressed–improved respondents appeared to make an excellent adjustment to their loss while showing no clear signs of working through the loss at any point following their spouse's death. Finally, it is widely assumed that bereavement is one of the most stressful life events that most people will encounter in the course of their lives. This may well be correct. Yet almost half of the sample showed little or no depression following their spouse's death, and approximately 10% of the sample showed

improved mental health following the loss. These results highlight the importance of maintaining a healthy skepticism toward traditional assumptions in the field and lend credence to the view that we still have much to learn about the variety of ways people cope with loss.

References

Bauer, J., & Bonanno, G. A. (2001). Continuity and discontinuity: Bridging one's past and present in stories of conjugal bereavement. *Narrative Inquiry, 11,* 1–36.

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.

Bolger, N., Zuckerman, A., & Kessler, R. C. (2000). Invisible support and adjustment to stress. *Journal of Personality and Social Psychology, 79,* 953–961.

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., & Field, N. P. (2001). Examining the delayed grief hypothesis across five years of bereavement. *American Behavioral Scientist, 44,* 798–806.

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., Notarius, C. I., Gunzerath, L., Keltner, D., & Horowitz, M. J. (1998). Interpersonal ambivalence, perceived dyadic adjustment, and conjugal loss. *Journal of Consulting and Clinical Psychology, 66,* 1012–1022.

Bonanno, G. A., Papa, A., & O'Neill, K. (2001). Loss and human resilience. *Applied and Preventative Psychology, 10,* 193–206.

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.

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

Brown, S. L., Nesse, R. M., Vinokur, A. D., & Smith, D. M. (2003). Providing support may be more beneficial than receiving it: Results from a prospective study of mortality. *Psychological Science, 14,* 320–327.

Cohen, D., & Eisdorfer, C. (1988). Depression in family members caring for a relative with Alzheimer's disease. *Journal of the American Geriatrics Society, 36,* 885–889.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98,* 310–357.

Davis, C. G., & Nolen-Hoeksema, S. (2001). Loss and meaning: How do people make sense of loss? *American Behavioral Scientist, 44,* 736–741.

Davis, C. G., Nolen-Hoeksema, S., & Larson, J. (1998). Making sense of loss and benefiting from the experience: Two construals of meaning. *Journal of Personality and Social Psychology, 75,* 561–574.

Davis, C. G., Wortman, C. B., Lehman, D. R., & Silver, R. C. (2000). Searching for meaning in loss: Are clinical assumptions correct? *Death Studies, 24,* 497–540.

Deutsch, H. (1937). Absence of grief. *Psychoanalytic Quarterly, 6,* 12–22.

Fraley, R. C., & Shaver, P. R. (1999). Loss and bereavement: Bowlby's theory and recent controversies concerning "grief work" and the nature of detachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment theory and research: Theory, research, and clinical applications* (pp. 735–759). New York: Guilford Press.

Futterman, A., Gallagher, D., Thompson, L. W., & Lovett, S. (1990). Retrospective assessment of martial adjustment and depression during the first 2 years of spousal bereavement. *Psychology and Aging, 5,* 277–283.

Haberman, S. J. (1978). *Analysis of qualitative data*. New York: Academic Press.

Horowitz, A. (1985). Sons and daughters as caregivers to older parents: Differences in role performance and consequences. *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.

House, J. S., Landis, K. R., & Umberson, D. (1988, July 29). Social relationships and health. *Science, 241,* 540–545.

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

Kline, P. (1999). *The new psychometrics: Science, psychology, and measurement*. New York: Routledge.

Kohut, F. J., Berkman, L. E., Evans, D. A., & Cornoni-Huntley, J. (1993). Two shorter forms of the CES-D Depression Symptoms Index. *Journal of Aging and Health, 5,* 179–193.

Lazare, A. (1989). Bereavement and unresolved grief. In A. Lazare (Ed.), *Outpatient psychiatry: Diagnosis and treatment* (2nd ed., pp. 381–397). Baltimore: Williams & Wilkins.

Lichtenstein, P., Gatz, M., Pedersen, N., Berg, S., & McClean, G. (1996). A co-twin-control study of response to widowhood. *Journal of Gerontology: Psychological Sciences and Sciences and Social Sciences, 51,* P279–P289.

Lieberman, S. (1979). Nineteen cases of morbid grief. *British Journal of Psychiatry, 132,* 159–163.

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

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.

Murrell, S. A., Norris, F. H., & Chipley, Q. T. (1992). Functional versus structural social support, desirable events, and positive affect in older adults. *Psychology and Aging, 7,* 562–570.

Neimeyer, R. A. (2000). Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death Studies, 24,* 541–558.

Neimeyer, R. A. (2001). Reauthoring life narratives: Grief therapy as meaning reconstruction. *Israel Journal of Psychiatry and Related Sciences, 38,* 171–183.

Neimeyer, R. A., & Levitt, H. (2001). Coping and coherence: A narrative perspective on resilience. In S. Snyder (Ed.), *Coping with stress* (pp. 47–67). New York: Oxford University Press.

Nolen-Hoeksema, S., & Ahrens, C. (2002). Age differences and similarities in the correlates of depressive symptoms. *Psychology and Aging, 17,* 116–124.

Norris, F. N., & Murrell, S. A. (1990). Social support, life events, and stress as modifiers of adjustment to bereavement in older adults. *Psychology and Aging, 5,* 429–436.

Nunnally, J. C. (1978). *Psychometric theory* (2nd ed.). New York: McGraw-Hill.

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

Rando, T. A. (1988). Anticipatory grief: The term is a misnomer but the phenomenon exists. *Journal of Palliative Care, 4,* 70–73.

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

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

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

Robinson-Whelen, S., Tadia, Y., MacCallum, R. C., McGuire, L., & Kiecolt-Glaser, J. K. (2001). Long-term caregiving: What happens when it ends? *Journal of Abnormal Psychology, 110,* 573–584.

Rzetelny, H. (1986). Emotional stresses in later life. *Journal of Gerontological Social Work, 8,* 141–151.

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.

Schulz, R., Beach, S. R., Lind, B., Martire, L. M., Zdanuik, B., Hirsch, C., et al. (2001). Involvement in caregiving and adjustment to death of a spouse: Findings from the caregiver health effects study. *JAMA, 285,* 3123–3129.

Sherbourne, C. D., Meredith, L. S., Rogers, W., & Ware, J. E. (1992). Social support and stressful life events: Age differences in their effects on health-related quality of life among the chronically ill. *Quality of Life Research, 1,* 235–246.

Stern, K., Williams, G. M., & Prados, M. (1951). Grief reactions in later life. *American Journal of Psychiatry, 108,* 290–294.

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.

Stroebe, W., Stroebe, M., Abakoumkin, G., & Schut, H. (1996). The role of loneliness and social support in adjustment to loss: A test of attachment versus stress theory. *Journal of Personality and Social Psychology, 70,* 1241–1249.

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

Worden, J. W. (1991). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (2nd ed.). New York: Springer Publishing Company.

Wortman, C. B., & Silver, R. C. (1989). The myths of coping with loss. *Journal of Consulting and Clinical Psychology, 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.

Zisook, S., & Shuchter, S. R. (2001). Treatment of depressions of bereavement. *American Behavioral Scientist, 44,* 782–798.

Zisook, S., Shuchter, S. R., Sledge, S. R., & Mulvihill, M. (1993). Aging and bereavement. *Journal of Geriatric Psychiatry and Neurology, 6,* 137–143.

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