

The Myths of Coping With Loss

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Drawing from theory and clinical lore, we consider how individuals are assumed to cope following irrevocable loss. Several assumptions are reviewed reflecting beliefs concerning the grieving process. Specifically, we examine the expectation that depression is inevitable following loss; that distress is necessary, and failure to experience it is indicative of pathology; that it is necessary to "work through" or process a loss; and that recovery and resolution are to be expected following loss. Although limited research has examined these assumptions systematically, available empirical work fails to support and in some cases contradicts them. Implications of our analysis for theoretical development and research are explored. Finally, we maintain that mistaken assumptions held about the process of coping with loss fail to acknowledge the variability that exists in response to loss, and may lead others to respond to those who have endured loss in ways that are unhelpful.

In this article, we focus on how people cope with loss events that involve permanent change and cannot be altered or undone. It is our belief that such experiences provide an excellent arena in which to study basic processes of stress and coping. In the health and medical areas, many specific losses might be considered irrevocable: the permanent loss of bodily function, the loss of particular body parts, the loss of cognitive capacity, the death of a loved one, or one's own terminal illness. In an attempt to advance theoretical development in this rich and complex area, this article updates an earlier review we completed on reactions to undesirable life events (Silver & Wortman, 1980). Because the most rigorous empirical studies have been in the areas of physical disability and bereavement, we shall focus on these two areas in this article.

When a person experiences an irrevocable loss, such as the death of a loved one or permanent paralysis, how will he or she react? We maintain that people hold strong assumptions about how others should respond to such losses. As we have discussed in more detail elsewhere (Silver & Wortman, 1980; Wortman & Silver, 1987), such assumptions are derived in part from the theories of loss offered by prominent writers in the area, and in part from clinical lore about coping with loss and our cultural understanding of the experience. As detailed below, individuals who encounter a loss are expected to go through a period of intense distress; failure to experience such distress is thought to

be indicative of a problem. Moreover, it is assumed that successful adjustment to loss requires that individuals "work through" or deal with their feelings of grief rather than "denying" or "repressing" them. Within a relatively brief period of time, however, people are expected to resolve their loss and recover their earlier level of functioning.

Because it is generally assumed that the coping process unfolds in a particular way, others may evaluate or judge those who do not conform to these expectations as reacting abnormally or inappropriately. For example, because they believe that people should recover relatively soon after the loss, outsiders might react judgmentally to continuing signs of distress (cf. Silver & Wortman, 1980; Tait & Silver, 1989). In fact, if laypersons hold unrealistically narrow views of what constitutes a normal grief response, they may have difficulty offering the appropriate forms of assistance to friends and family members who are trying to cope with loss. Moreover, because they too may hold assumptions about how one should react when a loss is experienced, individuals who have encountered loss may harshly evaluate their own responses and may believe them to indicate underlying problems or pathology (Silver & Wortman, 1980).

Because assumptions about the grieving process are likely to have a pervasive impact on how reactions to loss are evaluated, we feel it is important to identify those assumptions that are most prevalent in our culture and to consider systematically the available research data in support of each one. We have identified five assumptions that we believe to be very prevalent in the grief literature. In the following sections, the validity of each assumption is evaluated against the available research data. While much of the early work in this area suffered from serious methodological shortcomings (e.g., reliance on subjective impressions of unstructured interview data, unstandardized measurements, and biased samples, etc.; see Silver & Wortman, 1980, for a review), recent research in the bereavement and physical disability areas has improved on the deficiencies of previous literature. In the following discussion, we review only what we believe to be the best empirical work available to test the assumptions we have identified. Except where indicated, all of this work has used standardized outcome measures and

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For a more detailed discussion of these issues, the reader is referred to Wortman and Silver (1987).

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structured interviews of relatively large, unbiased samples and followed them over time. In the concluding sections of this article, we explore the implications of the available data for theory, research, and intervention following loss, and consider why such myths about coping with loss may have been perpetuated despite the absence of validating data.

Distress or Depression Is Inevitable

It is widely assumed in our culture that when a major loss is experienced, the normal way to react is with intense distress or depression. The most prevalent theories in the area of grief and loss, such as the classic psychodynamic 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 go through a period of intense distress or depression. In the recent authoritative report on bereavement published by the Institute of Medicine, it was stated that there is a "near-universal occurrence of intense emotional distress following bereavement, with features similar in nature and intensity to those of clinical depression" (Osterweis, Solomon, & Green, 1984, p. 18). Similarly, depression has been the foremost reaction reported and discussed in the literature on spinal cord injury (Bracken & Shepard, 1980; Deegan, 1977; Gunther, 1971; Knorr & Bull, 1970).

As empirical evidence has begun to accumulate, however, it is clear that the assumption of intense universal distress following a major loss such as bereavement or spinal cord injury may be unwarranted. It is true that in the bereavement literature, some studies have reported that feelings of sadness or depressed mood are fairly common. For example, Glick, Weiss, and Parkes (1974) have noted that 88% of the widows they studied experienced depressed mood (see also Clayton, Halikas, & Maurice, 1971). However, in those investigations that have included a more systematic and rigorous assessment of depression or distress, it is clear that such a reaction is by no means universal. In one study, Clayton, Halikas, and Maurice (1972) interviewed widows within 30 days of losing their spouse. Using strict diagnostic criteria to assess depression, Clayton et al. found that only a minority of respondents (35%) could be classified as definitely or probably depressed. Similarly, Vachon, Rogers, et al. (1982) found that 1 month after the loss, 30% of the widows they studied scored below 5 on the General Health Questionnaire (GHQ)—a score considered insufficient to warrant further psychiatric assessment. In their sample of primarily Mormon elderly bereaved individuals, Lund, Caserta, and Dimond (1986) reported that only 14.6% of the men and 19.2% of the women they studied at 3 weeks postloss evidenced "at least mild" depression on the Zung Depression Scale. In fact, only 12.5% to 20% of this sample reported scores exceeding the cutoff score delineated as indicating depression at any of six different assessment points from 3–4 weeks to 2 years postloss.

Examination of empirical data in the spinal cord injury literature reveals a similar pattern. For example, Howell, Fullerton, Harvey, and Klein (1981) conducted a careful assessment of 22 patients who had been injured approximately 1 month, and followed them for an average of 9 weeks. Each patient was interviewed utilizing the Schedule of Affective Disorders and Schizophrenia and completed the Beck Depression Inventory weekly.

Only a minority of patients (22.7%) experienced a depressive disorder following injury that met Research Diagnostic Criteria (see also Fullerton, Harvey, Klein, & Howell, 1981). Similarly, Lawson (1976) studied 10 spinal-cord-injured patients 5 days a week for the entire length of their rehabilitation stay. Despite a multimethod assessment of depression (self-report, professional ratings, and psychoendocrine and behavioral measures), there was no clear period of at least a week in which measures were consistently in the depressive range for any patient (see also Malec & Neimeyer, 1983). Thus, the few systematic investigations that are available have failed to demonstrate the inevitability of depression following loss.

Distress Is Necessary, and Failure to Experience Distress Is Indicative of Pathology

The clinical literature is clear in suggesting that those who fail to respond to loss with intense distress are reacting abnormally (e.g., Deutsch, 1937; Marris, 1958). Bowlby (1980) has identified "prolonged absence of conscious grieving" (p. 138) as one of two types of disordered mourning. In the previously mentioned Institute of Medicine report, "absent grief" was classified as one of two forms of "pathologic" mourning (Osterweis et al., 1984, p. 65). This report emphasized that it is commonly assumed, particularly by clinicians, "that the absence of grieving phenomena following bereavement represents some form of personality pathology" (p. 18). Although the authors noted that there is little empirical evidence in support of this assumption, they concluded nonetheless that "professional help may be warranted for persons who show no evidence of having begun grieving" (p. 65). The assumption that distress or depression is a necessary part of the grieving process is also quite prevalent in the literature on spinal cord injury (e.g., Karney, 1976; Kerr & Thompson, 1972; Nemiah, 1957; see Trieschmann, 1978, 1980, for reviews). In fact, authors have maintained that depression is therapeutic because it signals that the person is beginning to confront the realities of his or her situation (e.g., Cook, 1976; Dinardo, 1971; Nemiah, 1957).

The belief that distress should occur is so powerful that it also leads to negative attributions toward those who do not show evidence of it. One such attribution is that the person is denying the loss. As Siller (1969) has maintained regarding the disabled,

occasionally a newly disabled person does not seem to be particularly depressed, and this should be a matter of concern. . . . A person should be depressed because something significant has happened, and not to respond as such is denial. Such obvious denial is rare except in the case of a retarded person or in the very young. (p. 292)

A second attribution is that the person is emotionally too weak to initiate the grieving process. Drawing from clinical experience with patients undergoing psychiatric treatment, Deutsch (1937) maintained that grief-related affect was sometimes omitted among individuals who were not emotionally strong enough to begin grieving. A third attribution is that individuals who fail to grieve are simply unable to become attached to others. For example, Raphael (1983) suggested that among those who do not show signs of grief, the preexisting relationship may have been "purely narcissistic with little recognition of the real person who was lost" (pp. 205–206).

If, in fact, depression is necessary following loss, those people who experience a period of depression should adapt more successfully than those who do not become depressed. However, this view has not been substantiated empirically. In contrast, several studies have found that those who are most distressed shortly following loss are among those likely to be most distressed 1 to 2 years later. For example, Vachon, Rogers, et al. (1982) found that among 162 widows, an elevated score 1 month postloss on the GHQ, a measure of distress and social functioning, was the most powerful predictor of high distress 24 months later. Similarly, Lund et al. (1985–1986) found that the best predictor of long-term coping difficulties among elderly widows and widowers was the presence of strong negative emotional responses to the loss (such as expressing a desire to die and crying) during the early bereavement period (see also Bornstein, Clayton, Halikas, Maurice, & Robins, 1973; Parkes & Weiss, 1983, for similar findings).¹ Comparable results have been obtained by investigators studying spinal cord injury. In a cross-sectional study of 53 male spinal-cord-injured patients, Dinardo (1971) assessed depressed mood by self-report and professional assessments. Results indicated that the absence of depression was associated with higher self-concepts and with staff ratings of successful adjustment to the disability, leading the author to conclude that “those individuals who react to spinal cord injury with depression are less well adjusted at any given point in their rehabilitation than the individuals who do not react with depression” (p. 52) (see Lawson, 1976, and Malec & Neimeyer, 1983, for comparable findings).

An important component of the view that depression is necessary is that if individuals fail to experience distress shortly after the loss, symptoms of distress will erupt at a later point. Marris (1958) has commented that “much later, in response to a less important or trivial loss, the death of a more distant relative, a pet—the bereaved person is overwhelmed by intense grief” (p. 27) (see also Bowlby, 1980; Rando, 1984). It is also widely believed that the failure to grieve will result in subsequent health problems. The Institute of Medicine report (Osterweis et al., 1984) reviewed the work of several clinicians who suggested that those who fail to grieve outwardly may manifest their depression through a variety of physical symptoms or somatic complaints.

Despite its prevalence, available evidence provides little support for the assumption that those who fail to experience distress shortly after loss will have difficulties later. In the previously mentioned study of bereavement by Clayton et al. (see Bornstein et al., 1973), interviews were conducted with 109 widows and widowers at 1 month, 4 months, and 13 months postloss. As noted earlier, only 35% of these respondents were classified as either definitely or probably depressed at the 1-month interview. However, only 3 of the remaining 71 respondents had become depressed by the 4-month interview. Moreover, only 1 subject evidenced depression for the first time at 13 months postloss, leading the investigators to conclude that “delayed” grief is relatively rare. Similar findings were obtained in a longitudinal study of 99 widows conducted by Vachon, Sheldon, et al. (1982). Thirty-two of these women were classified as “low distress” by virtue of their scores on the GHQ 1 month postloss, and 94% continued to evidence “low distress” when interviewed 2 years later. In fact, only 2 women in the

study who had low distress scores at 1 month had high distress scores at the 2-year interview.

A very similar pattern of findings was obtained in our recent longitudinal study of 124 parents who had lost an infant to Sudden Infant Death Syndrome (SIDS; Silver & Wortman, 1988; Wortman & Silver, 1987, in press). Parents were classified as exhibiting low or high distress at the initial interview 3 weeks postloss on the basis of their scores on the depression subscale of the Symptom Check List-90 (SCL-90; Derogatis, 1977). As in the previously described research, most respondents in this study who showed low distress at 3 weeks also showed low distress 18 months later. Only a small percentage of the sample moved from low to high distress over the period of study. Those parents who were evidencing low distress shortly after their baby's death were no more likely than parents who reported high distress to indicate that the pregnancy had been unplanned or difficult to accept; nor did they differ in their evaluation of their babies as having been beautiful, intelligent, and happy while alive. Thus, these data fail to support the notion that absence of distress may be due to insufficient attachment to the lost loved one.²

In summary, the bulk of research to date provides little support for the widely held view that those who fail to exhibit early distress will show subsequent difficulties. The data clearly suggest that “absent grief” is not necessarily problematic, and, at least as it is assessed in the studies conducted to date, “delayed grief” is far less common than clinical lore would suggest.

The Importance of “Working Through” the Loss

It is widely assumed that a period of depression will occur once the person confronts the reality of his or her loss. Then, it is commonly believed, the person must “work through” or process what has happened in order to recover successfully (see, e.g., Brown & Stoudemire, 1983; Doyle, 1980). Implicit in this assumption is the notion that individuals need to focus on and “process” what has happened and that attempts to deny the implications of the loss, or block feelings or thoughts about it, will ultimately be unproductive (cf. Bowlby, 1980; Parkes & Weiss, 1983). Marris (1958) maintained that “if the bereaved cannot work through this process of grieving they may suffer

¹ Of course, this does not necessarily imply that it is detrimental to go through a period of depression following loss. Undoubtedly, some of the people who are most depressed after the loss may be those who have enduring psychological difficulties that were present prior to the loss. In the research that has been conducted to date, it is not possible to discriminate between those respondents who became depressed primarily as a result of their loss and those who had a lifelong history of psychological disturbance. Only prospective designs, which assess such confounding variables prior to the loss, can help to shed light on this issue. Because most loss events are relatively infrequent, prospective studies are prohibitively costly and thus have rarely been attempted.

² The only evidence for delayed grief that we have been able to uncover comes from a study by Parkes and Weiss (1983). These investigators found that widows who reported having had marriages characterized by high conflict displayed little or no emotional distress in the weeks following their loss. However, at the 13-month and 2- to 4-year follow-up interviews, these widows were evidencing greater difficulties than those women whose marriages were characterized by low conflict.

lasting emotional damage" (p. 29). Rando (1984) concurred with this assessment, stating that "for the griever who has not attended to his grief, the pain is as acute and fresh ten years later as it was the day after" (p. 114).

On the basis of statements such as these, it might be expected that those who show evidence of "working through" their loss in the weeks or months following it will be more successful in resolving the loss than those who do not. However, the limited evidence that is available suggests that this may not be the case. Although they did not assess "working through" the loss specifically, Parkes and Weiss (1983) conducted a comprehensive study of bereavement that provided data of possible relevance to this concept. Respondents were rated by coders on the degree to which they evidenced yearning or pining for the deceased 3 weeks after their loss. Subjects were divided into a "High Yearning" group, composed of those respondents who appeared to yearn or pine constantly, frequently, or whenever inactive, and a "Low Yearning" group, who yearned never, seldom, or only when reminded of the loss. In fact, high initial yearning was found to be predictive of poor mental and physical health outcomes at 13 months postloss. As Parkes and Weiss (1983) expressed it, "We might suppose that people who avoid or repress grief are the most likely to become disturbed a year later, yet this is not the case" (p. 47). Interestingly, high initial yearning was associated with poor outcome even at the final interview conducted 2 to 4 years after the loss.

In our previously described study of parents who suffered a SIDS loss (Silver & Wortman, 1988; Wortman & Silver, 1987), we also examined the impact of early evidence of "working through" the loss on subsequent adjustment. "Working through" was operationalized as active attempts by the parent 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. Results indicated that the more parents were "working through" the death at the 3-week interview, the more distressed they were, as measured by the SCL-90 18 months later. In addition, those subjects who showed the least evidence of emotional resolution 18 months after the death of their infant (measured by distress in thinking and talking about the baby, feeling bitterness about the loss, and being upset by reminders of the baby) were those most likely to be processing the loss shortly after the death.

To date, there is relatively little empirical evidence relevant to the issue of "working through." If behaviors such as yearning for the deceased or being preoccupied with thoughts about the loss are conceptualized as "working through," however, the available research challenges the assumption that the absence of this process is necessarily maladaptive. Like early evidence of intense distress, early signs of intense efforts to "work through" the loss may portend subsequent difficulties.

The Expectation of Recovery

It is generally assumed that although a person who experiences an irrevocable loss will go through a phase of intense distress, this will not last indefinitely. In fact, after a relatively brief period of time, the person is expected to achieve a state of recovery and return to normal role functioning (cf. Silver & Wort-

man, 1980). Almost every stage model of coping with loss postulates a final stage of adaptation, which may be called recovery (Klinger, 1975, 1977), acceptance (Kubler-Ross, 1969), or reorganization (Bowlby, 1980). "Chronic grief" or failure to recover is identified as a major type of "pathological" mourning in virtually every major treatise on the bereavement process (e.g., Bowlby, 1980; Osterweis et al., 1984; Raphael, 1983). Similarly, failure to accept the loss of one's abilities is felt to impede motivation and rehabilitation of the spinal-cord-injured patient (e.g., Heijn & Granger, 1974).

None of the theories postulate precisely how much time should elapse before recovery from an irrevocable loss. In the bereavement literature, notions about the length of the recovery process have been shifting over the last four decades. Early studies of bereavement suggested that its psychological impact was relatively transient. In fact, in his study of people who lost a loved one in Boston's Coconut Grove nightclub disaster, Lindemann (1944) painted an optimistic picture of the recovery process, noting that with appropriate psychiatric intervention, it was ordinarily possible to settle an uncomplicated grief reaction in 4 to 6 weeks. However, recent research evidence suggests that it may take considerably longer to recover from the loss of a loved one, especially when the loss is sudden and traumatic (see Silver & Wortman, 1980; Tait & Silver, 1989, for reviews). In the previously discussed studies by Vachon and her associates, 38% of the widows studied were experiencing a high level of distress after 1 year, and 26% were still classified as exhibiting high distress at the end of 2 years (Vachon, Rogers, et al., 1982; Vachon, Sheldon, et al., 1982). In the longitudinal study of widows and widowers conducted by Parkes and Weiss (1983), more than 40% of the sample was rated by trained interviewers as showing moderate to severe anxiety 2 to 4 years after the loss. Feelings of depression, as well as problems in functioning, were also quite common at the 2- to 4-year interview, particularly if the loss was sudden. Zisook and Shuchter (1986) had widows and widowers complete interviews and questionnaires at 11 points in time, ranging from 3-4 weeks after their loss to 4 years later. Even at 4 years postloss, at least 20% of the bereaved assessed their own adjustment as "fair or poor," while only 44% assessed it as excellent (see Lund et al., 1985-1986, for comparable findings).

A study by Elizur and Kaffman (1982, 1983), which examined behavior changes over a 3½-year period among normal kibbutz children whose fathers had been killed in war, found negative consequences in response to the deaths. While none of these children evidenced unusual psychopathology prior to their loss, they were subsequently found to be at risk for a variety of problems. Almost 50% showed emotional disturbance in each phase of the study—6, 18, and 42 months postloss. More than two-thirds of the bereaved children reacted with severe psychological problems and impairment in diverse areas of functioning. Similar findings were obtained in a study by Lehman, Wortman, and Williams (1987), which focused explicitly on the long-term effects of the sudden, unexpected loss of a spouse or child in a motor vehicle accident 4 to 7 years earlier. Interviews were conducted with bereaved respondents, who were matched with a control group of nonbereaved individuals on sex, age, income, education, and number and ages of children. Significant differences between bereaved and control re-

spondents were found on several indicators of functioning, including depression and other psychiatric symptoms, social functioning, divorce, psychological well-being, and mortality.

Taken together, the aforementioned evidence suggests that prevailing notions of recovery deserve reconsideration. There is growing evidence that a substantial minority of individuals continue to exhibit distress for a much longer period of time than would commonly be assumed.

Reaching a State of Resolution

It is widely assumed that over time, as a result of "working through" their loss, individuals will achieve a state of resolution regarding what has happened. One important type of resolution involves accepting the loss intellectually. Parkes and Weiss (1983) argued that people must come up with a rationale for the loss; they must be able to understand what has happened and make sense of it (see also Moos & Schaefer, 1986). Similarly, Craig (1977), in her writings on the loss of a child, maintained that an essential part of grief work is to resolve the meaninglessness of the crisis (see also Marris, 1958; Miles & Crandall, 1983). A second type of resolution involves accepting the loss emotionally. Emotional acceptance is thought to be reached when the person no longer feels the need to avoid reminders of the loss in order to function. The lost person can be recalled, and reminders can be confronted without intense emotional pain (Parkes & Weiss, 1983). It is generally expected that much of the grief work engaged in by those who have endured loss, such as reviewing the events of the death or the course of the illness or accident, will aid in resolution.

Although few studies have focused on the issue of resolution, the limited data that are available suggest that a state of resolution may not always be achieved (e.g., Silver, Boon, & Stones, 1983). In the study by Parkes and Weiss (1983), 61% of the respondents who had suddenly lost their spouse, and 29% of those who had had forewarning, were still asking why the event had happened 2 to 4 years later. More than 40% of those who had suddenly lost a spouse, and 15% of those with forewarning, continued to agree with the statement "It's not real; I feel that I'll wake up and it won't be true." Similar data were obtained in our aforementioned study of coping with the loss of an infant to SIDS. At all three of the time points we studied (3 weeks, 3 months, and 18 months postloss), the vast majority of respondents were unable to find any meaning in their baby's death and were unable to answer the question "Why me?" or "Why my baby?" (Wortman & Silver, 1987). A particularly intriguing feature of our data is that we found little evidence that resolution is achieved over time. In contrast, the number of parents who were unable to find meaning in their babies' deaths increased significantly between the first and second interviews.

The aforementioned study of the long-term impact of losing a loved one in a motor vehicle accident (Lehman et al., 1987) also found that even after 4 to 7 years, most respondents had not achieved a state of resolution. In this investigation, almost half of the sample had reviewed events leading up to the accident in the month prior to the interview. A majority of the respondents were unable to find any meaning in the loss, had had thoughts that the death was unfair, and had had painful memories of their spouse or child during the past month.

In the spinal cord literature, there is a dearth of longitudinal studies following individuals for very long after their injury. Nonetheless, there is limited evidence suggesting that it may take individuals longer to resolve their loss than is commonly assumed. In a cross-sectional study of patients disabled up to 38 years earlier, Shadish, Hickman, and Arrick (1981) reported that many of them still thought about the things they could not do since their injury and "really missed" these things almost weekly.

Considered together, these data provide convergent evidence that, contrary to popular belief, individuals are not always able to achieve resolution regarding their loss and to come up with an explanation for the experience that is satisfying to them. Particularly when the event is sudden, a majority of individuals appear to have great difficulty in coming to terms with what has happened.

Implications for Theory, Research, and Intervention

Theories of grief and mourning, as well as clinical lore, maintain that virtually all individuals who experience an important loss should go through the grief process, beginning with a phase of intense distress and followed by ultimate recovery over time as the person comes to terms with the loss (Donovon & Girtan, 1984; Jette, 1983; Osterweis et al., 1984). Alternate patterns are usually labeled as pathological or deviant (Brown & Stouemire, 1983; Osterweis et al., 1984; Simons, 1985). Our analysis suggests that, in contrast to this view, there are at least three common patterns of adaptation to loss. Some individuals indeed seem to go through the expected pattern, moving from high to low distress over time. But others appear not to show intense distress, either immediately after the loss or at subsequent intervals. Still others seem to continue in a state of high distress for much longer than would be expected.

Traditional theories of grief and loss are able to account for those who move from high to low distress and resolve their grief over time. But these theories offer little explanation of why some people might consistently respond with less distress than expected and others might fail to recover or resolve their loss over time. In this section we consider the theoretical, research, and clinical implications of each of these groups in turn.

Failure to Become Depressed

Because of the assumption that early distress is inevitable, limited research has carefully examined the range of emotions that may occur in the first few weeks or months after a loss. Are there some individuals who show very little, if any, feelings of distress (Silver & Wortman, 1988), or do virtually all people experience some feelings of sadness (Wright, 1983)? Can people show other indications of mourning, such as preoccupation with the loss or pining for it, without becoming depressed? Are those individuals who show little distress also likely to show few signs of positive emotion (Deutsch, 1937)? Among those who show very little distress, is this best understood as a "shock" or "denial" reaction, or is it a sign of coping strength and resilience? Research that assesses respondents frequently in the early period following loss (e.g., Lawson, 1976) would help to address these questions.

Although failure to become distressed following loss is typically viewed as indicative of a problem, we have little evidence to suggest that those who initially show minimal distress following loss are likely to become significantly depressed at a later point. In subsequent studies, it will be important to look closely at people who show low initial levels of distress. Are such people more vulnerable to subsequent minor losses, as some theorists would lead us to expect? Are they more likely to develop somatic symptoms or physical health problems (Brown & Stoudemire, 1983) or problems in other areas of their lives, such as at work or in their interpersonal relationships? The data we have reviewed above provide suggestive evidence that low initial distress may not signal pathology. However, more systematic data are needed before we can dismiss the firmly entrenched view that "absent grief" is a cause for concern. In collecting such data, it will be important to go beyond the self-report methodology that is used almost exclusively in current research on reactions to loss. Individuals who indicate that they are not distressed immediately after a loss may also be unwilling to admit subsequent problems in other areas of their lives. Supplementing self-reports of symptomatology with more objective indicators of problems, such as measures of behavioral and physiological functioning (e.g., from physical health records or from observational ratings made by members of the individual's work and social networks), are important directions for subsequent work in this area.

If results obtained from further studies are consistent with the results reviewed herein, we must acknowledge the possibility that a sizeable minority of people may come through the bereavement process relatively unscathed. As psychologist Norman Garmezy has indicated, "our mental health practitioners and researchers are predisposed by interest, investment, and training in seeing deviance, psychopathology, and weakness wherever they look" (Garmezy, 1982, p. xvii). By assuming latent pathology among those who fail to show intense distress following a loss, attention appears to have been deflected away from identifying strengths (e.g., high self-esteem; Lund et al., 1985-1986) or coping resources (e.g., premorbid coping styles or adequate social support systems; see Kessler, Price, & Wortman, 1985) that may protect these people from distress. The data also suggest that some people may have something in place beforehand—perhaps a religious or philosophical orientation or outlook on life—that enables them to cope with their experience almost immediately (Silver & Wortman, 1988). Clearly, future research is necessary to examine the role that such resources may play in protecting people from the deleterious effects of loss.

The implications of our analysis for treatment and intervention are straightforward. Rather than recognizing the absence of grief as a sign of possible strengths of the individual (Gans, 1981), the expectation that individuals must go through a period of distress may lead health care providers to provoke such a reaction, even if it is not warranted. For example, regarding spinal cord injury, Nemiah (1957) has written, "It is often necessary to confront the patient gently but firmly with the reality of his situation, and to force him into a period of depression while he works out his acceptance of his loss" (p. 146). When dealing with the bereaved, physicians have been reminded to encourage patients to express their distress, and to bring "latent

anger and guilt to a conscious level of awareness" (Brown & Stoudemire, 1983, p. 382). In a manual for grief counselors, Doyle (1980) has discouraged the use of tranquilizers or antidepressants by the bereaved during the early stages of grief, since grief "needs to be felt in all its ramifications" (p. 15) (see also Rando, 1984).

Failure to Resolve or Recover From the Loss

Because it is widely believed that individuals will recover from a loss within a year or so, only a handful of studies have focused on the issue of long-term recovery. Yet, as noted above, there appears to be considerable variability in the length of time it may take to recover from a loss, and some people do not seem to recover despite the passage of many years. This has led to increasing interest in identifying mediating factors that may promote or impede psychosocial recovery (Kessler et al., 1985; Silver & Wortman, 1980). Recent research has, in fact, identified factors that may enhance the likelihood that individuals will react to loss with intense and prolonged distress. These include the nature of the relationship with the deceased, circumstances surrounding the loss, the presence of concomitant stressors, and the availability of social support (see Wortman & Silver, 1987, for an extended discussion).

In our judgment, an unfortunate consequence of the pervasive belief in recovery from loss is that attention has been deflected away from examining the possible mechanisms through which loss may produce subsequent and continued mental or physical health problems. A number of different mechanisms have been suggested in the literature (Jacobs & Douglas, 1979; Klerman & Izen, 1977; Osterweis et al., 1984; Stroebe & Stroebe, 1983). For example, grieving appears to involve changes to the respiratory, autonomic, cardiovascular, and endocrine systems (see Osterweis et al., 1984, for a review). In fact, the Institute of Medicine report on bereavement concluded that "preliminary data now available make it clear that traumatic loss experiences may have a long-term impact on the body's immune system" (Osterweis et al., 1984, p. 170). Such changes may result in increased susceptibility to illness and infections, as well as long-term health problems, both of which may also have deleterious psychological effects. Loss may also result in changes in health maintenance behavior, such as eating regular meals and exercise. Moreover, loss of a loved one often removes a major source of social support, and this may account for the pathogenic effects of bereavement. Finally, experiencing an irrevocable loss such as bereavement or spinal cord injury might alter the individual's view of the world (e.g., Lilliston, 1985; Parkes & Weiss, 1983). Indeed, in their study of the long-term effects of losing a loved one in a motor vehicle accident, Lehman et al. (1987) found that many of the respondents had come to see the world as a hostile place where things can be taken away in a moment. Such an altered world view is likely to be associated with depression, passivity, and impaired motivation to engage in subsequent coping efforts. Clearly, evidence concerning the precise mechanisms through which loss leads to long-term difficulties is essential not only for theoretical advancement, but also to guide intervention efforts in the area of grief and loss.

The expectation that individuals will recover from irrevocable loss within a limited period of time may unfortunately lead

health care providers to react negatively to those who fail to recover. In fact, those who do not recover within the prescribed time limits have been derogated in the literature (e.g., Falek & Britton, 1974). And although it has been acknowledged that the progression to adjustment may be unsteady, health care professionals are nonetheless often reminded to encourage movement forward. As Stewart (1977-1978) has written, "To be blunt, a pat on the back and kick in the pants are often necessary" (p. 341).

Conclusion

As reviewed above, assumptions about the process of coping with loss fail to be supported and in some cases are contradicted by available empirical work on the topic. Why might such erroneous beliefs continue in the absence of validating data collected in methodologically rigorous research and in the presence of data indicating extreme variability in responses to loss? As Silver and Wortman (1980) discussed, even if they are not supported by data, widespread assumptions about the coping process may be particularly resistant to disconfirming evidence. Social psychological research has demonstrated repeatedly that "people tend to seek out, recall, and interpret evidence in a manner that sustains beliefs" (Nisbett & Ross, 1980, p. 192). Thus, the interpretation of data tends to be strongly biased by the expectations researchers, clinicians, and laypersons may hold (Nisbett & Ross, 1980; see also Goldiamond, 1975; Wright, 1983), and these errors in information processing lead people's implicit theories to be "almost impervious to data" (Nisbett & Ross, 1980, p. 169).

As noted earlier, the assumption that distress is inevitable shortly after a loss has resulted in its absence being treated as pathological, even if there is no objective reason to assume this to be true. Studies that fail to find problems resulting from the absence of grief may be dismissed for not looking long enough, not looking closely enough, or not asking the correct questions (Volkan, 1966). Such insistence on distress following loss has been labeled the "requirement of mourning" (Dembo, Leviton, & Wright, 1956; Wright, 1983). This hypothesis describes the need of outsiders to "insist that the person they consider unfortunate is suffering (even when that person seems not to be suffering) or devalue the unfortunate person because he or she ought to suffer" (Dembo et al., 1956, p. 21). This requirement of mourning may explain why health care professionals tend to assume the presence of significantly more distress following loss than individuals report experiencing themselves (Baluk & O'Neill, 1980; Gans, 1981; Klas, 1970; Mason & Muhlenkamp, 1976; Schoenberg, Carr, Peretz, & Kutscher, 1969; Taylor, 1967; Wikler, Wasow, & Hatfield, 1981).

A series of complementary processes might explain the perpetuation of the assumption that the presence of long-term distress is "abnormal." Silver and Wortman (1980) argued that outsiders may minimize the length of time a loss will affect an individual who encounters it because they may be unaware that, in addition to the loss itself, the individual must also contend with the simultaneous destruction of future hopes and plans that were vitiated by the loss. Outsiders may also be unaware of the possible alterations in views of the world that may occur as a result of a loss (Silver & Wortman, 1980). The fact that

individuals who have experienced loss are often implored to control their expressions of grief and to stop "dwelling on their problems" (Glick et al., 1974; Maddison & Walker, 1967) suggests that outsiders also believe that the distressed could behave more appropriately if they wished. In fact, as Wright (1983) maintained, society frowns upon open displays of distress and has a "requirement of cheerfulness" that in fact contradicts its simultaneous "requirement of mourning." It is likely that this subtle yet sometimes explicit message discourages the person who has encountered loss from expressing distress to others at all. Over time this process may become even more intensified. Perhaps so as to maintain harmonious social relations and not to be perceived as abnormal, the individual may continue to hide the true degree of his or her distress from members of the social network (Tait & Silver, 1989). Thus, the stigma that is associated with persistent difficulties following loss may result in self-presentational strategies that are in line with societal expectations, resulting in a discrepancy between public expressions and private experience of ongoing distress (Tait & Silver, 1989). The very act of concealing common aspects of the loss experience is likely to perpetuate the misconception that grief is time limited for all but the few whose reactions are deemed pathological.

In summary, we maintain that a complex mixture of biased input and interpretation of data by outsiders, their own personal needs, as well as limited opportunity for open communication between parties, has led to a perpetuation of unrealistic assumptions about the normal process of coping with loss. In addition, unrealistic assumptions held by health care professionals and the social network may also unnecessarily exacerbate feelings of distress among those who encounter loss, and lead to a self-perception that their own responses are inappropriate and abnormal under the circumstances.

Of course, the ability to identify pathological responses to loss would enable health care professionals to target those individuals who may be in need of professional assistance (Bracken & Shepard, 1980; Falek & Britton, 1974; Silver & Wortman, 1980). Perhaps this goal has overridden acceptance of alternatives to the current views regarding adjustment to loss. As Zisook and Shuchter (1986) have indicated, at the present time "there is no prescription for how to grieve properly for a lost spouse, and no research-validated guideposts for what is normal vs. deviant mourning. . . . We are *just beginning* to realize the full range of what may be considered 'normal' grieving" (p. 288, italics added). Recognition of this variability is crucial in order that those who experience loss are treated nonjudgmentally and with the respect, sensitivity, and compassion they deserve.

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