From vulnerability to resilience

Where should research priorities lie?

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Abstract: Recent decades have seen a shift in the focus of bereavement research from the mental and physical health consequences of bereavement to the exploration of the protective qualities that help people cope with loss. In this paper Margaret Stroebe reviews the literature produced by both camps and concludes that the pendulum may have swung too far. The literature indicates that the vast majority of bereaved people are, indeed, resilient and will cope without intervention. But policy-makers and health and social care practitioners need also to know that bereavement is associated with excess risk of early death and physical and psychological health problems. Psycho-social intervention should focus on such 'at-risk' groups.

Keywords: Mental health, physical health, risk, resilience, vulnerability

In recent decades there has been a shift in bereavement research from a focus on the vulnerability of bereaved people to one that emphasises people's resilience and strength in dealing with the loss of a loved one. Vulnerability research has documented the mental and physical consequences following the death of a loved one, and explored so-called risk factors: those personal and/or circumstantial and situational characteristics that cause some people to be more vulnerable than others to suffering from debilities associated with bereavement. There are good reasons to focus on vulnerability: if we want to help bereaved people in either an informal or professional capacity, we need to know what the potential health consequences are. We also need to know who is most likely to suffer such consequences, and to gain some estimates of how many people are severely affected. Many researchers have contributed to this effort, with perhaps the pioneering work of Colin Murray Parkes (see, for example, Parkes, 1972/1996) and Beverley Raphael (for example, 1983) providing the most important early stimulus to empirical research. Such efforts to document vulnerabilities continue, despite a shift toward emphasising resilience and people's abilities to come to terms with the stresses of bereavement.

In contrast to vulnerability research, research on resilience to stressful life events has focused on factors that guard against or help repair the damage of a stressful life event, looking at such aspects as sources of strength, processes accounting for positive outcomes and individual difference factors contributing to adjustment (see Friborg *et al*, 2006). Although empirical research on resilience in bereavement has been around for a number of decades too (for example, Costa & McCrae, 1988), a surge of interest has followed the more recent publications of George Bonanno and his collaborators (Bonanno, 2004, 2008; Bonanno, Boerner & Wortman, 2008). Bonanno (2008) has operationally defined resilience in terms of bereavement outcome as a stable pattern of low distress over time that should be distinguished from the reactions of maladjustment and recovery that are more frequently assumed to follow loss of a loved one. Bonanno (2008) drew the conclusion that: '… many and sometimes the majority of bereaved people will tend to experience only brief, short-lived distress reactions and manage to continue functioning at much the same level during bereavement as they had prior to the loss' (p11).

Bonanno investigated the resilient outcome pattern following the death of a loved one in a number of different studies (for reviews, see Bonanno, 2004, 2008; Bonanno, Boerner & Wortman, 2008), and consistently found distinctions between these stable patterns of low distress over time and reactions of maladjustment and recovery (see Figure 1).

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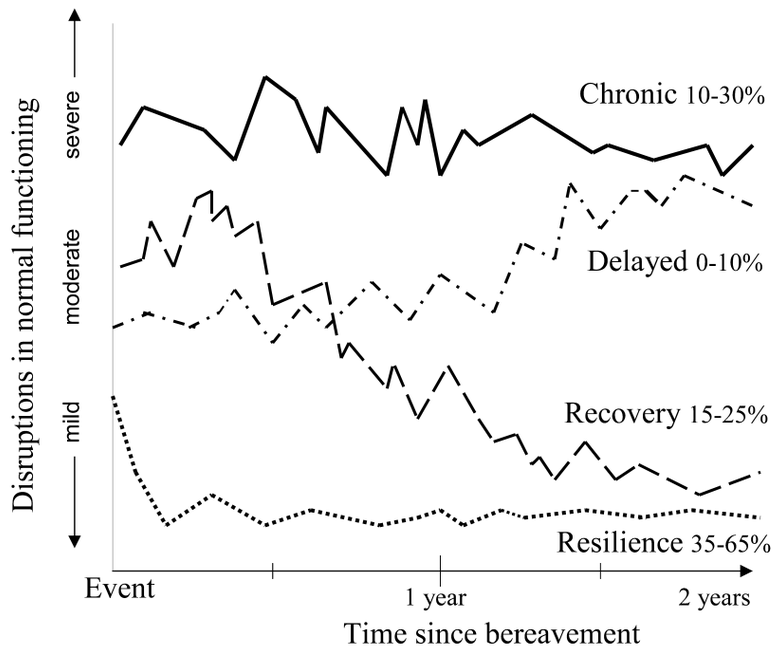
Figure 1: Disruptions in normal functioning over time following bereavement (Bonanno 2004)



Resilience research

A number of points need to be made about resilience research. First, it is important to note that Bonanno also stated: '… most participants, *including those exhibiting resilience,* experienced at least some yearning and emotional pangs in the early months after the loss' (Bonanno, 2008, p16; emphasis added). Thus, the fact that people are said to be resilient – according to Bonanno's definition – should not be taken to imply that there is no grief or grieving at all; it is simply that their levels of distress are relatively low and last only for a short period. As the work of Prigerson and her colleagues has demonstrated, high levels of yearning are a major criterion for grief complications (eg. Prigerson, Vanderwerker & Maciejewski, 2008). Thus, although apparently resilient people may score lower on such reactions to bereavement as yearning and longing, in some measure they experience similar reactions to those who are more extremely affected (the latter, rather than the former, being more likely to need and receive professional help [see Currier, Neimeyer & Berman, 2008; Schut *et al*, 2001; Schut & Stroebe, 2005]). Furthermore – and equally importantly – we have to consider the possibility that apparent 'resilience' may not turn out to be correctly labelled. For example, this category may include people who are not actually grieving, for one reason or another: they may, for example, not have been attached to the deceased. In this case, there would be a 'true' absence of grieving, with no question of there being 'resilience'. Of course, these people would probably not be expected to have even mild disruption in functioning shortly after bereavement; they would be below the mean for the 'resilience' sub-group shortly after bereavement, as depicted in Figure 1.

A second possibility is that grief may be absent, giving the appearance of resilience, but that underlying difficulties pertain. The absent/delayed/inhibited grief category of complicated grief has been recently debated, with Bonanno (2008) himself being one of the strong challengers. For example, Bonanno has argued that there is no empirical evidence for a pathological category of delayed grief. On the other hand, both clinicians and theoreticians have made strong cases for the phenomenon of absence of grief as reflecting a defensive reaction (see, for example, Mikulincer, 2008; Mikulincer & Shaver, 2008). While studies in the attachment literature have frequently reported no association between avoidant attachment and distress, it is noteworthy that avoidance has been associated with higher levels of somatic symptoms, 'implying that avoidant defences might block conscious access to distress without preventing the subtler and less conscious somatic reactions to loss' (Mikulincer, 2008, p36). Apparent absence of grief may, then, go hand-in-hand with other difficulties.

Finally, the resilient category may include larger proportions of men than women, simply because men's way of going about grieving may be less emotionally expressive (eg. Stroebe, Stroebe & Schut, 2001; Walter, 1999) and therefore their distress may not be picked up in self-report questionnaires. Gender differences in resilience have not yet been investigated (Bonanno, 2008; Bonanno, personal communication). In fact, most bereavement research has been conducted with women and we know relatively little about the ways that men grieve. But, from the research that is available so far, it seems likely that bereaved men (at least in traditional western cultures) might present themselves as more resilient, reflecting a 'stiff upper lip' attitude, while experiencing their grief (complications) in other ways and with other manifestations, such as high alcohol consumption or somatisation (see Stroebe, Stroebe & Schut, 2001).

Taken together, the above lines of reasoning suggest that researchers may sometimes be drawing faulty conclusions in assuming that people who show apparent resilience are really, in fact, resilient. There is a distinct possibility that vulnerable individuals may be wrongly classified and overlooked. These concerns would speak to the need for improvements in scientific investigation: for example, further specification of the types of people who are categorised within the resilient group (see Bonanno, 2008). Refining investigation to provide more accurate estimates of resilience will take time and research effort, but until we know more about this resilience category, it is hard to say whether current conclusions are painting too positive (or too negative, if the category includes many 'non-grievers') a picture about the robustness of the majority of bereaved people. So a continuing concern at present is that those in major professional health care roles, including policy-makers, may be wrongly guided toward concluding that bereaved people do not need help.

Vulnerability findings

How can we ensure that estimates of difficulties versus robustness following bereavement are as accurate as possible? One strategy – or, at least, a step in this direction – is to revisit research findings on vulnerability among the bereaved, to examine the extent of specific mental and physical health difficulties and to see whether these correspond in general with the results of resilience research reported by Bonanno. In other words, do prevalences of various health decrements 'mirror' the patterns of resilience shown in Figure 1? The remainder of this article will summarise major findings, drawing on the work of many research teams and our previous reviews to highlight the prevalence of various vulnerabilities associated with bereavement (eg. Stroebe, Schut, & Stroebe, 2007; Stroebe *et al*, 2008).

Research has covered not only the mortality of bereavement but also less extreme physical and psychological consequences of the death of a loved one. To start with the former, a

considerable body of evidence has accumulated on the mortality of bereavement. These studies have systematically examined whether the death of a loved one increases the risk of dying for the bereaved person, understood popularly as dying of a broken heart. Most findings indicate an early excess risk of mortality, although excesses have sometimes been shown to persist for longer than six months after bereavement. Widowers feature quite prominently among high-risk sub-groups: that is, they succumb to death relatively more frequently than widows, compared with their non-bereaved counterparts (see Stroebe, Stroebe & Schut, 2001). Although mortality is a drastic outcome of losing a loved person, it must be understood in terms of the absolute number of bereaved people who die. Baseline rates are low: in a category of males over 54 years, about five in 100 widowers compared with three in 100 married men would die in the first six months of bereavement (Stroebe, Stroebe & Schut, 2001). Thus, excess rates cannot be expected to show up among small samples of bereaved people (researchers often turn to national statistics to obtain large enough samples to establish excesses).

Physical health problems do occur in larger proportions of bereaved people, who are indeed more vulnerable than matched non-bereaved controls. To take a few examples, one study of fathers following the violent death of their child found indication of physical health deterioration over time: 14% said they were in poor health four months after bereavement, while as many as 24% reported ill health at 24 months (Murphy *et al*, 1999). In another study of younger bereaved spouses, 20% of the widowed (compared with three per cent of the married) were above the cut-off point for severe physical symptomatology at four to six months post-loss. After two years, the rate among the widowed declined to 12% (Stroebe & Stroebe, 1993). Research has shown not only physical health complaints, but also increases in disability and illness, with greater use of medical services reported in some studies, including elderly samples (Thompson *et al*, 1984). There is, worryingly, also some evidence that bereaved people with intense grief may not consult with doctors when they need to for physical health disorders (Prigerson *et al*, 2001), suggesting that there may be underestimation of physical health problems within this group.

It is clear from the scientific literature that bereaved people also suffer from psychological symptoms and ailments, ranging from loneliness and insomnia to distress and social dysfunction, and ranging from mild and comparatively short-lived to extreme and long-lasting symptoms over months and even years of bereavement. Thus, even without the necessity for (or appropriateness of) treatment there is mental suffering among people considered to be 'normally' (in the sense of uncomplicated) grieving – and, as acknowledged by Bonanno, who are within the resilient category. It nevertheless makes sense to focus on more severe psychological complications for comparison with the resilience prevalences in Figure 1.

The increase in risk of suffering from severe mental health difficulties among the bereaved range from psychiatric disturbances such as post-traumatic stress disorder (PTSD), through anxiety disorders and clinical depression, to complications in the grief process itself, currently termed prolonged grief disorder (which is not – yet – a separate diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders [APA, 1994]). Of course, different prevalences emerge not only for different disorders but also for different sub-groups of bereaved people, and they also vary according to type and duration of bereavement, among other things. Thus, the resulting pattern of findings is complex. Nevertheless, some key results give a general impression of the extent of difficulties within different categories of disorder.

There are excesses in rates of PTSD among the bereaved. In one study of parents five years after the violent death of their child, 27.7% of mothers, compared with 9.5% of non-bereaved mothers,

suffered from PTSD; among fathers the respective percentages were 12.5% compared with 6.3% (Murphy *et al*, 2003). In another study of spouses during their first two years of bereavement, 50% reached criteria for PTSD symptomatology at one of four points of measurement, while nine per cent did so at all four measurement points (Schut *et al*, 1991). Anxiety disorders other than PTSD include generalised anxiety disorders and phobic conditions, on the one hand, and separation anxiety/distress on the other (ie. disorders that may be heightened in more chronic or pathological forms following bereavement). Anxiety disorders are also found excessively among bereaved people, and it has been suggested that they are more prevalent than clinical depression (Raphael, Minkov & Dobson, 2001). However, research to establish more precise prevalences of anxiety disorders is lacking.

Clinical depression among the widowed in general has been documented for 24–30% two months post-loss, compared with 16% at one year (Zisook & Shuchter, 2001). Among elderly samples, rates tend to be lower, but one must be cautious in making age comparisons: for example, elderly bereaved suffer relatively more from a variety of longer-term problems (see Hansson & Stroebe, 2007). In one study, 12% of elderly widowers (compared with 0% of non-bereaved) suffered clinical levels of depression at six weeks post-loss (Byrne & Raphael, 1999). Similarly, in another study of elderly widows, 12% (compared with three per cent of non-bereaved) did so (Carnelley, Wortman & Kessler, 1999). Finally, estimates for complicated grief vary considerably too, with one review reporting a range from five per cent to 33% of acutely bereaved people reaching criteria for this category (Middelton *et al*, 1993). It is difficult to determine what the precise cut-off point for complicated grief should be (especially as criteria for a diagnostic category are still under development). However, Prigerson and Jacobs (2001) established an upper 20% criterion for 'caseness' of complicated grief among a large community sample (given that this threshold had emerged as the best for distinguishing individuals at risk for functional impairments), thus falling within the prevalence range found by Middleton and colleagues (1993).

Drawing conclusions

So what does this tell us about vulnerability compared with resilience? Some of the results on bereaved people's vulnerability to the range

Table 1: Prevalences – selected results

Health problems / disorder	Sub-group	Prevalence
Physical health difficulties (severe)	Young widow/ers	• 20% (4–6 months) • 12% (after two years) • cf. 3% married
Psychiatric disorders 1 PTSD	Partners	First two years: • 50% at 1 of 4 times • 9% at all 4 times
Psychiatric disorders 2 Clinical depression	Widow/ers	Two months after death: • 24–30% After one year: • 16%
Complicated grief	Widow/ers	• 5–33% acute grief period

of health problems/disorders outlined above are reproduced in Table 1, to illustrate the comparison with those of resilience presented in Figure 1. It becomes evident that, although a 'one-to-one' comparison is not possible (given the nature and limitations of the data collected on prevalences), a similar conclusion can be drawn from these two different approaches. Each line of research confirms that substantial minorities of bereaved individuals do suffer from severe consequences following the loss of a loved one, with a very rough but possibly conservative estimate of around 30% prevalence emerging not only from the resilience but also from the different health vulnerability areas, with the likelihood that further difficulties (and costs to the health care system) have gone undetected.

More generally, one can conclude that the growing body of research on resilience indicates much personal strength and positive outcomes to bereavement. It also points to individual difference factors that contribute to repairing the damage of bereavement (see Bonanno, 2008). Nevertheless, we should not lose sight of research on mental and physical health consequences of bereavement. The dominant message that 'bereaved people are resilient' should not be the (only) one that researchers convey to health care professionals and policy-makers. As outlined in this article, bereavement is associated with excess risk of mortality, particularly in the early weeks and months after loss. It is also related to decrements in physical health, as evidenced by the presence of symptoms and illnesses and the use of medical services. A substantial minority of bereaved people report a variety of severe psychological reactions; for some, mental disorders or complications in the grieving process itself ensue. Psychosocial intervention therefore needs to target high-risk people and those with complicated grief or bereavement-related depression and stress disorders. ■

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