
Resilience in the Face of Potential Trauma: Clinical Practices and Illustrations



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Many persons exposed to loss or potentially traumatic events manage the stresses of these experiences with minimal to no impact on their daily functioning. The prevalence of this resilient capacity has surprised researchers and clinicians alike and refocused clinical practice. We review three key points about resilience: resilience is different from the process of recovery; resilience in the face of loss or potential trauma is common; and there are multiple and sometimes unexpected pathways to resilience. We then present six clinical practices informed by the study of resilience, illustrating key points with clinical vignettes. © 2006 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 62: 971–985, 2006.

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It is a regrettable truth that most people will experience at least one violent or life-threatening event over the course of their life (e.g., Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) and almost everyone is likely to experience the pain and disorientation of losing a loved one. The stress of these experiences will tax even the hardest among us, potentially undermining our feelings of safety, threatening our sense of justice, and requiring us to adapt to altered life circumstances. Despite the near universality of these experiences, however, there are marked individual differences in the way people react to and cope with highly aversive events (Bonanno & Kaltman, 1999). Some people suffer from chronic distress, recurrent intrusive memories, or sadness for years after such experiences. Others suffer more acute reactions and then gradually return to former levels of functioning. Still others show surprisingly short-lived reactions and a relatively rapid return to their own previous levels of functioning.

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The range of reactions people exhibit when confronted with interpersonal loss or violent events has led to considerable controversy regarding people's capacity to cope with such experiences. This controversy is particularly marked in the bereavement literature, in which questions of what might be the "normal" course of bereavement, who might need or benefit most from grief-focused psychotherapy, and the efficacy of grief counseling itself have recently come under sustained critical scrutiny (Bonanno, 2004; Mancini, Pressman, & Bonanno, 2005). Even in the case of violent or life-threatening events, in which the research base for focused psychotherapy is strong, the general assumption that all people who endure such events would benefit from treatment has also been called sharply into question (McNally, Bryant, & Ehlers, 2003).

Of particular note is the growing awareness that many persons—often a majority—endure even horrific events without experiencing significant disruptions in functioning. Even when faced with the most highly aversive events, including such disparate experiences as direct exposure to the 9/11 terrorist attack, loss of a partner to acquired immunodeficiency disorder, an automobile accident, urban riots and violence, and physical assault, many if not most people demonstrate genuine resilience to their deleterious effects. We define this capacity for resilience as "the ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event such as the death of a close relation or a violent or life-threatening situation to maintain relatively stable, healthy levels of psychological and physical functioning" as well as "the capacity for generative experiences and positive emotions" (Bonanno, 2004, p. 20).

This resilient capacity has a number of implications for treatment. One clear implication is that many people effectively cope with the stresses of highly aversive events without formal treatment. A second related implication is that only a subset of persons who have endured a highly aversive event—those with clinically significant or prolonged difficulties—are appropriate candidates for treatment. In short, psychotherapy, which carries iatrogenic risks, should only be recommended for those in genuine need. A third implication is that the coping strategies of persons who demonstrate resilience can inform psychotherapeutic treatment of persons with more prolonged or significant difficulties related to a highly aversive event. In the present article, we advance three critical points: resilience represents a distinct outcome from that normally associated with recovery, resilience is more common than is generally thought, and resilience is associated with multiple and sometimes unexpected factors (Bonanno, 2004). On the basis of the study of resilience and its implications for therapy, we identify six clinical practices that can assist therapists in addressing issues of loss and trauma. We illustrate key points by using the words of people who have suffered loss or were in or near the World Trade Center during the 9/11 terrorist attacks.

Resilience Is Different From Recovery

Resilience is a complex phenomenon, as developmental researchers have long observed, resulting from a mix of factors including personality; interpersonal variables, such as supportive relationships; and the type, severity, and duration of the stressor. Thus, although people may possess characteristics that are globally associated with resilience, whether people actually exhibit resilience in the face of potential trauma can only be defined in terms of their actual outcome after a potentially traumatic event. The psychological study of resilience, therefore, dictates that we operationally define resilience as an outcome after a highly stressful event and then document the factors that either promote or detract from that outcome.

Initial studies into adult resilience in the face of potential trauma focused on how people coped with the premature death of a spouse at midlife (Bonanno, Keltner, Holen, & Horowitz, 1995). Although based on relatively small samples, these studies demonstrated that a stable pattern of low distress over time, or resilience, could be clearly distinguished from the more conventionally understood pattern of recovery. That is, bereaved persons who exhibit the recovery pattern struggle with moderate levels of symptoms and experience difficulties carrying out their normal tasks at work or in the care of loved ones, but they somehow manage to struggle through these tasks and slowly but gradually begin to return to their preloss level of functioning, usually over a period of 1 or 2 years. By contrast, persons who exhibit resilience seem to be able to go on with their lives with minimal or no apparent disruptions in functioning.

More recent studies have confirmed that resilience can be reliably distinguished from recovery. For example, Bonanno and colleagues (Bonanno, Moskowitz, Papa, & Folkman, 2005) obtained anonymous ratings of participants' adjustment from their close friends. Resilient individuals were rated by their friends as better adjusted before the loss than more symptomatic bereaved individuals and than a comparable sample of non-bereaved (i.e., married) people. For another example, in their high-exposure World Trade Center sample, Bonanno, Rennie, and Dekel (2005) extended this approach by providing participants' friends and relatives with a graphic representation and a narrative description of the prototypical outcome trajectories, including the resilient and recovery trajectories as well as chronic and delayed symptom patterns. They then asked the exposed participants' friends/relatives to assign the participant to the outcome trajectory that most closely matched their own observations of the participant's reaction from before to after 9/11. The friends/relatives were able to make this assignment with a high level of accuracy and closely matched the actual outcome trajectories derived from participants' symptom scores.

A criticism typically leveled against the idea of resilience has been that people who do not show much in the way of protracted reactions are merely exhibiting a superficial form of adjustment and, consequently, likely to manifest delayed reactions. However, no empirical study to date has identified delayed grief in more than just a few participants, and almost always representing only 2% to 3% of the total sample (for a review, see Bonanno & Field, 2001). Delayed trauma reactions have been observed with a somewhat greater frequency, sometimes ranging from 5% to 10% of exposed individuals. However, such reactions are typically characterized by elevated and near-posttraumatic stress disorder (PTSD) initial reactions that grow slightly worse over time (Bonanno et al., 2005). Thus, delayed trauma reactions are perhaps more appropriately considered as worsening trauma reactions.

It is important to note that the resilient pattern does not imply that such persons experience no upset related to the loss or aversive event, but rather that their overall level of functioning is essentially preserved. For example, in a sample of bereaved individuals who were followed from several years before the death of their spouse to several years afterward, almost half showed no clinical depression at any point in the study (Bonanno et al., 2002). However, when questioned about their experiences soon after the loss, about 75% of those showing a resilient outcome trajectory reported experiencing intense yearning (painful waves of missing the spouse) as well as pangs of intense grief in the earliest months of bereavement. Furthermore, all but one of the bereaved people who showed the resilient trajectory reported having experienced intrusive and unbidden thoughts about the loss that they could not get out of their mind, and that they found themselves ruminating, or going over and over what happened when the spouse died, in the earliest months of bereavement. The key difference here appears to be that resilient individuals are able to manage these difficult experiences in such a manner that they do not interfere with their ability to maintain functioning.

A key to the way resilient people coped so well with the death of their spouse despite the painful nature of their grief was suggested by several findings from a follow-up study (Bonanno, Wortman, & Nesse, 2004). First, resilient people were better able than other participants to gain comfort from talking about or thinking about the spouse. For example, they were more likely than other bereaved people to report that thinking about and talking about their deceased spouse made them feel happy or at peace. Second, resilient bereaved people also reported the fewest regrets about their behavior with the spouse, or about things they may have done or failed to do when he or she was still alive. Finally, resilient individuals were less likely to search to make sense of or find meaning in the spouse's death.

Resilience Is Common

Resilience to Loss

Wortman and Silver (1989) were among the first to note that many of the common assumptions or "myths" about coping with loss were in fact not supported by empirical evidence. Among these myths was the idea that distress is inevitable after the death of a loved one and that the absence of distress during bereavement is necessarily pathological.

Recent prospective studies have begun to reveal considerable individual differences in grief reactions (Bonanno & Kaltman, 2001). Generally, a minority of bereaved people, usually between 10% and 15%, suffer chronic grief symptoms beyond the first year after a major loss. This small proportion underscores the important personal and public health costs of bereavement. However, bereavement researchers and clinicians may have overgeneralized the experience of chronically grieving individuals to the normal population.

In fact, most people do not appear to suffer prolonged or extreme disruptions in functioning, and many appear to evidence a striking absence of dysfunction. For example, researchers in one study examined a number of different grief symptoms and reactions by using survey data from 350 widows and widowers (Shuchter & Zisook, 1993). At 2 months after the loss, 70% of their sample reported that they found it "hard to believe" that their spouse had actually died. However, more extreme cognitive difficulties were only exhibited by a considerably smaller portion of the sample. Even in the earliest point of bereavement, 2 months after the death of their spouse, only about one-fifth or fewer of the bereaved participants reported that they had difficulties concentrating (20%) or making decisions (17%). Again, although these data indicate that many bereaved people struggle with disruptions in their functioning in the first months after a loss, many and sometimes the majority do not.

More compelling evidence for the prevalence of resilience is found in the Changing Lives of Older Couples (CLOC) study. The resilient bereaved in this study showed little or no depression at each assessment point in the study, which began on average 3 years before the death of a spouse and continuing through 18 months after the spouse's death. The participants exhibited few grief symptoms (e.g., anger, yearning) during bereavement. Furthermore, the prevalence of resilience remained relatively constant regardless of whether the trajectory was defined by the simple absence of change from before to after bereavement or by more emergent statistical approaches (e.g., hierarchical cluster analysis).

Resilience to Potential Trauma

Although there is great variability in response to potential trauma events, resilience in the aftermath of potential trauma has been shown to be surprisingly common, even after the

most pernicious stressor events. The majority of persons exposed to violent or life-threatening events do *not* go on to develop PTSD, and a surprising proportion demonstrate resilience to such experiences. The first research that explicitly documented the resilient outcome trajectory after potential trauma were several studies of the September 11 terrorist attack in New York City. In one study, resilience was defined using the relatively conservative criterion of having few or no trauma symptoms and no depression at either 7 or 18 months after 9/11 (Bonanno, Rennie, et al., 2005). This pattern, which was validated by ratings from participants' friends and relatives, was evidenced by slightly more than one-third (35%) of the sample.

This study was unique in several ways. First, there were an unusually high proportion of chronic symptom reactions (29%) in the sample. Second, most participants in the study had directly witnessed death and serious injury to others and were themselves in serious physical danger during the attacks. Together, these findings suggested that at more extreme and pernicious levels of trauma exposure, resilience would be somewhat reduced but nonetheless prevalent.

Bonanno and colleagues (Galea, Bucchiarelli, & Vlahov, 2006) recently explored this possibility in a recent study of resilience across a range of exposure conditions by using a large ($N = 2,752$) probability sample of people living in or near New York City at the time of the September 11 terrorist attack. This sample was ideal for the study of resilience because it was representative of the broader New York population, as evidenced by the 2000 census data for the area, and provided access to subgroups that varied greatly in levels of exposure so as to produce noticeable variation in PTSD reactions (Galea et al., 2002).

In this study, resilience was defined by using a method of normative comparison similar to that employed in previous studies (Bonanno et al., 2005). When using this method, the prevalence of resilience for the entire contiguous New York area was 65.1%. Even among the groups with the most pernicious levels of exposure and highest probability of PTSD, the proportion that were resilient tended to be around 50% and never dropped below one-third for any level of exposure. The highest proportions of PTSD were evidenced among people who were in the World Trade Center (25.4%), were physically injured in the attack (26.1%), or had suffered the compound exposure of having lost a loved one during the attack *and* having witnessed the attack in person (31.3%). Despite these high prevalence rates for PTSD, resilience was nonetheless observed in 53.5%, 32.8%, and 33.4% of the respondents with similar levels of exposure, respectively. Together these findings indicate that although resilience is reduced at the highest and most demanding levels of exposure, it is nonetheless often still seen in up to half of the persons exposed and always remains prevalent enough to be considered a common and natural response to potential trauma.

The Heterogeneity of Resilience

In New York City after September 11, resilience was most prevalent among married as opposed to unmarried, divorced, or separated individuals. Resilience was also more common among younger people and males rather than females. Some surprising findings also emerged in these data. For example, although whites showed relatively high levels of resilience, the highest proportions were among Asian Americans. Additionally, although years of education showed a direct relationship to resilience, and more education was associated with more resilience, personal income showed a more complex association with resilience. People at low income levels tended to have less resilience and people at higher levels more. However, resilience was less common among people who had moderately high income.

Personality or coping style also plays a role in fostering adult resilience. It appears that there are at least two different styles of coping that often predict a resilient outcome: flexible adaptation and pragmatic coping. First, most people capable of resilience in the face of adversity are genuinely healthy people. These individuals appear to possess a capacity for behavioral elasticity or *flexible adaptation* to impinging challenges. Examples of such variables are ego resilience and hardiness. Second, the idea of *pragmatic coping* stems from the fact that some people are able to achieve resilience to adversity by means that may not be adaptive under normal circumstances. Examples of this type of strategy include repressive coping, dismissive attachment, and the habitual use of self-enhancing attributions and biases.

Findings of this sort underscore a crucial point of departure in comparisons of resilience among children and adults. Whereas childhood resilience is typically understood in response to enduring corrosive environments, resilient coping among adults is more often a matter of coping with an isolated and usually (but not always) brief stressor event. The key point is that whereas corrosive environments require longer-term adaptive solutions, isolated stressor events often oblige a more *pragmatic* form of coping, a whatever-it-takes approach that may involve behaviors and strategies that are less effective or even maladaptive in other contexts.

There is now substantial evidence that resilience to interpersonal loss or violent or life-threatening events is neither a reflection of extraordinary coping abilities nor a pathological inability to experience the pain of loss. Rather, resilience appears to be a normative expression of the human capacity to cope with and even thrive after the most extreme life events. What does this capacity tell us about early psychotherapy for persons who have suffered a loss or endured a violent or life-threatening event?

Traditional Grief Counseling Approaches

A widespread assumption among clinicians and researchers alike is that active efforts are required to cope with loss, a process called *grief work*. Models for grief counseling frequently employ specific procedures to promote the bereaved person's efforts to work through the loss. For example, bereaved persons are implored to accept the reality of the loss, to review specific memories and express feelings (particularly negative ones) associated with the lost loved one, and to make active efforts to relinquish their attachment (e.g., Rando, 1993).

A related clinical assumption is that the absence of overt distress in response to bereavement is itself indicative of a pathological condition, because it suggests that the person is inhibiting or dissociating from negative feelings or lacked a strong attachment to the deceased. When a person does not display overt distress, he or she may be presumed to be avoiding the "tasks" of grieving. Such responses to loss have often been thought to portend later and much more severe difficulties that could be prevented by engaging in "grief work" processes. But rather than being seen as denial or a reflection of poor attachment to the deceased, which are the most common explanations for absent grief, low levels of distress after the loss of a loved one can be viewed as evidence of adaptive resilience to its potentially deleterious effects.

Given the assumptions embedded in the grief work perspective, it is not surprising that a variety of interventions have been targeted specifically at persons suffering from bereavement. What is surprising, however, is that *existing clinical interventions for bereavement have proved to be generally inefficacious* (Jordan & Neimeyer, 2003). Two recent meta-analytic studies compared randomly assigned grief treatment and control groups. In

contrast to the generally robust effect sizes typically observed for psychotherapeutic outcomes, grief-specific therapies produce only small and relatively inconsequential effects (Neimeyer, 2000). Importantly, in one of these analyses, 38% of the individuals receiving grief treatments grew worse relative to no-treatment controls (Neimeyer, 2000).

Grief work may be most indicated for persons who internalize their grief symptoms. Internalizing difficulties, such as self-recrimination, hopelessness, and sadness, are thought to be more responsive to therapeutic procedures that focus on insight; externalizing symptoms, such as substance use and acting out behaviors, are thought to be more responsive to skill- and symptom-focused interventions. There is evidence that internalizing responses to bereavement may predispose a person to a more severe grief reaction (Nolen-Hoeksema, Parker, & Larson, 1994), further supporting the idea that grief work may only be indicated for a small subset of bereaved persons.

Why have grief counseling interventions been generally ineffective? One explanation is that the treatments may often be targeted to the wrong population. It seems probable that a grief-focused intervention would prove particularly ineffective for persons whose chronic symptoms are less a function of grief than of preexisting psychopathological conditions (Mancini et al., 2005). Another explanation for the lack of efficacy found for grief therapies is the overinclusion of bereaved individuals who have moderate or minimal symptoms and thus have no need for treatment (Jordan & Neimeyer, 2003). Because of the smaller scope for improvement for this group, the inclusion of persons with moderate or minimal symptoms in efficacy studies of bereavement interventions would almost certainly diminish the overall impact of the treatment. Still another reason for the ineffectiveness of grief counseling is that the therapeutic models typically used are founded on mistaken notions of the grief work perspective. Because these ideas have not been supported by research, many of the underlying principles of traditional grief counseling lack empirical support.

In the context of these considerations, it is with considerable optimism that we point to the effectiveness of a new bereavement intervention that specifically targets only those bereaved individuals who have the most extreme and complicated grief reactions (Shear, Frank, Houck, & Reynolds, 2005). Shear and associates' method is also differentiated from previous types of bereavement intervention in that it utilizes treatment elements with proven effectiveness for other related problems. Because the approach involves a number of different components, it is not yet clear which of these components is the active ingredient of the treatment. Nonetheless, this new method represents an important step toward an effective treatment for bereavement that is grounded in empirical evidence and that targets those who might need it most.

Trauma Interventions and Critical Incident Debriefing

In contrast to the questionable evidence base for traditional grief counseling models, there is substantial support for the usefulness of interventions for trauma reactions that meet PTSD criteria. The active ingredient of trauma interventions has not been explicitly identified, but there is evidence for positive results with exposure therapy (Foa et al., 1999), which involves confronting memories of the traumatic stressor (imaginal exposure) and situations that evoke unrealistic fears (in vivo exposure), and with eye-movement desensitization therapy (Taylor et al., 2003), in which imaginal exposure, free association, and other techniques are combined with an external visual stimulus (Shapiro, 1995).

A particularly controversial approach has been psychological debriefing. Originally developed as a brief group intervention to help ease psychological stress among emergency

first responders, psychological debriefing has gradually been applied in an individual format and often indiscriminately as a blanket intervention for the entire population of people exposed to a potential traumatic event. Indeed, one of us (A.D.M.) recalls being approached the night of September 11 and handed a card as he exited a commuter train, with the suggestion to call the number if he needed help. The immediate response of the writer was to wonder whether he did need help, even though he had not previously considered his response worthy of intervention, as the event was still unfolding.

An alternate approach to critical incident debriefing has been proposed in which individuals are screened for possible risk factors for the development of PTSD, including previous trauma, few close relationships, and anxiety symptoms (Litz, Gray, Bryant, & Adler, 2002). Unlike the one-size-fits-all orientation of psychological debriefing, this approach is designed to target individuals who have symptoms or risk factors and to exclude individuals who display resilience. In this way, Litz and colleagues' method is consistent with the essential distinction between recovery and resilience described earlier. However, it is important to note that in studies in which early intervention resulted in a worse outcome than that of nontreatment controls, the negative effects were most prominent among survivors who had the highest initial symptom levels (Mayou, Ehlers, & Hobbs, 2000). Such sobering findings make a strong case for caution in applying early interventions and illustrate the imperative need for further research on these issues.

In addition to the cautionary tales regarding grief counseling and psychological debriefing, there are a number of positive messages and recommendations that can be derived from research on resilience. One important point is that it is no longer tenable to believe that all persons who endure a highly aversive event are certain to benefit from psychotherapy. It is increasingly clear that only those persons who demonstrate significant or prolonged disruptions in functioning should be candidates for intervention. Thus, the coping processes of people who demonstrate resilience—defined as the ability to maintain relatively stable, healthy levels of psychological and physical functioning in the face of an extreme life event—should generally be allowed to unfold without formal treatment. On the other hand, substantial percentages of people do, of course, have significant difficulties coping with extreme life events and thus are appropriate candidates for treatment. It may be possible eventually to identify individuals at suitable risk to warrant early prophylactic measures. However, as the sobering research on debriefing has shown, we do not yet have sufficient assessment markers to detect those individuals.

The research reviewed here makes clear the necessity for rethinking some prevalent approaches to loss and trauma. We now propose clinical practices for loss and trauma that are based on the study of resilience. To illustrate our main points and provide some clinical texture, we use quotations from people who have recently endured the death of a spouse or who were in or near the World Trade Center on September 11, 2001.

Clinical Practice 1: Do Not Recommend Therapy for All Bereaved Persons

A significant percentage of bereaved persons can be expected to demonstrate resilience to the negative effects and thus do not require formal treatment. Although bereaved persons who struggle with moderate levels of symptoms and experience some difficulties carrying out their normal tasks at work or in the care of loved ones may appear to be candidates for therapy, evidence generally does not support a grief-focused treatment for this group of bereaved persons either. Rather, though they experience some clear difficulties in the aftermath of the loss, bereaved persons who exhibit this pattern of grief typically slowly

begin to return to their former level of functioning, usually over a period of 1 or 2 years. This process should generally be allowed to unfold without formal treatment, unless the symptoms worsen or are excessively protracted. The subset of bereaved persons for whom psychotherapy is most clearly warranted are those who have particularly severe symptoms of grief soon after the loss or whose symptoms persist unabated for a long period (at least 1 year). We would note that this reaction represents a relatively small percentage of bereaved persons, usually 10%–15%.

Clinical Practice 2: Beware of Pathologizing Resilient Responses to Loss or Traumatic Events

Another important consideration involves the common tendency, in part derived from widely held cultural assumptions, to interpret resilient responses to loss or traumatic events as “denial” or a pathological refusal to experience pain. We would propose that clinicians be particularly mindful of this tendency to assume that all persons should experience pronounced difficulties in response to extreme events. Given the overwhelming evidence that resilient coping is associated with healthy functioning, it seems increasingly clear that resilience reflects an inherent and beneficial human capacity for managing extremely stressful events.

Clinical Practice 3: Be Attentive to Processes of Identity Continuity and Change

The emotional upheaval surrounding the death of someone important in one’s life or the experience of a violent or life-threatening event can be particularly damaging to a person’s underlying sense of identity. Familiar routines or rituals are often disrupted; social roles may be dramatically changed; a person’s feelings of safety in the world may be undermined. Deeply grieving people often report that they feel as if a piece of them is missing, as if the self is incomplete. Likewise, traumatized individuals commonly experience the self as damaged or inferior. By contrast, one of the characteristics that seem to distinguish resilient individuals is that despite the sometimes convulsive changes that may accompany potentially traumatic events, they are able to experience an underlying continuity in the self and, armed with that continuity, to respond flexibly to the demands of a changed world. For example, after the untimely death of a spouse, one resilient bereaved person remarked:

Basically, I’m, uh, the only thing that’s missing, that’s changed is she’s not here. I don’t think I’m any different for it, um, other than you know, now I know what loss means. And I know what a devastating event is, uh, you know, and I . . . and there are moments when I’m by myself. . . . I’m terribly lonely, um, but I’m still doing the same thing, doing the same job, uh, making the same money, living in the same house, all that. You drive in the same cars, doing the same outside activities running with the same friends and people. No, nothing has changed in that regard, the outside stuff. I mean there’s still that loneliness at times but those moments get further and further apart. (Bauer & Bonanno, 2001)

A similar sense of continuity is also described by those resilient to other types of potentially traumatic events. For example, although he had lost his place of work and nearly lost his life during the September 11 attack in New York City, one survivor stated: “I am alive. Each day when I wake up, I realize that I am still alive. The horror of that day is still there, but for some reason I survived. I almost feel guilty about it. I lost something but I still have what I enjoy in life. I can still run and swim, and I can still enjoy the

theater. I can continue to do all those things. Maybe I enjoy them even more now that I know how wonderful that is.”

What is perhaps most notable here is that despite the experience of loss and a brush with death, these individuals nonetheless manage to retain an underlying experience of continuity in daily life, a particularly valuable resource in times of stress.

How can therapists promote such continuity? One strategy may be simply to encourage the client to participate in ordinary activities and to continue to fulfill social role obligations. Another is to help clients identify and take stock of what is continuous in their life, from friendships to family relationships to hobbies to a weekly basketball league.

It is also possible that the experience of loss or trauma may promote a changed and expanded understanding of the possibilities of self. One of the hallmark characteristics of resilient individuals seems to be that they retain the enduring capacity for generative experiences. They may seek to broaden their behavioral repertoire and redefine their beliefs, trying out new roles and new relationships, engaging in new activities, and testing new values. Here is one bereaved person describing a renewed assertion of self:

I think the major change I've noticed in myself over the past year is, um, more accepting of just things that happen in life and not getting upset and not forcing things. . . . Um, there are also different things that are important to me now than there were then. I mean, friends were important then; they're more important now for different reasons, uh, on a deeper level. I'm more selective about those people I spend time with. I'd rather be alone than be with people I really don't enjoy or, uh, who don't understand me or who I don't have an affinity for. I'm really amazed at the strength that I've exhibited over the past year and the just sort of tenacity to get on with life.

A resilient survivor of a life-threatening event similarly reported, “My family expected me to stay home for a while. I think my friends did too. But I couldn't see it. People at work need me. That is what I do. I couldn't let those people down. That's who I am. It's my job and I need to do it. I wouldn't be me otherwise.”

What about people who take longer to rebound from loss or trauma, people who evidence the classic recovery trajectory? We can in fact also find evidence of identity continuity, albeit in a more tenuous form, in this group. These vignettes are particularly interesting, however, in that they suggest routes for possible clinical intervention. As one bereaved person put it:

I don't know yet what I'm becoming or what I am. I have less of a sense of identity than I did before. I wouldn't go so far as to say as it does with some of the questionnaires, “Have you lost your sense of identity?” I mean I feel like me, whoever that is, and, of course, my other roles are still there but I'm more than just my role. I mean I'm not just a mother and a wife and I'm not the wife anymore—I'm still the mother—but the rest of what I am feels all very ill defined right now. . . . I have less sense of self. Not that my self is less; just that it's—I don't quite know what it is anymore. I used to have things that I really wanted to do still and wanted to maybe be still. . . . Now that seems unimportant so I don't really know . . . but I don't quite know what to be . . . so I feel sort of in limbo still. . . . I guess I am basically the same person. I have this overall sense of being me the way I've always been me, whatever that is.

Here there is room for professional guidance. Indeed, this kind of internal engagement with the self may be particularly amenable to further development in a therapeutic setting. A variety of strategies may facilitate this process, including helping the person to identify his or her self-understanding, discussing the difficulties inherent in trying out new roles, identifying goals that might go with this renewed self, or even assigning homework related to these new roles. These strategies may help the person to consolidate

a renewed sense of self and yet retain a sense of continuity with the past, a critical task for a person struggling with his or her own self-definition.

Clinical Practice 4: Encourage the Appropriate Expression of Positive Feelings

Another important component of resilience is positive emotion. A number of studies have found that the expression of negative emotion is associated with more distress and long-term difficulties and that positive emotional expression is consistently associated with better outcomes (Bonanno et al., 1995; Bonanno et al., 2005).

How can these findings be translated into clinical practice? One way would be for clinicians *not* to assume that all persons who have experienced loss or a potentially traumatic event need to express negative emotions associated with loss. Adopting this stance would not preclude a focus on painful or negative feelings. Rather, we are suggesting that the expression of negative emotions should not be seen as necessary or inherently therapeutic and nor should the absence of such expression be viewed as a form of denial. Other ways that clinicians could enhance positive emotion would be to provide opportunities for clients to reflect positively on their relationship with the deceased and to encourage their involvement in positive experiences. Thus, the therapist could ask the client to recall positive aspects of the relationship, affirm the client's right to have pleasurable experiences even after a loss, and encourage the client to engage in pleasurable activities even if they seem to be distractions from the upset the person is experiencing.

In our experience, bereaved people often feel they are "not supposed" to have many positive experiences, or that it is simply not appropriate to laugh openly while grieving, especially in the early days and weeks of bereavement. Yet, we see no reason for this kind of prohibition. Obviously, one would need to observe social conventions for decorum during culturally sanctioned mourning ceremonies. But beyond such occasions, we suggest that it could only benefit the bereaved to be encouraged to enjoy and share in positive and humorous moments with others as freely and as fully as possible.

Clinical Practice 5: Promote the Flexible Regulation of Emotional Expression

Another important characteristic of resilience is the capacity for flexible regulation of emotional expression. Recent research has suggested that adjustment is less dependent on the use of particular strategies than on the *flexible application* of coping strategies in a manner that corresponds with the nature of the stressor. In a similar vein, emotion theorists have also argued that whether one expresses or suppresses emotional expression is not as important for adjustment as is the *ability flexibly to express or suppress as demanded by the situational context*. Consistently with this logic, Bonanno and associates (2004) showed that resilience among New York City college students in the aftermath of September 11 was not clearly associated with either emotional expression or emotional suppression. Rather, the best predictor of adjustment in the 2 years after September 11 was flexibility in emotion regulation, measured as the ability to engage in either suppression or expression when instructed to do so. Although we know of no attempts to teach these kinds of skills directly, we hold the strong hunch that this kind of flexibility might be learned or with practice improved among individuals who lack such abilities.

The therapist may wish to assess whether a client habitually or inflexibly employs particular strategies for managing strong feelings. We would further note that a particular reliance on suppression—the inhibition of behaviors associated with a specific emotional experience—may exact real costs on a person's functioning. Because of the cognitive

resources it requires, the use of suppression typically inhibits the person's ability to absorb information (emotional enhancement shows similar effects but is a less routine strategy) and can impair interpersonal functioning (Gross & John, 2003), potentially depriving the person of useful resources. As we describe in the next section, interpersonal resources are a vital asset in adapting to stressors.

On the basis of the findings on flexibility in emotional regulation, therapists may wish to help clients develop different strategies for managing emotion, which could promote elasticity in their use. One alternate strategy to emotional suppression, for example, is cognitive reappraisal, which involves construing a potentially stressful event in benign or growth-oriented terms in order to diminish its emotional impact. For example, a bereaved person who is preparing to attend a memorial for his or her loved one may feel intense worry over the potential of being overwhelmed by the event. The use of suppression in such a context would likely entail some costs in deriving support from others and in cognitive integration of the loss. In contrast, by using cognitive reappraisal, the memorial could be construed as an opportunity to experience a reconnection with the lost loved one and to share that experience with close others. As is readily apparent, interventions that promote this type of cognitive restructuring are standard therapeutic techniques. Nevertheless, given the findings on resilience and flexible coping, we think it important to emphasize their potential role in adaptation to extreme stressors.

Clinical Practice 6: Encourage Appropriate Self-Disclosure

Ample research has identified the adaptive consequences of talking about acute stressors or trauma, a process that appears to promote important processes of cognitive integration and restructuring. In the context of bereavement, however, the positive effects have been less clear. Indeed, researchers have recently examined the effects of written and verbal forms of emotional disclosure during bereavement and found no evidence that the disclosure of grief-related emotion improved adjustment (M. Stroebe, Stroebe, Schut, Zech, & van den Bout, 2002). Given such findings, it is worthwhile to consider an important moderating factor in disclosure: social constraints or the extent to which others are seen as available and willing to listen. Without a supportive environment, the benefits of disclosure are diluted.

The important role of social constraints against disclosure was highlighted in a recent study examining self-enhancement (overly positive views of the self) and coping with high exposure to the September 11 terrorist attacks (Bonanno et al., 2005). Persons who had a self-enhancing bias were more likely to show resilience to the potentially traumatic effects of the attacks, but these effects were fully mediated by their perceptions that others would be inclined to listen to their disclosures about the experience. In other words, one of the reasons self-enhancers coped well with this tragedy was that they viewed others as willing to listen to them talk about it. These and other findings have clearly demonstrated the central role that perceived qualities of the social environment play in disclosure's beneficial effects.

In terms of clinical intervention, the findings on disclosure suggest that, rather than unilaterally promoting the disclosure of negative feelings about the loss and discounting the expression of positive ones, clinicians should adopt a neutral, nondirective stance with regard to disclosure. The therapeutic context should of course be a safe environment in which disclosure is supported and insight and meaning construction are enhanced. However, it may be equally if not more important to help clients assess their own social milieu—the personal world of “would-be listeners” (Harber & Pennebaker, 1992)—so as

to better determine how and when effective disclosure in broader contexts might be achieved. As Kelly and McKillop (1996) so astutely noted, the usefulness of verbally disclosing traumatic experiences with others depends at least in part on whether or not the social environment is perceived to be receptive, supportive, or willing to offer help. We concur wholeheartedly with their wise counsel that talking about traumatic events may only be helpful when listeners are discreet, nonjudgmental, or likely to help. Otherwise, it may be preferable to help clients find other pathways and ways of coping. Here again we see the importance of flexibility in coping.

Clinical Issues and Summary

There is clearly still much to learn about the role of resilience in psychotherapy. Perhaps one of the most important implications of the study of resilience is that it may lead to new treatments for those who fare less well during bereavement. In this article, we have identified six clinical practices derived from the study of resilient coping strategies. Although these practices are by no means exhaustive, we hope that they can inform strategies for addressing the unfortunately common issues of loss and trauma that present themselves in therapy. We would emphasize that these practices are not intended to replace proven treatments for PTSD. Rather, we hope that these practices might tune the ear of the practicing therapist and help inform, in a more general sense, his or her approach to loss and trauma, which may include determining when not to recommend treatment.

One final important area is the enormous question of ethnic and cultural variations in resilience during bereavement. Western, independence-oriented countries tend to focus more heavily than collectivist countries on the personal experience of grief (Bonanno, Papa, Lalande, Zhang, & Noll, 2005). What are the implications of such cultural beliefs about the self for the treatment of persons suffering from trauma or bereavement? Unfortunately, little is yet known about the extent to which loss and trauma reactions might vary across cultures. Some evidence suggests that bereaved people in China recover more quickly from loss than do bereaved Americans and that for the Chinese coping is enhanced by a continuing psychological bond with the deceased. By contrast, American bereaved persons who maintain a bond with the deceased do less well. This suggests an even subtler implication of resilience for psychotherapy—that processes of identity continuity and reformation may have cultural variants, further underlining the heterogeneity of people's reactions to and strategies for coping with potentially traumatic events. Perhaps even more intriguing, these data raise the question of whether different cultures may learn from each other about effective and not so effective ways of coping with extreme adversity or whether the salutary effects of such practices are inherently bound to the cultures in which they emerged.

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