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The Effectiveness of Individual Counseling, Group Therapy, and Self Help as Treatment Methodologies in Working with the Widowed

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THE EFFECTIVENESS OF INDIVIDUAL COUNSELING, GROUP THERAPY, AND SELF HELP AS TREATMENT METHODOLOGIES IN WORKING WITH THE WIDOWED

by

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VITA

The author, Patricia Forrester Martin, is the daughter of George Joseph Forrester and Colleen (Dirkman) Forrester. She was born June 17, 1943, in Toledo, Ohio.

Her elementary school education was obtained at St. Angela Hall in Toledo, Ohio. She attended St. Ursula Academy, also in Toledo, where she graduated in 1961.

In September 1961, she entered Villanova University, and in June 1965, received the degree of Bachelor of Science in Nursing.

Her work experience has been varied. She has been a staff nurse in Boston, Massachusetts, and has served as a hospital supervisor and an assistant education and training coordinator while a member of the United States Army Nurse Corps. She also worked with retarded adults in the Chicago area. She has been a lecturer at various colleges on loss issues, self-help and the widowed experience. She was the leader of a self-help group for widows and has run groups for high school students following a death of a family member, peer or teacher. At the present time she works as a counselor for a truants alternative program in Lake County, Illinois.

She was married in December 1967, and her son was born in July 1969. She was widowed in 1976.

DEDICATION

Forrest R. Martin

1943-1976

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CHAPTER I

INTRODUCTION

At some point in life everyone experiences the loss by death of someone close to them. Many individuals will have to suffer the pain of losing a spouse. Many people, both counselors and others, will attempt to give comfort and support to someone who is grieving. Death and bereavement may seem like an unpleasant topic for discussion, but knowledge of what to do and say can make both experiencing and witnessing grief much easier. No amount of study can replace actual experience, but study can deepen understanding and make a person more effective in dealing with the problems posed by grief (Parkes, 1979).

Death, dying, and bereavement involve a person in the process of mourning. In society as it is today, this process is often misunderstood. As familiarity and contact with death has declined, our society and many of its institutions have grown insensitive. Few seem to understand or recognize the need for grief work. Professionals often confuse normal grief with pathology and/or see the need for intensive therapy. The bereaved are often given strong sedatives and expected to suppress feelings and emotions in public and private as well. When Elizabeth Kubler-Ross first approached the staff of a large Chicago hospital with the request that she would like to do a study on dying patients, she was informed that in the entire 600-bed hospital there was not a single dying patient (Fulton in Silverman et al., 1974). All of this makes

the process of mourning very difficult for the bereaved. Grief and mourning are a normal and natural part of life. Most people work through it successfully. Even though grief is a part of normal growth and development, the death of a loved one and the subsequent mourning period can be a terrible and terrifying experience. Feelings can run the gamut from confusion to despair and loneliness. The bereaved individual might feel both energized and exhausted within moments of each other. There is often guilt, anger, and fear. Grief is a complex combination of reactions and feelings. Grief hurts!

Although grief is a different and individual process for each person, it is determined by a combination of psychological, social and physiological factors. Rondo (1984) relates the following areas which can affect grief.

1. Psychological includes such factors as: coping behaviors, personality and mental health, the relationship with the deceased, past experiences with loss, the level of maturity and intelligence, social, cultural, ethnic, religious background, the educational, economic and occupational status, and the presence or absence of other stresses or crises.

2. Social includes such factors as: the availability of the support system, the help and acceptance of its members; the bereaved's socio-cultural ethnic, religious/philosophical background; the educational, economic and occupational status; and the presence or absence of the funeral.

3. Physiological includes such factors as: the use of drugs and sedatives, good nutrition, rest, sleep, and exercise to maintain

physical health.

The purpose of this thesis is to examine how the widowed deal with the pain of losing a spouse. Included in this will be a discussion of individual counseling, group counseling, and self-help groups as each specifically relates to the bereavement of widows and widowers. Each treatment methodology will be discussed. A chapter on studies comparing these methods will be included. Examples of Chicago area programs will be given. These will be used to highlight some of the services that are available to the widowed. The final chapter will include suggestions for further research.

Historical Description of the Grief Process

In 1917 Sigmund Freud published "Mourning and Melancholia." In this classic work he tried to stress the importance of mourning and to describe the normal process of grief. Although death and grief have always been a part of life, it was not until recent years that researchers began to study the process of grief and mourning. Although some of our terminology has changed since Fritz (1930) studied "fifteen fatherless families" (p. 553), much of it has remained the same. In the early 1930's Eliot (1932) described bereavement as a crisis. He discussed feelings of abandonment, shock, and denial and included guilt and sometimes anger. He also discussed persistent longing and a disruption of the usual pattern of life.

Fulconer (1942) described the grieving process in terms of stages beginning with shock and ending with the repatterning of a new life. Both Eliot and Fulconer recognized that grief was not just a

single stage, but divided it into phases leading to readjustment. Eric Lindemann (1944) in his landmark study of the survivors of the Cocoanut Grove nightclub fire in Boston, cited five major characteristics of grief. They are: (a) somatic distress-choking, sighing, shortness of breath, exhaustion and digestive disturbances; (b) preoccupation with the image of the deceased--this goes along with a feeling of distance from other people; (c) guilt--the survivors blame themselves for the death; (d) hostile reactions--irritability, anger, and some worry that this might lead to insanity; and (e) loss of patterns of conduct--the sense of normal activity is gone after the death of the spouse. Lindemann's classic description of the acute reaction to bereavement is still applicable today.

> The picture shown by persons in acute grief is remarkably uniform. Common to all is the following syndrome: sensations of somatic distress occurring in waves lasting from twenty minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing, an empty feeling in the abdomen, lack of muscular power, and an intense subjective distress described as tension or mental pain. (p. 141)

Peter Marris (1958) studied London widows, most of whom had been bereaved an average of two years. These women still felt that their lives were empty and that they had not reached recovery and readjustment. Engel (1961) described grief as a healing process. His description of the normal stages of grief are: shock and disbelief, developing awareness, restitution, resolving the loss, idealization, and the outcome.

John Bowlby (1961) has written extensively on loss. He differentiated three main phases in grief: the urge to recover the lost object, disorganization and despair, and reorganization. Bowlby's

attachment theory conceptualizes the tendency for human beings to make strong affectional bonds, and he describes what occurs when those bonds are broken. The basis for these attachments, according to Bowlby, develop in early life and come from a need for security and safety. Parkes (1970) has researched and studied grief in great depth. He discusses four phases of mourning. The first is a period of numbness which occurs soon after the time of the death. The second phase is one of yearning. The bereaved tends to deny the permanence of the death and longs for the deceased to return. The third phase is disorganization and despair. It is difficult for the bereaved person to function even in familiar surroundings. In the final phase the bereaved begin to put their lives back together. There is much overlap in the works of Bowlby and Parkes. As of 1980, Bowlby, who originally omitted the phase of numbness, now endorses the same phases as Parkes.

Elizabeth Kubler-Ross (1969) in her pioneering work On Death and Dying discussed the five stages through which a person proceeds when dying. Since then these stages have also been used to identify the grief of the bereaved. The stages denial and isolation, anger, bargaining, depression, and finally acceptance have been the subject of much discussion in recent years, as some felt that these stages were to be gone through in order. The author has stated, however, that this was never her intention.

Parkes (1972) has described grief as an illness from which the mourner will eventually recover. The controversy as to whether grief is a disease or merely part of the human condition continues (Lindemann, 1944; Parkes, 1965; Silverman and Copperband, 1975). However, Silverman

(1981) states that "if grief is indeed an illness, the mourner must assume that something is wrong with her as she is assailed by the intense and unfamiliar feelings following her loss and that she can be 'cured' of pain and disruption by the right treatment" (p. 25). It seems that this view of grief being a temporary illness just reinforces the idea of helplessness. It would be more reasonable to help the widow understand that the pain of grief is a normal reaction to the death of a spouse as Lindemann (1944) discussed (Silverman, 1981).

Moses (1984) in his description of grieving discusses states of grieving rather than stages, since stages imply order and steps that he does not feel occur in an organized manner in grief. Moses states that people feel different things at different times and often have many confusing feelings all at the same time. Moses describes grief as a process in which the bereaved separates from a significant lost dream, fantasy, illusion or projection into the future. Grieving is something we do, a process that goes on, something we experience.

Worden (1982), although not disagreeing with the concept of stages and phases, feels that they imply passivity, something that just has to be experienced. He suggests on the other hand the idea of tasks, which implies action and is more consistent with Freud's idea of "grief work." Rondo (1984) feels that grief is actual work which uses both physical and emotional energy. Grieving also entails a longing for not only the person but also for the "hopes, dreams, fantasies and unfulfilled expectations that the griever held for that person and for their relationship" (p. 20). Along with Worden's and Rondo's encouraging writings and their suggestions of actively working through tasks, perhaps

it can then be implied that mourning can be influenced from the outside. This then can be a basis for reaching out by the widowed for help from a counselor, support group or self-help group.

Worden (1982) formulated the following tasks of grieving: first, to accept the reality of the loss; second, to experience the pain of grief; third, to adjust to an environment in which the deceased is missing; and fourth, to withdraw emotional energy and reinvest it in another relationship. These tasks will be covered in more depth in Chapter II. Along the same lines, Parkes and Weiss (1983) have also suggested the idea of action oriented tasks. Their belief is that individuals who recover from bereavement will not return to being the same people they were before the death of their spouses. The authors do not suggest however, that the widowed block out and forget the past. They suggest the following distinct tasks in the recovery process, some of which seem similar to Worden's tasks. The first task is that the loss be accepted intellectually. The second task is that the loss be accepted emotionally. The third task that the individual's model of self and outer world change to match the new reality.

This thesis will take an action oriented approach to bereavement as have Worden, Parkes, and Weiss. This research also hopes to show the benefit to a bereaved individual of receiving help and support from either individual counseling, group counseling, or a self-help group, or from a combination of the above.

Incidence of Mortality & Morbidity in Widowhood

In the last 20 years much in the way of studies has been done on the mortality and morbidity of widows. In discussing which widows

would be the most at risk, Parkes (1972) states:

> ...from the evidence available, the high risk case would be a young widow with children living at home and with no close relatives living nearby. She would be a timid, clinging person who reacted badly to separation in the past and had a previous history of depressive illness. Closely bound up with her husband in an over-reliant or ambivalent relationship, she would not have prepared herself for this unexpected and untimely death. Cultural and familial tradition would prevent her from expressing the feelings that then threatened to emerge. Other stresses occurring before or after the bereavement--such as loss of income, changes of home, and difficulties with children--would increase her burden. Although she may at first appear to be coping well, intense pining would subsequently emerge, together with evidence of pronounced self-reproach and/or anger. These feelings, instead of declining as one might expect, would tend to persist. (p. 147)

Kraus and Lilienfeld (1959) noted a high mortality among the widowed, especially men under age thirty-five. Young et al. (1963) studied widows over age fifty-four. It was found that there was a significantly higher death rate within the first six months, but no differences were found after that. Reese and Lutkins (1967) studied the mortality of 371 individuals from Wales. The study found that in the first year of bereavement twelve percent died, compared to one percent of the controls. The difference was significantly higher for men. Madison and Viola (1968) studied 375 widows (over age 50) in Boston and Sydney, Australia. The study showed that one-fourth of the young widows reported significant deterioration in health within the first thirteen months. The researchers felt that psychological symptoms dominated the picture. At thirteen months, Parks and Brown (1972) found that the subjects were characterized by disturbances of sleep, appetite and weight, by complaints of depression, restlessness, indecisiveness, sense of strain, and by an increased consumption of alcohol, tobacco, and tranquilizers. It was also found that they were more likely to have been

admitted to a hospital. Although Heyman and Gianturco (1973) did not study mortality, their study found little change in health. Clayton (1974) studied 109 widows and widowers and found that there was no difference in mortality but there was a significant change in psychological and physical depressive symptoms. Another study by Helsing et al. (1981) found that mortality rates were about the same for widowed as for married females, but significantly higher for male widowed. Mortality rates for widowed males who remarried were lower. It was also found that mortality increased with the move to a nursing home or chronic care facility. Although the above mentioned studies seem contradictory as to the mortality and morbidity in bereavement, they do seem to show that there are some negative changes in physical health and mental health status. The widowed also seem to be affected by such variables as the ways they cope with stress, the availability and adequacy of their social network, plus factors such as financial stability and religious commitment (Gallagher et al., 1982).

Lopata (1969, 1979) found that widows reported a great variation in adjustment, but loneliness was perceived as their most frequent problem. The needs of each widow depend on the particular combinations of personality and circumstances. The community in which the widow lives can do much to contribute to her adjustment by providing widow-to-widow groups. The research done in Boston and New York (Parkes and Brown, 1972; Glick et al., 1974; Hiltz, 1977; Silverman, 1981) is an example of help provided by the community (Lopata, 1973).

The death of a spouse changes the way individuals view not only themself, but the world. Is this a crisis? Can it be viewed as a

preventive mental health problem? When the emotional equilibrium of a person is disrupted by a change in a life situation in which the usual coping mechanisms fail, and balance is not restored within a short period of time (a few hours to a few days), it can be termed a crisis (Burgess and Lazare, 1976). Caplan (1959) sees a crisis as being composed of an increase in inner tensions, evidence of unpleasant emotional feeling, and disorganization of functions.

It seems to follow that the mental health profession has a responsibility to be knowledgeable about death and the bereavement crisis. Perhaps too, some of the mortality and morbidity that occurs in widowhood could be avoided or prevented by the formation of self-help groups for the widowed and by offering group therapy and individual counseling by professionals knowledgable on the subject of grief.

Definition of Terms

For the clarity of this paper, it is important that a definition of the following terms be presented.

Grief and Mourning - "Grief is a process of realization, of making real the fact of the loss" (Parkes, 1979, p. 156). Worden (1982) refers to the term mourning as "the process which occurs after a loss" and grief as "the personal experience of the loss" (p. 31). Osterweis et al. (1981) offer the following definitions. Grief is "the feeling (affect) and certain associated behaviors, such as crying," and the grieving process as, "the changing affective state over time." Mourning in the social science sense is, "the social expressions of grief, including mourning rituals and associated behaviors," and bereavement is "the fact of loss through death" (pp. 9-10). Rondo's (1984)

definitions seem to be the most encompassing. She defines grief as "the process of psychological, social and somatic reactions to the perceptions of loss" (p. 15). According to the author this implies that grief is:

> (a) manifested in each of the psychological, social and somatic realms; (b) a continuing development involving many changes; (c) a natural, expectable reaction to the experience of many kinds of loss, not necessarily death alone; and (d) based upon the unique, individualistic perception of loss by the griever, that is it is not necessary to have the loss recognized or validated by others for the person to experience grief." (p. 15)

For the purpose of this thesis grief will be used to describe the feeling, and the term mourning will be used to describe the process that occurs. What is to be stressed in this terminology is the idea of activity and movement. Mourning is an active state and process. This parallels Worden's (1982) discussion of tasks of mourning, in that there is an implication of an activity taking place. Also included in the definition of terms is the idea that there is work that must be accomplished.

Bereavement - The state of having suffered a loss through death (Rondo, 1984; Osterweis et al., 1984).

Sudden Death - This is a death that occurs without warning. Some features involved in dealing with the survivor of a sudden death are: (a) a sense of unreality, (b) guilt feelings, (c) the need to blame someone or something, (d) the involvement with medical or legal authorities, (e) a sense of helplessness in the survivor, (f) the possibility of agitation, (g) a sense of unfinished business, and (h) a need to understand why the death occurred (Worden, 1982).

Anticipatory Grief - This term refers to the feelings that occur

when a loss is expected. It is the grieving that occurs prior to the death itself (Worden, 1982; Rondo, 1984). Both Parkes and Weiss have written at length on anticipatory grief. It should be realized, however, that even if a death is recognized before it occurs, this does not mean that the grief following the death will be less. The course of death as suggested by Parkes and Weiss (1983) is not that anticipatory grief is less painful, but that an unexpected loss can overwhelm some individuals and that their recovery can become more difficult. Although knowledge of the death can allow time for differences with the dying person to be reconciled and plans to be made, this is not always what occurs. The responses to knowledge of a death are very individual.

Suicide - Although suicide is a sudden death, it is a death in which a person has chosen to die, not to live. This is probably the most difficult death for the survivor to resolve. Some of the special features that must be dealt with are: (a) the shame and stigma attached to suicide, (b) the intense guilt and the tendency to feel responsible for the actions of the deceased, (c) anger, (d) feelings of rejection and abandonment, (e) fear of their own self-destructive urges, (f) the need to see the death as an accident (distorted thinking), and (g) lack of support from friends (Worden, 1982).

High Risk Widows - Studies have been done concerning factors which can cause the bereaved individual to be at an increased risk for mortality, morbidity, increased use of health services, and an increase in health threatening behaviors such as drinking, smoking, and the taking of drugs. Some of the factors which influence this behavior are age,

sex, type of relationship with the deceased, nature of the death, cultural factors, and socioeconomic status (Osterweis et al., 1984).

Uncomplicated (Normal) Grief Reactions - Included in this are: (a) feelings of sadness, anger, guilt and self-reproach, anxiety, loneliness, fatigue, helplessness, shock, yearning, emaciation, relief and numbness; (b) physical sensations, hollowness in the stomach, tightness in the chest and throat, oversensitivity to noise, weakness in the muscles, lack of energy and dry mouth; (c) cognitive thought patterns, disbelief, confusion, preoccupation, a sense of presence of the deceased, and hallucinations (both visual and auditory); (d) behaviors, sleep disturbances, appetite disturbances, absent-minded behaviors, social withdrawal, dreams, avoiding reminders of the deceased, searching and calling out, sighing, crying, visiting places or carrying objects that are reminders of the deceased, and treasuring objects that belonged to the deceased (Worden, 1982). These show the large range of feelings, actions, and behaviors that can take place in a survivor. These behaviors do not signify pathology and should be perceived as normal as long as they occur within a normal time period and are not prolonged.

Complicated (Abnormal) Grief Reactions - Rondo (1984) states that these reactions include a disturbance in the normal progress towards resolution. The following are examples:

Prolonged or Chronic Grief - The normal phases may become longer or especially intense. This makes resolution and change difficult. It never is brought to a satisfactory conclusion (Worden, 1982; Osterweis et al., 1984).

Delayed Grief - Normal grief may be postponed sometimes for years. A full grief reaction then occurs at the later time usually over something that does not seem appropriate to the intensity of the reaction (Worden, 1982; Rondo, 1984).

Absent Grief - The feeling of grief and the behaviors of mourning are totally absent. The bereaved may be completely denying the death or still in the state of shock (Rondo, 1984). The bereaved seems to be coping well and is carrying on as though nothing has happened. But they are tense and sometimes short-tempered. They do not bring up the death and avoid reminders (Bowlby, 1980).

Abbreviated Grief - Although often confused with unresolved grief, it is a normal form of grief. Abbreviated grief is a shortened form and often occurs because a replacement for the deceased person is found (marrying soon after the death) or because of insufficient attachment. It has also been found that in some individuals if a significant amount of anticipatory grief has been completed, then the bereavement period is shortened (Rondo, 1984).

Limitations of Study

Although it was originally hoped that this paper could be written to specifically deal with the problems of the younger widow, this was not possible due to the lack of available research. Included in this paper is information on both widows and widowers. Most of the information presented concerns widows as there is very little specifically written about widowers. One study (Heineman, 1982) suggests that (a) statistically, widowhood is more often a woman's problem than a man's problem; (b) the norms and values of society often intensify the problems

of women; and (c) widows are less likely to remarry. This paper will not include a discussion of whether widowhood is easier for a man or woman. This paper will include information on all ages and both sexes of widowed individuals. Age and sex will be discussed as it is applicable in each situation. Also having direct bearing on the process of mourning is the type of death of the spouse. Whether the death was sudden, anticipated, or a suicide is included as it applies. This paper does not deal with the variables in ethnic, cultural and religious groups relative to the mourning process.

Organization

This paper offers a historical perspective to each treatment methodology discussed and how it specifically applies to the widowed. Examples and discussion are given as applicable. A chapter on the studies comparing different treatment methodologies and their benefits is also presented. A chart showing specific methods, population, types of evaluation and measures and results is included. Descriptive data of Chicago area programs is provided. The final chapter summarizes and analyzes the data presented. The issues raised by the lack of research findings are discussed. Ideas for further research are presented.

This thesis provides a systematic review of the development and use of treatment methodologies currently being used to work with the widowed. It is hoped that this paper will assist the reader in a better understanding of these methods, their similarities, differences and effectiveness.

CHAPTER II

INDIVIDUAL COUNSELING

The death of a spouse ranks highest on the Holmes and Rahe scale of stressful life events. Colin Murray Parkes (1972) states, "The loss of a husband or wife is one of the most severe forms of psychological stress, yet it is one that many of us can expect to undergo at some time in our lives" (p. xi). Engel (1961) compares the psychologically traumatic experience of being severely wounded or ill. Engel discusses that even as it takes time to recover from physical trauma, so it also will take time to recover from a psychological one. He sees the psychological process of mourning as similar to the physiological healing of the body.

Normal reactions and emotions that follow the death of a spouse can be wide and varied. Some individuals find that they have a difficult time working through their feelings and emotions on their own. They need direction on how they can best go through the process of mourning and return to a normal, yet changed, life. Worden (1982) makes a distinction between grief counseling and grief therapy. Worden suggests grief counseling helps bereaved individuals bring normal, uncomplicated grief to an effective conclusion within a reasonable amount of time. Grief therapy, however, deals with grief that is abnormal or complicated. Grief therapy deals more with individuals who have delayed, excessive, prolonged, or absent grief. Pathological or abnormal grief usually is manifested by a prolonged reaction, a somatic or behavior

symptom, or an exaggerated response. This chapter will not deal with grief therapy as it is seen by Worden. It is the basic premise of this paper that grief is the normal reaction to a loss. Uncomplicated grief should not be seen then as a type of mental illness. It usual to feel pain and to suffer after a spouse dies. If the issues are dealt with in the earlier stages of bereavement, then the need for professional psychotherapeutic services may be averted (Worden, 1982). Counseling can often make the difference between a bereaved's impaired functioning or a return to normal functioning. Grief counseling with widowed individuals should then be seen as a preventive mental health issue. It is very important to deal with grief as it occurs. Sometimes when the process of mourning is avoided the individual can encounter problems years later. Counselors do not always recognize unresolved grief. Unresolved grief issues are frequently buried at the basis of the problems for which individuals seek therapy. Frequently you will hear someone say to a bereaved person, "time heals" or "it will just take time." Time is helpful in the grief process only if the bereaved person is not denying, delaying, or inhibiting his or her feelings about the loss (Rondo, 1984).

Chapter II will include a discussion of individual counseling and its specific application to the bereaved. Included will be the goals of bereavement counseling, problems and areas of concern, the different tasks and phases of mourning, and specific treatment techniques that can be used with the widowed.

Goals of Bereavement Counseling

Jackson (1957) views the caregiver's goal as assistance to the

bereaved person in releasing emotional ties with the deceased in spite of the discomfort and pain it might cause. The bereaved person must be helped therapeutically to yield to the grief process. This involves looking realistically at the loss and not trying to escape or deny it. The bereaved must understand the grief can be delayed but it cannot be postponed indefinitely.

Schoenberg (1980) offers the following aims of bereavement counseling:

1. To offer basic human comfort and support.
2. To encourage the expression of grief in all its complex affects as appropriate to this person, this loss, and this relationship.
3. To promote the mourning process as appropriate to this person, this loss, and this relationship.
4. To recognize and accept that bereavement counseling is a facilitating process and much of the client's grief and mourning will still be carried through in private and with other supportive family members and friends; it may not require the counselor's presence or guidelines. (p. 154)

It is important for the counselor to realize that it is not the counselor's job to replace the family or social network of the bereaved person. It is the counselor's job to facilitate the extra work needed. It is Schoenberg's belief that counseling should be provided on a human and informed basis for each individual client in terms of the client's particular assessed needs and diagnosis in view of the client's family, groups, or community.

Worden (1982) states that the main goal in working with grief is to help the person complete any "unfinished business with the deceased and be able to say a final good-bye" (p. 36). He sees the goals of grief

counseling as corresponding to the tasks of mourning to be discussed in the next section. The specific goals are:

1. To increase the reality of the loss.
2. To help the counselee deal with both expressed and latent affect.
3. To help the counselee overcome various impediments to readjustment after the loss.
4. To encourage the counselee to make a healthy emotional withdrawal from the deceased and to feel comfortable reinvesting that emotion in another relationship. (p. 36)

In accord with this, Raphael (1977) has shown that some of the morbidity that follows bereavement can be avoided when counseling is done at the time of crisis.

Individual Counseling with the Widowed

Freuling (1982) states that "counseling is a helping relationship in which one party seeks to facilitate the development of informed choices and meaningful actions at a critical time within the context of another's life" (p. 171). According to Freuling the four points that are stressed in this definition are that first the relationship is one in which both the client and the counselor have a responsibility. This relationship implies action. The second point is that it occurs at difficult times in a person's life. This is a main concept of crisis intervention, and a person has a great opportunity for growth and change. Third, and perhaps the most important, is that the decisions and actions will take on meaning only if they take place within the context of the person's life. Finally, counseling implies a relationship between the helper and the person being helped. It is assumed that people seeking help will leave the relationship in better condition than

when they entered it. The important skills for the counselor are to take time, to listen, to clarify and reflect, and to supply relevant information (Freuling, 1982).

Following the initial few weeks after the death of a spouse the widowed often find it difficult and sometimes impossible to express their grief. Friends and relatives find the widowed's open expression of pain difficult to accept. Watching the widowed person cry often makes them feel helpless and uncomfortable. It can remind them of their own vulnerability and death. It is also possible that people expect the bereaved to be strong. The grief of a widowed person resembles an iceberg. There is a small section on top of the water that shows, but frequently the largest part is hidden from the world. According to Kreis and Pattie (1982) the bereaved person is often "afraid" to confide real feelings not only to others but sometimes also to themselves. It is in this area the counselor who works with the widowed can help.

Lindemann (1944) described what he considered to be the three important tasks which must be accomplished in grieving. They are release or freedom from the bondage of the deceased, readjustment to the world in which the deceased no longer exists, and the beginning of new relationships. It was Lindemann's feeling that unless these tasks were completed the mourning process could not be successfully completed.

Jackson (1957) discusses the following nine areas of concern. They are offered here as ideas and preparation for what a counselor might expect to deal with when counseling a widowed person. He suggests that these problems should be brought up by the client not the counselor.

1. There may be a problem with accepting the pain of bereavement. Often the client only needs reassurance that it will not go on forever and that it is natural and normal to feel pain.

2. The bereaved may want to review and discuss the relationship they had with the deceased. When a spouse dies it is important to talk about the deceased. Usually just listening sympathetically is helpful.

3. The bereaved person may want to talk about feelings and how they have changed.

4. Sometimes the feelings associated with grief are new and have never been experienced by a person before. It is important to offer support that what the person is feeling is not unusual and that the person is not going crazy.

5. The bereaved person may want to discuss how to deal with their changed feelings.

6. The bereaved may want to discuss the feelings of hostility and anger that he/she is experiencing and perhaps does not understand.

7. The bereaved may be feeling some confusion about how to think and feel about the deceased in the time ahead.

8. The bereaved may have some guilt feelings. Guilt is not an unusual feeling in a survivor.

9. The bereaved may need to discuss feelings about beginning a new mode of living, with relationships with new people and a new lifestyle.

The above problem areas are presented by Jackson (1957) as possible behaviors that might be encountered in counseling. The ninth point discussed by Jackson appears to be a preliminary for the writings

of Silverman who wrote extensively that widowhood was a time of transition and the main need of the widowed was to change roles. In 1975 Silverman and Copperband commented that:

> The roles as man or woman are no longer that of husband and wife, but widower and widow. To become a widow involves a new definition of self as a single person. Without the benefit of a marital relationship from which one formed and focused one's daily life, the widowed person must learn to live with loneliness and yet find new purpose....Widowhood involves working at "living without." (pp. 9, 10)

This role change and time of transition is something that a counselor must be aware of when working with the bereaved. There must be assistance in finding a new focus for life while dealing with the biggest problem of the widowed, that of loneliness (Lopata, 1973, 1979).

Czillinger (1978) worked for many years as a hospital chaplain and offers the following suggestions to counselors who want to help the bereaved come to terms with the reality of death.

1. You must face your own feelings about death. It is acceptable that you do not know what to say.

2. People in grief often withdraw. Sometimes the counselor must take the initiative.

3. The counselor should not be afraid to show emotion. Crying can be therapeutic and it can also be meaningful to the bereaved.

4. Touching is very important. Having someone touch you or hold you helps to ease the loneliness. It means that, if only for a short time, you are not alone.

5. The counselor should give reassurance that feeling sorry for themselves is all right at the beginning. It is natural for the bereaved to feel like a victim.

6. Pain and anger need to be expressed by the bereaved. These feelings should not be kept inside as they may cause problems at a later time.

7. Remarks about 'God's will' often sound meaningless and can do harm. The bereaved may feel bitterness toward God. It often takes time for there to be acceptance in this area.

8. Expressing the truth and facing it can help to heal a person. Talking about the death can help the bereaved face fears and feelings about loss.

9. Children have feelings too, but they are often overlooked when someone dies. The children have very real needs that must be addressed, and yet the adult who is mourning may be unable to deal with the child's feelings.

10. As a counselor it is important to be sensitive to what a bereaved person is feeling and where that person is in the mourning process.

It is interesting to observe the openness of Czillinger's discussion. His suggestions that sometimes the counselor must take the initiative and reach out to the bereaved is different from Jackson's approach that these problems should be brought up by the client. Some of the differences may be due to the number of years between publications.

Kozma and Stones (1980), writing in Schoenberg, discuss treatment techniques and intervention programs for bereaved elderly that aimed specifically at "preventing intense grief reactions, reducing intense grieving, and encouraging long-term reconstruction of the bereaved's attitudes and interaction strategies" (p. 233). While these

are aimed specifically at the elderly, the authors believe they may still be beneficial to the younger bereaved.

Kozma and Stone's recommendations on treatment techniques are as follows:

1. In prebereavement counseling, attention should be given to monitoring the physical health of survivors above sixty years of age. It is important to be aware of age differences in bereavement. Caring for a dying spouse can result in the greater loss of health in the elderly than in a younger person.

2. There is a difference in the expression of grief between the old and the young. It is often difficult to judge the intensity of grief, and interventions should be offered to the elderly even if they seem to be doing well.

3. Prolonged grief is more likely in the elderly than in the young. Long-term treatment should be provided to the elderly for this reason.

4. There needs to be an evaluation of intervention programs. A determination should be made of the factors that contribute to a reduction in the intensity and duration of grief.

Miller (1982) emphasizes that since grief counseling focuses on one major issue it does not take as long as usual therapy. He states that if positive results and changes are not seen by the fifth session, significant change will probably not occur from that particular client-counselor association. The bereaved often feel they need a nuts and bolts type of guidance in relation to successful coping patterns and how to survive emotionally. The widowed must be helped to focus on

certain crucial questions, such as, who they are, what they want to do with the remainder of their lives, where, and with whom they want to do it. This can be a time of personal and emotional growth and the counselor is in an ideal position to promote this growth. In fact, the widowed may emerge from their grief with a commitment to completely change their lives by going to school, changing careers, or starting a new job. Frequently a bereaved person will find unknown strengths within. The bereaved can grow and change and even become a better person after the trauma of losing a spouse.

J. William Worden (1982), a psychologist and researcher in the field of terminal illness and suicide, has written what might be considered the first comprehensive book about grief counseling. Worden's work is based on the theory of attachment and loss proposed by John Bowlby (1977). Worden's approach that grief and mourning are a natural and normal process is not new. He stresses, however, that the mourning process implies work. He has therefore devised four tasks of mourning which must be finished before mourning can be completed and equilibrium reestablished in the person's life. The tasks do not follow a specific order, yet some of them need to be accomplished before others. Outlined below are Worden's four basic tasks of mourning.

1. <u>To accept the reality of the loss</u>. When someone dies there is a sense of unreality. The first task is to understand and to believe that the person is truly dead and that reunion is not possible, at least in this life. Denying is the opposite of accepting. This can result in a slight distortion, or progress as far as a delusion. Denial of

either the facts of the loss or the meaning of the loss can cause a person to remain at Task I and never move on.

2. To experience the pain of grief. When someone we love dies, we experience not only emotional pain but physical pain. If we negate or deny the pain, we are not feeling. Examples of ways of short-circuiting Task II are to idealize the deceased, or by pretending that the deceased was not a good person, or to travel to escape feelings and emotions about the deceased.

3. To adjust to an environment in which the deceased is missing. At approximately three months the widowed person begins to realize what it is like to live in a world without the spouse. The deceased person had many roles in their life together. Now the widowed person must do those things alone. Sometimes, in learning to cope, the bereaved learn new skills and abilities which they might never have thought possible. If this is short-circuited the widowed person can remain helpless or may even just withdraw.

4. To withdraw emotional energy and reinvest it in another relationship. This can be a difficult task for many as they believe that they are being untrue to their spouses. By reinvesting feelings with another person, the widowed person might end up in another loss situation, or the children might disapprove or resent the new person. In hindering this task the bereaved hold on to the past and do not risk loving again. Parkes (1972) study showed the remarriage figure for widows was approximately twenty-five percent. It was slightly higher for the younger widow and for widowers. The remarriage rate for divorced

persons was seventy-five percent (Worden, 1982). Worden states that for many, Task IV is the most difficult to accomplish. Life does go on.

Worden (1982) further discusses principles and procedures he believes should be followed to make grief counseling effective. They can serve as guidelines for the counselor to help the widowed person come to a resolution of grief.

Principle One: Help the survivor actualize the loss. One of the most effective ways to help the widowed is to encourage them to talk. The bereaved need to discuss the death over and over again. It will sometimes take months for the widowed person to believe that the spouse is really dead and not going to return. This can be difficult for family and friends. The counselor needs to encourage the client to talk about memories.

Principle Two: Help the survivor identify and express feelings. The counselor needs to help the client talk about and identify such feelings as anger, guilt, sadness, anxiety, and helplessness. These feelings can often cause a great deal of confusion in the bereaved and sometimes need clarifying.

Principle Three: Assist living without the deceased. There are often decisions that must be made. The counselor can assist the bereaved by helping the bereaved learn problem solving skills. There is also the loss of a sexual partner. This should not be either over or under-emphasized. Major life changes should be discouraged.

Principle Four: Facilitate emotional withdrawal from the deceased. The bereaved must learn to form new relationships. They must also not get into inappropriate relationships too soon. There needs

to be a pulling away from the deceased spouse. The bereaved person must learn to live a new life before attempting to replace the spouse.

Principle Five: Provide time to grieve. It takes time to let go of a relationship when a spouse has died. Each holiday, birthday, or special day is painful. The first anniversary is an especially difficult time. This can be an important time for the counselor to contact the bereaved person. Mourning is a long process and although the counselor may not see the widowed person frequently, the intervention role may go on over a long period of time.

Principle Six: Interpret "Normal Behavior." It is not unusual for the bereaved to feel that they are going "crazy." It is important for the counselor to have an understanding of what normal grief behavior is so the counselor can offer reassurance to the bereaved. Such behaviors as hallucinations, distractibility, and preoccupation with the deceased are not unusual (Parkes, 1972).

Principle Seven: Allow for individual differences. Each person's behavior in response to death will be different. It is sometimes difficult for some people to understand that not all grief is shown through tears. The counselor sometimes must explain this and interpret behavior.

Principle Eight: Provide continuing support. As has been mentioned previously, there will be difficult periods for the bereaved. It is important for the counselor to realize that working with the widowed sometimes spans a long period of time. Continuing support from the counselor is very important, especially in the first year. Sometimes

only a telephone call is necessary or perhaps a referral to a support group.

Principle Nine: Examine defenses and coping styles. It is important for the counselor to discuss defenses and styles of coping with a client and to identify effectiveness or problems. The counselor can then work with the client to find appropriate and effective ways of solving problems and coping with the stress of the death of a spouse.

Principle Ten: Identify pathology and refer. It is important for a counselor to be able to recognize when pathology is present and a referral necessary.

The above mentioned principles are merely guidelines for counselors. Each idea will not be applicable to each client. It seems apparent, however, that a counselor should have a good basic understanding of grief if the counselor plans to be of help to the widowed.

Beverly Raphael (1983), a psychiatrist in Australia, has written extensively on the subject. She suggests the following questions be used in making an assessment of a client to see if mourning is progressing, if there is a risk for poor outcome and resolution, or if there is pathology present. The questions are:

1. Can you tell me a little about the death? What happened? What happened that day?
2. Can you tell me a little about him, about your relationship from the beginning?
3. What has been happening since the death? How have things been with you and your family and friends?
4. Have you been through any other bad times like this recently or when you where young? (Raphael, 1983, pp. 362-366)

Raphael (1983) emphasizes that several factors seem associated with the risk of pathological outcomes in mourning. The circumstances surrounding the death, the relationship with the deceased, the ability of the family and friends to support the mourning process, multiple crises or stressors at the time of death or since, and other unresolved grief or loss issues can impact greatly on the outcome of the mourning process.

Rondo (1984) states, "expressing the feelings of loss, anger, and sadness that come with the death of a loved one is a necessary part of the resolution of grief. But by itself it is not enough" (p. 75). Sometimes the bereaved have truly attempted to resolve their feelings about the death of a spouse, but they have simply not gone far enough. They have not completed or finished their grief. The following intervention strategies for the counselor are suggested by Rondo (1984). They can be useful to the counselor to help the bereaved complete work on their grief.

1. Make contact and assess - The relationship of the counselor and bereaved person is very important. Rondo suggests using Raphael's (1983) before-mentioned assessment questions.

2. Maintain a therapeutic and realistic perspective - Counselors must remember that they can not eliminate the bereaved's pain. It is important to show genuine care and concern even if it means expressing emotion openly. Be sure to let the bereaved know there is hope that this pain will not go on forever.

3. Encourage verbalization of feelings and recollection of the deceased - The counselor must listen in a non-judgmental manner and give

the bereaved person the opportunity to "identify, accept and express" the various feelings of grief (p. 30). It is important for the bereaved to review his/her relationship with the deceased in a realistic manner.

4. Help the bereaved to identify and resolve secondary losses and unfinished business - It is necessary for the counselor to help the bereaved to uncover any other losses or dreams that will not occur because of the death. Some of these, such as loss of status, of self, of family, etc., can stand in the way of a successful completion if they are not discussed and dealt with.

5. Support the bereaved in coping with the grief process - Help the bereaved understand coping skills and work with the bereaved in areas that are deficient. The mourning process is painful and unique for each person. The counselor needs to let the bereaved know that the counselor understands this. The death of a spouse will affect all the areas in the bereaved's life. Often the bereaved seem to feel that grief should be over too soon. Help to keep this in proper prospective. Encourage both physical and mental health.

6. Help the bereaved to accommodate to the loss - It is important for the counselor to use this intervention at the proper time and not too early in the mourning process. It is important to understand that after suffering a death of a spouse, the bereaved will be different. The counselor can provide help to the bereaved about the new identity and the new roles that are assumed. Sometimes new skills will have to be learned. Although the bereaved will want to keep alive the memory of the deceased, the bereaved must develop a new relationship with them.

7. Work with the bereaved to reinvest in a new life - This will occur well along in the mourning process. The bereaved must be encouraged to form new relationships. However, this must not be forced. The bereaved must find new people and areas of interest. Out of each major loss or crisis there can be gain. At an appropriate point the counselor should attempt to point this out to the bereaved person.

These suggestions are offered by Rondo (1984) to be used within certain limits. There will be times that a bereaved person will need just the quiet, accepting presence of the counselor. There will be other times, however, when a more directive approach will be appropriate. The counselor must always be aware that a further referral might be necessary.

Schwab (1979) found that sometimes words are less important than someone's mere presence and willingness to listen. At times counselors and people in general are uncomfortable around bereaved individuals. Davidowitz and Myrick (1984) did a study of twenty-five individuals who recently experienced a death in their immediate family. They discussed the kind of responses they received during their bereavement and whether the responses were helpful or non-helpful. Eighty percent of the statements made to the subjects were judged to be non-helpful and non-facilitative. The following list was given by the authors as representative samples of the responses.

Facilitative

Come be with us now.
You're being very strong.
It's OK to be angry with God.
It must be hard to accept.
That must be painful for you.
You must have been very close to him.
Tell me how you're feeling.

How can I be of help?
Let's spend some time together.
Go ahead and grieve.
People really cared for him.
I'm praying for you.

Non-Facilitative
He (God) had a purpose.
It's God's will.
Be thankful you have another son.
I know how you feel.
Time makes it easier.
You shouldn't question God's will.
You have to keep on going.
You have to get on with your life.
It's inevitable.
You're not the only one who suffers.
That is over now, let's not deal with it.
The living must go on.
She has led a full life. (p. 6)

Davidowitz and Myrick (1984) found that the facilitative statements focusing on feelings and actions tended to be well received by the bereaved. Although there is of late, increased literature on counseling and death, there has been very little actual research on what to say to a bereaved person.

In working with people recovering from emotionally traumatic events such as the death of a spouse, Weiss (1985) feels that therapy should not only reduce undesirable defenses against the pain and the loss of bereavement (Lindemann, 1944), but it also should help in the process of recovery. This process, according to Weiss, has three components: cognitive resolution, emotional resolution, and appropriate identity change. Cognitive resolution means "making sense of an event" (p. 1). It is a way of understanding. People seem to need an explanation. Weiss suggests that bereaved individuals often find help in talking with others with similar problems or experience. The telling and retelling seems to bring coherence and understanding.

The second component is emotional resolution resulting in the ability to think of the event without distress or becoming upset. Until this is achieved, functioning can be impaired. Emotional resolution is more difficult to achieve than is cognitive resolution. It is the constant reviewing of feelings and issues connected with the death. It is the reliving, element by element. It is the thinking about alternatives until each has been confronted. Eventually memories will no longer be able to cause distress for the bereaved. According to Weiss (1985), emotional resolution is never complete but the times of pain are fewer.

The final component is that of a changed identity. The bereaved must begin to see themselves as they are now. The bereaved must make a commitment to the future. The image of the person before the death is no longer a valid image. They can never be that person again, but the new identity formed emphasizes strength that can move on from the painful to the more important things in life.

Weiss (1985) states that once you have suffered from an emotional trauma you are never the same person again. The way you see yourself and others and the way you look at life in general is permanently changed. Recovery means not returning to what you were, but planning for the future and enjoying it. Widows and widowers have often discussed their feelings of bereavement and grief by saying that you don't get over it, you just get used to it, or you learn to adjust (Silverman, 1970).

In her dissertation of theoretical frameworks for grief counseling Giblin (1984) discussed the psychoanalytic, humanistic and

behavioristic theories as they applied to working with the widowed. Based on works of Freud (1917) and Lindemann (1944), Giblin discussed the goals of grief counseling as being the ability of helping to break the bonds between the deceased and the bereaved, and to form new relationships. According to psychoanalytic theory the issues being dealt with are the necessity of encouraging the bereaved to talk about the experience of the loss and for the bereaved to discuss feelings and emotions, in particular anger and guilt. Psychoanalytic theory also suggests that previous losses affect how present bereavement is managed.

Giblin sees the primary goal of humanistic counselors "helping people to be the best that they can be, to lead their lives to the fullest" (p. 114). Clients also need to learn to accept suffering, to find meaning in it, and to learn to begin to live again. Humanists see grief as a normal process. They feel that counseling is only necessary for the few who show abnormal symptoms. Giblin's examples of humanistic theorists are Rollo May and Viktor Frankl.

The goals of the behavioristic grief counselor are to support the clients during the depression following the death so that they will accept its reality and to learn some new ways and techniques of confronting problems. Giblin uses Ramsay's flooding therapy, Aaron Beck's cognitive therapy, and the Gestalt techniques of fantasy and third-chair as examples.

The general population has a distorted and inaccurate perception of the length of mourning. At Lutheran General Hospital's Conference on Grief, March 28, 1984, Glen W. Davidson, Ph.D. noted that the Chicago Tribune completed a survey after the Viet Nam War. They asked people

on the street how long mourning lasted. The answer varied from forty-eight hours to two weeks. Grief often resembles a roller coast. The bereaved person will seem to be functioning well and suddenly they will seem depressed again. Often it is only what seems to others like a small thing that impaired the person--such as going Christmas shopping alone. The process of mourning is often two steps forward and one back. It is difficult to make general statements regarding the length of grief. What Lindemann (1944) felt only took months to resolve later researchers felt took a year. It was felt that after a year the bereaved would have lived through each birthday, anniversary, and each day for an entire year. The more current thinking is that grief may take as long as three years to be resolved, but the most intense symptoms seem to subside within six to twelve months. At events such as births and weddings, etc., grief may surface again for the widowed (Rondo, 1984).

What are the indications that grief has ended? Parkes (1972) and Bowlby (1980) feel that grief is ended when the reorganization phase is completed. Lindemann (1944), Parkes (1972), and Weiss (1983) state that the tasks of mourning must be completed before grief can be ended. Lazare (1979) suggests that the recovered person is less depressed, has a more normal sense of time, feels a different type of sadness than before, is able to discuss the death with more composure, stops searching for the spouse, and is beginning to have new relationships. Parkes and Weiss (1983) discuss the aspects of recovery after the death of a spouse. They suggest the person's level of functioning will change; the person will begin to solve problems; there will be an acceptance of the loss; the person will be able to socialize again; attitudes toward

the future will be more positive and realistic; health will improve or be at a pre-bereavement level; levels of anxiety, depression, guilt, anger, and self esteem will be appropriate; and, the person will have a better ability to cope with future losses.

This chapter included a review of the significant literature in the area of individual counseling for the bereaved illustrating specific areas of concern in working with the widowed, the importance of good assessment procedures, and specific treatment techniques that can be used in counseling the widowed. Chapter III will provide information on group counseling and how it is used with the widowed.

CHAPTER III

GROUP THERAPY FOR THE WIDOWED

Chapter III includes a discussion of the characteristics of group therapy. A discussion of group therapy as it applies specifically to the widowed, with special emphasis given to the issues that are significant in bereavement, will follow. Specific examples of groups used for the widowed will be given.

There are numerous definitions of groups and group therapy with a great deal of overlap in these definitions. Some of these definitions are more specific to the characteristics, motivation of the groups and goals of the specific types of group that they represent. A basic definition of group therapy by Corsini (1957) states: "Group psychotherapy consists of processes occurring in formally organized, protected groups and calculated to attain rapid ameliorations in personality and behavior of individual members through specified and controlled group interactions" (p. 5).

Eric Berne (1966) discusses "group treatment" as referring to the treatment of psychiatric patients when a trained leader meets with a specific number of patients (not more than eight or ten) at a specified place for a specified period of time. It is distinguished from individual counseling by seeing more than one patient and from group meetings which are attended by large numbers (more than twenty) and from meetings of small groups by the fact that the purpose is to alleviate psychiatric disabilities.

Shaw (1976) defines a group as "two or more persons who are interacting with one another in such a manner that each person influences and is influenced by each other person" (p. 11). Shaw also interprets a small group as having twenty or less members but in most cases less than five.

Although some authors (Gazda, 1975; Slavson, 1979) differentiate between group therapy, group counseling, group psychotherapy, encounter groups, T-groups, and sensitivity groups, for the basis of this paper group counseling and group therapy will be used synonymously.

Characteristics of Group Therapy

According to Slavson (1979), certain characteristics and elements are essential for a well functioning group. First, the group should be small and structured with not more than eight people. Slavson states that groups that are smaller than five tend to "reinforce each other's problems and 'play into' one another's neuroses" (p. 148). The second characteristic of a therapy group is the function of the therapist. He believes the therapist should not occupy the center position at all times. The third characteristic of a successful group is that the group should be structured with clients selected by diagnostic criteria. And the last consideration should be the freedom and spontaneity of both action and verbalization.

Yalom (1975) states that therapeutic change is accomplished through the following factors: instilling hope, universality, information, altruism, re-working the primary family group, new socialization techniques, imitative behavior, insight into self, group cohesiveness,

catharsis, and existential factors (freedom, responsibility, meaning in life, contingency).

Group counseling can be a powerful tool for change. Individuals can confirm their ideas, values, and beliefs by the feedback of others in the group. There can be an increase in self-awareness and reality testing through group counseling (Osipow, Walsh and Tosi, 1980). Cohen and Lipkin (1979) feel that group therapy is the most effective when:

> ...members join with the expectation that they will receive a great deal of help from the sessions...expect support and acceptance from the others in a nonjudgmental atmosphere that encourages sharing and self-exposure...accept responsibility for increasing the self-esteem of the others. (p. 13)

Most authors feel that the best size for group therapy is between five and ten with the ideal number at eight. This allows for drop-outs, illness, etc. Also to be mentioned here is the difference between an open and a closed group. A closed group meets for a specific number of times. No new members are admitted during this period. An open group has no specific number of meetings. It is on-going. New members can join at any time and members can also leave at any point (Kirschling and Akers, 1983).

Group Therapy for the Widowed

When a spouse dies there is eventually a need to redefine one's groups. The bereaved individual is no longer married, however the bereaved person might not as yet feel single. The bereaved are in a middle area, a time of transition. The widowed must learn to live as a single, formerly-married person. A group can be a positive way to move to the next step (Peterson and Briley, 1977; Silverman, 1981).

After the death of a spouse nothing is more helpful than the presence of an "accepting, caring, nonjudgmental other" (Rondo, 1984). A group can be therapeutic for just this reason. A sense of connection can develop with others who have the same or similar problems. In a group there is an opportunity to model behavior for others who have been through similar experiences. Members can find a feeling of acceptance and belonging (Spiegel and Yalom, 1978). Members of a therapy group can also profit from the "helper-therapy principle" (Reisman, 1965) in which they gain confidence and worth as they learn to help others instead of just accepting help (Rondo, 1984).

In 1969 the Widows Consultation Center was established in Manhattan. It was a pilot project funded by the Prudential Insurance Company of America to learn more about widows and their problems and how community agencies could more effectively be of help to them. The Widows Consultation Center provided individual counseling, social activities, legal and financial consultants if needed, as well as widows' discussion groups. Although the other services provided by the Center were also helpful, we will deal with only the group discussions in this chapter (Horowitz, in Linzer, 1977).

A long-term problem widows seem to face is loneliness (Lopata, 1969; Hiltz, 1977). One solution to loneliness is to develop new identities, roles, relationships, and activities (Lopata, 1969; Hiltz, 1977; Silverman, 1981). Loneliness seems to be helped by being with others who share similar problems. The Widows Consultation Service was hopeful that counseling groups would become a social unit which would also have outside social contacts. This is especially important if a particular

widow is having a difficult time. The members are encouraged to call and show concern. It was felt that this was helpful to both the widow and the other members (Reisman, 1965). It was also thought that this helped to build cohesiveness in the group (Hiltz, 1975).

It was the opinion of the Widows Consultation Service that although group discussion can be a very effective method of treatment, it can also be useless or even harmful. This can be the case if the individual is unable to relate well to the other members or to the leader. The widowed must be able to interact with the other members and able to understand the problems of widowhood.

Examples of Group Therapy/Group Discussions

The Widows Consultation Service began its group discussions in January 1971. The beginning was not an easy one. A therapist from an outside agency was asked to lead the group. The therapist was not able to control the group nor was she able to deal with the group's questions about grief. The Widows Consultation Service had difficulty finding a leader who would have both the skills and the ability to lead a group of widows. Hiltz (1975, 1977) stresses that it is important for the therapist to have knowledge about grief and bereavement in order to set a mood or tone for the groups. The discussions should be constructive and not depressive.

The purpose of the groups started by the Widows Consultation Service was two-fold. The first process was "the expression and working through of bereavement (guilt, anger, depression)" and the second was "the finding of a new identity for themselves" Hiltz, 1977, p. 88). These can also be thought of as "letting go" and the building or starting

a new life. One group leader expressed the hope that the widows would gain insight into what the situation really was and not just how they wished it could be. The groups also functioned as a way to reduce loneliness, and as a "bridge" or a means of support to widows as they began new friendships and relationships (Hiltz, 1975; Hiltz, 1977).

The decision was made that the participants in each group should be fairly homogeneous as far as age, socio-economic levels and similarity of problems. This happened by accident with the first groups at the Center. The younger widows came to the night meetings since most of them were working during the day, and the older widows seemed to prefer the daytime meetings. The different leaders of the groups preferred different sizes ranging from a minimum of three to the maximum of ten.

The duration of the group was seen as four months to a year with meetings being held weekly (Hiltz, 1975, 1977). The group leaders found that there were three areas that needed special skill and techniques in working with the widowed. These aspects were getting the group started, getting the shy or quiet members involved, and keeping the more aggressive members controlled (Hiltz, 1977). These areas are similar to those of leaders working with any type of group. To this must also be added a knowledge of grief and bereavement.

It was found by the Widows Consultation Service that the initial meetings sometimes had a negative and depressing effect. However, the widows learned to move from this initial aspect and from sharing miseries to becoming a cohesive group. They learned to care and to make supportive comments to those members having problems (Hiltz, 1975, 1977). The Center found that it was very important to prepare the widows

before they attended their first meeting. It was important for the widows to know that they might find themselves more depressed at the beginning of the sessions, but that this would only be temporary. The widows were also told that they should expect to find that this could be a painful time. They would find themselves dealing with repressed memories and unexpressed feelings (Hiltz, 1977). The Center felt that the prototype of the client that they hoped to serve was a widow within the first year of the death of her spouse.

Situation/Transition groups have been used as a method of dealing with some stressful life situations. The use of these groups can be an important primary preventive approach for mental health. A Situation/Transition group offers "a sheltered, structured social environment where people who feel singled out by their life event can meet with others and make new friends" (Schwartz, 1975, p. 746).

Situation/Transition groups have five essential features. First, they are oriented to helping members cope with some shared external event on a personal level. Next, they meet regularly over a period of time, usually from four to fifteen weeks, with five to twelve people attending. Third, Situation/Transition groups are led by a trained professional. It is in this way that they differ from selfhelp groups. Fourth, Situation/Transition groups offer information, social support, and an opportunity for interaction with others. And last, it is not necessary for members to support a particular moral or behavioral value system (Schwartz, 1975).

Schwartz (1975) finds that the group is seen as a "safe" place, a place to get support and acceptance. The group also functions in a

way so that the members are free to discuss feelings. The group is also a place to ventilate feelings without becoming a burden to friends and relatives. It is also beneficial to listen to others' problems. Much can be learned. Another function of Situation/Transition groups is information sharing. Information can reduce uncertainty. Situation/Transition groups provide a sense of community and an opportunity for socialization. Another function of these groups is to help the member in an avoidance of self pity. Caplan (1964), in his discussion of a preventive approach to mental health, suggests that if a group or population is given adequate psychological resources, emotional difficulties will decrease. Most Situation/Transition groups have as their "implied or explicit intent" to provide such resources (Schwartz, 1975, p. 749).

Andre and Susan Toth began a group therapy program for widows in the late 1970's at the Sisters of Charity Hospital in Buffalo, New York. The women chosen for the group had all been widowed between six and fourteen months. The authors felt that individuals widowed up to four months could still be in the shock stage and might not be as receptive to therapy. The women were of different socio-economic backgrounds and ages. The authors felt that this mix would not jeopardize the quality of the experience. It was decided to have twelve members in the group and hold six sessions. It was also decided that there would be specific issues for discussion, but time would be left for individual concerns to be expressed. The purpose of the group was to "allow individual women to share with each other the meaning of widowhood" (Toth and Toth, 1980, p. 63). The authors felt that as therapists they could

provide a safe environment. They hoped that the group would develop a sense of identity which would be helpful to the widows in dealing with their situation (Toth and Toth, 1980).

Twelve widows came to the first meeting. An introduction to the program and a statement about confidentiality was made. Then each woman was asked to discuss her husband's death. The Toths stated that this first meeting was the most dramatic and that by the end of the meeting there were no longer twelve strangers but a cohesive group. Some of the discussions in the following meetings centered on health problems, support or lack of it from friends and relatives, and the fact that they were not alone. The therapist helped them to perceive that what they were feeling concerning their personal identity, guilt and anger was normal. Follow-up sessions were undertaken at three, six, and twelve month periods (Toth and Toth, 1980).

The Toths had conducted three groups for widows at the time of publication of their article. However, no hard statistical data was included. The authors did state that the widows felt they were already beginning to express their feelings and that the experience had been useful.

At the Forum for Death Education and Counseling Conference, Jane Marie Kirschling and Sally Akers (1983) discussed an explorative study which they had done on the use of time-limited groups as a form of support for the recently bereaved. These bereaved individuals were associated with a hospice program. Hospice programs provide care for the terminally ill, but with an emphasis on living and not dying. It is part of human nature to want to control our lives. Illness takes away this

control for both the patient and their significant others. In terminal illness, time does not heal, but rather is a constant reminder of the impending death.

The authors state that there should be close contact with the survivors after the patient's death. They felt that the most time efficient way to provide this contact and support during the time of bereavement is through group experiences. The authors found that their participants chose to participate in the group (between six and eight months) after the death of the hospice patient. It would seem, according to the authors, that individual counseling would be more appropriate immediately after the death and during the initial months. Some time and distance from the death seem to be of some benefit in the group experience (Kirschling and Akers, 1983).

Kirschling and Akers (1983) suggest that when groups for the bereaved are formed, certain factors be considered. If the groups are to be closed in character and have time limits, they recommend that the membership be homogeneous in regard to the phase of bereavement since this will help with the rapid development of rapport and sharing. If the groups are to be open in character and ongoing in nature then the more heterogeneous the group members, the better. The variety in the group can be helpful to keeping the momentum going.

The authors selected a group discussion for their project for two major reasons. The first reason was that it seemed to be the most efficient means for intervening with the bereaved population. The second reason was that they felt that there would be some specific therapeutic factors that would benefit the recently bereaved. The following are the

particular factors; the instillation of hope, universality, the imparting of information, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors which were previously discussed by Yalom (1975).

Although the Kirschling and Akers (1983) study was small (out of 79 contacted, 13 indicated an interest), the authors felt the research was indicative of the need for support following the death of a significant other. Group counseling was a means of providing this follow-up care for the families of hospice patients, that despite the fact that all of the subjects in the study were not widows, this study is of interest as it gives specifics regarding time, structure, size and length of groups.

Chapter III discussed characteristics of group therapy which was followed by a discussion of group therapy as it specifically applies to the widowed. Included was a presentation of therapist-group behavior issues. Chapter IV will discuss the self-help movement and its application to the widowed.

CHAPTER IV

SELF-HELP FOR THE WIDOWED

This chapter will cover the categories, typologies and the definitions of self-help groups. A discussion of self-help groups for the widowed will be included.

The most widely cited definition of self-help groups is by Katz and Bender (1976). They describe self-help groups as:

> ...voluntary small group structures for mutual aid in the accomplishment of a specific purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem, and bring about a desired social and/or personal change. The initiators and members of such groups perceive that their needs are not or cannot be met by or through existing social institutions. Self-help groups emphasize face-to-face social interactions and the assumption of personal responsibility by members. They often provide material assistance, as well as emotional support; they are frequently "cause" oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity." (p. 9)

To this definition Gartner and Reissman (1977) add some very specific features which help to distinguish a self-help group from service organizations, unions, cartels, and corporation boards.

1. Self-help groups always involve face-to-face interactions.
2. The origin of self-help groups is usually spontaneous (not set up by some outside group).
3. Personal participation is an extremely important ingredient, as bureaucratization is the enemy of the self-help organization.
4. The members agree on and engage in some actions.
5. Typically the groups start from a condition of powerlessness.
6. The groups fill needs for a reference group, a point of connection and identification with others, a base for activity, and a source of ego reinforcement." (p. 7).

Lieberman and Borman (1979) feel that self-help groups traditionally are defined as being:

> ...composed of members who share a common condition, situation, heritage, symptom, or experience. They are largely self-governing and self-regulating. They emphasize self-reliance and generally offer a face-to-face or phone-to-phone fellowship network, available and accessible without charge. They tend to be self-supporting rather than dependent on external funding. (p. 2)

The growth of extrafamilial groups during the Industrial Revolution was the probable beginning of self-help groups. During this time the 19th century friendly societies had over one million members who helped cope with difficult living conditions. The roots of today's self-help groups come from not only the friendly societies but also the trade union, the consumer cooperatives, and ethnic groups of the early 20th century (Katz and Bender, 1976).

In the 1930's a number of self-help groups were founded. They ranged from a group that worked to help the members combat the effects of unemployment and the Great Depression, to concentration camp victims, and the parents of handicapped children. During this period Alcoholics Anonymous was founded. It has become the basic model for many other self-help groups that were founded later (Gartner and Riessman, 1977).

Katz (1981) states that the last ten to fifteen years has seen a dramatic increase in the formation of the number of self-help groups. This increase has been rapid and dynamic. The estimate in 1976 by Katz and Bender of some several million members in one half-million groups is probably very conservative today.

Categorization and Typologies

Killilia (1976) tried to bring some order to the terminology and activities of self-help groups. She developed and cataloged twenty "categories of interpretation" (p. 39). These categories have been helpful in defining the boundaries for inclusion. The range of activities of self-help groups are definitely extensive. Lieberman and Borman (1979) focus on two divisions of self-help groups. The first division includes groups that focus on controlling or modifying behaviors and attitudes. Some examples of this type of self-help group are Alcoholics Anonymous, TOPS, Recover, Inc. These groups provide support not only at meetings, but as often or whenever the members might need it. The second division of groups used by Lieberman and Borman is the group that focuses on adaptation and coping through internal behavioral attitudinal, or affective changes. An example of this type of group would be Compassionate Friends. Other examples would be those groups focused on a medical condition such as diabetes, epilepsy, etc. They provide members with specific methods to help cope with the major life changes they are facing.

Katz and Bender (1976) suggest the following as typology of self-help organizations. Groups that are focused on (a) self-fulfillment or personal growth, (b) social advocacy groups, (c) those that create an option for patterns of living, and (d) those groups that provide refuge for desperate people who are trying to find protection from the pressures of life.

Riessman (in Mallory, 1984) states that the effectiveness of self-help groups can vary greatly. Some of this variance depends on the

leader or facilitator. The facilitator or leader of a self-help group should be aware of the following characteristics which can make groups effective.

1. Effective groups will have a shared commitment and cohesiveness with a strong norm of giving help to other members.

2. Groups should be continually adding new members and the older members should be assuming the helper role.

3. The various kinds of leadership should be shared and distributed among the members.

4. Definite traditions and structures in groups are also important.

5. Effective self-help groups maintain a relationship with professionals so that they may receive assistance, referrals, sponsorship, training, and consultation.

6. Groups need to be able to deal realistically with the problems of regression and relapse.

7. Groups also should have faith in themselves and their capabilities to deal with the needs and problems of their members.

8. Groups that are composed of members of similar background, age, education, and interests seem to be more effective.

9. It can be helpful to a group to have one or two "energy" people to keep things moving.

10. Another area that can help groups be more effective is to add a social aspect or recreational activity to the meetings.

Mallory (1984) discusses the following basic premises and assumptions on which self-help is founded. There are resources available

to meet members needs. Some of the members may make use of them more than others will. The entire group together knows more than the separate individuals alone. Each person has worth and can add value to the group. The individual is the final authority on what will work best or what is needed the most. A positive group experience means that the group uses open and honest communication. According to Mallory (1984) a group facilitator will perform the role best if the facilitator is "a positively focused person with a belief and a trust in the capacity of others to make healthy decisions and act in their own best interests. The facilitator needs skills to communicate these beliefs, and to help create a group atmosphere of trust and acceptance" (p. 14). To accept all behaviors is very different from being accepting of an individual. A group without guidelines can be a group that is not safe for the members or at best one that wastes a member's time. "Self-help groups, although therapeutic, are not therapy groups" (Mallory, p. 24). Facilitators must understand the difference. Each member is an expert in a self-help group. New ideas and support are gained by the sharing of experiences of the members.

Self-Help Groups for the Widowed

If grief has been described as an illness from which the bereaved will eventually recover (Parkes and Brown, 1972), then the bereaved must feel that there is something wrong with them that needs to be "cured." It seems more reasonable to help the bereaved understand that pain is a normal reaction to the loss of a spouse (Lindemann, 1944). These feelings are not unusual and are actually normal and healthy (Silverman, 1977).

The first widow-to-widow program grew out of a pilot study of a target population of widowed individuals under 60 years of age. The researchers felt that as a result of beforementioned studies on mortality and morbidity, this group had a high risk of developing mental illness. One of the major goals of mental health planning is the development of programs for prevention of emotional disorders (Silverman, 1967). There has been a great deal of discussion about the stages and phases of mourning (Lindeman, 1944; Tyhurst, 1957; Bowlby, 1961; Parkes, 1972). But it is only lately that there has been some understanding of the problems that result from the redefinition of the role of the individual as they change from married to widowed. Lopata (1979) states that the original and even some of the current widow's groups are based on the idea that the support network of widows is different from that of a married woman. Lopata feels that the process of widowhood changes a woman. A married woman and a widow will see the same situation differently. Lopata stated that many of the subjects in her study were expected by family and friends to make changes in their lives (stop mourning, get jobs, sell house, get rid of deceased's clothes) before they were ready. Some of these changes were then made too soon or were inappropriate at that time.

Silverman (1967) suggests that there should be some specific services available to meet the needs of these widowed individuals during the different stages of mourning. The first step in Silverman's research was to discover which services were in existence and when and how they were utilized. If it is to be truly a program of preventive intervention, the service should be available immediately or very soon after the

death; it should be available to all in the at-risk population; it should have a mandate from the community to act; and, it would be able to provide a full range of services to meet the needs of the identified population (Caplan, 1964). Silverman's study found that the most effective caregiver to the newly widowed was another widowed person who has recovered. This individual seems to be able to provide not only friendship, but a link to available community services. They are also able to provide support when the newly bereaved person is ready to move from one stage of bereavement to the next (Silverman, 1967).

Silverman (1969) sees grief as a "process that has a beginning, a middle, and an end, at which point the bereaved should be recovering" (p. 334). Silverman indicates that grief is a transitional process dealing with the following points:

1. Grief should only be considered as acute and not chronic.

2. Most caregivers either try not to deal with the bereaved, or want them to recover as soon as possible.

3. Those already widowed realize that grief can be just temporary and that it does not have to last forever (Silverman, 1969).

In this pilot study on widows, it was found that most people do not want to get close to a bereaved person. The assistance that is offered is superficial, filled with platitudes, and with no comprehension or understanding of what is really needed to help the widowed person cope with the pain, or to make the important changes to begin a new life (Silverman, 1972). This study by the Harvard Medical School found that most mental health agencies work with people who suffer from specific psychiatric illnesses, not those going through life crises. It was also

found that people tend to live in communities with similar types i.e., married with children. When someone is widowed, they not longer fit into this married community. It was this realization that led to the creation of the widow-to-widow program (Silverman, 1969).

The widow-to-widow program offered assistance to a target population of newly widowed individuals under age sixty in a specific area of Boston. Information on race and religion was provided by the Bureau of Vital Statistics and funeral directors. Five widowed aides representing the dominant religious and racial groups in the area were recruited to work with the target population. Two points seemed important to the researchers. First, the widowed aides should live near the newly widowed so they could be seen as neighbors and second, they should be of the widow's own or of a similar background and faith. The aides were chosen not because of their education, but because they were able to empathize and understand others. Four of the aides were in their midforties and the fifth was in her early sixties (Silverman, 1969).

The program began in June 1967. A personal letter offering condolences was sent by the aide to each newly widowed person. This letter proposed a meeting time and asked that the widowed call if they did not want to be visited. In the first seven months 110 widows were included in the sample. Of these, nineteen could not be located, and eleven told the aides not to visit. Twelve more widows felt that the program was a good idea, but that they did not need such assistance. The aides dealt with sixty-four widows. Half of the subjects the aides saw in person, and the rest they talked with regularly on the phone (Silverman, 1969). The aides found that the new widow, for the most part, just

wanted to talk. She seemed to need to discuss how her husband died, her loneliness, financial problems, children, and work. It seemed that what most new widows needed was "only the special help that comes from having a friendly ear to listen and a shoulder on which they can, in a sense, cry without feeling that they are imposing or being told to 'keep a stiff upper lip' and to control themselves" (Silverman, 1969, p. 335).

The aides were able to provide concrete services sometimes such as help in finding a job or advice on finances. What seemed to be the most important help, however, was the offer of friendship. This meant that the aides and the widow spend time visiting in each other's homes, going out socially and just being together.

The aides found that there were two basic problems facing the new widows that they met. The first problem was to accept their changed marital status. The second was to learn how to manage their own lives and become independent. The aides felt that the first step on the road to recovery was to attempt to change the new widow's feelings about still being married. They identified three areas of concern in this: making decisions independently, learning to be alone, and the importance of making new friends (Silverman, 1970).

To answer some of the changing needs of the widows, the researchers organized group meetings. These meetings dealt with such problems as what to do with their spare time, how to go back to work, and the biggest problem which was dealing with their children's reaction to the father's death (Silverman, 1969).

The researchers designed the program so that an ongoing relationship would be formed with the aides, and they would then be able to help

the widows through the different stages of grief. The goal of the research was to explore the various needs of widows during bereavement and to devise ways of helping them to be more effective in coping with their problems. It was hoped that the widows and widowers would develop a club for themselves which would in fact be a self-help group (Silverman, 1969).

In Winnepeg, Canada a widow-to-widow program was started with aides working under professional direction. The goals of this program included: (a) offering a role model to the new widow, (b) offering a supportive experience by giving her the opportunity to verbalize, (c) offering hope by letting the widow know that someone cared and that grief is normal after a loss, (d) giving information on widowhood and help in getting established again, and (e) giving information about the resources available in the community (Hiltz, 1977).

Peterson and Briley (1977) suggest that when a marriage ends in widowhood, an individual frequently finds that she has different needs, and that although her old friends can be kind and somewhat helpful, they do not meet the widow's needs. The authors discuss that there is a need for two kinds of groups. The first group would help with the healing phase and the second group would then help the widow to begin a new life.

In self-help groups there is often an important progression that occurs. The widow can move from being a recipient of help and support to becoming a provider of service. This is an important function of self-help as it helps to develop a sense of independence and worth in the widowed. There needs to be hope that some day the pain will decrease

and that life will once again have some meaning. Self-help groups can be very therapeutic in this way, as they can show a newly bereaved individual that a person can get past the pain and that life can be happy again (Rondo, 1984). In long term adjustment self-help groups can provide an important service. Widows who have already been through the grief process act as role models. Relinquishing old status and identity is difficult, but the importance of re-establishing selfesteem, new roles, retraining for new work, and perhaps relearning socialization skills are demonstrated by members of a self-help group. It is in the area of acting as role models that self-help groups are particularly helpful (Raphal, 1983).

Chapter IV has discussed self-help groups, their types and focus. The literature on self-help groups specifically formed to serve the needs of the widowed was reviewed and particular programs were described. The next chapter will review the literature on the research studies that have been done on individual counseling, group counseling, and self-help for the widowed.

CHAPTER V

STUDIES

Although there are many well-conducted studies on the increased risk of psychiatric and psychosomatic disorders following the death of a spouse, it is only in recent years that researchers have begun to study the effectiveness of the treatment methodologies used in counseling the bereaved. It is important for professionals who come in contact with the bereaved, either before or after the death of the spouse, to have some knowledge of available methods so that advantageous treatment or referrals can be made.

In a comprehensive review of the literature only six studies were found which measured the effectiveness of treatment methodologies in working with the widowed. These research studies are discussed on the following pages with a chart showing highlights provided for quicker reference. The methods evaluated in this chapter will include individual or one-to-one counseling, professionally facilitated groups, and self-help groups.

Gerber 1975

Gerber et al. (1975) did a controlled, prospective, longitudinal study. One hundred and sixty-nine individuals were assigned randomly to the intervention group containing 116 or to the control group of 53. A psychiatric social worker or a psychiatric nurse offered weekly meetings for six months to the widowed spouse or to all family members who

lived in the same household. These were the spouses of individuals who died either from cancer or cardiovascular disease. The subjects were followed for three years. Although originally the meetings were planned for either the office or home, some of the widowed individuals preferred telephone contact with occasional office or home meetings. Interviews were done at two, five, eight and fifteen month intervals and medical indicators were reported. Those subjects who were physically healthy at the time of bereavement seemed to benefit the most. During the time of the intervention and shortly afterwards the supported subjects reported less drug use, less illness, and fewer visits to physicians than the control subjects. At fifteen months there were no significant differences in major illnesses. The most significant differences were found at five and eight months (Gerber, 1975; Osterweis et al., 1984).

Raphael 1977

In 1977 Beverly Raphael, a psychiatrist in Sydney, Australia, did home interviews and one-to-one counseling during the first three months following the death of a spouse. She was testing the effectiveness of brief supportive therapy. Data from previous retrospective studies (Madison and Viola, 1968) and prospective studies (Helsing and Szklo, 1981) led to the development of predictive indices. These indices (perceived nonsupportiveness of the social network, particularly traumatic circumstances of the death, a highly ambivalent marital relationship and the presence of concurrent life crises) were enough to place this group at greater risk. Two hundred recently bereaved women under the age of 60 were assessed within the first seven weeks following the deaths of their husbands. The initial segment of the interview was

nondirective and used to establish rapport, gather demographic and background information, and to find out the areas of concern. This data was then examined for the criteria of high risk already mentioned. When present, the subjects were randomly assigned to experimental (N=31) and control (N=33) groups, with low-risk widows forming a residual control group (N=138). The intermediate goals of the intervention were to promote normal grieving, to review the positive and negative aspects of the relationship with a gradual going over, and finally giving up the relationship. A general health questionnaire was mailed to the subjects at 13 months with a personal follow-up if no reply was received. The differences at 13 months showed a significantly poor outcome of the subjects in the control group although the major area of difference was in the number of visits to the doctor. The accomplishment of the intermediate goals in which normal grieving was promoted, was felt to contribute to a significant lowering of morbidity. The author suggests replication of this study. If replication supports the validity of the results, the author's suggestion is to use this research as the basis for further bereavement research and application to a broad-based community preventive program (Raphael, 1977, 1978, 1983).

Barrett 1978

Only Barrett's study has compared different mutual support approaches. Two hundred and thirty-nine widows responded to a news item in the Los Angeles Times or one of the other six area newspapers. Of these, 70 widows were randomly assigned to one of three types of groups; self-help, confidant, and consciousness-raising. Based on the work of Silverman (1970) the premise for treatment in all three types of groups

was that widowed women would be able to help each other cope with the stresses of widowhood.

The subjects ranged from age thirty-two to age seventy-four. The length of time the subjects had been widowed was from less than one month to twenty-two years, with a median of approximately five years. Almost half of them had had their husbands die suddenly and two-thirds stated that they had never considered the possibility of being widowed.

The subjects were assigned to three groups, and each group would focus on a specific aspect of widowhood. The self-help group discussed "specific problems of widowhood." The confidant group focused on "the development of friendships" between pairs of widows. The consciousness-raising group focused on "the roles of women in society." Seventeen subjects were also assigned to a nonintervention control group.

Each group met for two hours a week for seven weeks. The different types of groups were led by two female doctoral students in clinical psychology. Unlike Silverman's approach the leaders were not widowed. Personality, attitude, and behavioral measures were obtained at pretest, post-test, and at a fourteen week follow-up.

One of the major findings of this research was that a significant change occurred in all groups, including the control group. The control group believed that even the promise of a small group experience in the future was therapeutic. The self-help format was the least effective. Most self-help groups are not led by a professional. Although the leader attempted to take a very limited role, this could still have been counter-productive. The response of the confidant group was more variable. The two leaders both felt that these groups were the most

difficult to lead. The idea of becoming well acquainted with only one widow seemed to cause apprehension. The researchers felt that the confidant group might have been more effective if limited to widows who have no confidant prior to treatment. The consciousness raising group was the most effective of the three types of groups. The outcome of the consciousness group was similar with both therapists. The therapists felt that due to the structure of the group, all members were able to participate and that this contributed to the success. The sex role oppression of women was an easy outlet for anger and, as has been observed before, can be facilitative in the treatment of depression. Another interesting finding was that widows of all ages and duration of widowhood enrolled in the program and seemed to benefit from the group. The researchers suggest that this refuted the commonly held views that the stresses of widowhood are limited to a particular age or that only the recently widowed need help.

At post-test all subjects in all conditions had significantly higher self-esteem, experienced a significant increase in intensity of grief, and had significantly more negative attitudes toward remarriage. All subjects in all groups seemed to be more likely to give up the view that others' needs were more important than their own. This may be one advantage of a group opposed to individual counseling. It was also found that more positive health predictions were found among the experimental subjects. The groups were also effective in helping with loneliness. The most positive life changes were found in the members of the consciousness raising group. The fact that the most positive changes were found in the members of the consciousness raising group lends

support to Silverman's (1971, 1977, 1981) ideas that widowhood should be thought of as a transition in life and that the important movement changes widows must make are those involving their self-image and roles (Peterson and Bailey, 1977; Barrett, 1978; Osterweis et al., 1984).

Vachon et al. 1980

Phyllis Silverman has written extensively about the functioning and benefits of the self-help group model and its importance in preventive intervention (Silverman, 1967, 1969, 1971, 1972). To date, however, the only truly rigorous study on the effectiveness of the widow-to-widow model was done in 1980 by Vachon et al. They conducted a two year controlled prospective study on 162 widows in Toronto, Ontario, Canada. Subjects were widows of men age sixty-seven years of age and younger. This age was chosen so as not to confuse the problems typical of aging with those of bereavement. The median age of the subjects was fifty-two with the range from twenty-two to sixty-nine years. Most subjects were considered middle-class. The majority of the widows were Canadian born, Protestant, and lived with someone else (usually their children) at the time of the research. Twenty-nine percent were employed outside their homes and seventy-one percent were considered housewives. The cause of death in eighty-one percent of the cases was due to chronic diseases with the median length of final illness being about six months. The remaining seventeen percent died from diverse causes but usually unexpectedly. Sixty-eight randomly selected women were offered one-to-one and later, group support. This was provided by trained widow helpers. The remaining subjects (N=94) were assigned to a non-

intervention control group that received no intervention other than the data-gathering interviews.

The widow helpers conducted interview sessions in each woman's home at one, six, and twenty-four month intervals. The helpers were individuals who had worked through their own grief and had gone through a training seminar that examined problems of bereavement, methods of supportive counseling, and the availability of community resources. Unlike professional programs this program accepted the fact that either the widow or the widow helper could make the first contact. This project acknowledged the fact that newly widowed women are often passive and have difficulty reaching out for help, yet need to know help is available.

There were no differences between the treatment and control groups at one month. At six months the findings related primarily to intrapersonal adaptation. The subjects who received intervention were significantly more likely to perceive their health as better, less likely to see and depend on old friends as much, and less likely to anticipate difficulty in adjusting to widowhood. At twelve months interpersonal adaptation was better. The treatment group was significantly more likely to feel "much better," to have made new friends, to have started new activities, and were less likely to feel the need to keep up a front instead of expressing their true feelings. At twenty-four months the treatment group was better than the control group on all measures. The high-risk subjects in the treatment group were significantly more likely to have shifted to a low-distress group than those in the control group.

The researchers suggest that the best predictor of bereavement outcome was perceived social support.

In the "pathway of adaptation" of this study the socialization process became significantly different in the two groups at twelve months. The researchers observed that only by progressing through the inward and outward (or intra and inter) stages could a significant decrease in overall disturbance and dysfunction be achieved. These stages of adaptation appeared to be accelerated by participation in the experimental or treatment group. Those subjects in the control group did not display similar progress. The widow-to-widow self-help group seemed to provide emotional, cognitive, and practical support to the subjects (Vachon et al., 1980; Raphael, 1983; Osterwies et al., 1984).

Constantino 1981

Depression and diminished social interaction are two major behavior patterns observed in bereavement. This research attempts to study the changes in behavior of widows who received bereavement crisis intervention compared to widows in a socialization group and others in a control group.

The subjects were twenty-seven widows between the ages of thirty and sixty-nine who lived within a forty mile radius of a major city in southwestern Pennsylvania. The subjects were all widows whose husbands had died within six months of this study from either a malignancy and/or heart disease. The subjects did not have a history of psychiatric illness, were not at the time receiving any other type of psychiatric intervention, and were not taking any kind of psychotropic medications. Men

were not included in the study to ensure homogeneity of the samples, to foster group cohesiveness, and to simplify control.

The assignment of subjects was made as widows indicated a willingness to participate in the study. The first seven widows were assigned to the bereavement crisis intervention group. Ten widows who were unable to attend group meetings at the scheduled time, but were willing to fill out questionnaires, were assigned to the control group. Another ten widows were assigned to the socialization group.

The two leaders were psychiatric-mental health nurses with master's degrees and broad clinical experience in crisis work and group therapy. The leaders held the bereavement crisis intervention group in an appropriate group therapy room. The socialization group met in the family room of one of the leaders for two planning meetings. From that point on the leader's residence was used as a departure point for the four remaining socialization activities. The frequency and time intervals of the meetings were not discussed by the author.

Depression increased in the control group, decreased in the socialization group, and significantly decreased in the bereavement crisis intervention group. According to the researchers, an effective methodology in decreasing depression in widows could be using a planned, time-limited, phase-specific group, held in a controlled setting, and led by a trained leader.

The researchers were also testing for social adjustment. Their findings showed there was a significant increase of adjustment in the bereavement crisis intervention group compared to the other two groups.

Although there were changes in all three groups, the one common factor among all groups was loneliness. Even though the widows reported decreased feelings of depression and increased social activities, they all still complained of loneliness.

The author felt that the results of this study were significant. However, since the assignment to groups was not random and the samples were small, the results should not be generalized. The study should be replicated to determine whether variables such as age, time since the death, educa- tion, religion, etc. would have an effect on the results, and follow-up research should be done. The research base should also be broadened and perhaps changed to include widowers and families (Constantino 1981).

Lieberman and Borman 1981

In 1978 the authors began one of the first published large scale follow-up studies of self-help groups' effectiveness. The study hoped to establish whether intensity of involvement with the group was related to bereavement outcome. Intensity of involvement was described as the number of meetings attended and the leadership roles held.

This study surveyed current members of Theos (They Help Each Other Spiritually), a national organization of primarily Protestant widows and widowers. Questionnaires were also mailed to former members as well as those individuals who chose not to join the group. In July 1979, 1478 questionnaires were mailed to individuals across the United States and Canada. Seven hundred and twenty-one widows and widowers returned the first questionnaires. A follow-up questionnaire was sent one year later and five hundred and two responded. The break down of

the population is as follows: forty percent were in their fifties; twenty percent were over 60 years of age. The education levels of the subjects were as follows: eight percent did not complete high school, fifty-three percent were high school graduates, sixteen percent had some college, and seventeen percent were college graduates. Six percent of the subjects had children and fifty-four percent still had children living at home. Before the spouse's death, approximately three-quarters of the men and half of the women were working. After the death, the men's employment status did not change. The women's employment status increased by thirteen percent so that at the time of the second questionnaire, sixty-three percent of the women were working.

The researchers coded the responses into eighty-three categories and then grouped them into seven areas: (1) loneliness, 22%; (2) loss, 5%; (3) psychological symptoms (depression, guilt, anxiety, etc.), 5%; (4) head of household problems of social and emotional nature, 15%; (5) head of household problems of a more instrumental nature, 16%; (6) concerns about being single and feeling out of place, 19%; and (7) interpersonal frictions such as loss of old friends, 5%. Further analysis showed 32% of the population studied had concern with depressive symptoms related to grief, 41% had problems with their new head of household, adult role, and 20% were concerned with their new single role.

In the findings of this study the authors found that two groups of subjects seemed to have a better outcome. These subjects were former members and those members who were still active. They exchanged help with each other through Theos, and this had become their new social network. The findings seemed clear to the researchers. Active

participation had a positive effect on mental health status, and through this participation, the subjects developed important new relationships through which they could give and receive help.

The following chart summarizes the highlights of the studies discussed in this chapter.

Table 1

Summary of Research on Treatment Methodologies Used With the Widowed

Author and Date	Population	Intervention Used	Type of Evaluation Measures Used	Results
Gerber et al. 1975	Bereaved spouses from a HMO assigned randomly to support group (116) or control group (53).	Psychiatric social worker and nurses individual counseling and talk by telephone during the first six months of bereavement.	Controlled, prospective longitudinal study. Interviews done at 2, 5, 8, and 15 months. Measured medical, social, and psychologic adjustment. Review of medical records.	1. Subjects healthy at the time of spouse's death benefited the most. 2. Supported individuals had fewer prescription drugs, doctor visits, and felt ill less often 3. There were no significant differences in major illnesses. 4. Most differences were noted at 5 and 8 months.
Raphael 1977	Random allocation of high risk widows (lack of social support and ambivalence in marriage relationship) aged 60 or less within the first 7 weeks of death of spouse. Experimental group (31), control (33), low risk (138).	Psychiatrist did individual counseling, supporting and facilitating the grieving process. Home interviews at 6-12 weeks after death.	Matched controls, intervention and non-intervention groups. Assessment of health change at 13 months. Preventive intervention programs.	1. Significant difference at 13 months for visits to doctor for general symptoms. 2. No significant differences in frequencies such as sleep, appetite, shortness of breath, dizziness. 3. In control group there was more weight loss, increased smoking and alcohol intake.

Table 1 (continued)

Author and Date	Population	Intervention Used	Type of Evaluation Measures Used	Results
(Raphael continued)				4. Support of social network seemed to be key. 5. At 13 months, high-risk widows with support seemed more like low-risk widows.
Barrett 1978	70 urban widows (average length of bereavement 5 years) assigned randomly to a self-help, confidont, or a consciousness raising group and control group.	Groups led by two nonwidowed clini-doctoral students for two hours per week for seven weeks. Premise was that widowed women would be able to help each other cope with stresses of widow-hood.	Eighteen personality, attitude behavioral measures obtained at pretest, post-test and follow-up. Physical, emotional and social function-ing indexes were developed by author.	1. At post test all sub-jects had higher self-esteem, more intense grief and negative atti-tudes toward remarriage. 2. Most positive life changes were made by consciousness raising and fewest by self help group. 3. All experimental groups changed views that others' needs were more important than their own. 4. Group example and role models are an ad-vantage of groups over individual intervention.

Table 1 (continued)

Author and Date	Population	Intervention Used	Type of Evaluation Measures Used	Results
Barrett 1978 (continued)				5. Positive health prediction among the experimental subjects. 6. High rates of contact were generated among the subjects and seemed effective against loneliness.
Vachon et al. 1980	162 widows whose husbands had died at 7 Toronto hospitals. Median age was 52. Random assignments were made to intervention and nonintervention groups.	Trained widow helpers were paired with widows for individual support and practical assistance. This was followed by group support. No predetermined number of meetings or length of intervention.	Controlled prospective study with assessments at 1, 6, 12, and 24 months. Goldberg Health Questionnaire and other indices with structured interview.	1. All subjects were the same at 1 month. 2. Experimental group better on intrapersonal adaptation at 6 months. 3. Experimental group better on interpersonal adaptation at 12 months. 4. At 24 months high risk widows had become low risk. 5. Perceived social support seemed to the subjects to be the key.
Constantino 1981	27 widows age 30-69 who were within 6 months of death of husband. Widows lived within a 40 mile radius of a	2 psychiatric mental health nurses were leaders. Subjects assigned to bereavement	Controlled study with pre and post questionnaire. Depression Adjective Check List, Social Adjustment Scale and	1. Depression decreased in the BCI and socialization groups and increased in the control group. 2. Socialization

Table 1 (continued)

Author and Date	Population	Intervention Used	Type of Evaluation Measures Used	Results
Constantino (continued)	Pennsylvania city. Husbands had died from a malignancy and/or heart disease. Subjects did not have history of psychiatric illness, were not in treatment at present time, nor receiving psychotropic medication.	crisis intervention (7), socialization (10), or control groups (10).	Self Report.	decreased in the control group, increased slightly in socialization group and increased considerably in BCI. 3. Loneliness was adjective checked by all 3 groups. In spite of the increase in socialization and the decrease in depression, the widows were still "lonely."
Lieberman and Borman 1981	Members (current and former) of Theos groups across the U.S. and Canada. 721 responded to the first questionnaire, 502 to the second. Widows were 93% of the study and 80% were under age 60.	Mutual support group for widows and widowers.	Surveys to measure psychosocial adjustment, depression, and self-reported personal growth, mailed one year apart.	1. Personal growth varied with the intensity of the involvement in the groups as reported by the subjects. 2. More intense involvement, better outcome for depression and self-esteem.

Summary of Findings

The results given in the before-mentioned studies indicate the need for some type of intervention following the death of a spouse. It is difficult to generalize, however, from such limited research. The evidence does suggest professional counseling, trained volunteers, and self-help groups can reduce psychosomatic and psychiatric disorders resulting from the death of a spouse (Gerber, 1975; Raphael, 1977; Barrett, 1978; Vachon et al., 1980). Treatment seems to be the most beneficial for the widowed who perceive their families as unsupportive or the widowed who are at special risk (Raphael, 1977; Vachon, 1980). According to Parkes (1980), it should not be assumed that all widowed individuals will need counseling. However, those who do become involved seem to benefit from the opportunities to express grief. They also benefit from the assurances that the physical symptoms they experience are normal and that their feelings are not uncommon. Treatment often gives them the opportunity to discuss their present lives and make plans for their futures. Frequently the bereaved need both permission to mourn and permission to stop (Parkes, 1980).

In discussing treatment methodologies, Parkes and Weiss (1983) suggest that the studies that have been done each emphasize a different aspect of counseling. It is not clear which components of the interventions were the most beneficial, as the counselors tailored their methods to suite the individual needs of the clients. Most studies do agree, though, on the importance of accepting the loss and the need to move on with life. The authors see these as two constants in all of the studies. They seem undecided however as to which program of intervention

is the most helpful. Individual therapy can give a widowed individual a professional ally. Groups can provide a temporary community which can provide a person with information, but which also can show them they are dealing with issues that are not uncommon. The self-help groups provide information, support, and connections to others with similar problems, all of which are aimed at beginning a new life.

The research dealing with the effectiveness of treatment methodologies is minimal. However, it serves as a beginning. At this point, although the research is only basic, it does point to the fact that in some situations, counseling can be effective and helpful to widows and widowers who are learning to deal with the death of their spouses. A great deal more must be done before there is a clear picture of which method would be most applicable or helpful in which situation. The implications of this in a preventive mental health view is only just beginning to be appreciated.

Six studies researching the effectiveness of the different treatment methodologies in working with the widowed have been discussed in this chapter. The next chapter will provide information on existing local programs illustrating the different methodologies.

CHAPTER VI

LOCAL PROGRAMS

The following are examples of programs currently existing in the Chicago area. The examples included are representative of both self-help groups and professionally facilitated counseling groups. Also included is information from some counselors who, in individual counseling, deal specifically with grief and loss issues with the widowed.

The self-help groups section includes examples of groups which provide training and back-up professional support for the leaders as well as those that do not. The Widows Rap Group at Ravenswood Medical Center is an example of a group with training and back-up for its leaders. Young Widows North is representative of programs which do not have training or professional support but receive financial support. The Naim Conference and Theos are examples of large, nationally known self-help groups which, besides providing understanding and spiritual support, deal with the social aspects of widowhood. The professionally facilitated support groups in the Chicago area that are mentioned are the Grief and Growth groups at Lutheran General Hospital and the widows groups at the Mayer Kaplan Jewish Community Center.

Descriptive data about each program will be provided and a history, when available, will be given. The purpose and goals will be discussed. Also included will be the populations served with age, sex, and number of members enumerated where possible. Information on whether the group is open or time limited and whether the groups have open or

topics for discussion will be stated as possible. The information concerning these groups and programs will be provided in as much detail as is possible. The purpose of this chapter is not to be judgmental or critical about the example programs, but rather to offer them to the reader for information. The following are examples of groups in the Chicago area.

Widows Rap Group--Ravenswood Medical Center

The Consultation and Education Department of Ravenswood Medical Center began its services to widows and widowers in 1975. This was a result of information from the census bureau that in some census tracts, twenty-five percent of all women with children were widows. Ravenswood offers three basic services: the Widow/Widower Phone Outreach Program, rap groups for widows and widowers, and a social group named Solos. Since 1975 Ravenswood estimates that they have probably served at least 1,000 widowed.

The telephone outreach program serves widowed in all areas of the city. The contact person will call a widowed individual at a set time once or twice a week to offer support. They will continue calling for as long as it seems necessary. The purpose of this program is to reach out to the newly widowed. Support is given by acting as a teacher, a role model, and as someone to help make the transition to their status a little easier. The widow aide volunteers receive approximately three months of training. The training they receive includes knowledge in communication skills, listening skills, the stage of grieving, community and social service resources, and how to give support. Supervision is provided by the staff of the Consultation and Education Department. The

aides also have meetings to share concerns and learn from each other's experiences.

The Rap Groups for Widow/Widowers are held approximately eight times a year and usually have eight individuals in each group. The groups meet for eight weeks and each individual is asked to make that time commitment. The purpose of the groups is to help the widows and widowers begin to make new friends and discuss feelings about being widowed. The group leaders receive training in how to lead a rap group and also receive supervision on an on-going basis.

Ravenswood also runs a social group named Solos. This group is for widowed individuals who are not particularly interested in the other services but are looking for socialization and activities to do with others. Most of the people who attend these activities come to hear the speaker, enjoy the food, or for the opportunity to meet people and make new friends.

Although Ravenswood is a community based hospital and many of the group and service participants are from the near-by community, the programs are open to everyone. The Consultation and Education Department is continually developing new programs that will be helpful. The department attempts to reach out to the community with new programs that can be helpful to those attempting to deal with grief. Some of the programs that have been developed for widows and widowers involve training for parents to help their children grieve, rap groups for children, and grief training for clergy.

Ravenswood Hospital's Consultation and Education Department has been attempting to help even those who have been widowed for twenty-five

years or more. These frequently older widows seem to be looking for support and services around the issues of aging, health, loss of friends, and financial problems. There is also a particular need in the age range of those widowed between ages 40 and 62. This group seems to have particularly severe financial pressure as social security benefits for children usually have been discontinued and their own benefits have not as yet begun. Some of these women have never worked before and are trying to adjust not only to widowhood but also to trying to begin a career.

The Widows Rap Group at Ravenswood is an example of a time limited self-help group whose leaders have specific training and professional support as needed.

Young Widows North

Young Widows North began in 1976. It is sponsored by Piser Funeral Home. Seymour Mandel, one of the owners of Piser's, lived next door to a young woman whose husband died at age thirty. The woman had a two-year-old daughter and was pregnant with another child. At the same time as the death of his neighbor, the funeral director went to a funeral directors convention where Phyllis Silverman spoke of her work with the Israeli war widows. Since most of the Israeli soldiers were young men, their widows were also young. From the insight she gained in Israel she developed a format for a self-help for widows group. It was this group that Dr. Silverman was discussing at the convention. When the funeral director returned the Chicago area he offered to give the financial support for a group if his neighbor would run it.

When the group first began there were only five widows in attendance. All had been widowed for approximately one to two years, but each

expressed the fact that they felt their mourning process would have been easier if they had known each other from the beginning. They continued to meet once a month and the size of the group began to grow.

Young Widows North is a self-help group which serves the widow under age forty to forty-five. This widow is usually struggling with trying to raise children alone (although having children is not a prerequisite to belonging). The group has an open ended format. All widows regardless of stage of bereavement are welcome at the meetings.

The group meets on the third Friday of each month. On alternating months there will be either a speaker or a group discussion. Some examples of the types of speakers are lawyers, financial analysts, social security representatives, psychologists both child and adult, and even a home handyman specialist. The group discussions range from the needs of children with only one parent, to how to get through the holidays alone or dealing with one's mother-in-law now that one's husband is dead. The topics for the speakers and the discussions come from the needs and desires of the members.

The leadership of the group evolves from within the membership and to this point has developed naturally. The mailing list continues to contain approximately one hundred names from year to year with new members joining and marriage and natural progression in life accounting for the attrition. Some of the original group still get together about once a year or if someone has a problem. Meetings are held in members' homes and have anywhere from five to fifty widows present. The group does not include widowers. The length of bereavement ranges from one month to sometimes as long as six or seven years. There is no charge

for membership. Young Widows North is an example of an open-ended self-help group without specific training for the leaders or professional support.

Naim

Naim is a Roman Catholic support group for widows and widowers and an example of a local chapter of a national self-help group for widows and widowers. The title is derived from the biblical account of a village by that name in which Christ brought back to life the only son of a widow who lived there (Luke 7:11-17). Membership is open to all ages of Catholic widows and widowers and the non-Catholic spouses of deceased Catholics. The members of Naim are of all ages, nationalities, and socio-economic backgrounds. The organization offers emotional support, empathy, spiritual opportunities, advice, and social activities. It can be a place to talk, to listen, to help or just to be social.

The purpose of Naim is to help the widowed person by giving emotional support and understanding. Widowed individuals must learn to function in a society geared to couples. Naim suggests that no one is able to understand the problems of the widowed as well as another widowed person. It has been stated many times by many researchers that loneliness is a major problem of widowhood. Naim emphasizes that people can help with the emptiness and loneliness. Through loving support and understanding the members of Naim help the newly widowed cope with and live through their grief. It is their belief that at the end of this process that the widowed can emerge as individuals who have something to offer to others.

The Naim Conference is composed of individual chapters which are not just parish organizations. New members are entitled to join whichever chapter they wish to join. Each chapter meets monthly for an informal business meeting that is followed by refreshments and a program or discussion. Many of the chapters also have an additional social event such as a dinner, a picnic, or an activity such as going to a play. These events provide an entry into a social life for the widowed who must learn to go places alone after the death of a spouse.

Naim offers opportunities for spiritual activities which are provided through a city-wide day of renewal, and days of sharing, caring, and reaching out. Some chapters also have designated times that they will attend Mass together. Naim attempts to reach out to the newly widowed by periodically offering conferences which include representatives of many of the chapters. At these meetings a panel of speakers, including a priest, a lawyer, and widowed individuals, provide information on the problems the widowed face and offer ways to cope with them. These meetings offer an opportunity to meet others in a similar situation, to discuss problems, and to learn possible solutions. It is recommended that a widowed individual attend one of these larger conferences before joining a chapter so that they can make judgments about which chapter might interest them.

Theos

Theos, like Naim, is a nationwide self-help group for the widowed. It was founded by Bea Decker in 1962. Decker was widowed with three young daughters and found that there was no place to turn for help and guidance in starting a new life.

Theos, meaning They Help Each Other Spiritually, has over one hundred active chapters in the United States and Canada. The organization, now incorporated as a non-profit, tax-exempt group, has a national volunteer Board of Directors, one-fourth of whom must be widowed. The local chapters use widowed volunteer leaders to operate the groups. There is an advisory council of community professionals who serve as resources for outreach, programming, and referral. The advisory council provides stability to the chapters, assuring its continuance beyond the present leaders and members.

The basic principle of Theos is that a person who has suffered from the pain of losing a spouse can be of great help to another who has suffered a similar loss. The interaction between the two is beneficial to both of them. The goal of Theos is that people will grow beyond the need for the organization.

Meetings are held according to the needs and desires of the local chapters. The programs are varied,including both educational and social aspects.

The Growth and Grief Groups

Lutheran General Hospital in Park Ridge, Illinois takes an active approach to the survivors of those who die in this hospital. The hospital pastoral care staff is in contact with all the patients admitted to the hospital. The staff are also notified when a patient dies. They are then able to offer support to the bereaved at the time of death and follow-up care after the death. The hospital pastoral counselor closest to the family sends a letter to the family after the death. A short,

easy to read pamphlet describing the programs offered through their Grief and Growth program is included.

Emotional support groups are offered for the following: parents who have had a child die, parents of a stillborn or an infant death, adolescent groups for teens who are trying to deal with the death of a parent, sibling or friend, widows and widowers over age sixty and widows and widowers under age sixty, and groups for anyone trying to deal with the death of someone they love.

Reverend Lee Josten facilitates both groups for the widowed. He states that they are divided because the issues and problems seem to be different for each age. The members of the groups over sixty want to discuss ways to reestablish a social network, whereas those under sixty seem more concerned with raising children and how to reenter the single life.

The groups meet twice a month and average in size between eight and twelve members. The open-ended groups seem to have a basic nucleus of people who come to most of the meetings. There are usually between one and three new people each time. Reverend Josten states that although there is no real pattern, most of the members come to meetings for several months. The groups do not have specific topics for each meeting but discuss what seems important to the individuals on a given night.

The Grief and Growth program, although specifically for the family and friends of those who died in Lutheran General Hospital, is also open to anyone in the community who is having trouble dealing with the death of a loved one. The groups have been meeting for the last ten years, but the hospital has stepped up the program in the last four

years. It is the belief of the program that not only can the bereaved survive, but it is possible to experience growth in positive ways that the individual never realized were possible before. The program attempts to give emotional support and guidance. Their pamphlet states that their main belief is that "grief needs to be experienced, rather than avoided, in order for healing and wholeness to take place" ("Grief and Growth" pamphlet, Lutheran General Hospital, p. 2). The Grief and Growth Groups at Lutheran General Hospital are examples of professionally facilitated discussion groups for the widowed.

Mayer Kaplan Jewish Community Center Widows Group

The Widows Group at the Mayer Kaplan Jewish Community Center in Skokie, Illinois began in 1978. At the present time the center is running two counseling groups. One group is facilitated by a social worker who is also a widow. The other group leader is a widow with special training, but without an advanced degree.

The center runs on-going groups with each leader negotiating time and length for each group. Groups meet either weekly or monthly with the average length of time being eight sessions. Renegotiation to extend the time is possible. One group has run for approximately one year. The groups do not have specific set topics, but discuss whatever the members decide is important.

The groups are not divided by age, although this was the original intention. It was hoped that the groups could be divided into groups for under age forty, the forties and the fifties, and a group for sixty and over. Since beginning the groups, the center has run only one group for the younger widow with five or six widows attending. The center does

feel that age is an important distinction. In reality most of the widows who attend the groups tend to be in their fifties and sixties. The center keeps a list of widows and will begin a group as needed or make a referral as is necessary.

Although the groups are sponsored and held at a Jewish center, adherence to religious belief is not a prerequisite. However, since the groups are located at the center, most of the members tend to be Jewish. Religion is discussed, but only as it applies to widowhood.

Originally the center hoped to include men in the groups. This was attempted, but was unsuccessful. The center found two problems in attempting to include men. First, men are not widowed as frequently, so their numbers are fewer. Secondly, the men did not seem as free or as able to openly discuss their problems. They seemed particularly uncomfortable in mixed groups. The center does run a drop-in center for both widows and widowers. This, however, is a social group, not a counseling group.

Individual Counseling--Counselors' Comments

The following information was reported by counselors who primarily focus on grief and bereavement counseling. Although there are many issues which the widowed must confront, there seem to be certain issues that are more common than others.

Loneliness, as reported earlier in this paper, seems to be a major problem. The widowed want to understand why they have to be alone at this point in their lives. They had a happy life, and they don't want to have to start over. They wonder what life would have been like if their spouse would not have died.

The widowed also feel the need to hide their true feelings since their friends and relatives do not seem to be able to tolerate open expressions of grief. They feel anger, but are embarrassed to be angry at someone who is dead. They feel anger at being left alone. They feel betrayed. The young widowed feel jealousy and resentment when they see older couples together. They feel cheated.

The widowed sometimes feel that they are going crazy. They often think they see or hear their spouses. They forget and call them on the phone only to hear a surprised secretary's voice. They don't seem to be able to concentrate or remember things anymore. They think that they are the only ones experiencing these situations and feelings.

The widowed find they must struggle to find a new identity. They are no longer married even though it takes time to realize that. They are now widowed and that is a word that is difficult even to say at the beginning of their new state. They must then learn to move from the identity of being widowed to that of a single person. They must move from being "we" to being "I."

When dealing with the bereaved there is often a fear of being widowed again. The bereaved feel that if they don't risk, then they will not get hurt again. There is a vulnerability in the widowed. This can be a dangerous area in the mourning process where they can become emotionally paralyzed. They need to learn new coping mechanisms to live life more effectively.

Counselors must be aware of how the death occurred so that they will know how to approach the bereaved. The feelings of the bereaved are different after a chronic illness, a sudden death, or a suicide.

Counselors must also be aware of their own feelings in dealing with a widowed person. Often counselors will push a client too fast, perhaps because their own feelings about grief interfere. It is important to work with the client to help the client find out what are their capabilities and not strain their capacity for change, redirection, and flexibility.

In working with a client counselors must be sure to find out how individuals handled earlier deaths and find out if there are any unresolved losses in the client's past. Unresolved grief can cause problems years later and can also affect how a person deals with the present loss.

This chapter has discussed some of the currently available programs in the Chicago area. These examples were chosen to illustrate specific points and characteristics of the treatment methodologies discussed in this thesis. Chapter VI attempts to give a descriptive analysis of each program, it's goals, history, and the population served in regards to numbers, sex, and age.

Chapter VII, the final chapter of this research, presents a summary of the information on the treatment methodologies used in working with the widowed. A chart demonstrating the particular elements and factors of each treatment methodology is presented. A section on implications for counseling is included and indications and recommendations for further research are provided.

CHAPTER VII

SUMMARY AND CONCLUSIONS

This thesis provides a discussion of three treatment methodologies that are used in working with widowed individuals. An explanation of individual counseling, group therapy/counseling, and self-help groups is given. A discussion of how each methodology is used in working with the widowed, and the research studies that have been done using them are analyzed. Examples of local programs are supplied.

After the death of a spouse there is a time period when it is normal to mourn and to feel grief. If the bereaved do not deal with their feelings at this time, problem grief or abnormal grief can result. Unresolved grief issues often surface years later as the basis of current problems. If bereavement issues are dealt with at an earlier time, then the need for in-depth long-term psychotherapeutic services can possibly be averted (Worden, 1982).

Individual counseling can be helpful immediately after the death of a spouse when the widow or widower needs an "accepting, caring, nonjudgmental other" to listen (Rondo, 1984). The widowed need an opportunity to say a last good-bye to the deceased (Worden, 1982). Raphael (1977) states that some of the morbidity that follows bereavement can be avoided if counseling would take place soon after the death.

Individual counseling provides intensive, one-to-one help which, especially within the beginning weeks after the death of a spouse, is most beneficial (Osterweis et al., 1984). Individual counseling, due

to its nature, does not provide a service to great numbers of bereaved individuals. It also tends to be more expensive than either group counseling or self-help. A counselor's approach to individual counseling can provide the basis for teaching and education about grief and bereavement. It does not, however, provide opportunity to share similar experiences with others, the opportunity for social support, feedback, or the opportunity to be with others so that a decrease in loneliness results. Individual counseling offers fewer opportunities for rehearsing new behaviors. However, group counseling and self-help groups are excellent for such rehearsals.

Group counseling can be a dynamic tool for change. Individuals have an opportunity for an increase in self-awareness. They can test their values, beliefs, and ideas through the feedback from others in the group (Osipow et al., 1980). They have the opportunity to test new behaviors on other members of the group (Mazda, 1975; Yalom, 1975; Cohen and Lipkin, 1979; Slavson, 1979; Osipow et al., 1980). The transition from married to widowed to single is accomplished when a widowed individual acknowledges a redefinition of status and groups (Peterson and Briley, 1977). The universality of emotions and problems in widowhood results in feelings of acceptance and belonging. A sense of connection with others who have similar experiences makes the widowed individual feel not quite so alone. A group can provide a new social outlet for the widowed to replace the social life that ceased with the death of the spouse (Schwartz, 1975; Yalom, 1975; Parkes and Weiss, 1983).

It is important for widowed individuals to be prepared for the feelings that might occur at their first group meeting. Often depression

occurs as the individual recalls memories or unexpressed feelings (Hiltz, 1977). Widowed individuals progress from their beginning experiences in group meetings in which they share their own grief and miseries to the level of learning to make supportive comments and to care about the other members of the group (Hiltz, 1975, 1977). Schwartz (1975) states that a group is a "safe" place. Groups are a place to get support and acceptance from others. A group can also be a place to discuss feelings and thoughts that might not be understood by those who have not lost a spouse.

Andre and Susan Toth (1980) did not include widowed individuals in their groups until four months after spousal death. The Toths' believed receptiveness to therapy might be impaired as newly widowed individuals might still be in the shock stage. The Toths' groups included individuals from different socio-economic backgrounds and different ages who were widowed from 6 to 14 months. This mix did not jeopardize the quality of the experience. Kirschling and Akers (1983) state that their groups were closed in character and the membership homogeneous in regard to the phase of bereavement. The homogeneity encourages more rapid rapport and sharing. It was also their recommendation that if groups are open in character, the members should be more heterogeneous. The heterogeneity helped keep the momentum of the group active. Hiltz (1975, 1977) found that although group counseling and group discussion can be an effective treatment with the widowed, it can also be useless or even harmful if the individual is unable to relate well to the other members of the group or to the leader. Widowed individuals must be at a place where they are able to interact with

others and must be at a point in their widowhood where they can understand the problems of widowhood.

Groups can lessen the feelings of isolation. Finding other people with similar fears, problems, and anxieties dispels the feeling of being the only person who is suffering in this way. Groups can teach specific skills and provide a sense of "family." When effective, a group can help to change previous distorted beliefs and teach new behaviors and healthier ways to live life (Cohen and Lipkin, 1979).

Self-help groups, although having many of the same characteristics, also have many differences. The main difference is in the leader or facilitator of the group. The self-help group leader is not a professional. However, the self-help leader needs many of the same characteristics. The leader needs to be a person who is positively focused. The leader must believe people have the ability to make effective decisions in their own best interests. The leaders need to be empathetic. An effective leader imparts these beliefs in an atmosphere of trust and acceptance. Group knowledge, more extensive than individual knowledge, is an important source for information and problem-solving techniques. It is, however, each person's decision as to which solution is the best for them (Mallory, 1984).

According to Parkes (1980) the underlying assumption of a self-help group is that the problems of a widowed person can best be understood by another widowed person. Demonstrating this is the widow-to-widow program conducted by Phyllis Silverman at Harvard University from 1964 to 1974. The only other existing service at that time was, for the most, individual counseling. However, counselors willing and able to

discuss grief were rare. Counseling implied mental illness to many, so the widowed often did not always seek help. Today's widow-to-widow programs often differ much in their formats from the original model. Some offer only group support and discussions. Others offer one-to-one outreach. Some of the groups have professional backup support whereas others have no professional involvement. Some of the programs offer training in how to lead groups and how to deal with the bereaved. Other programs even offer support groups for the leaders. Self-help groups have enabled the widowed to find others with whom they can discuss their problems and perhaps, in the discussion, find solutions. Sharing is one of the elements distinguishing this methodology from others. The widow helper may not be a peer in any way other than that she is a survivor who has coped and adapted successfully with the same problems. The widow helper has received an education by experience rather than through books (Silverman, 1981). Role models are another important part of self-help groups as it is through others' behaviors that solutions to problems can be found (Raphael, 1983).

Peterson and Briley (1977) and Silverman (1981) have discussed the transitions of widowhood. Some theories about the nature of grief encourage counselors to focus on guilt and anger as reasons the widowed have difficulty adjusting to the death of a spouse. Silverman (1981), however, states that the process of transition is the most significant aspect of effectively dealing with grief. A new life must be started and the old one left behind.

To date there have been only six studies completed on the effectiveness of the treatment methodologies discussed in this thesis.

This lack of information and research causes difficulties in making generalized statements about the results. The research studies done on the treatment methodologies found that the social network was of great importance (Raphael, 1977; Vachon, 1980). The health of supported research subjects (fewer doctor visits, prescriptions) was positively affected by participating (Gerber, 1975; Raphael, 1977). Personal changes (higher self-esteem, intrapersonal and interpersonal adaptation) occurred in the experimental subjects (Barrett, 1978; Vachon, 1980). Social adjustment (Constantino, 1981; Vachon, 1980) and the ability to reach out and help or relate to others was another positive change found in the research population (Lieberman and Borman, 1981).

From the present research it seems apparent that interventions do have positive effects on bereavement. Until more research is completed it is difficult to generalize. It appears, however, that treatment is beneficial if performed by a counselor or self-help leader knowledgeable in the area of grief and bereavement. As stated earlier in this study, individual therapy gives a widowed individual a professional ally. Groups provide information, support, and connections to others with similar problems and even perhaps the beginning of a new life (Parkes and Weiss, 1983).

The chart on the following pages indicates the different elements and factors which determine the effectiveness of the treatment methodologies based on available research and literature.

Table 2

Differentiating Elements and Factors of Treatment Methodologies

	Individual	Group Counseling	Self-Help
One-to-One Attention	Yes (Osterweis et al., 1984; Rondo, 1984)		
Numbers Served	Less (Naar, 1982)	More (Naar, 1982)	More (Naar, 1982)
Expense Cost	More (Naar, 1982)	Less than individual (Naar, 1982; Malloy, 1984)	Free or inexpensive (Malloy, 1984; Naar, 1982)
Professionals	Yes (Schwartz, 1975)	Yes (Schwartz, 1975)	Only as consultants (Malloy, 1984)
Group Leaders		Professionals with knowledge of grief (Hiltz, 1971, 1975)	Widowed non-professionals (Parkes, 1960; Malloy, 1984)
Support from Others		Yes (Gazda, 1975; Cohen and Lipkin, 1979; Slavson, 1979)	Yes (Vachon et al., 1980; Parkes and Weiss, 1983)
Universality/Sharing of Experiences		Yes (Schwartz, 1975; Yalom, 1975; Cohen and Lipkin, 1979; Parkes and Weiss, 1983)	Yes (Parkes and Weiss, 1983)

Table 2 (Continued)

	Individual	Group Counseling	Self-Help
Socialization		Yes (Yalom, 1975; Constantino, 1981)	Yes (Silverman, 1967; Vachon, 1980) Lieberman and Borman, 1981)
Feedback from Others		Yes (Gazda, 1975; Cohen and Lipkin, 1979; Slavson, 1979; Osipow et al., 1980)	Yes (Malloy, 1984)
Rehearsal of New Behaviors	At a disadvantage (Naar, 1982)	More (Mazda, 1975; Yalom, 1975; Cohen and Lipkin, 1979; Slavson, 1979; Osipow et al., 1980)	More (Naar, 1982)
High Risk Widows	Good results (Raphael, 1977)		Became low risk at 24 months (Vachon, 1980)
Immediately after Death	More helpful (Kirschling and Akers, 1983; Rondo, 1884; Osterweis et al., 1984)	Not recommended until 4 months (Toth and Toth, 1980; Kirschling and Akers, 1983)	
Cognitive Awareness	Superior--focus is on one person (Naar, 1982)	Some--but concentration is less (Naar, 1982)	Some--but no professional direction (Naar, 1982)

Table 2 (continued)

	Individual	Group Counseling	Self-Help
Loneliness		Decreased (Hiltz, 1977; Barrett, 1977; Silverman, 1981)	Decreased (Barrett, 1978; Silverman, 1981)
Importance of Social Network	Yes (Raphael, 1977)		Yes (Vachon et al., 1980)
Education/Teaching		Yes (Cohen and Lipkin, 1979; Kirschling and Akers, 1983; Parkes and Weiss, 1983)	Yes (Parkes and Weiss, 1983)
Personal Growth through Helping Others		Yes (Reisman, 1965; Hiltz, 1975, 1977; Rondo, 1984)	Yes (Reisman, 1965; Rondo, 1984)
Role Models		Yes (Spiegel and Yalom, 1978)	Yes Barrett, 1978; Raphael, 1983)
Methods of Redefining Groups		Yes (Peterson and Briley, 1977; Silverman, 1981)	Yes (Peterson and Briley, 1977; Silverman, 1981)
Change in Health Status	Positive (Gerber, 1975; Raphael, 1977)	Positive (Barrett, 1978)	Positive (Barrett, 1978; Vachon et al., 1980)
Changes in Self-Esteem and Adaptive Measures		Positive (Barrett, 1978)	Positive (Barrett, 1978; Vachon et al., 1980; Lieberman and Borman, 1981)

Table 2 (continued)

	Individual	Group Counseling	Self-Help
Depression			Decreased (Constantino, 1981; Lieberman and Borman, 1981)
Preventive Mental Health	Yes (Raphael, 1977)		Yes (Caplan, 1964; Silverman, 1967)

Implications for Counseling

It is hoped that some of the basic information in this thesis will provide the counselor with an understanding of the grief and mourning process the widowed experience. An important implication for counselors provided by this thesis is that not all widowed individuals will need counseling. Grief after the death of a spouse is a normal reaction.- Individuals with support from family and friends frequently are able, after time, to adapt and go on with their lives. Counselors should be aware that those individuals who develop problems in their bereavement are often those that do not have anyone to talk with. At time the widowed individual's family and friends are unable, for whatever reason, to give the necessary emotional support and allow an open expression of grief. It is also important to remember that it takes time to recover from the death of a spouse.

Another area of importance to the counselor is the counselor's own ability to deal with death. Not only has this area been ignored over the years in medical and nursing schools, but also in the counseling profession. A counselor who has difficulty in dealing with clients regarding grief must be aware of this, and perhaps look at their own feelings and reactions and how these affect their dealings with clients. If a counselor is unable to work with bereaved individuals, the counselor must make adequate referrals.

Although there are now groups such as the Forum for Death Education and Counseling and the American Association for Suicidology attempting to deal with the issues of grief and bereavement, more dissemination of

information to varied professionals and lay individuals would be helpful. Professionals who come in contact with the bereaved need to have some knowledge of appropriate actions and responses. More training on interventions and treatment methodologies needs to be available through hospitals, schools, mental health clinics, and for private practitioners, etc.

In working with the bereaved, counselors should also be aware of assessment techniques. Knowledge of the signs and symptoms of abnormal grief are very important. With all clients, counselors should always ask about previous losses and deaths. It is important to know how the bereaved survived and handled these prior losses. These losses may indicate how the client will manage the present loss.

As has been discussed in this thesis, there are different treatment methodologies that are available for working with the widowed. Knowledge of these methods and their applicability for each client is the counselor's responsibility. At various times and points in the mourning process certain methodologies would be more appropriate than others.

It is the counselor's responsibility to learn and understand the area of grief and bereavement. This area can cause painful reactions in not only clients but also counselors. It is an area that needs to be better explored and researched for new treatment and assessment techniques. This is an area of counseling where there is much to be accomplished.

Recommendations for Further Research

Even though the last ten years has seen an increase in the research and information in the area of bereavement, there is still much that needs to be accomplished. Education, awareness, and the availability of both information and resources need to be accessible.

The following are recommendations for further research suggested by this study:

1. Most of the completed studies have not to date been replicated so that generalization of the results is difficult.

2. There is no evidence that all bereaved individuals need or want treatment. More research needs to be accomplished in the areas of which interventions are the most appropriate for which individuals at which point in the mourning process. Such research should consider age and sex groupings.

3. The empirical data on response to loss is minimal. The theoretical base needs expansion and to be translated into operational definitions for general use.

4. More research needs to be completed on who will be "at risk" in bereavement.

5. The research on loss and children needs to be increased and expanded. Research on whether the treatment methodologies discussed in this thesis are applicable to children needs to be completed.

6. This thesis found minimal empirical research on men's reactions to loss. Men appear to deal with their problems alone, or

perhaps are forced to do so due to a lack of available services. Studies need to be completed to see if the treatment methodologies discussed in this thesis are applicable to men, and if not, what approaches would attract them if they needed treatment.

7. There are very few definitive writings on actual clinical treatment techniques with the widowed. Information on developments in the treatment phase of clinical practice needs publication.

8. The variation in an individual's reactions to the death of a spouse need to be explored in greater depth. Culture, ethnicity, pre-existing personality variables, and the relationship of the bereaved to the death are some of the major determinants to be studied.

9. Raphael (1983) discusses ideas that circumstances, support of family and friends, the relationship with the deceased, multiple crises, and unresolved losses can affect the mourning process. Further research should be done to explore this theory.

10. The role of the professional with self-help groups needs further exploration.

The death of a spouse is one of the most difficult and painful situations a person will ever have to face. Nothing in life can prepare you for this. However, incredible growth, maturity, and change are possible if the widowed person is willing. Widowhood may seem like a huge mountain that must be climbed, but climb the widowed must if they want to survive.

> "Life is like a circle, what seems like the
> end may really just be the beginning."
>
> Ivy Blake Priest

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

November 26, 1985
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