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THESIS – THÈSE

Title of Thesis – Titre de la thèse

Living Through Loss: An Investigation of the Impact of a Bereavement Support Group upon the Grieving Process.

Degree for which thesis was presented
Grade pour lequel cette thèse fut présentée

M.Ed

Year this degree conferred
Année d'obtention de ce grade

1985

University – Université

UofA

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LIVING THROUGH LOSS: AN INVESTIGATION OF THE IMPACT OF A BEREAVEMENT SUPPORT GROUP UPON THE GRIEVING PROCESS

by

JANET CARYK

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF EDUCATION

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

Fall, 1985

THE UNIVERSITY OF ALBERTA

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DEGREE FOR WHICH THESIS WAS PRESENTED MASTER OF EDUCATION

YEAR THIS DEGREE GRANTED Fall, 1985

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Date..September 30, 1985..........

Dedication

For my father, William Caryk

(1929 - 1982)

We never had a chance to say good-bye

Abstract

The general purpose of this study was to investigate whether or not participation in a bereavement support group facilitated the grieving process. More specifically, it was hypothesized that participation in a support group would have a positive impact on three dimensions of the grief experience: a loss of meaning in life, feelings of helplessness, and low self-esteem.

A total of 11 bereaved subjects participated in the study. However, 2 individuals dropped out prior to completion. All subjects were members of the Living Through Loss program offered by the Family Service Association of Edmonton.

The study was comprised of two distinct phases. The purpose of Phase I was to descriptively investigate the effects of participation in a bereavement support group. In order to obtain clinical data this researcher participated in a Living Through Loss group as a member/observer.

Phase II involved the administration of a battery of standardized tests to a second independent group of 4 bereaved individuals. These instruments were used to test the hypothesis that participation in a bereavement support program would have a positive effect on meaning in life, helplessness and self-esteem. Five standardized test instruments were utilized in Phase II. These were: (1) The Grief Experience Inventory; (2) The Purpose in Life Test; (3) The Seeking of Noetic Goals Test; (4) Rotter's

Internal-External Locus of Control Scale; (5) The Canadian Self-Esteem Inventory for Adults.

The results of Phase I suggested that the Living Through Loss program is a legitimate and effective mode of intervention in terms of bereavement counselling. Clinical observation and participant feedback confirmed that involvement in a bereavement support group had a positive impact upon these grieving individuals.

The findings of Phase II were less conclusive than those of Phase I. While test results did not unanimously support the hypothesis under investigation, positive changes were observed in that 2 of the 4 subjects showed a reduction in grief intensity. Finally, research and counselling implications were discussed in relation to the study.

ACKNOWLEDGEMENTS

The author wishes to recognize all those who contributed their encouragement and support.

Dr. F. Boersma

Dr. H. Janzen

Dr. K. Ward

Dr. P. Calder

Ms. S. Elder

Ms. K. Martin

Mr. R. Bunker

Ms. H. Caryk

Ms. D. Caryk

Ms. K. Hildebrand

Participants of the Living Through Loss Program

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1. INTRODUCTION

The death of a significant person can be the most devastating crisis an individual will encounter in his or her lifetime. If the loss is not dealt with effectively, unresolved grief can lead to serious problems in living (Barrett, 1978; Parkes, 1972; Lindemann, 1944). More specifically, Simos (1979) proposes:

> Unresolved grief festers like a deep wound covered by scar tissue, a pocket of vulnerablity ever ready to break out anew. Incomplete or partial grieving leaves residue for future difficulties and becomes the forerunner for a wide range of physical, emotional, and mental disorders. (p. 4)

Given that the bereavement experience can have significant detrimental consequences upon mental and physical health, the necessity of preventative therapeutic intervention is apparent. The purpose of this project was to contribute to the bereavement literature by testing the general hypothesis that a bereavement support program can facilitate the grieving process.

The literature states that grief is often accompanied by a loss of meaning or purpose in life, intense feelings of helplessness, and low self-esteem. It was further hypothesized that participation in a bereavement group could have a positive impact on these aspects of the grief experience.

According to Simos (1979), "For life to be tolerable after a loss, there must be a search and restoration of a sense of meaning" (p. 211). The death of a significant

person constitutes a radical change which can challenge our basic assumptions about the world around us. It is not uncommon to hear the bereaved say that life has lost all meaning for them. Glick, Weiss, and Parkes (1974) state, "Widows and widowers sustain a loss of a major part of their lives and with it of assumptions about themselves and their futures, about their roles and responsibilities, about the fundamental meanings of their lives" (p. 300). According to Marris (1974), the long period of uncertainty and anxiety that follows bereavement is due to a loss of meaning.

"Bereavement is an experience of loss of control, in which one is often a passive victim of an external event" (Simos, 1979, p. 79). A death crisis forces upon us the reality that ultimately we are not in control of our own destinies. As a result, we can experience intense feelings of helplessness. A death crisis can also alter an individual's perception of his or her ability to influence the outcomes of future events. The bereaved individual, having been powerless to avert the loss, may generalize feelings of helplessness to other situations.

Although there are several definitions of self-esteem in the literature, psychologists generally agree that self-esteem is an appreciation of one's self-worth. Coopersmith (1967) states that individuals who possess low self-esteem tend to experience feelings of distress, self-hatred, psychosomatic symptoms, and feelings of depression. According to Simos (1979), "Loss always carries

with it a threat to self-esteem" (p. 20). The loss of a significant person has a great potential for damaging one's self-esteem.

The Living Through Loss Program is a bereavement support service offered by the Family Service Association of Edmonton to adult individuals who have experienced the death of a loved one. Its basic purpose is to provide a positive emotional and educational experience, as well as a supportive atmosphere where grief can be shared. A maximum of eight group members meet once a week for 3 hours. The program runs for 8 weeks and is facilitated by a certified psychologist.

In summary, the purpose of this project was to determine whether a bereavement support program could facilitate the recovery of bereaved individuals. Specifically, it was hypothesized that participation in a support group would have a positive impact on three dimensions of the grief experience: loss of meaning in life, feelings of helplessness, and low self-esteem.

This study was comprised of two distinct phases. In Phase I this researcher participated as a member of a Living Through Loss group. This involvement allowed the investigator to become familiar with the agenda and to observe and describe the group process first hand. The purpose of Phase I was to generally assess whether a bereavement support group meets the needs of the bereaved, and whether participants perceive the Living Through Loss

Program as a positive learning experience.

Phase II involved the administration of a battery of standardized tests to a second independent group of bereaved participants. A subject by subject analysis of the pre and post-variable data was completed in order to assess the impact of the program upon three specific features of the grief experience: the loss of purpose in life, helplessness, and low self-esteem.

2. REVIEW OF THE LITERATURE

"At the present time no comprehensive psychology of loss and grief exists" (Simos, 1979). According to Solomon (1977), "No exact delineation or explanation of the experience of grief or bereavement has become universally acknowledged" (p. 211). He cites ethical considerations as the crucial reason for the paucity of empirical research:

> We cannot set up controlled laboratory experiments to simulate acute loss and subsequent grief, nor in normal circumstances would we ask a genuinely bereaved person if we may observe their state of grief; we are usually absent when the loss is initially experienced, and we are unlikely to be invited to watch the person who is experiencing acute grief. (p. 211)

The review of the literature will include a discussion of the grieving process and describe its impact upon the bereaved individual. An overview of the significance of community based bereavement programs will be presented along with a detailed description of the Living Through Loss Program. Finally, it will present and describe three dimensions which appear to be involved in healthy recovery: the restoration of meaning, self-esteem, and control.

2.1 THE GRIEF PROCESS

Grief is a multidimensional process. Although each of us reacts uniquely to the death of a loved one, there are several predictable and identifiable features associated with the grief experience. The purpose of this section is to synthesize the current literature as it relates to the major

characteristics of the grieving process.

Thomas Eliot (1932) presented the first accurate description of grief. He noted that recently bereaved individuals experienced feelings of abandonment, shock, denial, guilt, anger, and an intense and persistent longing for the deceased. In addition, Eliot pioneered the first empirical study of typical uncomplicated reactions to bereavement and distinguished between successful and unsuccessful recovery patterns. Later, Fulconer (1942) extended Eliot's work and presented a stage theory of grief. Together, they recognized that rather than being a single emotional state, grief was a process which included successive phases.

In the current literature, grief reactions are generally conceptualized as occurring in stages. Simos (1979) suggests that there are three phases of grief: shock, acute grief, and integration of the loss and grief. Temes (1980) calls these phases numbness, disorganization, and reorganization, while Bowlby (1961) suggests that the process, "begins with anxiety and anger, proceeds through pain and despair, and if fortune smiles, ends with hope" (p. 317). Others (Kavanaugh, 1972; Kubler-Ross, 1969; Parkes, 1972) have also presented stage approaches to grieving. However, the literature maintains that these phases are not discrete or sequential. Forward movement is often followed by regression. Also, it is not necessary to experience every stage and the intensity and duration of these stages varies

between individuals.

2.1.1 Impact of Death

Initial responses to the death of a significant person include shock, alarm, and denial. These reactions appear to be most acute in cases of sudden death when there has been no forewarning (Glick, Weiss and Parkes, 1974). Newly bereaved often describe themselves as being in a state of unreality and feeling numb, confused, and empty. Individuals in shock often react without emotion. According to Blank (1969), shock is a protective mechanism which protects the individual from overwhelming and painful emotions. It can persist for hours, days or weeks. However, as some of the numbness subsides, pervasive sadness and sorrow emerge which are expressed by crying and sobbing. Widows in the Glick, Weiss, and Parkes (1974) study also reported an inability to concentrate, loss of self-control, deep despair, and anxiety regarding an uncertain future. Somatic reactions described by these authors were insomnia, lack of appetite, tension, dizziness, nausea, and gastrointestinal disorders.

According to Simos (1979), "The reaction to shock is alarm. Alarm is defined as fear or anxiety caused by the sudden realization of danger" (p. 50). The loss of a loved one, especially someone the survivor depended upon and who provided security, can result in intense feelings of panic. Widows, for example, often experience a great deal of anxiety knowing that they now have to deal with all of their

responsibilities alone. This is especially apparent for those who now have to assume the role of family breadwinner.

In the early part of grief, denial is regarded as a healthy and appropriate response which insulates the full impact of reality. Simos (1979) proposes, "As the first reaction in every major loss, denial serves to provide a moratorium in time to protect the individual from a flood of emotions and a new reality" (p. 62). Gradually, everyday life reminds the bereaved of their loss and the death becomes more and more real.

2.1.2 Acute Grief

There are several features associated with the phase of acute grief which occurs when the shock of the death subsides. Depression is the most common symptom. Parkes (1972) has elaborated on this point by suggesting that "The most characteristic feature of grief is not prolonged depression but acute and episodic 'pangs'. A pang of grief is an episode of severe anxiety and psychological pain. At such a time the lost person is strongly missed and the survivor sobs or cries aloud for him" (p. 57). Pangs of grief are most frequent in the early weeks of bereavement and become less frequent as time passes. However, events or objects which remind survivors of their loss can precipitate pangs of grief. Events such as birthdays, date of death, and anniversary occasions are particularly painful reminders of the loss.

Parkes (1972) proposes that survivors often experience a compulsive need to retrieve the lost person. He calls this "searching" and described it as, "a restless activity in which one moves towards possible locations of a lost object. The person who is searching has to select places in which to look, move towards them, and scan them; he must also select what to see" (p. 64). The terms "pining" or "yearning" are used to describe the emotional accompaniments of searching behavior. The following behaviors are associated with searching: alarm, tension, a state of arousal, restless movement, preoccupation with thoughts of the lost person, development of a perceptual set for that person, loss of interest in personal appearance and other matters which normally occupy attention, direction of attention towards those parts of the environment in which the lost person is likely to be, and calling for the lost person (Parkes, 1972, p. 65). These features generally characterize the behavior of bereaved individuals.

Lindemann (1944) has described the searching behaviors of survivors as aimless hyperactivity. Parkes (1972), on the other hand, suggests that searching has the specific aim of finding the lost person, although individuals may or may not be consciously aware of the urge to search. Since the bereaved individual tends not to admit to this irrational aim, these behaviors are usually regarded by them and outsiders as aimless.

The bereaved are often preoccupied with thoughts of the deceased and with the events which led up to the loss. Painful memories of the death are repeatedly experienced. In his 1917 essay, Mourning and Melancholia, Freud described grief as the means by which the energy that bound the individual to the significant person was progessively withdrawn:

> The testing of reality, having shown the loved object no longer exists, requires forthwith that all libido shall be withdrawn from its attachments to this object. Against this demand a struggle of courses arises - it may be universally observed that man never willingly abandons a libido-position, not even when a substitute is already beckoning to him. The struggle can be so intense that a turning away from reality ensues, the object being clung to through the medium of a hallucinatory wish-psychosis. The normal outcome is that deference for reality gains the day. Nevertheless its behest cannot at once be obeyed. The task is now carried through bit by bit, under great expense of time and cathectic energy, while all the time the existence of the lost object is continued in the mind. Each single one of the memories and hopes which bound the libido to the object is brought up and hyper-cathected, and the detachment of the libido from it accomplished. Why this process of carrying out the behest of reality bit by bit, which is in the nature of a compromise, would be so extraordinarily painful is not all easy to explain in terms of mental economics. It is worth noting that this pain seems natural to us. The fact is, however, that when the work of mourning is completed the ego becomes free and uninhibited again. (p. 154)

The activity of repeatedly going over the loss in one's mind was termed "grief work" by Freud. This process has been labelled "obsessional review" by Glick, Weiss, and Parkes (1974) and appears to have a positive effect upon grief. In their Harvard study of widows they found that, "Obsessional review was sometimes useful in that it helped the widow

integrate the reality of the death emotionally as well as cognitively" (p. 126). Parkes (1972) explains:

> At such a time there is a conscious need to 'get it right' and getting it right is not just a matter of recalling the traumatic event correctly; it includes the need to 'make sense' of what has happened, to explain it, to classify it along with other comparable events, to make it fit into one's expectations of the world. (p. 96)

He further argues, "Grief work is the process of learning by which each change resulting from the bereavement is progressively realized (made real) and a fresh set of assumptions about the world established" (p. 164).

Widows in Parkes'(1972) London study also reported illusions of having seen or heard their dead husbands. As Parkes pointed out, "Ambiguous impressions will be interpreted to fit the looked-for object and attention will be focused upon them until the mistake has been corrected" (p. 68). He further suggests that the bereaved develop a perceptual set for the lost object or have in mind a picture of the deceased to aid in their search. They often direct their search towards places or objects most closely associated with the deceased. Calling for the lost person is also often associated with searching.

Parkes (1972) considers that the bereaved derive a sense of comfort by maintaining a belief that the deceased is nearby. Widows in his study also reported experiencing vivid and realistic dreams of their dead husbands which also provided them with comfort.

Anger is another prominent aspect of grief. According to Bowlby (1969), it is a normal component of grief and is considered by him to be an integral reaction to loss. Anger may be directed at the dead person, at those believed to be responsible for the loss, or at death itself. This is a period of supersensitivity for the bereaved; their anger is often misdirected at family and friends over trivial matters. This emotion often causes the bereaved a great deal of confusion especially when their anger is directed at the decreased. Over one-half of the widows in Parkes' (1972) London study presented general irritability and bitterness. He states, "This was commonly associated with the feeling that the world had become an insecure or dangerous place, an attitude that often persisted throughout the first year of bereavement" (p. 102). Worden (1982) has suggested that anger stems from two sources: frustration and helplessness. Frustration is the result of having been unable to do anything to prevent the death. A sense of helplessness and anxiety results from the awareness that the bereaved individual now exists without the dead person.

Guilt or self-reproach is another characteristic of the grieving process. Simos (1979 asserts, "It is generally held that guilt, self-reproach and even fleeting suicidal thoughts can be normal following a major loss, provided they do not take on structure and planning" (p. 115). She suggests that suicidal ideation is the result of wanting to escape the pain of grief. It may also result from a wish to

join the dead person.

Glick, Weiss and Parkes (1974) found that 47% of the widows in their study gave some indication of self-reproach. The bereaved may feel guilty about having been absent when the death occurred. They often feel that they could have done something to prevent the death. Guilt can also arise when survivors experience a sense of relief that the ordeal is over, as may occur in cases where the deceased suffered from a terminal illness. Guilt is often intensified if the past relationship with the deceased was characterized by hostility or negative feelings. Survivor guilt can be particularly severe in cases of bereavement by suicide.

Another component of grief is identification. "Identification occurs when individuals incorporate within themselves a mental picture of an object and then think, feel and act as they conceive the object to think, feel and act" (Simos, 1979, p. 143). In this case a survivor identifies with the deceased individual. The bereaved may take on some of the characteristics of the lost person such as interests, values, mannerisms, or other specific traits. A survivor can also identify with the illness which resulted in the death of the deceased to the point of presenting similar symptoms. According to Parkes (1972), "Identification with the lost person is one of the methods that bereaved people adopt to avoid the painful reality of loss; as such it may delay acceptance of the true situation but, like most other coping mechanisms, it is only

intermittently effective" (p. 128).

The major characteristics of the middle phase of the grieving process have been presented. Again, it is important to keep in mind that there is often great variation between individuals with regard to the intensity and duration of these features. However, in general it is during the period of disorganization that the bereaved experience the gradual realization that there is no hope of retrieving the lost person.

2.1.3 The Recovery Process

"The recovery to creative living is through the painful process of grief itself. There are no shortcuts" (Simos, 1979, p. 38). Unfortunately, the passage of time in itself will not heal the pain of grief. Grief needs to be fully experienced and worked through before recovery can occur. The reparative process demands energy as well as emotional and social readjustment. It is a slow process with many factors influencing the outcome. Failure to recover from bereavement can have significant detrimental consequences upon mental and physical health. Successful recovery, on the other hand, can enhance personal growth and enrich the quality of life.

Clinebell (1966) suggests that the tasks of grief work are threefold: acceptance of the reality of the loss, surrender of emotional ties to the deceased, and the formation of new relationships. He suggests that successful

recovery occurs when all three tasks are completed. Worden's (1982) conceptualization of successful grief work is similar; recovery requires the acceptance of the reality of the loss, experiencing the pain of grief, adjustment to an environment without the deceased, and the reinvestment of emotional energy into other relationships. Worden makes the following observation:

> One benchmark of a completed grief reaction is when the person is able to think of the deceased without pain. There is always a sense of sadness when you think of someone that you have loved and lost, but it is a different kind of sadness - it lacks the wrenching quality it previously had. One can think of the deceased without physical manifestations such as intense crying or feeling a tightness in the chest. (p. 16)

Parkes and Weiss (1983) propose that recovery from bereavement involves an intellectual acceptance of the loss, emotional acceptance of the loss, and a change in the individual's model of self and outer world to match a new reality. According to these authors, intellectual acceptance involves formulating an adequate account or explanation of how the death occurred. Emotional acceptance takes place when reminders of the death no longer overwhelm the bereaved individual with sadness and pain. Parkes and Weiss (1983) write, "For this state to be reached, there must be repeated confrontation with every element of the loss until the intensity of distress is diminished to the point where it becomes tolerable and the pleasure of recollection begins to outweigh the pain" (p. 157).

Self, or identity, referred to in their last task, is described as "a reasonably consistent set of assumptions about one's own self" (p. 160). For the newly bereaved individual, consistency of identity is lost to a certain degree. Specifically, societal roles and their requisite functions may be drastically altered as the result of the death of a significant other. For example, the woman who loses her husband is no longer considered by society to be a wife. She is a widow. However, she may still act as though the marriage is intact. When reality contradicts her behavior, an uncomfortable conflict in identities occurs. Parkes and Weiss (1983) explain, "Whenever we become aware of a discrepancy between the world that is and the world we had assumed to exist, we experience a sense of bewilderment or discomfort" (p. 160). Eventually, the bereaved come to recognize that they are now without a partner, and a predominant identity emerges. These authors propose that the completion of these tasks is essential if recovery is to occur.

Simos' (1979) view on recovery integrates those already stated. She suggests, "Healing comes from an immersion in the pain, actually a reattachment through memory to the valued object, the ability to endure the pain of grief, eventual relinquishment of the attachment, and finally reattachment to new people, values, and goals" (p. 38). Favorable outcome according to this author is characterized by the following features:

> Acceptance of the reality of the loss and return to physical and psychological well being, diminished frequency and intensity of crying, restored self-esteem, focus on the present and future, ability to enjoy life again, pleasure at awareness of growth from the experience, reorganzation of a new identity with restitution of the loss, and loss remembered with poignancy and caring instead of pain. (p. 33)

The experience of grief, if worked through successfully, can result in positive personal growth. As Caine (1974) suggests, "Grief can represent emotional growth, an enrichment of the self" (p. 67). Speaking from her own personal experience with loss and grief, she writes:

> There is no avoiding the natural progression of grief - nor should one want to. In this country, devoted as we are to the pursuit of happiness, we tend to forget that happiness has its price and that love must be paid for. And the coin with which some of us pay is grief. Amazingly, in the course of paying, one discovers a synergistic effect. By experiencing one's grief and accepting it, one grows in warmth, in understanding and in wisdom. I can testify that while my grief has been a bitter burden, it has also changed me and made me more aware of the importance of living each "minute of running time" to the utmost. (p. 69)

Caine illustrates several themes found repeatedly in the literature and in the personal testimonies of individuals who have had loss experiences. First, grieving and saying good-bye require courage to face the pain. Second, healing necessitates that grief be fully experienced and expressed, and finally, recovery and growth are indeed possible.

2.1.4 Pathological Grief

Unfortunately, the outcome of bereavement is not always favorable. Grief is not always worked through in a healthy manner. If issues remain unresolved and grief tasks are not completed, subsequent psychological difficulties may develop. According to Engel (1962), "Some people never completely dissipate the sense of loss and their dependence on the lost object and they remain in a prolonged, even permanent stage of unresolved grief" (p. 280). Failure to recover from bereavement has been described in the literature by terms such as abnormal, atypical, morbid, pathological, and maladaptive grief.

There appear to be many features that characterize poor outcome. Lindemann (1944) proposed that morbid grief reactions represent distortions of normal grief. They are typically characterized by a delay or postponement of grief reactions. Distorted reactions include: overactivity without a sense of loss, the acquisition of symptoms belonging to the last illness of the deceased, extreme hostility towards specific persons, changes in relationships to friends and relatives, and prolonged social isolation in addition to agitated depression.

Parkes (1972) concurs that typical grief reactions can be considered to be distortions or exaggerations of the normal grieving process. He found that atypical grief reactions were likely to include ideas of guilt or self-reproach and the tendency for the grief reaction to be

delayed. Parkes further found "Intense separation anxiety and strong but only partially successful attempts to avoid grieving, were evident in all the forms of atypical grief I have come across" (p. 136). Simos (1979) suggests that poor outcome can be characterized by the following features:

> Acceptance of the reality of the loss with lingering sense of depression and physical aches and pains, diminished sense of self-esteem, reorganization of a new identity with constriction of personality and involvement, and vulnerability to other separations and losses. (p. 33)

Counsellors and other helping professionals must be aware of the distinction between "normal" grieving and pathological grieving. Although many of the features of the grieving process resemble those found in psychiatric disorders, it would be a mistake to label and treat a healthy reaction to a life crisis as a psychiatric illness. Pathological grief reactions, on the other hand, are not healthy responses to loss. They tend to be characterized by delay of grief, prolongation of grief, excessive guilt, and an exaggeration of the features of normal grief.

2.1.5 Determinants of Grief

There is no shortage in the literature of the number of factors that affect outcome of grief. According to Parkes and Weiss (1983), the determination of favorable or unfavorable outcome is complex and the research findings to date have been inconsistent. Also, Bugen (1977) points out that the current available literature is primarily

restricted to studies involving widows. However, the prediction of outcome remains an important issue in bereavement research. Why is it that some individuals recover from bereavement while others experience complete breakdowns and require psychiatric care?

Uroda (1977) suggests that there are three important recovery parameters to consider. These are the personality of the bereaved, the relationship to the deceased, and the cultural norms for the expression of emotion. He suggests that the approaches we use to cope with bereavement are related to our personality and to the methods we generally employ to deal with stressful situations. Accordingly Uroda argues, "If denial or repression is the person's fundamental line of defense, there may be great difficulty in accepting the reality of the loss" (p. 187). On the other hand, he suggests, "More flexible and adaptive personalities are likely to deal with their frustations by changed behavior rather than by denial and fixation" (p. 187).

The relationship of the bereaved individual to the deceased is Uroda's second variable involved in recovery. The stronger the bond or attachment between them, the greater will be the impact and the effects of the death. Dependency relationships can be the most severely affected.

Societal norms and attitudes also have an effect upon recovery. In our society the bereaved are encouraged to control their emotions and overcome their loss quickly. This pressure often succeeds in suppressing necessary grief work

and delaying the reparative process.

Maddison (1967) is more explicit in his discussion of predictors of unfavorable recovery. From his study of conjugal bereavement he derived the following factors which appeared to contribute to the increased probability of poor outcome: (1) inadequate and ineffectual environmental support; (2) age of widow less than 45 with dependent children; (3) evidence of pre-existing marital difficulties; (4) protracted death (associated with severe suffering and disfigurement) maximizing pre-existing ambivalence and leading to feelings of guilt and inadequacy; (5) prior history of severe reaction to death of another family member; (6) additional stresses or crises in close temporal relationship to bereavement; (7) continued reaction formation against dependence; and (9) poor interpersonal relationship with own mother or husband's family.

Parkes (1972) also presents a similar but more exhaustive list of parameters predictive of poor outcome (See Appendix A). However, these variables appear to have been later condensed by Parkes and Weiss (1983) as a result of their Harvard bereavement study. These authors suggest that there are three primary determinants of pathological grief. They found: (1) Sudden, unexpected bereavements were a major precursor of poor outcome; (2) Reactions of anger and/or self-reproach, often associated with ambivalence toward the former partner, were associated with poor outcome; (3) Reactions of intense yearning; often associated

with a supposedly dependent relationship with the former partner, were also related to poor outcome.

Parkes and Weiss (1983) found that successful recovery from bereavement was less likely to occur if the death happened without forewarning. In contrast, Maddison (1968) and Clayton (1973) found no relationship between outcome and length of time for which the death had been anticipated.

In the Harvard study, Parkes and Weiss (1983) divided their bereaved subjects into two groups, a brief forewarning group (less than 3 days warning that death was imminent) and a long forewarning group (more than 2 weeks warning). They found that the brief forewarning group tended to display three features that have been shown by Parkes (1965) to characterize the grieving of bereaved individuals who subsequently sought psychiatric help. These features were an inability to acknowledge the reality of the death, guilt, and anger. The long forewarning group tended not to exhibit these features. Only 9 percent of the brief forewarning group showed good outcome as opposed to 56 percent of the long forewarning group. They have labelled the symptoms which arise from unanticipated and untimely death the Unexpected Loss Syndrome. According to Parkes and Weiss:

> It is characterized by a reaction that includes difficulty in believing in the full reality of the loss, avoidance of confrontation with the loss, and feelings of self-reproach and despair. As time passes, the bereaved person remains socially withdrawn and develops a sense of the continued presence of the dead person, to whom he or she continues to feel bound. But this feeling does not protect the bereaved person from loneliness, anxiety and depression. These remain severe and hamper the

person's ability to function socially and occupationally. (p. 93-94)

Secondly, Parkes and Weiss (1983) found that prolonged grief tended to occur when the surviving spouse had experienced a conflict-ridden marriage rather than a marriage characterized by contentment, happiness, and low conflict. Sixty-one percent of the Low Conflict bereaved group returned to effective functioning after 13 months while only 29% of the High Conflict group exhibited good outcome at this time. Finally, they found a significant association between intensity of yearning and the extent to which the survivor had depended upon the deceased. Dependency was defined as, "the inability to function adequately in the roles or ordinary life without the presence, emotional support, or actual help of the partner" (p. 135). Those survivors who were highly dependent on their spouses were found to be significantly more likely to display chronic or unyielding grief.

Bugen (1977) presents a slightly different model for the prediction of bereavement outcome. He proposes that outcome is a function of the interaction betwen closeness of relationship (central vs peripheral) and perception of the preventability of the death (preventable vs non-preventable). Centrality and peripherality refer to the closeness in the relationship between the survivor and the deceased. The preventability variable indicates that the survivor believes that the death could have been avoided. It

also refers to the survivor's belief that they contributed directly or indirectly to the death. Unpreventability, on the other hand, indicates that the survivor believes that nothing could have been done to avert the death. Given these two dimensions, Burgen argues that the following four outcomes are possible: (1) If a central relationship existed between survivor and deceased and the survivor believes that the death could have been prevented, the grieving process will be intense and prolonged; (2) If a central relationship existed between the survivor and the deceased and the survivor believes that the death could not have been prevented, the grieving process will be intense but brief; (3) If a peripheral relationship existed between the survivor and the deceased and the survivor believes that the death was preventable, the grieving process will be mild but prolonged; (4) If a peripheral relationship existed between the survivor and the deceased and the survivor believes that the death was unpreventable, then the grief process will be both mild and brief.

Worden (1982) suggests that the secondary gain a survivor may find in his or her grieving is another variable to consider. According to this author, "A survivor might get a lot of mileage in his social network out of grieving and this would have an effect on how long it goes on. However, extended grieving can have an opposite effect and alienate the social network" (p. 31).

Several variables predictive of poor bereavement outcome have been presented. However, given that grief is a highly individualized experience, responses to death will vary immensely. Based on these predictors, then, a person who would be expected to have an unsuccessful recovery can still present a favorable outcome. The opposite is also true. An individual expected to show a good recovery can indeed present an unfavourable outcome.

2.2 BEREAVEMENT SUPPORT PROGRAMS

Health care professionals are slowly recognizing the need for the delivery of supportive community based services to the bereaved. A variety of community preventive intervention programs have been developed in the last 15 years. Unfortunately, these programs are often discontinued due to insufficient funding (DeGraves, 1977). This is probably a reflection of western society's negative attitude toward death and grief in general.

The need for support during bereavement has been well documented in the literature. Maddison and Walker (1967) demonstrated that social support is associated with emotional adjustment among the bereaved. They found that widows who perceived a lack of support during their crisis tended to exhibit physical and emotional difficulties which led to a deterioration in health. Other studies (Arkin, Battin, Gerber & Wiener, 1975; Parkes, 1975; Raphael, 1977) have shown that supportive treatment for the bereaved has

produced positive psychological results. According to Simos (1979), "Support whether by families, relatives, friends or helpers is the keynote to intervention in loss" (p. 213).

There are many definitions of social support in the literature. Caplan (1974), who has written extensively on the subject, proposes that support systems are:

> ...continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validations of their expectations about others... People have a variety of specific needs that demand satisfaction through enduring interpersonal relationships... Most people develop a sense of well-being by involving themselves in a range of relationships that in toto satisfy these specific needs... (p. 4-5).

Cobb's (1976) definition focuses on the importance of information derived from support networks. He defines social support as, "Information leading the subject to believe that he is cared for and loved, esteemed and a member of a network of mutual obligation" (p. 300).

Community based bereavement programs are generally classified into two categories: self-help groups which utilize a peer counselling approach and groups which employ professional guidance. A growing number of people are joining self-help groups. Their estimated membership in Canada is in the hundreds of thousands (Romeder, 1982). Self-help groups have become an important way of supporting individuals and families during crisis periods. In a Health and Welfare Canada document entitled Self-Help Groups in Canada, Romeder (1982) proposes, "Most self-help groups are a powerful means of prevention in that they make it possible

to reduce the risk of disease that result from exposure to the stressful psycho-social situations associated with various crises or other difficult situations" (p. 18).

The Widow to Widow program developed by Silverman (1970) is an example of a supportive program that utilizes non-professionals. Care-givers are widows who have themselves recovered from bereavement. This model was used to develop the New York Widows' Consultation Centre and the Winnipeg Consultation Centre. According to Silverman (1970):

> The purpose of any program in preventive intervention is to prevent emotional breakdown in a vulnerable population. While, at this point, we cannot demonstrate that we are achieving this goal in the Widow to Widow Program, it becomes clear that the aides are indeed very helpful to the widows they reach and that in good part their ability to do so is a consequence of their being widowed themselves. (p. 545)

Barrett (1978) has found that programs based on the Widow to Widow model can foster psychological and emotional change. Nyberg and Griffiths (1978) created their own bereavement support group and found that the group process did have a facilitative effect upon grieving. These authors offer several reasons for the validity of the shared grieving approach:

> We believe that people experiencing a similar life crisis have something of value to offer each other. They show each other that, in most instances, it is natural to feel as they are feeling. It is reassuring to know in this time where strong feelings can be prevalent, that weeping is a normal outlet, that anger and bitterness are understandable, that fears of going mad are common and that it will be a long time before relief is felt. This kind of coming together and sharing, at a time when they are faced with loss, isolation, a

> sense of emptiness and general "closing off" of old avenues, offer the group members the opportunity for their lives to begin to "open out" again, with new contacts, new experiences, and the feeling that they can share and are not too empty to give. This opening out is potentially the beginning of readjustment and reinvestment in their lives. (p. 27)

Parkes (1980) reviewed a number of research studies involving grief counselling services and made the following conclusion:

> The evidence presented here suggests that professional services and professionally supported voluntary and self-help services are capable of reducing the risk of psychiatric and psychosomatic disorders resulting from bereavement. Services are most beneficial among bereaved people who perceive their families as unsupportive or who, for other reasons, are thought to be a special risk. (p. 9)

On the other hand, Vachon, Lyall, Rogers, Freedman-Letosfsky, and Freeman (1980) found that while the presence of supportive relationships is valuable during the initial phases of bereavement, they have no significant association with later recovery.

"Grief must be shared with another person" (Simos, 1979, p. 6). Bereaved individuals often feel a pressing need to talk about their feelings of grief and about the deceased. However, they are often prevented from ventilating their feelings by family members and friends. Platitudes which encourage bereaved individuals to "get on with your life" and "cheer up", at a time when they are emotionally unprepared to do so, serve to cut off their expressions of grief. Widows in the Maddison and Walker (1967) study

regarded these types of responses as unhelpful and extremely irritating. Similarly, participants in the Living Through Loss group also considered these interactions to be extremely unhelpful. There are several possible explanations for why people prevent the bereaved from expressing their feelings. Often those people who have not experienced a loss by death have personal fears about death. Therefore, they are extremely uncomfortable about the subject and either consciously or unconsciously avoid its discussion. Another possibility is that well-intentioned individuals do not wish to "upset" the bereaved by discussing the deceased. Finally, there appears to be a societally imposed grieving deadline of about one year which is not to be exceeded. Grieving beyond one year is often discouraged. In bereavement groups the open expression of feelings and emotions is encouraged, regardless of the amount of time that has passed since the date of death.

Bereaved individuals may feel that they are going crazy. Often, they do not understand the normalcy of their emotions, or that grief is a psychologically healthy and necessary process. Support groups provide an educational experience in that participants learn that their feelings are a normal reaction to their loss. They also learn how grief can affect them physically and intellectually as well as emotionally. Groups offer an opportunity to meet others who are experiencing similar feelings; as alliances develop among the group members, they quickly find out that they are

not alone. They also receive emotional support and encouragement from helpers who are aware of their psychological needs. At the very least, groups provide the bereaved with an opportunity to engage in a new activity at a time when initiating new activities is very difficult.

2.2.1 The Living Through Loss Program

The Family Development Program of the Family Service Association of Edmonton began to provide bereavement services in April, 1981. The following information was provided by Ms. Karen Martin, Family Development Coordinator of the Family Service Association of Edmonton (Personal correspondence, May, 1984). An earlier study conducted by this organization found that bereavement resources in Edmonton were greatly lacking, particularly, in the areas of professional expertise and leadership for support groups. Therefore, a bereavement program was established on the basis of the following goals:

1. To provide a comprehensive community based service of support and information to the bereaved.
2. To provide an educational service to the general public and professionals on meeting the needs of the bereaved in their communities.

Currently, the Family Service Association offers four Living Through Loss courses per year, workshops, seminars, home visits and a series of public bereavement information sessions.

The Living Through Loss program runs for eight weeks and is facilitated by a certified psychologist. A maximum of eight group members meet once a week for three hours. An outline of the general agenda of the sessions is provided in Appendix B.

Adults of all ages have participated in this program. Their bereavement experiences are all unique. Some have experienced a recent loss while others have experienced their loss several years ago.

According to Ms. Martin, the Living Through Loss program does not provide therapy. She makes a clear distinction between therapy and the services provided by the bereavement program. Ms. Martin explained that Living Through Loss is based on the belief that most people can overcome most crises with information and support rather than therapy. The following excerpt was taken from a report completed by a Family Service Association of America Task Force on Family Life Education, Development, and Enrichment (1976). It reflects the philosophy of the Living Through Loss Program:

> There are real but sometime elusive differences between therapy and educational goals, despite the overlapping which emerges from educational and therapeutic components and the stress to change common to all groups. Traditional therapy rested on a medical model and on concepts of disease entities. Today therapy continues to tie to pathology and dysfunction. Family Life Education, in contrast, is tied to concepts of human growth development, and potential. The resources of the individual are the primary emphasis.
>
> The focus is on the development of knowledge and understanding of life's stages and life's tasks in order to prepare the individual to deal with

> life's eventualities. The focus is on skill development and the behavior to be dealt with is clearly specified to help the client obtain problem-solving and conflict resolution skills. The assumption is that behavioral and feeling changes can occur without the focus on the genesis and dynamics of behavior.

2.3 PERSONALITY VARIABLES ASSOCIATED WITH GRIEF

2.3.1 Meaning in Life

Simos (1979) suggests that the experience of bereavement can radically change our understanding of the meaning of things. She proposes, "For life to be tolerable after a loss, there must be a search and a restoration of meaning" (p. 211). As was mentioned previously, the bereaved often feel compelled to make sense out of their loss experience and to generate explanations for the death. This is likely a part of their search for meaning.

According to Frankl (1939), "Man's search for meaning is a primary force in his life" (p. 154). He advocates that the meaning of life differs between individuals and is highly transitional. Frankl suggests that there are three ways to discover meaning in life; (1) by doing a deed; (2) by experiencing a value and (3) by suffering. Suffering the loss of a loved one presents a great challenge to find meaning.

Silver and Wortman (1980) propose that the ability to find meaning does play a role in recovery from crisis. They write:

> When a person is suddenly, uncontrollably victimized by criminal assault, disease, physical disability, or loss of a loved one, psychological adjustment may well be influenced by the individual's ability to find meaning or purpose in his or her misfortune. (p. 317)

Simos (1979) further suggests, "Only through restoration of meaning can loss become an influence for growth in the lives of the bereaved, and even in the lives of the generations that follow them" (p. 215). Related studies (Cornwell, Nucombe, & Stevens, 1977; Helmrath & Steinitz, 1978) found that the ability of parents to find meaning in the loss of a child has a positive effect upon recovery.

2.3.2 Helplessness

"Bereavement is an experience of loss of control, in which one is often a passive victim of an external event" (Simos, 1979, p. 79). A death crisis forces upon us the reality that, ultimately, we are not in control of our own destinies. As a result, we can experience intense and overwhelming feelings of helplessness and powerlessness. According to Seligman (1975), "A person or animal is helpless with respect to some outcome when the outcome occurs independently of all his voluntary responses" (p. 17). This is precisely what occurs in the situation of the bereaved individual. Simos (1979) suggests that helplessness has two aspects, "the helplessness in longing for that which is irretrievable, and the helplessness in facing the future without that which has been lost" (p. 79).

2.3.2.1 Relationship Between Helplessness and Locus of Control

The locus of control construct originated within Rotter's Social Learning Theory. It refers to an individual's beliefs about causality, the relationship between personal actions and outcomes. The construct is used to investigate helplessness as a personality variable.

An individual's expectations with regard to responses and outcome can be arrayed along a locus of control continuum. External locus of control refers to the pervasive belief that events or outcomes occur independently of personal efforts. Therefore, individuals whose generalized expectancies are described as external tend to attribute outcomes to factors such as luck, fate, or chance. Internal locus of control refers to the belief that one's actions do have an impact upon events and outcomes. Thus, an individual's expectancies regarding personal actions and outcomes can be described more or less as either internal or external. However, as Lefcourt (1976) cautions:

> ... it is to be understood that the responses given to locus of control related questionaires are not identical to the construct, locus of control, nor perhaps to those phenomenologically real and private thoughts of individuals pertaining to causality. They are but rough approximations of what is believed to be a person's expectancies about control. (p. 112)

Lefcourt (1980) argues that an external locus of control impedes the coping process and is associated with negative feelings. He writes:

> In general, persons who have described themselves as holding generalized expectancies of external control appear to behave in ways that are congruent with descriptions of helplessness. They are less likely to be active in the pursuit of information related to the state of their own well-being, are less likely to use information if it is available, and are less likely to express those positive affects that are associated with a state of well-being than are internals. (p. 247-248)

Lefcourt suggests that given this knowledge, the shifting of an individual's locus of control from an external to an internal position would appear to be a natural goal for therapists. Singer (1965) writes:

> ... the single proposition which underlies all forms of psychotherapy, the proposition that man is capable of change and capable of bringing this change about himself ... were it not for this inherent optimism, this fundamental confidence in man's ultimate capacity to find his way, psychotherapy as a discipline could not exist, salvation could come about only through divine grace. (p. 16)

To what extent does a death crisis alter an individual's perception about his or her ability to influence future outcomes? Unfortunately, there is little research regarding the impact of a death loss upon locus of control. However, related research involving other types of traumatic events has shown that locus of control scores do shift with relevant environmental events. For example, Smith (1970) examined the locus of control scores of individuals who presented themselves at a crisis intervention center. Smith hypothesized that an acute crisis would result in helplessness and a generalized external locus of control. Further, he proposed that upon resolution of the crisis,

individuals would return to a more internal locus of control. Upon completion of a six week treatment program, Smith found that these individuals' loci of control significantly shifted to become more internal. In other related studies, (Bryant & Trockel, 1976; Murphy & Moriarity, 1976) investigators have shown that the occurrence of traumatic events in early life were related to highly external orientations in adulthood.

2.3.3 Self-esteem

According to Simos (1979) "Loss always carries with it a threat to self-esteem" (p. 20). The bereavement experience can have a potentially negative effect on the way in which survivors evaluate themselves in terms of personal worth. Bowlby (1961) suggests that the world and the self are experienced by the bereaved as poor and empty and that this accounts for much of the loss of self-esteem.

Coopersmith (1967) defines self-esteem as:

> ... the evaluation which the individual makes and customarily maintains with regard to himself; it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, succcessful, and worthy. (p. 5)

Low self-esteem is often associated with the following features; social withdrawal, self-hatred, submissiveness, anxiety, depression, self-consciousness, and lack of confidence (Coopersmith, 1967).

Maslow (1943) argues that self-esteem is one of several basic needs that all individuals possess:

> All people in our society (with a few pathological exceptions) have a need or desire for a stable firmly based, (usually) high evaluation of themselves, for self-respect, or self-esteem, and for the esteem of others. By firmly based self-esteem, we mean that which is soundly based upon real capacity, achievement, and respect from others. Satisfaction of the self-esteem need leads to feelings of self-confidence, worth, strength, capability, and adequacy of being useful and necessary in the world. But thwarting of these needs produces feelings of inferiority, of weakness and of helplessness. (p. 371)

The experience of bereavement may lead to feelings of insecurity, vulnerability, isolation, and abandonment; these in turn can negatively affect one's level of self-esteem and general state of well-being.

2.4 GENERAL RESEARCH HYPOTHESIS

The general hypothesis that governs this thesis is that participation in the Living Through Loss program has a positive impact upon the grieving process. It is suggested that the information, support, and encouragement received in a bereavement support group can facilitate grieving and can help survivors integrate their losses more effectively.

2.5 SPECIFIC RESEARCH HYPOTHESES

Death challenges our sense of meaning in life. The bereaved often comment that their lives lack purpose and direction. The research suggests that finding meaning in our losses can have a positive effect on the recovery process.

It is proposed that the Living Through Loss program will facilitate the survivor's search for meaning, and therefore enhance the possibility that their loss experience will eventually lead to personal growth.

It has been suggested that bereavement is an experience of loss of control and results in helplessness. Given the relationship between the locus of control construct and helplessness, it is herein proposed that individuals are likely to develop an external locus of control as a result of bereavement. In other words, the bereaved will tend to perceive their personal actions as being ineffective or as having no impact upon future events or outcomes. The general hypothesis of this thesis suggests that participation in a bereavement support program facilitates recovery and leads to a resolution of the loss. With regard to recovery and locus of control, Smith (1970) found that the resolution of a crisis leads to internal control. It is therefore proposed that participation in a bereavement support group will produce an internal locus of control as a consequence of the resolution of the crisis.

The research suggests that a healthy level of self-esteem is necessary in order for an individual to maintain a general sense of well-being. The bereavement experience has the potential for lessening one's self-esteem because of the overwhelming sense of self-reproach, frustration, and helplessness that often accompanies loss. It is suggested that the Living Through Loss program

facilitates the recovery process by enhancing the self-esteem of its participants.

3. METHODOLOGY

3.1 Introduction

The research was designed to investigate both descriptively and experimentally whether membership in a bereavement support group could facilitate the recovery of bereaved individuals. Specifically, the goal of this study was to test the hypothesis that participation has a positive effect on three aspects of the grief experience: meaning in life, helplessness, and self-esteem.

3.2 Sample

Although a total of 11 subjects were initially involved in this study, 2 subjects dropped out of Phase I. The following information provides brief descriptions of each individual within each phase of this study.

Phase I (November - January 83/84) Participants

Subject 1

Subject 1 was a 36 year old woman. Three months prior to the commencement of the program her 45 year old husband of 5 years died suddenly of a heart attack. She has two step-sons living at home. Subject 1 is employed full-time outside the home.

Subject 2

Subject 2 was a 57 year old woman. Her husband, aged 58, died 6 weeks ago, following a lengthy ordeal with cancer. They had been married for 35 years. She has two

children who do not live at home. She has not been employed outside the home for many years.

Subject 3

Subject 3 was a 39 year old woman. Her 69 year old mother died on Easter Sunday, 1983, following a lengthy illness. She is married and has two children living at home. She is not employed outside the home.

Subject 4

Subject 4 was a 50 year old female. Her 19 year old son died suddenly of a rare disease 5 years ago. Her brother died during her participation in the Living Through Loss program. She is currently separated from her husband and has one daughter living with her. Her other two children live with their father. She is employed part-time outside the home.

Subject 5

Subject 5 was a 55 year old woman. Her sister died suddenly one month ago. Both her parents also died within the last year and a half. She is divorced and lives with her teenage daughter. She is employed full-time outside the home.

Subject 6

Subject 6 was a 28 year old female. She gave birth to a stillborn 2 months ago. She is married and employed full-time outside the home. Subject 6 dropped out of the program after 3 sessions.

Subject 7

Subject 7 and Subject 5 were sisters. Subject 7 was physically disabled and currently not employed outside the home. She is 48 years old. Subject 7 dropped out of the program after one session.

Phase II (February - May 1984) Participants

Subject 1

Subject 1 was a 27 year old woman. She was driving the car in which her 20 month old nephew, sister, and uncle were killed as the result of an auto accident. The accident occurred 4 months ago. Subject 1 is divorced.

Subject 2

Subject 2 was a 39 year old woman. She is a student. Her mother died 6 months ago of a heart attack at the age of 73. Subject 2 is divorced and has two children.

Subject 3

Subject 3 was a 41 year old woman. Her 41 year old husband committed suicide one day before their divorce was to become final (2 years ago). She has two children and is employed full-time outside the home.

Subject 4

Subject 4 is a 46 year old woman. Her 50 year old husband died of an accidental self-inflicted gunshot wound one month ago. She is retired and has three children.

3.3 Procedure

Phase I

This study was comprised of two distinct phases. Phase I descriptively investigated the effects of participation in a bereavement support group. It involved this researcher's participation as a member of the Living Through Loss program. The purpose of this involvement was to allow the investigator to become familiar with the agenda of the program and to experience and describe the group process and its members first hand.

Phase II

Phase II involved the administration of a battery of standardized tests to a second independent group of 4 bereaved participants. These tests were used to assess the impact of the bereavement program upon three aspects of the grief experience: meaning in life, helplessness, and self-esteem. They were administered approximately one week prior to the start of the program and again approximately one week after the completion of the program. Demographic data for all the participants were collected during the screening interviews and from information provided by the group facilitator.

3.4 Instrumentation

Five standardized test instruments were used to assess impact of grief, purpose in life, helplessness, and self-esteem. These were: (1) The Grief Experience Inventory;

(2) The Purpose in Life Test; (3) The Seeking of Noetic Goals Test; (4) Rotter's Internal-External Locus of Control Scale; and (5) The Canadian Self-Esteem Inventory for Adults.

Grief Experience Inventory (GEI)

The instrument used to obtain a general profile of grief symptoms was the Grief Experience Inventory. This instrument, designed by Sanders, Mauger, and Strong (1979) is in the form of a 135-item true or false questionnaire. Content areas include: Somatic, Emotions, Interpersonal Relations, and Thought Content. Raw scores are converted to T-scores and according to the authors, the larger the T-score, the greater the intensity of the behavior measured by the scale.

Sanders, Mauger, and Strong (1979) report scale reliability values that varied between 0.52 and 0.87 for a sample of 22 college students, and values ranging from 0.18 to 0.69 for 79 bereaved individuals. According to these authors, "The lower test-retest coefficients obtained from this group are most likely the results of the many real changes in the experience of grief during the 18 month period between the test administrations".

Purpose in Life Test (PIL)

The instrument used to measure the degree to which an individual has found meaning in life was the Purpose in Life Test designed by Crumbaugh and Maholick (1964). This is an attitude scale constructed from the orientation of

Logotherapy. It is used to determine existential vacuum. Existential vacuum refers to the state of emptiness experienced when one does not possess meaning or purpose in life.

Part A of this test is comprised of 20 statements. Each statement is answered by responding to a 7 point rating scale. Part B involves the completion of statements and Part C involves writing a paragraph describing the individual's aims, ambitions, and goals. Parts B and C are interpreted clinically and were not used in this analysis.

Raw scores have a range of 61 to 140 ($\bar{X}$=102, SD=19). According to the authors, raw scores of 113 or above suggest the presence of definite purpose while raw scores of 91 or below suggest the lack of clear meaning or purpose.

Seeking of Noetic Goals Test (SONG)

The seeking of Noetic Goals Test (SONG) designed by Crumbaugh (1977) is a complimentary scale to the Purpose in Life Test and is used to measure the strength of motivation to find meaning in life. According to the author, "Combined use of the two scales has proved helpful in determining the probability of successful therapeutic intervention".

The SONG is comprised of 20 statements. The subject circles their response on a continuum of one to seven. Scores have a range of 20 to 140 with a normative cutting score of 79, a mean of 73, and a standard deviation of 14 for normals. The higher the score, the greater is the motivation of the individual to seek meaning. Crumbaugh

(1977) reported reliability as 0.71+0.04 (Pearson product-moment), Spearman-Brown corrected to 0.83.

Rotter's Internal - External Locus of Control Scale

The Rotter Internal-External Locus of Control Scale designed by Rotter (1966) was used to assess locus of control as a measure of helplessness. The test contains 23-question pairs plus six filler questions. Each pair is comprised of an external and an internal statement, and the respondent chooses the one which they agree with the most.

Scores range from zero (most internal) to 23 (most external) with a mean of 8.2 (SD=4.0) for males, a mean of 8.5 (SD=3.9) for females, and a mean of 8.3 (SD=3.9) for both sexes combined. Rotter (1966) reports test-retest reliabilities for several samples that vary from 0.49 to 0.83 depending upon the time interval and the sample involved. Internal consistency coefficients of 0.65 to 0.79 are also reported by Rotter.

Canadian Self-Esteem Inventory for Adults

The Canadian Self-Esteem Inventory for Adults designed by Battle (1977) was used to obtain a measure of self-esteem. The test is comprised of forty items to which the subject responds either yes or no. The instrument measures an individual's perception in the areas of self, personal, and social.

The self-esteem score is the total number of items checked off by the respondent which indicates high self-esteem. Battle (1977) reports a mean of 23.97 (SD=5.16)

for males, a mean of 23.33 (SD=5.66) for females and a mean of 23.48 (SD=5.48) for the sexes combined. Battle reports a test-retest reliability of 0.81 and internal consistency correlations of 0.78, 0.57 and 0.72 for general self, social self, and personal self subscales, respectively.

3.5 Analysis

The criterion used to assess significant changes on the Grief Experience Inventory was proposed by Sanders, Mauger, and Strong (1979). According to these authors, "At least five, if not ten, T-score points change should be used as a rule of thumb before inferring that a change has occurred". Therefore, an observed change of at least 5 T-score points was necessary in this study before inferring that change had occurred in terms of any subscale.

The criterion for determining significant differences on the remainder of the four tests was a score change of at least one standard deviation from the mean of the test.

3.6 Limitations of the Study

Evaluation of client change upon termination of therapy remains a problem for counsellors. There are several limitations to this type of research, all of which apply to the present project.

Given that there was no control group of non-treated bereaved subjects and no control over external factors which may have contributed to the outcome, it is not possible to

positively conclude that the program was responsible for differences observed. Similarly, although clients may report behavior changes one cannot assume that these changes extend beyond the counselling situation. On the other hand, behavior change is not necessarily the goal of grief counselling. Zilbergeld (1983) refers to two types of therapy outcome: people-changing and people-providing. Contrary to the widely held opinion that the final goal of counselling is to bring about some attitudinal or behavior change in the client, Zilbergeld suggests, "The most common products of most therapies are not behavior change but caring, comforting, and structuring" (p. 152).

Other limitations include the size of the sample and the fact that all of the subjects are female. Given that greater sampling error occurs with a small sample, it is difficult to generalize conclusions. Similarly, it may not be appropriate to apply the results to bereaved males since expressions of grief and grief related behaviors can conceivably differ between the sexes.

Finally, and perhaps most importantly, gathering data on a highly emotional and sensitive group of grieving individuals is a difficult and delicate task. Research may be considered to be an intrusion, and grief is a personal experience which many do not wish to share on paper. To quote one participant:

> I think these forms are too lengthy and repetitive. I really think that these deep questions are too hard for most people under stress to answer. Most of them are ambiguous, too general. I really disagree

with your giving a grieving person all these questions. I'm remembering when just after my husband's death, I could hardly write my own name on a cheque, much less concentrate on a questionnaire such as yours.

4. FINDINGS AND CONCLUSIONS

4.1 Phase I: Observations and Impressions

The purpose of Phase I was to descriptively investigate whether participation in a bereavement support group has a positive impact on the grieving individual. Positive impact was defined as bringing the bereaved individual nearer to a resolution of their loss. It does not necessarily mean the completion of the grief process but rather, that positive changes occur in terms of feelings, attitudes, or behaviors which help the individual to deal more effectively with their loss.

This researcher participated as a member of the Living Through Loss program in order to become more familiar with the issues and concerns of the bereaved and to observe and present their progress over the eight sessions. As a means of assessing the effectiveness of the program, Phase I identifies participant's expectations of the group and explores their perceptions and attitudes toward their crisis.

Effective listening is the most important skill for helpers involved in bereavement counselling. Problem solving approaches are ineffective for the most part simply because you cannot problem solve the death of a loved one. There are no "cookbook" solutions or package programs one can follow in order to finish the business of mourning. However, the literature does suggest guidelines which can help to make

grief counselling effective. Worden (1982) has suggested ten counselling principles: Help the survivor actualize the loss; Help the survivor to identify and express feelings; Assist living without the deceased; Facilitate emotional withdrawal from the deceased; Provide time to grieve; Interpret "normal" behavior; Allow for individual differences; Provide continuing support; Examine defenses and coping styles; and Identify pathology and refer.

What are the expectations of the bereaved when they join the Living Through Loss Program and does the program satisfy these needs in terms of following the above guidelines? During the initial interview with the facilitator, a registration form was completed by the participants of Phase I. It asked the question, "What do you need to help you deal with your loss?" The following responses were derived from these registration forms:

- "to help me start to feel and care again"
- "support and new direction, I don't know"
- "understanding that my feelings are not weird"
- "self-esteem, losses of children leaving home, dealing with divorce, how to understand my emotions"
- "support and information"
- "closeness and I need to deal with my emotions"

These responses indicate a need for support and a concern about the overwhelming emotions arising from the grief experience. Frequently, bereaved individuals do not

understand that their feelings are a normal reaction to a very stressful situation. In addition, if they perceive a lack of support in their environment, the problem is compounded because they feel totally alone.

The following is a progressive summary of the issues and concerns raised by participants over the course of the eight sessions. The first session consisted primarily of introductions with participants sharing the "story" of their loss and explaining why they had decided to attend. Group members shared their feelings about their pain and helplessness. Concerns were raised regarding loneliness, new responsibilities, and how other family members were reacting to the loss.

A great concern of the participants was the fear that they were going "crazy", that some of their feelings and behaviors were extremely bizarre and abnormal. Members related the behaviors that they had engaged in after the death which they considered to be indicative of mental illness. These included memory lapses, lethargy, dreaming of the deceased, and searching for the deceased. Many of the thoughts, feelings, and behaviors were similar between individuals. The realization that others felt similar emotions and had engaged in similar behaviors appeared to alleviate their anxiety. In addition, the confirmation by the facilitator that these behaviors were not unusual dispelled some of their fears.

Each member had joined the program at a different point in the grief process. This was indicated by the differences between members with regard to their emotional acceptance of the death, the amount of anger still felt as a result of the loss, as well as the degree of emotional pain and current level of adjustment. Some participants were still experiencing intense levels of turmoil. However, differences in grieving did not affect the sharing that took place in the group. All members, regardless of the present intensity of their pain, were willing to share their personal experience and listen to those of others. Group comraderie evolved during the first session with members offering support to each other as well as an increased willingness to disclose something of themselves and the deceased.

The sessions progressed with an increasing amount of verbal spontaneity and personal disclosure. Often, the facilitator found it difficult to limit the sessions to three hours because of the intense participation. With the exchange of phone numbers in the second session, a supportive network developed outside of the program, and members contacted each other on a social basis. This would appear to indicate a heightened energy level among the participants, as many had related that their lack of energy had made it difficult to make even simple decisions about going out. Practical advice regarding lawyers, funeral homes, finances, and insurance matters was often exchanged during the sessions. One participant even accompanied

another to her lawyer's office to provide moral support.

A session often began with participants sharing any "left-over" concerns about the previous meeting or their experiences during the week. Those who were recently bereaved were particularly vulnerable to stress. Encounters with insensitive friends and colleagues as well as physical reminders of the deceased such as their personal possessions were emotionally stressing. These experiences often resulted in the intensification of crying, depression, and anxiety.

Members discussed the new social difficulties that had arisen since their losses. One widow related that the affection which her male friends had previously expressed toward her had stopped soon after her husband's death. Other participants related similar experiences with friends and relatives who withdrew social contact after the funeral. In addition, those women who had lost their husbands perceived that their new status as widows had substantially decreased their desirability, and they were apprehensive about being single again in a couple oriented society.

One of the major themes which developed from the discussions involved the insensitivity of eager advice givers. Members shared feelings of anger and resentment toward individuals who were continually offering platitudes and meaningless condolences. One participant expressed resentment at the mass produced sympathy messages in the cards which she had received. Others were outraged by suggestions such as "I know how you feel", or "You will get

over this". Comments which minimized their loss such as "You're lucky to have other children", were regarded as extremely unhelpful.

The general group concensus was that the majority of people were not deliberately trying to be insensitive, but rather, they simply did not know what to say or do. The group's offering to caregivers was that if one did not know what to say, it was better not to say anything and just listen. Genuine comments such as, " I don't know how you feel, but I do care" were perceived by the participants as honest and sensitive.

The members were also tired of the injuctions that they had encountered which prevented them from grieving and discussing the deceased. They were often discouraged by others from crying and talking about the circumstances of the death. The attitudes of these people suggested to them that it was better to try to forget and move on with their lives, something that was impossible for them to do at this point.

Hostility was also directed toward institutions. For example, one member expressed anger toward the hospital where her son had died. Hospital personnel released the news of the boy's death to his sister over the telephone. Another was upset with the funeral home for not following her explicit instructions. The young woman who gave birth to a stillborn was outraged when the nurses assumed from her calm behavior that she had accepted her loss, and then asked her

to give support to other women on her ward who had also lost their babies.

Christmas was a difficult time for most of the individuals especially those who were recently bereaved. They wanted the holiday season to be over as quickly as possible. Most had made plans to keep busy. At this time participants were working on collages that told a pictorial story about the deceased. It involved creating a poster that described the dead person. After Christmas each member brought their collage to the session and shared it with the group. The creation of the collage and its presentation was an especially difficult confrontation. Collages included photographs of the deceased and depicted special memories. For some members it was an extremely painful exercise that resurrected fears of becoming overwhelmed or losing control. However, the group concensus was that it had been a valuable experience. One participant made the following comment about her collage:

> The collage was extremely difficult but very beneficial. It forced me to think about all the facets of life with my husband and to decide how to describe him as an individual. I enjoyed being able to talk about him - society does not normally give you the freedom of talking about someone who has died.

As was presented earlier in this chapter, Worden (1982) has outlined several counselling objectives for helpers working in the area of bereavement. These guidelines were observed in practical application during the course of the Living Through Loss sessions and lends credibility to this

program as an effective mode of intervention.

Helping the survivor actualize their loss refers to the complete awareness that the death has occurred and that the deceased will not return (Worden, 1982). Talking about the circumstances of the death or telling the "story" to others is a prerequisite of actualization. The Living Through Loss program provided an opportunity for its members to experience the pain of grief and encouraged them to talk about their current loss as well as previous losses. These discussions consolidate the reality and finality of the death. Participation in a homogenous group has an advantage in that the survivor knows that they are relating to others who truly understand their grief and are willing to listen. Attendance in itself may be indicative that the survivor is overcoming denial, since they are willing to associate and identify with other bereaved individuals.

The second principle refers to identifying and expressing the emotions of anger, guilt, helplessness, and sadness. Although there was a great deal of anger directed at specific individuals and institutions, there was no anger observed to be aimed directly toward the deceased. There are several possible explanations for this observation. The group itself may have had an inhibitory effect upon the open expression of anger and negative feelings towards the deceased. In general, anger with the dead individual is not acknowledged by society to be an appropriate emotional response and is often considered to be irrational, since the

dead person ususally has no choice in the matter of dying. Other possibilities are that these individuals have not yet consciously acknowledged their anger, may not be ready to confront this emotion, or have previously dealt with it and thus, it is no longer an issue for them. Finally, not every survivor will feel anger toward the dead person. The absence of the overt expression of guilt feelings was also noted in the group. Guilt feelings tend to be more pervasive in cases of bereavement resulting from suicide. However, phrases such as "if only I had ... " and " I should have ..." , while not overt expressions of guilt, do suggest that the individual is experiencing some level of guilt. Helplessness and sadness were frequently expressed by the participants. The widow who had been married for over thirty years expressed the greatest amount of anxiety about facing the future alone.

Helping the survivor adjust to life without the deceased is Worden's (1982) third counselling principle. Decision making is especially difficult for the recently bereaved, and a great deal of support is required in the adjustment process. The group becomes a sounding board against which members can test their ideas. Problems with step-parenting, marriage, and estate settling were some of the difficulties discussed. The greater the group participation, the greater the number of alternatives that were generated.

Providing encouragement to invest in new relationships is the fourth guideline. It relates primarily to survivors who have lost a spouse. The two widowed members of the group were experiencing acute grief and related that they had no intention of currently becoming involved in a serious relationship. Support and encouragement will be especially important when, and if these widows decide to enter into a conjugal relationship.

Providing time to grieve involves the awareness that anniversary occasions and holidays are difficult times for survivors, especially during the first year of bereavement. Worden (1982) suggests that an effective intervention is to aid the survivor to prepare for such occasions in advance. The Christmas holidays were discussed by the group and members had the opportuity to mentally prepare themselves by talking about their expectations and apprehensions. For one member, Easter was a difficult time of the year because her mother had died on Easter Sunday, and this would be the first anniversary of her death.

There is a great deal of fear among survivors that they are going crazy. The bereaved require continual support and reassurance that the feelings they are experiencing are normal and often temporary. The Living Through Loss program normalizes grief related emotions and behaviors by providing participants with information as to how the process affects them physically, emotionally, intellectually, and spiritually. In addition, the group approach can facilitate

awareness because individuals see that there are others who are having similar experiences.

Everyone's grief is unique. No two people will react the same way to a loss. The group facilitator verbally acknowledged and respected the fact that each participant was dealing with their grief in their own way. It is not unreasonable to expect that these individuals would, in turn, allow for individual differences in grieving among their own family members. Some concern had been expressed in the group about differences between family members in their styles of grieving.

Worden (1982) suggests that the bereaved require continuing support. Upon termination of the Living Through Loss program, follow-up meetings are arranged by the participants. These meetings generally take place once a month at a member's home. They continue for as long as the members want to meet. At the present time, four follow-up meetings have taken place between the Phase I participants. The group facilitator also remains accessible aside from these meetings.

Worden's (1982) ninth counselling guideline involves examining defenses and coping styles. Group discussions often focused on the methods the participants employed to alleviate stress. They were encouraged to reflect upon those methods which had been sucessful in reducing stress in the past, as well as to develop new positive approaches. Progressive relaxation was introduced as one way to manage

stress.

The last principle is to identify pathology and refer to additional professional resources. According to Worden (1982), "For some people, grief counselling or the facilitation of grief is not sufficient and the loss or the way that they are handling the loss may give rise to more difficult problems" (p. 48). The purpose of the initial Living Through Loss interview is too screen applicants in order to determine whether the program is suitable in terms of their needs.

Finally, there is one additional indication that the Living Through Loss group provides grieving individuals with a positive experience. Recently, participants from several groups have joined together to form the Bereavement Support Society of Alberta. Their eagerness and willingness to reach out to other bereaved individuals and their desire to increase public awareness in the areas of death and bereavement strongly suggests that their own experience with a support group has been a positive one.

4.2 Phase I: Conclusions

Phase I was a descriptive investigation designed to assess whether a bereavement support program has a positive impact upon grieving individuals. The Living Through Loss program follows counselling guidelines which have been shown to facilitate the grief process. This suggests that it is a legitimate and effective mode of intervention.

No one can be expected to resolve a death loss over the course of eight group sessions. The passage of time in itself is necessary for healing to occur. However, the process can be facilitated by providing support, information, and an opportunity to experience grief. This is supported by feedback offered by the members of the Living Through Loss program. The following comments were offered by some of the participants of Phase I:

> I have found the group to be loving and supportive, and feel that if I am in difficulties, there really are people out there who care. I feel that this group has made me realize that other folk are hurting too and we are all a part of people who have similar needs and ours are not always unique, and perhaps in helping others we erase some of our own hurts.
>
> I believe that the group has helped me in so much as it showed me first of all that all of my thoughts and feelings were normal. The first meeting made me realize that I was not the only one who lost someone dear. It also made me want to help others in the group who I felt needed it more than I. It was also beneficial to unburden to strangers who were nonjudgemental. Another benefit was the making of new friends.
>
> What the group did was help me realize that I could make other goals and plans for myself - that the small day to day goals/plans would eventually expand to larger ones. And that I had to accept that things would never be the same for me again. The group helped me see that other people had the same grief/pain at their loss - that it was <u>OK</u> to feel like that - that I had a right to feel that pain/grief/anger whenever I wanted to. I learned to accept my feelings - but also to put myself first - to do what was right for me.

4.3 Phase II: Analysis of Data

The purpose of Phase II was to experimentally test the hypothesis that a bereavement support group has a positive impact on three aspects of the grief experience: a loss of meaning of life, helplessness, and low self-esteem. A battery of standardized tests was administered to four participants prior to their involvement in the Living Through Loss Program and again upon their completion of the program. Pre and post-variable data were obtained for comparison between and within subjects. The purpose of the Grief Experience Inventory (GEI) was to compare general pre and post-profiles of grief symptomology.

Subject 1

Subject 1 was driving the car in which her 20 month old nephew, sister, and uncle were killed as the result of an auto accident which had occurred 4 months previously. Figure 1 depicts a preliminary GEI profile of intense grief which is reflected by the elevation of the individual percentile scores of each subscale (Table 1). Subject 1 obtained her highest percentile score (99%) on a scale which measures withdrawal from social contacts, suggesting severe social isolation. The profile further indicates intense feelings of guilt (92%), anger (86%), despair (94%), and the presence of a great deal of physical stress (97%). In addition, the profile further suggests that Subject 1 has difficulty controlling her emotions (64%), feels numb and confused (Depersonalization Scale, 79%), and has a heightened

TABLE 1 : COMPARISON OF PRE AND POST TEST SCORES FOR SUBJECT 1

GRIEF EXPERIENCE INVENTORY

SCALE	PRE-TEST SCORES RAW SCORE	PRE-TEST SCORES T-SCORE	PRE-TEST SCORES PERCENTILE	POST-TEST SCORES RAW SCORE	POST-TEST SCORES T-SCORE	POST-TEST SCORES PERCENTILE
DESPAIR	15	64	94	6	46*	44
ANGER/HOSITILITY	7	63	86	4	51*	54
GUILT	4	66	92	0	40*	19
SOCIAL ISOLATION	7	79	99	2	47*	45
LOSS OF CONTROL	6	54	64	4	45*	30
RUMINATION	-	-	-	-	-	
DEPERSONALIZATION	7	60	79	6	55*	63
SOMATIZATION	14	69	97	7	52*	60
DEATH ANXIETY	6	54	67	0	28*	1

	PRE-TEST SCORES RAW SCORE	PRE-TEST SCORES PERCENTILE SCORE	POST-TEST SCORES RAW SCORE	POST-TEST SCORES PERCENTILE SCORE
PURPOSE IN LIFE TEST	77	9%	116*	77-78%
SEEKING OF NOETIC GOALS TEST	110		94**	
ROTTER INTERNAL-EXTERNAL LOCUS OF CONTROL SCALE	9		13**	
CANADIAN SELF-ESTEEM INVENTORY	15	8%	31*	98%

* denotes significant (+) change ** denotes significant (-) change

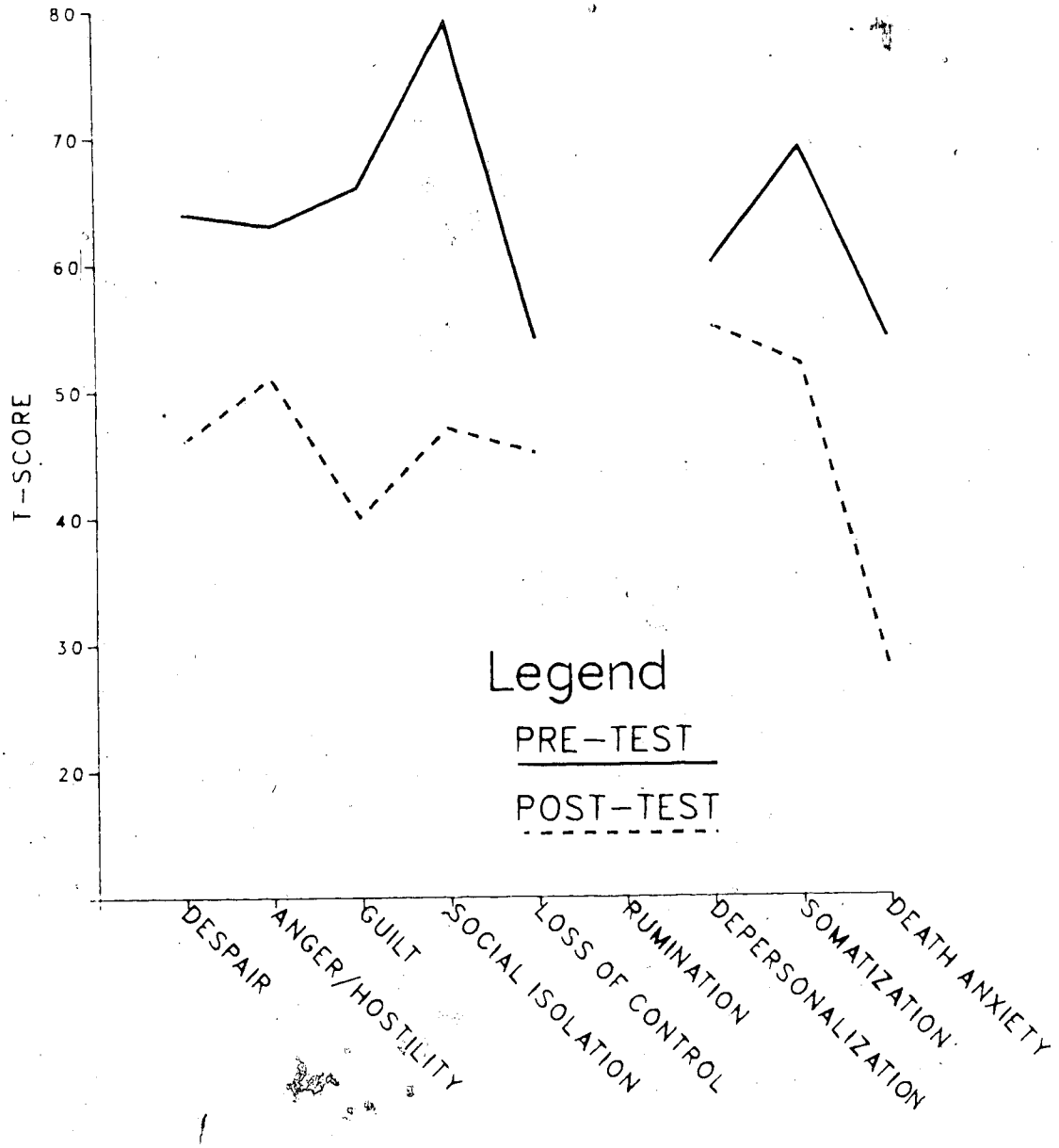

Figure 1. COMPARISON OF PRE AND POST GRIEF EXPERIENCE INVENTORY PROFILES FOR SUBJECT 1.

personal awareness of death (67%). No score was calculated for the Rumination Scale as the subject failed to complete many of the questions related to this scale.

Overall, the post-GEI as illustrated by Figure 1 is one of less intense grief when compared to the initial profile. Table 1 indicates significantly lower percentile scores were obtained in the areas of guilt (19%), death anxiety (1%), social isolation (45%), and despair (44%). Less dramatic percentile score changes were observed on measures of physical distress (60%), control over emotions (30%), anger (54%), as well as a measure of shock, confusion, and numbness (Depersonalization Scale 63%). However, these changes can be considered significant in terms of the criterion given for this test.

According to Sanders, Mauger, and Strong (1979), a change of at least 5 T-Score points should be observed before inferring that a change in grieving has occurred. Given this criterion, comparison of pre and post-test findings for Subject 1 suggest that overall significant changes have occurred with regard to grief symptomology. This is illustrated by Figure 1 which presents a graphic comparison of the two GEI profiles. The overall intensity of grieving has substantially decreased with the most significant percentile score changes occurring in the areas of guilt, death anxiety, and social isolation. However, there was a possible explanation for this change. Subject 1 is native Indian and she strongly believes in the

significance of dreams. During her participation in the Living Through Loss program, she dreamt that her dead sister and nephew had come to her and asked that she let go of them. According to native beliefs, the souls of the deceased cannot be at peace unless the survivors relinquish their grief.

Subject 1 obtained a raw score of 77 on the Purpose of Life Test (Table 1) which places her in the 9th percentile (X=102). According to Crumbaugh and Maholick (1969), raw scores of 91 or below suggest the lack of a clear purpose or meaning in life. However, the raw score of 110 obtained on the seeking of Noetic Goals Test (Table 1) indicates that she is motivated to find meaning. Her score is almost three standard deviations above the mean (X=73). According to Crumbaugh (1977), these two scores in conjunction suggest that while Subject 1 currently lacks a definite purpose in life, she does possess the motivation to seek meaning.

In contrast to her original score of 77, Subject 1 obtained a raw post-test score of 116 on the PIL which suggests that she currently possesses a clear purpose or meaning in life. The change appears even more significant when one compares the percentile scores of 9% and 77%. She obtained a raw post-test score of 94 on the SONG (Table 1) which is 16 points lower than her original score. However, given that her current Purpose in Life score reflects a satisfactory level of life meaning, she may currently lack the motivation to seek more.

A comparison of Subject 1's pre and post-test scores on the Purpose in Life Test and the Seeking of Noetic Goals Test suggests a definite change with regard to the meaning in life variable. The initial results indicated that Subject 1 lacked a definite purpose or meaning in life although she possessed motivation to seek meaning. In contrast, the subsequent results described an individual who possesses a definite purpose in life and currently is not motivated to seek more.

Subject 1 obtained a raw pre-test score of 9 on the Rotter Internal-External Locus of Control Scale (Table 1) which suggests that she can be described as possessing an internal locus of control. Her score indicates that she tends to perceive the occurrence of events as being contingent upon her own actions rather than luck or fate. The post-test score of 13 indicates a change towards a more external perception of control.

Subject 1 obtained a pre-test score of 15 on the Canadian Self-Esteem Inventory for Adults (Table 1). A raw score of 15 (8th percentile) is more than one standard deviation below the mean and suggests that Subject 1 possesses a low level of self-esteem. Feelings of depression, self-dislike, pessimism, and social withdrawal often accompany low self-esteem. Subject 1 achieved a post-test score of 31 (98th percentile) suggesting a current healthy level of self-esteem. A change of approximately three standard deviations is observed when the pre and

post-self-esteem scores are compared. This suggests that there has been a significant positive change in Subject 1's perception of her self-worth.

In summary, it appears Subject 1 has experienced a dramatic positive change with regard to grief symptomology. In addition, positive change was observed on measures of purpose or meaning in life and self-esteem.

Subject 2

Subject 2 experienced the death of her mother 6 months prior to joining the Living Through Loss program. The preliminary GEI profile as presented by Figure 2 suggests that she was experiencing intense grief. This is evidenced by the elevation of several subscale T-scores. According to Sanders, Mauger, and Strong (1979), the larger the T-score, the greater the intensity of the behavior measured by the scale. The highest percentile score was obtained on the guilt scale (98%) suggesting that she felt that she was in some way to blame for the death. In terms of percentile scores, Table 2 indicates significantly intense feelings of social isolation (92%), physical stress (97%), and loss of control over emotions (92%). Scales measuring despair (60%), anger (68%), depersonalization (79%), preoccupation with thoughts of the deceased (67%), and personal awareness of death (67%) are also significantly elevated. However, Figure 2 indicates that these features are somewhat less intense than her feelings of guilt, social isolation, and physical stress.

The post-GEI test results (Table 2) indicate significantly lower percentile scores on measures of guilt (8%), depersonalization (37%), despair (26%), and death anxiety (39%). Physical stress (80%) and degree of social isolation (67%) also decreased. No change occurred on measures of anger (68%) and preoccupation with thoughts of the deceased (67%). Table 2 also shows a significant percentile score increment on the Loss of Control Scale (99%) suggesting an even greater inability to control emotion than was indicated on the initial profile.

Subject 2 obtained a pre-test score of 100 on the Purpose in Life Test (Table 2) which placed her in the 45-46th percentile range. According to Crumbaugh and Maholick (1969), this score falls within an uncertain range and is considered "undefined". An undefined score suggests neither a clear meaning in life nor the lack of clear meaning. The raw score of 85 obtained on the Seeking of Noetic Goals Test (Table 2) suggests that Subject 2 does possess the motivation to seek meaning. With regard to the post-test findings, Subject 2 obtained a raw score of 102 on the Purpose in Life Test (Table 2), which is only 2 points above her initial score of 100 and therefore was not considered a significant change. This score falls within the 49-51st percentile range and again places her in the undefined range. The raw post-test score of 71 obtained on the Seeking of Noetic Goals Test (Table 2) is one standard deviation below her original score which indicates

TABLE 2 : COMPARISON OF PRE AND POST TEST SCORES FOR SUBJECT 2

	GRIEF EXPERIENCE INVENTORY					
	PRE-TEST SCORES			POST-TEST SCORES		
SCALE	RAW SCORE	T-SCORE	PERCENTILE	RAW SCORE	T-SCORE	PERCENTILE
DESPAIR	10	54	60	4	42*	26
ANGER/HOSITILITY	5	55	68	5	55	68
GUILT	5	74	98	1	47*	48
SOCIAL ISOLATION	5	66	92	3	54*	67
LOSS OF CONTROL	8	64	92	9	69**	99
RUMINATION	6	55	67	6	55	67
DEPERSONALIZATION	7	60	79	4	47*	37
SOMATIZATION	14	69	97	10	59*	80
DEATH ANXIETY	6	54	67	4	46*	39

	PRE-TEST SCORES		POST-TEST SCORES	
	RAW SCORE	PERCENTILE SCORE	RAW SCORE	PERCENTILE SCORE
PURPOSE IN LIFE TEST	100	45-46%	102	49-51%
SEEKING OF NOETIC GOALS TEST	85		71**	
ROTTER INTERNAL-EXTERNAL LOCUS OF CONTROL SCALE	18		12*	
CANADIAN SELF-ESTEEM INVENTORY	14	7%	19	26%

* denotes significant (+) change

** denotes significant (+) change

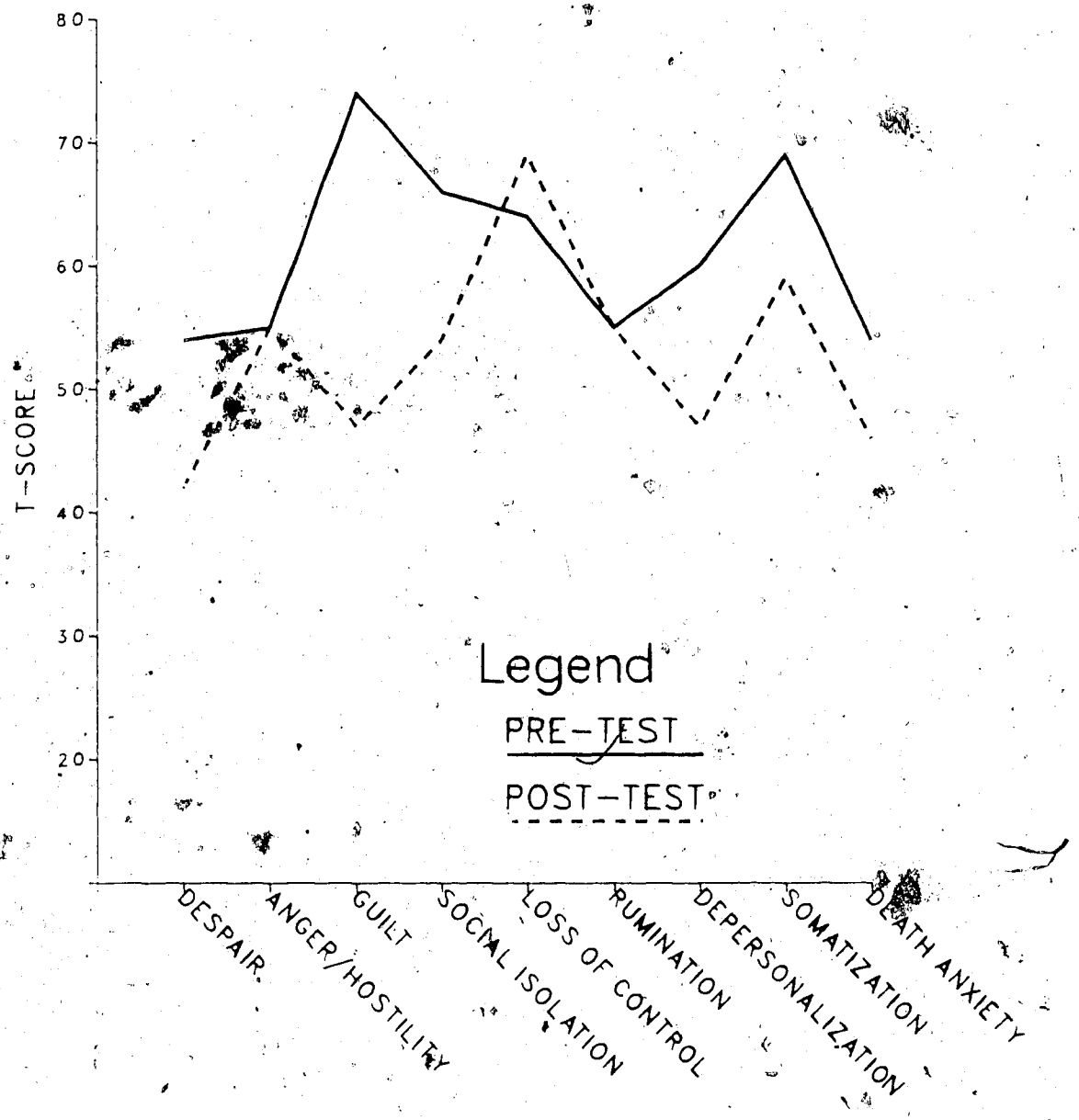

Figure 2. COMPARISON OF PRE AND POST GRIEF EXPERIENCE INVENTORY PROFILES FOR SUBJECT 2.

significantly less motivation to seek meaning than was originally shown.

A comparison of the pre and post-test findings for Subject 2 indicates that a significant change did not occur with regard to the meaning in life variable. Both PIL scores fall within an undefined range. The post-test score on the SONG is significantly lower than the pre-test score suggesting that strength of motivation to seek meaning has decreased.

Subject 2 obtained a raw score of 18 on the Rotter Internal-External Locus of Control Scale which suggests an external perception of control. Subject 2 is more likely to attribute the occurrence of events to luck or fate, rather than to her own actions. Her post-test score of 12 (Table 2) falls half-way between the most internal possible score (0) and the most external score (23) on this test. A comparison of pre and post-test scores on the Rotter Internal-External Locus of Control Scale for Subject 2 indicates a significant increase in her belief that events are internally controlled as opposed to externally controlled.

Subject 2 obtained a score of 14 (7th percentile rank) on the Canadian Self-Esteem Inventory for Adults (Table 2) which is indicative of low self-esteem. Her post-test score of 19 (26th percentile), an increment of five points towards the mean, suggests a more positive appraisal of self-worth than was previously indicated. This change was not considered significant.

In summary, Subject 2 experienced positive changes on all measures of grief symptomology with the exception of Anger and Rumination which remained constant and Loss of Control which increased. A comparison of pre and post-test scores indicated no significant changes on measures of self-esteem and purpose in life. Significant changes were observed in terms of a decrease in motivation to seek meaning and an increased internal perception of control.

Subject 3

Subject 3's husband committed suicide one day before their divorce was to become final (2 years ago). The preliminary GEI profile of Subject 3 as illustrated by Figure 3 suggests significant difficulty with emotional control (99%), intense feelings of anger and hostility (95%), as well as preoccupation with thoughts of the deceased (92%). The percentile score of 79 obtained on the Depersonalization Scale suggests that Subject 3 is experiencing a high degree of confusion, shock, and numbness. The Death Anxiety Scale, which measures one's personal fear of death, is also significantly elevated (77%). The GEI profile indicates that feelings of hopelessness (Despair Scale), guilt, physical stress, and social isolation are considerably less intense. These percentile scores fall below the 50th percentile.

The post-GEI profile as illustrated by Figure 3 appears to present greater intensity of grief symptomology when compared to the initial profile. Table 3 indicates

TABLE 3. : COMPARISON OF PRE AND POST TEST SCORES FOR SUBJECT 3

SCALE	PRE-TEST SCORES			POST-TEST SCORES		
	RAW SCORE	T-SCORE	PERCENTILE	RAW SCORE	T-SCORE	PERCENTILE
DESPAIR	6	46	44	4	42	26
ANGER/HOSTILITY	8	67	95	8	67	95
GUILT	0	40	19	1	47**	48
SOCIAL ISOLATION	2	47	45	4	60**	84
LOSS OF CONTROL	9	69	99	7	59*	79
RUMINATION	8	64	92	11	72**	99
DEPERSONALIZATION	7	60	79	5	51*	50
SOMATIZATION	3	42	24	4	44	32
DEATH ANXIETY	7	59	77	9	68**	95

	PRE-TEST SCORES		POST-TEST SOCRES	
	RAW SCORE	PRECENTILE SCORE	RAW SCORE	PERCENTILE SCORE
PURPOSE IN LIFE TEST	117	79%	119	82%
SEEKING OF NOETIC GOALS TEST	95		100	
ROTTER INTERNAL-EXTERNAL LOCUS OF CONTROL SCALE	Incomplete		Incomplete	
CANADIAN SELF-ESTEEM INVENTORY	29	91%	30	95%

* denotes significant (+) change

** denotes significant (-) change

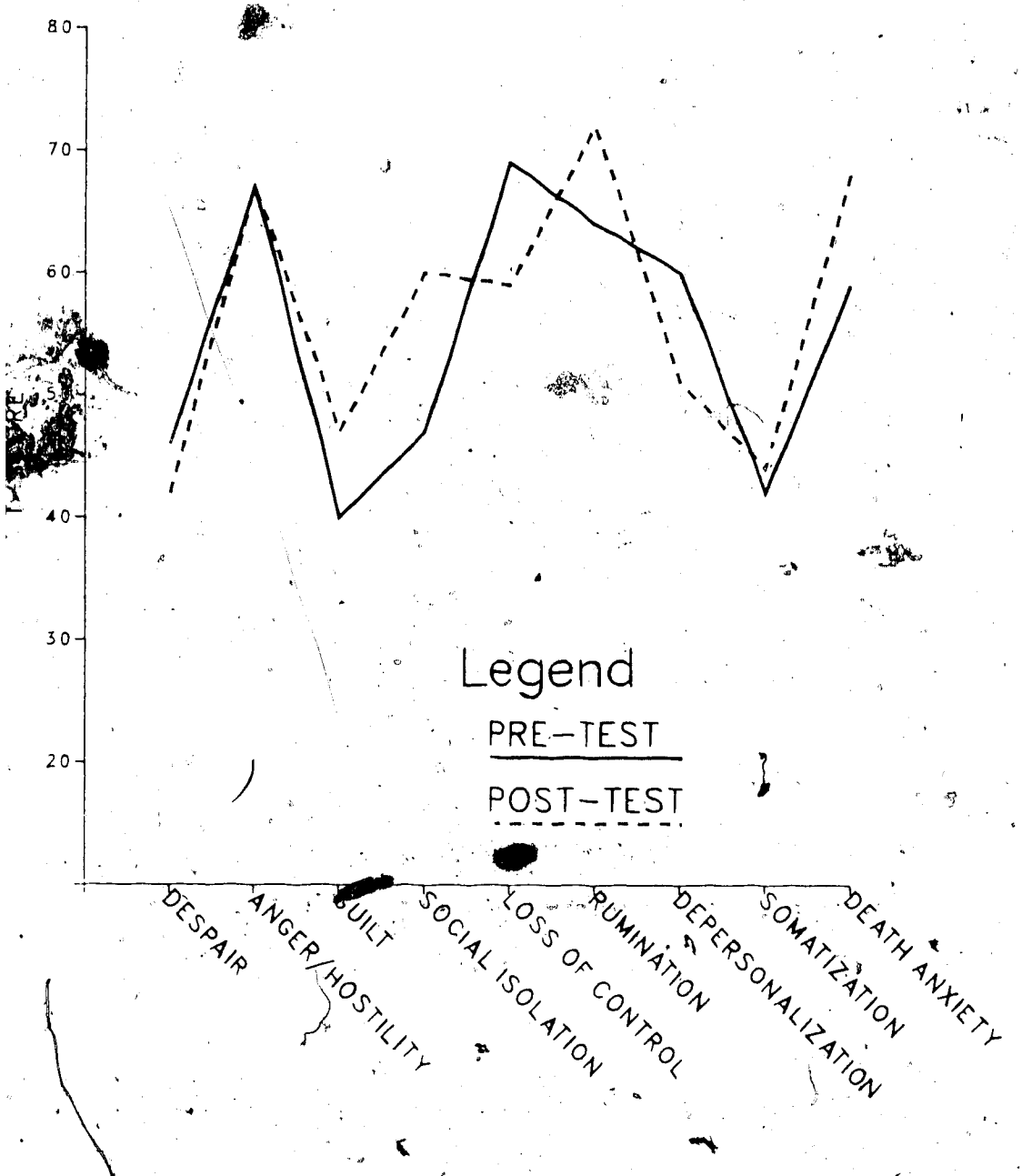

Figure 3. COMPARISON OF PRE AND POST GRIEF EXPERIENCE INVENTORY PROFILES FOR SUBJECT 3.

significant T-score increments on measures of social isolation, guilt, rumination, and death anxiety. Non-significant changes occurred on measures of physical stress, anger, and despair. Two sub-scales reflect significant positive changes. Subject 3 is currently experiencing greater control over her emotions and less intense feelings of hopelessness as well as a reduction in shock and confusion.

Subject 3 obtained a raw score of 117 and a percentile score of 79 on the Purpose in Life Test (Table 3) indicating that she possesses a definite purpose or meaning in life. The raw score of 95 obtained on the Seeking of Noetic Goals Test (Table 3) indicates motivation to seek even greater meaning. Examination of the post-test findings show no significant change when compared to preliminary findings. These scores again suggest that Subject 3 has a definite purpose in life and the motivation to seek even greater meaning.

The results of the Rotter Internal-External Locus of Control Scale were incomplete.

Subject 3 achieved a score of 9 (1st percentile) on the Canadian Self-Esteem Inventory (Table 3) which suggested that she possessed a healthy level of self-esteem and considers herself to be a worthwhile and capable person. The post-raw score of 30 (95th percentile) indicates that level of self-esteem remained high.

In summary, a comparison of pre and post-GEI profiles suggests that the intensity of grieving significantly increased in terms of guilt, social isolation preoccupation with thoughts of the deceased, and death anxiety. While positive score changes were observed on measures of purpose in life, motivation to seek meaning and self-esteem, these changes were not considered significant.

Subject 4

Subject 4 lost her husband one month ago as the result of an accidental self-inflicted gunshot wound. Table 4 indicates that she obtained her highest pre-test GEI percentile score on the Death Anxiety Scale (99%) which measures presonal awareness or concern about death. Scales measuring physical stress (87%) rumination (81%), depersonalization (79%), and anger (77%) are also significantly elevated. Her lowest percentile socres were obtained on scales measuring despair (53%), loss of control (47%), guilt (19%), and social isolation (4%).

The post-GEI profile of Subject 4 as illustrated by Figure 4 indicates an overall increase in the severity of grief symptomology. In terms of percentile scores, Table 4 shows increments on all scales with the exception of Guilt (19%), Somatization (87%), and Social Isolation (4%) which remined constant and Death Anxiety which decreased to the 95th percentile rank from the 99th percentile rank. However, in terms of the criteria, there are only three significant changes on this profile. Table 4 indicates significant

TABLE 4 : COMPARISON OF PRE AND POST TEST SCORES FOR SUBJECT 4

GRIEF EXPERIENCE INVENTORY

SCALE	PRE-TEST SCORES RAW SCALE	T-SCORE	PERCENTILE	POST-TEST SCORES RAW SCORE	T-SCORE	PERCENTILE
DESPAIR	8	50	53	11	56**	66
ANGER/HOSITILITY	6	59	77	7	63	86
GUILT	0	40	19	0	40	19
SOCIAL ISOLATION	1	35	4	0	35	4
LOSS OF CONTROL	5	49	47	8	64**	92
RUMINATION	7	59	81	9	68**	97
DEPERSONALIZATION	7	60	79	8	64	95
SOMATIZATION	12	64	87	12	64	87
DEATH ANXIETY	10	72	99	9	68	95

	PRE-TEST SCORES RAW SCORE	PERCENTILE SCORE	POST-TEST SCORES RAW SCORE	PERCENTILE SCORE
PURPOSE IN LIFE TEST	105	56-57%	108	62-63%
SEEKING OF NOETIC GOALS TEST	76		89	
ROTTER INTERNAL-EXTERNAL LOCUS OF CONTROL SCALE	7		7	
CANADIAN SELF-ESTEEM INVENTORY	24	54%	22	41%

* denotes significant (+) change ** denotes significant (-) change

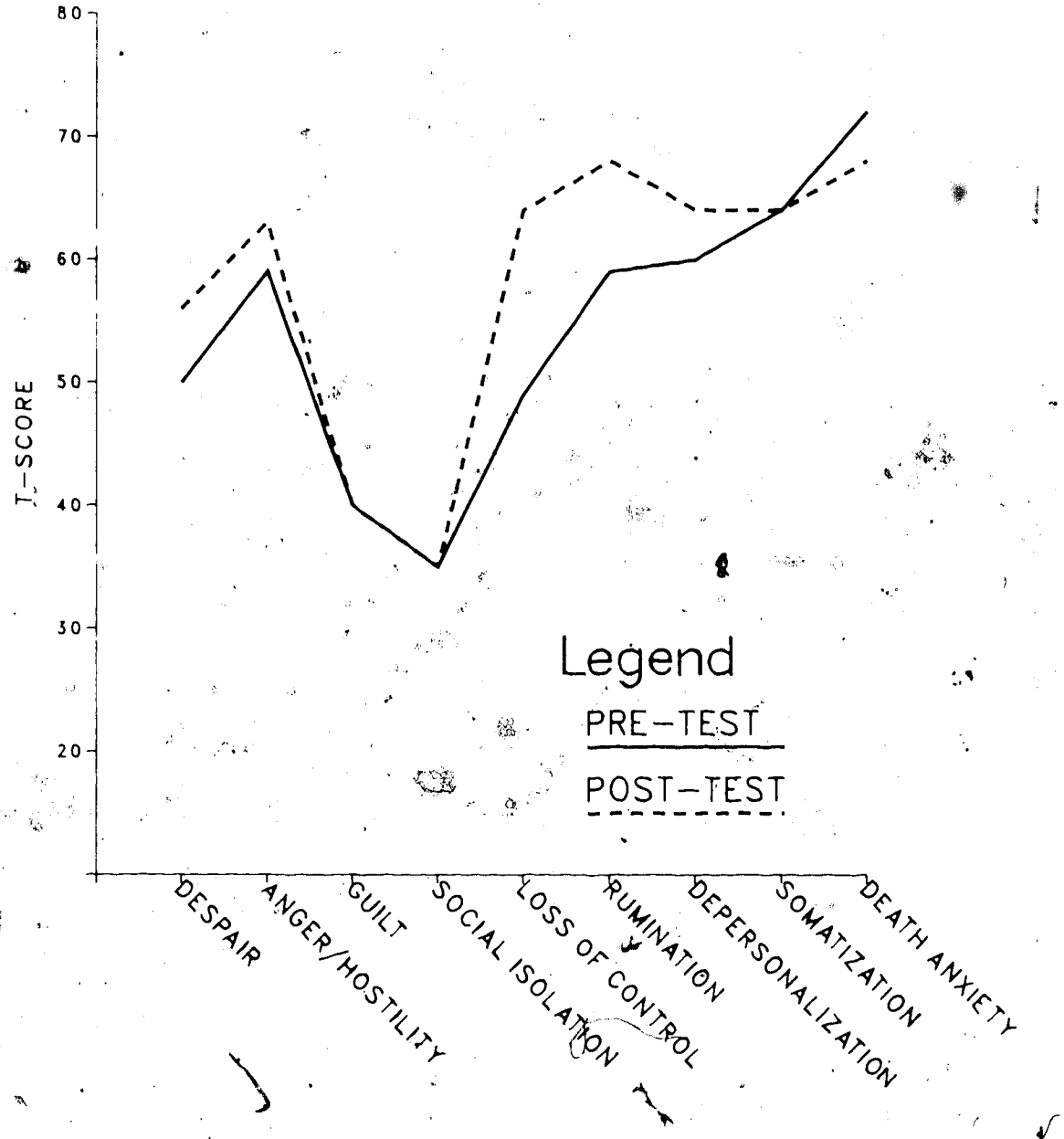

Figure 4. COMPARISON OF PRE AND POST GRIEF EXPERIENCE INVENTORY PROFILES FOR SUBJECT 4.

T-score increments on measures of preoccupation with thoughts of the deceased, loss of control, and despair.

Subject 4 obtained a raw score of 105 on the Purpose in Life Test (Table 4) which placed her in the 56-57th percentile range. This score falls within the undefined range. Subject 4 obtained a raw score of 76 on the Seeking of Noetic Goals Test (Table 4). This score is slightly above the mean for this test (X=73). Her raw post-test PIL score of 108 which placed her in the 62-63rd percentile range, once again falls within the undefined range. The SONG raw post-test score of 89 indicates that there has been an increase in her level of motivation to seek meaning. However, this change is not considered significant.

The Rotter Internal-External Locus of Control raw score of 7 (Table 4) obtained by Subject 4 indicates that she [redacted]ngly believes the occurrence of events to be contingent upon her own actions. There was no score change with regard to the variable of control as measured by post-testing.

Subject 4 achieved a raw score of 24 on the Canadian Self-Esteem Inventory (Table 4) which placed her in the 54th percentile range and suggests a healthy level of self-esteem. Her post-test score of 22 was slightly below the mean for females (X=23.33), but this score change is not considered significant.

In summary, the post-GEI profile indicated that Subject 4 was experiencing significantly greater grief post-test symptomology on three measures: Despair, Loss of Control,

and Social Isolation. Significant changes were not observed with regard to the variables of purpose in life, motivation to seek meaning, control, and self-esteem.

4.4 Phase II: Summary and Conclusions

A comparison of the individual GEI profiles illustrates three important features of the grieving process. First, each individual's grief is unique and different. Figures 1 through 4 show that the four subjects presented profiles which differed in overall configuration as well as in the intensity of emotions measured by the various scales. Secondly, these profiles confirm that grief is a multidimensional process rather than a single emotional state. This was demonstrated by the changes which occurred between the pre and post-GEI profiles for each subject. Finally, the grieving process does not necessarily progress in a positive sequential fashion over time. For example, post-test results show that Subjects 3 and 4 were experiencing significantly more intense grief symptoms than was originally assessed.

Tables 1 through 4 illustrate the pre and post-test findings for the variables of meaning in life, control, and self-esteem. All subjects showed changes in the predicted direction on the meaning in life variable as measured by the Purpose in Life Test. Subject 1 achieved a significant change in terms of raw score points with Subjects 2, 3, and 4 obtaining minor increments of 2 or 3 points. Results of

the Seeking of Noetic Goals Test indicate that although Subjects 3 and 4 experienced an increase in their level of motivation to find meaning, these changes were not considered significant. The scores for Subjects 1 and 2 show significant change in level of motivation to seek meaning. However, the decrement shown by the scores of Subject 1 may be explained by her achievement of an accompanying high score on the Purpose in Life Test. Given that she currently possesses a satisfactory level of life meaning, she may no longer be motivated to seek more.

A comparison of the scores which subjects obtained on the Rotter Internal-External Locus of Control Scale shows that Subject 2 developed a significantly more internal perception of control. In contrast, Subject 1 developed a significantly external orientation while Subject 4 showed no change, with both of her scores indicative of an internal perception of control. No score was available for Subject 3.

Results of the Canadian Self-Esteem Inventory for Adults indicated that all subjects showed gains in self-esteem with the exception of Subject 4 whose raw score dropped by 2 points. However, only Subject 1's score was considered significant. It is interesting to note that Subjects 1 and 2, whose original scores suggest low self-esteem, showed the most positive gains.

The purpose of Phase II was to experimentally test the hypothesis that participation in a bereavement support group has a positive impact on the grieving process. Specifically,

Phase II assessed whether participation positively influenced three features of grief: a loss of meaning in life, helplessness, and low self-esteem. This hypothesis was not unanimously supported by the data (Tables 1-4). In general, the data show that only 2 of the 4 subjects experienced positive changes in terms of grief intensity.

There are at least three explanations for the increases in grief intensity illustrated by the post-GEI profiles of Subjects 3 and 4. Given the fluctuating nature of the grief process, some regression can be expected between two test sessions. Participation in itself can result in a temporary increase in the intensity of grief because of the very fact that permission is given to ventilate emotions. Finally, 8 weeks may not be a realistic timeframe in which to expect significant changes to take place.

Overall, the data do not consistently support the specific hypothesis that participation in a bereavement support group has a positive impact on meaning in life, control, and self-esteem.

5. DISCUSSION AND IMPLICATIONS

5.1 Introduction

The general purpose of this study was to investigate whether or not participation in a bereavement support group facilitated the grieving process. More specifically, it was hypothesized that participation in a support group would have a positive impact on three dimensions of the grief experience: a loss of meaning in life, feelings of helplessness, and low self-esteem.

5.2 Discussion

Grief is a normal reaction to loss. Most individuals recover from a death loss without requiring any special treatment aside from the support of their family and friends. Others, who for a variety of reasons are unable to emotionally adjust on their own, sometimes seek out the services of professional caregivers. For those who require counselling, bereavement support services such as the Living Through Loss program, provide an alternative to traditional therapy.

Clinical observation revealed that the Living Through Loss program follows counselling guidelines which have been shown by Worden (1982) to be effective in facilitating the grieving process. Feedback from participants suggested that they perceived the program to have provided a positive emotional and educational experience. The results of Phase I

confirmed previous findings by Barrett (1978), Parkes (1980), and Silverman (1970). These authors have concluded that the shared grieving approach facilitates recovery from bereavement.

The purpose of Phase II was to experimentally test the hypothesis that participation would have a positive impact on three specific features of the grief process: a loss of meaning in life, helplessness, and low self-esteem. This hypothesis was not unanimously supported by the test results. In general, the data revealed that only 2 of the 4 subjects experienced positive changes in terms of a lessening of grief intensity as measured by the Grief Experience Inventory.

In order for grief counselling to be effective, two essential elements must be present as part of the counselling process: information and support (Parkes, 1980; Simos, 1979; and Worden, 1982). Unfortunately, grief is generally not recognized as being a normal life process. Therefore, grieving individuals often succumb to the erroneous belief that the emotions that they are experiencing are a form of mental illness. "Am I going crazy?" was the most common question asked by the Living Through Loss participants. Effective grief counselling provides individuals with accurate information that normalizes their experience. For example, restlessness, exhaustion, memory lapses, and searching are typical responses to loss and the bereaved need constant

confirmation that such feelings and behaviors are normal. Thus, educating individuals as to how grief can affect them physically, emotionally, intellectually, and spiritually is an important goal of counselling. Membership in a homogeneous group offers bereaved individuals the additional advantage of discovering for themselves that others share similar feelings and concerns.

Bereavement support groups do not offer any shortcuts through the process of grief. There simply are no magic cures and no guarantees that participation will result in immediate relief. In the present study, 2 individuals experienced increases in the intensity of their grief, as was demonstrated by the results of the pre and post-testing with the Grief Experience Inventory. Temporary relapses can be expected due to the fluctuating nature of the grief process and because the support group has afforded them the opportunity to progress with their grief work.

5.3 Research Implications

Support programs have recently become a popular means to assist people in crisis. However, there is little documented research available that demonstrates exactly what the benefits are. The current study has implications for future research specifically in the area of bereavement support programs.

During the course of this project, the writer became aware of the resistance of participants toward completing

tests. It is possible that the use of standaridized test instruments is not appropriate for this population given the supersensitivity and concentration difficulties that often accompany the grief experience. One suggestion is that researchers attempt to develop and utilize other methods of assessment. For example, a personal journal for subjects to record their feelings might be analyzed for content. This may be a more appropriate means of collecting information.

The current study employed several subjects to assess the effects of participation in a bereavement support group. However, the single case study may be a more useful tool for studying the hypothesis under investigation. This approach is likely to generate indepth data as compared to the general perspective offered by this project. In addition, the single case study has the potential for being significantly more personal and as a result the subject may be more willing to share information.

The current research focused on the subjective experiences of the participants as a means of assessing the impact of the Living Through Loss program. A suggestion for further investigation is to evaluate behavioral changes in addition to subjective changes. One possible consideration would be to obtain specific feedback from family members regarding their perceptions of the progress of the bereaved individual. A check list of specific behaviors could be utilized as part of the assessment.

Further research might investigate whether there is an optimum time to intervene with bereavement counselling. Would a bereavement support program be more beneficial if it were utilized during the earlier or later stages of the grieving process? The concern here is whether bereavement counselling is realistic during the early stages of grieving given that shock and disbelief are typical initial responses.

The Living Through Loss program is offered to individuals regardless of the nature of the death loss. However, do people grieve the various death losses differently? In other words, is the process different in cases of suicide or murder as compared to a more natural cause of death? If the grieving process is significantly different perhaps we need to make bereavement programs more specific to the nature of the loss.

Phase I of this project involved two members of the same family. One of these members terminated after only one session. Members of the same family grieve differently for the same death loss and one could ask whether the presence of a relative has an effect on the open expression of emotion.

The Living Through Loss program utilizes both a didactic and an experiential counselling approach. Future research could be aimed at evaluating which of these two methods are the most effective in terms of facilitating the grieving process. For example, the findings of Phase I

suggested that the Living Through Loss participants perceived the collage exercise to be very helpful.

Finally, future studies on this topic would ideally involve control groups of bereaved subjects who do not receive counselling. This design would allow for comparison between groups and the investigator would have more control over the variable of time. In other words, given that the passage of time is an important factor related to recovery, would similar findings been achieved if the Living Through Loss participants had not been involved with any type of support service?

5.4 Counselling Implications

The present study has implications for professionals and non-professionals involved with individual grief counselling and group work. The delivery of effective support services to the bereaved necessitates that counsellors examine their own personal feelings and attitudes toward loss. Worden (1982) discusses several issues which may impede the progress of grief counselling. The intensity of the client's grief may make it difficult for the counsellor to feel that they are being helpful and this impotence can lead to frustration and anger on the part of the counsellor. Similarly, observation of intense grief can create a great deal of stress and discomfort for helpers causing them to terminate counselling too soon. Bereavement counselling can also make the helper painfully aware of his

or her own personal losses, which if unresolved, can interfere with the helper's effectiveness. Fear of future losses can also create a great deal of anxiety for the counsellor, especially when the client's loss is that which is feared. Finally, Worden suggests that bereavement counsellors are confronted with the inevitability of death and loss and that this can create additional anxiety and hinder the counselling process. Therefore, counsellors need to be aware of their own feelings about death and recognize their limitations. Equally important is a thorough understanding of the grieving process, a sound knowledge of counselling principles which facilitate recovery, and the recognition that grief counselling can encompass more than only death losses.

In order to raise public awareness, counsellors must become more involved in educating the community about bereavement issues. Similarly, professional organizations must take responsibility for monitoring caregivers to ensure that they possess the necessary training and skills. According to Rapheal (1983), "It is quite clear from our own experience that a bereavement may open up many sensitive issues, the handling of which may require considerable psychotherapeutic skills. Thus, knowledge of bereavement patterns and associated dynamics is critical, as is training in the skills required to deal with them" (p. 400-401). This statement raises the issue of the role of volunteers and peer counsellors involved in bereavement support services.

While it is generally acknowledged that lay counsellors can provide valuable support services for individuals in crisis, further investigation is necessary. According to Parkes (1980), "the value of services that lack the support of trained and experienced members of the caregiving professionals remains to be established" (p. 6).

It is clear that further investigative study in the area of bereavement and bereavement counselling is required. Possible directions for future research include: the effects of educating children about death and loss; support for the terminally ill and their families; standardized grief assessment methods; care [illegible] care-giver; medications and the grieving process; and the assessment and identification of individuals at special risk. Finally, new means of community support involving insurance company personnel, police, funeral home employees, and others remain to be developed.

6. BIBLIOGRAPHY

Barrett, C. J. (1978). Effectiveness of widows' groups in facilitating change. Journal of Consulting and Clinical Psychology, 46 1, 20-31.

Blank, H. R. (1969). Mourning in death and bereavement. A. H. Kutscher (Ed.) Springfield: Charles C. Thomas Pub.

Bowlby, J. (1961). Processess of mourning. International Journal of Psychoanalysis, 42, 317-340.

Bryant, B. K. & Trockel, J. F. (1976). Personal history of psychological stress related to locus of control orientation among college wormen. Journal of Consulting and Clinical Psychology, 44 , 266-271.

Bugen, L. (1977). Human grief : A model for prediction and intervention. American Journal of Orthopsychiatry, 47, 2, 196-206.

Caine, L. (1974). Widow : The personal crisis of a widow in America. New York : William Morrow & Company.

Caplan, G. (1974). Support systems and community mental health: Lectures on concept development. New York: Behavioral Publications.

Clayton, D. J. (1973). The clinical morbidity of the first year of bereavement: A review. Comphrehensive Psychiatry, 14, 151-157.

Clinebell, H. (1966). Basic types of pastoral counselling. Nashville, Tenn: Abingdon Press.

Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic medicine, 38, 300-314.

Coopersmith, S. (1967). The antecedents of self-esteem. San Francisco: Freeman.

Cornwell, J., Nucombe, B., & Stevens, L. (1977). Family response to loss of a child by sudden death syndrome. The Medical Journal of Australia, 1, 656-658.

DeGraves, D. (1977). Development of a service in grief intervention. Psychiatric Nursing, Nov.-Dec., 9-11.

Eliot, T. B. (1932). The bereaved family. Annals of the American Academy of Social Science, 160, 184-190.

Engel, G. L. (1962) Psychological development in health and disease. Philadelphia: Saunders.

Frankl, V. E. (1939). Man's search for meaning. New York: Pocket Books.

Freud, S. (1959). Mourning and melancholia (1917) collected papers. New York: Basic Books, 4, 152-170.

Fulconer, D. M. (1942). The adjustive behavior of some recently bereaved spouses: A psycho-sociological study. Unpublished Doctoral Dissertation, Northwestern University.

Gerber, I., Wiener, A. Battin, D. & Arkin, A. (1975). Brief therapy to the aged bereaved. In Bereavement: Its psychosocial aspects. B. Schoenber, I. Gerber, A. Wiener, A. H. Kutscher, D. Peretz, A. C. Carr (Eds.) New York: Columbia University Press.

Glick, I. O., Weiss, R. S. & Parkes, C. M. (1974). The first year of bereavement. New York: John Wiley and Sons.

Helmrath, T. A. & Steinitz, E. M. (1978). Death of an infant: Parental grieving and the failure of social support. The Journal of Family Practice, 6, 785-790.

Kavanaugh, R. E. (1972). Facing death . New York: Penguin Books.

Kubler-Ross, E. (1969). On death and dying. New York: Macmillan Company.

Lefcourt, H. M. (1976). Locus of control: Current trends in theory and research. New York: Halstead.

Lefcourt, H. M. (1980). Personality and locus of control. In Human helplessness: Theory and applications. J. Garber & M. Seligman (Eds.) London: Academic Press.

Lindemann, E. (1944). The symptomology and management of acute grief. American Journal of Psychiatry, 101, 141.

Maddison, D. (1967). The factors affecting the outcome of conjugal bereavement. British Journal of Psychiatry, 113, 1057-1067.

Maddison, D. (1968). The relevance of conjugal bereavement for preventive psychiatry. British Journal of Medical Psychology, 41, 223-233.

Maddison, D. & Walker, W. L. (1967). Factors affecting the outcome of conjugal bereavement. British Journal of

Psychiatry, 113, 1057-1067.

Marris, P. (1974). Loss and Change. New York: Pantheon Books.

Maslow, A. (1943). A Theory of Human Emotion. Psychology Review, 50, 370-396.

Murphy, L. B. & Moriarity, A. E. (1976). Vulnerability, coping and growth from infancy to adolescence. New Haven: Yale University Press.

Nyberg, V. & Griffiths, J. (1978). Shared grieving. In The Family Welfare Association: Bereavement Papers. London: E. E. Owens.

Parkes, C. M. (1965). Bereavement and mental illness. British Journal of Medical Psychology, 38, 1-26.

Parkes, C. M. (1972). Bereavement: Studies of grief in adult life. New York: International Universities Press.

Parkes, C. M. (1975). The emotional impact of cancer on patients and their families. Journal of Larynology and Utology, 89, 1271-1279.

Parkes, C. M. (1980). Bereavement counselling: Does it work? British Medical Journal, 281, 3-6.

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

Raphael, B. (1977). Preventive intervention with the recently bereaved. Archives of General Psychiatry, 34, 1450-1454.

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

Romeder, T. (1982). Self-help groups in Canada. Ottawa: Dept. of National Health and Welfare.

Seligman, M. E. P. (1975). Helplessness: On depression, development and death. San Francisco: W. H. Freeman.

Silverman, P. R. (1970). The widow as caregiver in a program of preventive intervention with other widows. Mental Hygiene, 4, 540-547.

Silver, R. L. & Wortman, C. B. (1980). Coping with undesirable life events. In Human helplessness: Theory and applications, J. Garber & M. Seligman

(Eds.), New York: Academic Press.

Simos, B. G. (1979). A time to grieve: Loss as a universal human experience. New York: Family Service Association of America.

Singer, E. (1965). Key concepts in psychotherapy. New York: Random House.

Smith, R. E. (1970). Changes in locus of control as a function of life crisis resolution. Journal of Abnormal Psychology, 75, 329-332.

Solomon, H. M. (1977). Grief and bereavement. International Journal of Social Psychiatry, 23, 3, 211-222.

Temes, R. (1977). Living with an empty chair: a guide through grief. New York: Irvington Publishers.

Uroda, S. F. (1977). Counselling the bereaved. Counselling and Values, April, 185-191.

Vachon, M. L. S., Lyall, W. A. L., Rogers, J., Freedman-Letofsky K., and Freeman, S. J. J. (1980). A controlled study of self-help intervention. American Journal of Psychiatry, 137, 11, 1380-1284.

Worden, W. (1982). Grief counselling and grief therapy. New York: Springer.

Zilbergeld, B. (1983). The shrinking of America: Myths of psychological change. Boston: Little, Brown and Company.

A P P E N D I C E S

APPENDIX A

DETERMINANTS OF THE OUTCOME OF BEREAVEMENT

ANTECEDENT

Childhood experiences (especially losses of significant persons)
Later experiences (especially losses of significant persons)
Previous mental illness (especially depressive illness)
Life crises prior to the bereavement
Relationship with the deceased
- Kinship (spouse, child, parent, etc.)
- Strength of attachment
- Security of attachment
- Degree of reliance
- Intensity of ambivalence (love/hate)

Mode of death
- Timeliness
- Previous warnings
- Preparation for bereavement
- Need to hide feelings

CONCURRENT

Sex
Age
Personality
- Grief proneness

Socio-economic status (social class)
Nationality
Religion (faith and rituals)
Cultural and familial factors influencing expression of grief

SUBSEQUENT

Social support of isolation
Secondary stresses
Emergent life opportunities (options open)

Taken from: Parkes, C. M. (1972) Bereavement: Studies of grief in adult life. New York: International Universities Press.

APPENDIX B

LIVING THROUGH LOSS OUTLINE

Session One

Sharing the "story" of each group member and introducing each person and "the loss".

Homework: Plot a time line of the losses in your life. Keep an individual journal of thoughts, feelings, concepts during Living Through Loss sessions.

*Establish a phone list of numbers to be distributed to each group member.

Session Two

Outline Grollman's Ten Guidelines.

- content relates to each individual's feelings about how these guidelines related to their lives.

Share Time Lines of Losses

Homework: Begin work on collage either in group session or at their home. Collage is of loss they experienced - memories of person, special traits, etc.

Session Three

Outline 4 Dimensions of Individual (Physical, Emotional,

Intellectual, Spiritual)
And How These Are Affected During The Grief Process.

- discussion focuses on how to deal/cope with problems in these areas. Eg. take out how to sleep better, focus on nutrition, etc.

Demonstration with group members of progressive relaxation techniques.

Homework: Practice relaxation techniques at home. Leader could make relaxation tape for each member.

Session Four

Focus on Spiritual Issue - Stimulus Used Is Harold Kushner's Book Why Do Bad Things Happen To Good People? Utilize A Tape Of Him Discussing The Book's Ideas.

- Group discussion on intellectual, spiritual, and emotional issues of bereavement.

Present a book list related to bereavement.

Session Five

What To Do And Not To Do? How Are They Coping Now? What Works And Doesn't Work? Creative Problem Solving/Brainstorming Ideas.

- Emphasize the fact that certain behaviors/actions are "normal" even though they may seen bizarre/abnormal.

Begin Presentation Of Collages - Allow Time And Encourage Group Involvement So That The Group Gets A Sense Of What The Person Who Dies Was Like.

Sessions Six and Seven

Continuation Of Collage.

Discussions that sometimes come up during these sessions: Euthanasia, What Helps? What Doesn't, How to Turn This Event From Negative To Positive, (eg. advocacy issues, public speaking, support group continuation), How to Tell Children About Death, video presentation (Kubler-Ross), etc.

Session Eight

Celebration of Life! This is An Attempt To Close The Group Process On A Positive Note! Food! Drink!, Etc. Encourage Post-Group Cohesiveness, Eg., Once A Month Togetherness.