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Adult Bereavement:

A Critical Review of Theories and Treatment Outcome Studies

A Psy.D. Clinical Dissertation

Presented to the Faculty of the

California School of Professional Psychology

San Diego

In Partial Fulfillment of

the Requirement for the Degree

Doctor of Psychology

---

by
Sharon Elise Durland, M.A.
1999

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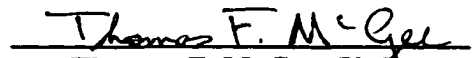

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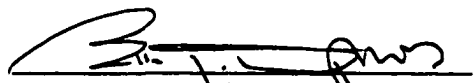

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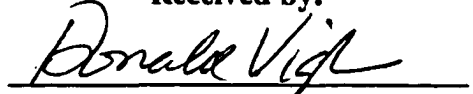

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To Steven

What greater thing
is there
for two human souls
than to feel that they
are joined for life –
to strengthen each other
in all sorrow,
to minister
to each other
in all pain,
and to be
with each other
in silent
unspeakable memories...

George Eliot

And to the Women

Michelle
Karoneee and Lisa
Audra
Julie
Lawrie
Lisa F.H.
Melanie &
Gay

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CHAPTER 1

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CHAPTER I

OVERVIEW

Studies of adults who have lost a loved one reveal a number of common emotional, physical and social consequences that are adaptive reactions to grief in some cases, and maladaptive, chronic conditions that are disabling in the worst of circumstances. The loss of an adult child, friend, lover or parent may result in a variety of problems for the bereaved, including emotional distress and depression (Clayton, Herjanic, Murphy et al., 1974; Hodgkinson, 1982; Stroebe, Stroebe & Domittner, 1988; Windholz, Marmar & Horowitz, 1985), physical deterioration and increased hospital visits (Gerber, Rusalem, Hannon, Battin & Arkin, 1975; Lundin, 1984; Maddison & Viola, 1968; Parkes & Brown, 1972), and compromised coping and life skills (Carey, 1979; Maddison & Viola, 1968; Vachon, Sheldon et al., 1982). It is believed that early intervention in the individual's grief process may reduce these problems and help facilitate a person's successful movement toward emotional and physical health.

In the treatment of adult bereavement, a number of approaches have been employed to aid in the immediate reduction of symptomatology and prevent the exacerbation of the grief reaction. Cognitive-behavioral, psychodynamic and other process-oriented theories are most prominent in guiding the treatment of bereaved adults. Additional treatments have been developed based on less comprehensive theoretical models, including gestalt therapy, feminist-based treatments and self-help approaches. A

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common thread weaving through all theories is the importance of expression of affect and the repetitious review of the lost relationship (Lindemann, 1944; Parkes, 1980; Ramsay, 1977; Raphael, 1983; Raphael & Middleton, 1987; Shackleton, 1984; Walls & Meyer, 1985; Windholz, Marmar & Horowitz, 1985). Despite this important commonality, the research is far from conclusive on the value of psychotherapy in the treatment of bereaved populations. While many of the clinical outcome studies demonstrate efficacy, others raise questions concerning the applicability of psychotherapy for adults with common and pathological grief reactions. In large part due to the wide variability in procedures among the studies, the literature is unclear about the benefits and disadvantages of grief therapy.

The purpose of this dissertation is to assess the value of psychotherapy for bereaved adults. This is accomplished in three phases. First, the theoretical and treatment literature is broadly reviewed. The primary focus of this initial discussion is to (a) show the connection between treatment techniques and their theoretical basis; (b) summarize the results of controlled and uncontrolled studies to identify substantive conceptual and methodological issues; and most importantly, (c) generate more specific questions or criteria to be explored in Chapter II. Chapter I begins with a brief examination of the epidemiology of mortality, normal and pathological grief, "working through" loss, manner of article selection for this dissertation, and ideal standards for treatment evaluation. It concludes with a discussion of each of the major and minor theoretical and atheoretical contributions to our understanding of grief.

The second phase of discerning the value of therapy for bereaved adults occurs in Chapter II, and is a formal synthesis of the controlled studies only. An outcome study's

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value is determined not just by the significance of its results, but on a careful balancing of methodological concerns with the strength of the findings. By delineating all the variables (for example, size of sample, number of measures, use of a follow up assessment time, statistical calculations on individual constructs, etc.) within each article and setting standards by which to assess the treatment studies, I draw firmer conclusions on the efficacy of different types of treatment.

In order to complete the assessment of therapy for bereaved adults, I compare and contrast Horowitz's stress response syndromes approach to a clinical examination of psychotherapy with three bereaved women in Chapter III. This third phase of evaluating grief therapy offers a real world perspective on how a theory and treatment model operate in clinical work. In summary, this document involves a careful examination of the existing theory and research in order to suggest a new and original way of explaining, organizing and understanding the treatment of bereaved adults.

Epidemiology of Mortality

Although there are a number of sources of data on death by marital status, race and age, few report on mortality for adult bereaved populations who lose an adult child, parent or friend. In this section, data on conjugal loss is reviewed.

Loss of one's spouse is a more common reality for married women than for men. According to an 1997 issue of Newsweek (June 30), the average life expectancies for adults between the ages of 20 and 59 are 73 years of age for men and 80 years for women. "The probability of widowhood is much higher for women, who usually marry men older than themselves, despite the fact that they outlive men by 7-8 years" (Barrett, 1978, p.21).

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In fact, according to the Census Bureau (Monthly Vital Statistics Report, 1997), married men die at almost twice the rate of women of all races. Interestingly, *widowed* men of all races between the ages of 45 and 54 die at more than twice the rate of *widowed* women, that is, 1400 per 100,000 versus 642 per 100,000 respectively. Divorce and gender are also highly correlated with mortality. For black and white divorced people, men die at approximately twice the rate of women for all ages. In Stroebe and Stroebe's (1983) review of mortality and illness risks following bereavement, men have consistently elevated mortality rates compared to women; this is thought to be related to widowers' reduced level of social support in comparison to widows (p. 287). In fact, Campbell and Silverman (1996) suggest that losing a spouse is "at the top of the list of life's most stressful events" for both sexes (p. 18). Although conjugal loss is only one type of loss, it is a significant one that is associated with morbidity and mortality.

Diagnosis: Normal and Pathological Grief

According to the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (APA, 1994), bereavement (V62.82) is viewed as part of the normal reaction to loss, and some grieving individuals present with symptoms characteristic of a Major Depressive Episode (e.g., sad feelings, insomnia, decreased appetite, and weight loss). "The duration and expression of 'normal' bereavement may vary considerably among different cultural groups, and Major Depressive Disorder (MDD) is generally not given unless the symptoms are still present two months after the loss" (p. 684). The DSM-IV (1994) suggests six criteria that may occur during the initial two months that if present, may indicate a preferential diagnosis of MDD over bereavement. These include: (a) guilt

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about things other than the actions taken or not taken; (b) thoughts of the death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; (c) morbid preoccupation with worthlessness; (d) marked psychomotor retardation; (e) prolonged and marked functional impairment; and, (f) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person."

Although the description of bereavement outlined in the DSM-IV (1994) aids the clinician, it also holds some diagnostic limitations. While studies most often compare the grief reaction with depression (Bornstein, Clayton, Halikas, Maurice, & Robins, 1973; Jacobs et al., 1989; Zisook & Schuster, 1991) and Post Traumatic Stress Disorder (PTSD) (Jacobs, 1993; Parkes, 1982; Rando, 1984; Worden, 1983), the grief presentation varies *widely* and proper diagnoses may include anxiety, mood, psychotic, and/or substance abuse disorders. The emphasis upon depression may mislead the clinician, and fail to normalize the range of symptomatology with which the bereaved may present. Furthermore, the range of symptoms, intensity and duration of the grief reaction hinge upon the relationship with the deceased, and personality and environmental variables; "two months" is an approximate time period which fails to capture the broad range of time periods for which the bereaved may mourn for a lost loved one (Wortman & Silver, 1987, p. 216).

A significant problem in the grief literature is the absence of a widely agreed upon operational definition of grief (Melges & Demaso, 1980; Raphael, Middleton, Marinek, & Misso, 1993). The ambiguity of its appearance is evidenced throughout the literature.

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For example, in describing therapeutic approaches to complicated grief, Rando states, "In general, the goal of therapy is to convert the syndrome into a more normal pattern in which the individual is able to mourn appropriately" (p. 266), although the concepts of "normal" and "appropriate" are never delineated. Thus, it is no surprise that the DSM-IV (1994) diagnosis of bereavement and differentiation of normal and pathological grief reflect the ambiguity prevalent in much of the bereavement literature. Most researchers suggest a cluster of symptoms to characterize loss, including pining, preoccupations, and a symbolic search for repair (Bowlby, 1980; Parkes & Weiss, 1983; Horowitz, Wilner, Marmar et al., 1980). Similarly, Hodgkinson (1982) suggested that grief is a process that contains various emotional components such as "shock, denial, disorganization, despair, guilt, anxiety, aggression, resolution and reintegration" (p. 29). Concurring with earlier theorists, Callahan and Burnette (1989) state that the typical grief process includes denial of loss, anger, attempts to regain the loved one, disorganization, depression and acceptance of resolution (p. 153). Clearly, the bereaved present with a host of diverse emotional and physical reactions that appear to defy the limitations of a paragraph in the DSM-IV (1994).

Despite the absence of a concrete definition for the different types of grief, duration and quality of symptoms seem to differentiate normal from pathological bereavement for most authors. There is general agreement that healthy grief requires some amount of affective expression that Rando (1984) suggests may take up to three years to be resolved with the more intense reactions subsiding between six and twelve months post-loss. Commonly, pathological labels of grief are indicative of time, including

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"abbreviated," "exaggerated," "inhibited," and "delayed" (Averill, 1968; Barbato, 1992; Lieberman, 1978; Lindemann, 1944; Parkes, 1965; Rosen, 1988). The essence of uncomplicated grief appears to be the client's progression over time; "normal" grief reactions may exceed a couple of years, so long as the client approaches the prior level of psychological, interpersonal, and work functioning.

Qualitatively, normal and pathological grief are commonly differentiated by symptom levels (Bugen, 1977). According to Horowitz et al. (1980), normal grief, however painful, "is not overwhelming, interminable, or prematurely interrupted. Competent self-images and readiness for a new attachment are stabilized" (p. 1160). Typically, and depending upon the degree of social interaction with the lost one, the bereaved's life is modified forever; however, it is the ability of the bereaved to function adaptively under the revised conditions that determines their place on a continuum of health and dysfunction.

The Concept of "Working Through" the Loss

"Working through" is a widely used expression in the bereavement literature. In Schut, de Keijser, van den Bout and Stroebe's (1996) study, the focus of the experimental group was on "accepting the reality of the loss, working through emotions and adjusting to the new social situation" (p. 358). Freud states, "when the work of mourning is completed the ego becomes free and uninhibited again" (1925, p. 245). Freud and Schut et al.'s description of grief work are similar to Lindemann's (1944) suggestion that the patient has to "accept the pain of the bereavement, review the relationship with the deceased, and become acquainted with the alterations of one's own modes of emotional

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reaction. One's fear of insanity, fear of accepting the surprising changes in one's feelings, especially the overflow of hostility, have to be worked through" (p. 147). "Working through" is also the fifth phase of Horowitz et al.'s (1993) model of mourning. It is described as, "recollections of the deceased and contemplations of self with reduced intrusiveness of memories and fantasies, increased rational acceptance, reduced numbness and avoidance, more dosing of recollections and a sense of working it through" (p. 764).

In summary, working through refers to a patient's transition from a state of distress to one of relative health. Distress may be marked by avoidance or overt symptoms of depression, anxiety, PTSD, or other diagnoses. Freud (1925), Horowitz (1993) Lindemann (1944) and Schut et al. (1996) offer similar interpretations of grief that suggest that "working through" involves a patient's transition from emotional discomfort, or even obsession, to "a sense" of resolution, a reduction of symptomatology, and an increase in well-being through verbal and non-verbal expressions of affect.

Method and Type of Article Selection

This paper reviews the empirical literature on adult bereavement, beginning with Lindemann (1944). Controlled and uncontrolled studies of adult loss were obtained from databases including ERIC, MEDLINE, PsychINFO, and PsychLIT, and under words like "grief," "bereavement," "complicated loss," "adult mourning," and combinations of the above words. Reference lists of grief-related books and journal articles were also reviewed for additional relevant work on bereavement. The intent was to review only those studies based on empirical, scientific methodology; thus, case studies were excluded.

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The studies reviewed in this paper include adults who have lost an adult child, spouse, friend or parent due to homicide, suicide, traffic accidents, war and most illnesses. Studies of loss due to AIDS or Sudden Infant Death Syndrome (SIDS) are excluded due to the special cultural and emotional factors connected with these conditions. The grief reaction for people who lose a loved one due to AIDS entails specific considerations; the societal implications of having a gay or lesbian relative may curtail or contain one's ability to express grief, to elicit support from the community, or even to admit to the cause of death (Folkman, 1997). While death is never opportune, some loss seems more catastrophic than others, such as the loss of a newborn child sleeping in its crib versus the death of a 85-year-old grandparent. Loss of a minor-child also involves a series of emotional factors that are beyond the scope of this article, and thus studies are restricted to adult and elderly populations.

Ideal Standards for Treatment Evaluation

In the following review, controlled and uncontrolled studies are evaluated on the basis of seven methodological criteria as defined by Foa and Meadows (1997) in their review article of the outcome literature on the treatment of PTSD. Bereavement articles which approach these "gold standards" (p. 453) will be examined in more detail; those studies that clearly veer from these important factors will be de-emphasized. Chambless and Hollon's (1998) article on empirically supported treatments will also be used as a guideline in determining the relative value of an outcome study.

The first criterion outlined by Foa and Meadows (1997) is the presence of clearly defined target symptoms. The rationale for this criterion is to (a) aid in the selection of

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measures that specifically gauge that symptom; (b) facilitate a greater magnitude of effect (i.e., it is easier to detect significant results if participants begin with high symptom levels); (c) reduce biases that minimize treatment efficacy or inflate effects; and, (d) establish clear inclusion and exclusion criteria for purposes of replication. A second criterion suggested by the authors is the use of reliable and valid measures, a third is the use of masked evaluators at initial, intermediate and follow-up assessment times.

Another criterion is the level of training of the assessors. If there are assessors evaluating treatment efficacy (e.g., interviews with the client), they should be given appropriate training in the assessment criteria and should be able to achieve interrater reliability. Foa and Meadows (1997) encourage the use of "manualized, replicable, specific treatment programs" that facilitate consistency of the intervention across therapists and replication of the outcome study by future researchers, and random assignment procedures of participants to treatment and control conditions (p. 453). A final consideration is the degree to which the study adheres to its stated treatment modality. "Were the treatments carried out as planned, and did components of one treatment condition drift into another?" (Foa & Meadows, 1997, p. 455). Treatment adherence may be assessed by the review of audio/video recordings by independent evaluators, or supervision by senior clinicians.

An additional factor not included by Foa and Meadows but that may be relevant is the qualifications of the treating clinician (e.g., intern, social worker or psychologist). Ideally, the treating clinician should have appropriate training and background in the

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treatment that is provided. Also, the training and experience of the provider should be consistent across treatment conditions.

Chambless and Hollon (1998) also propose ways in which to evaluate a treatment outcome study. Based on the American Psychological Association's Division 12 Task force on Psychological Interventions, the authors operationalize "empirically supported therapies" as "clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population" (p. 7). The authors explain that for a treatment to be "efficacious," it must have demonstrated efficacy in *at least two studies* by *independent research teams*. Thus, Chambless and Hollon offer useful guidelines in assessing treatment and scientific research.

In the remaining pages, different theories and treatment outcomes studies of grief are reviewed. Less well-developed, more superficial models will be discussed at first, followed by an examination of more comprehensive approaches, including psychodynamic, cognitive-behavioral and Horowitz's theory and treatment of stress response syndromes.

DESCRIPTIVE APPROACHES

Compared to the process-oriented theories (e.g., dynamic theory, cognitive-behavioral theory) that seek to explain the genesis, course and resolution of grief, some "stage" and "phase" theories describe the symptoms and outward appearance of the bereaved individual only, without theorizing on the origin and mediating factors of bereavement. Stage theories predict a relatively reliable transition from one type of symptomatic expression to the next. For example, Rando (1984) suggests three broad stages including avoidance, confrontation, and re-establishment. In contrast, the phase

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theories typically propose that clients may progress through some stages, and then revert back to earlier ones, reverse the order of symptoms, or skip some phases entirely.

Bugen (1977) proposed a phase theory of grief based on two dimensions: (a) centrality/peripherality of the relationship, and (b) preventable/unpreventableness of the loss. Centrality is defined as the degree of closeness the bereaved had with the deceased, whereas preventable is described as the degree to which the death could have been avoided. Bugen's phases include shock, disorganization, searching behavior, emotional components, resolution and acceptance, and reintegration. The author suggests some cognitive restructuring if the primary issue is guilt around the death, and more traditional grief work interventions such as review of the feelings toward the deceased and a "letting-go" process (p. 206) if centrality of the relationship is dominant. For its simplicity and ability to explain individual variability, this theory is appealing. However, it does not propose a new treatment approach, nor are its theoretical components based on clinical findings, field work, or empirical study.

Stage models have been proposed by a number of authors. Rando (1984) proposed three broad phases of grief including avoidance, confrontation, and re-establishment. A second theory was suggested by Engel (1962; 1964; in Rando, 1984) with stages that included denial and shock, developing awareness, and resolution. Recovery according to Engel involves adapting to the new situation by assuming prior, functional ways of behaving, as well as developing new friendships and activities. An additional stage theory of grief was proposed by Kubler-Ross (1970) whose five-stage model focused on more cognitive components including denial, rage and anger, bargaining

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for the return of the lost person, disorganization and acceptance. And finally, Bowlby and Parkes (1970) suggested a four-stage theory including (a) numbness: shock and lack of acceptance; (b) pining: yearning for and attempting to regain the deceased; (c) disorganization: acceptance of the loss, depressed affect, sleep and appetite disturbances, reduced goal-directed activity; and, (d) reorganization. As is apparent, stage theories are abundant, and all attempt to predict the course of the typical grief reaction.

Obviously the most significant critique of the stage theories is their failure to represent the universal bereavement experience that they purport to do. Wortman and Silver's (1989) research informs us that some people never recover and others never even experience grief; the premise that distress is inevitable or that failure to experience it equates with pathology is not certain (p. 350). Thus, there is information that contradicts the concept of the stage theories. According to Bugen (1977), stages are not separate entities nor successive; they are idiosyncratic in length and intensity, and people do not necessarily experience each step. Another important consideration are the clinical implications for the individual who deviates from the stage models; might this imply regression or pathology? Stage models do not accommodate pre-morbid or pre-loss personality, history, environmental and cultural variables which may impact the course of bereavement (Clegg, 1988, p. 66).

Despite the popularity of this type of theory, no empirical studies have been conducted employing these descriptive models of bereavement. The absence of controlled studies based on descriptive models may be indicative of their underdeveloped theoretical premises, or inability to be applied to a scientific model of study.

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CLIENT-CENTERED AND GESTALT APPROACHES

Although all therapies emphasize the importance of the client's subjective experience and the value of tapping this emotion, gestalt and client-centered therapies aim to intervene at the most rudimentary level of the client's emotional experience and work to facilitate associated expression. The "gestalt" of a phenomenon involves the "whole" of the experience including psychological and biological components. Hence, in the treatment of grief, a gestalt technique might enable a client to access an affective experience that *most* resembles the reality of the event, thus dismantling some defense mechanisms (e.g., denial, intellectualization) that might otherwise intervene in therapy.

Both Smith (1985) and Barbato and Irwin (1992) have reviewed the application of client-centered therapies in the treatment of bereavement. The authors suggest that client-centered therapy helps the therapist to "capture the precise essence of the client's experience" (p. 24) in complicated grief reactions. Likewise, gestalt therapy is deemed to be an "insight-oriented" therapy that will enable the client to access feelings of inner self-worth and movement toward health. Feelings are examined *as if* they were being experienced now for the first time; clients are encouraged to relive the experience as fully as possible via role play, the "empty chair" technique and the non-verbals evidenced in these demonstrations. Although the significance of such interventions is deemed vital, the author does not articulate how client-centered and gestalt therapies explain the grief reaction, its resolution, or how "true expression" facilitates recovery; that is, the grief literature based on humanistic theory does not explain how grief is triggered, maintained or resolved.

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Smith (1985) endorses the empty chair technique for the alleviation of depression in pathological grief. Appropriate for all types of loss, this gestalt intervention helps to recreate the situation in which the client can "psychodramatically" encounter the lost object. Smith emphasizes the process of saying good-bye through a series of steps in that the client envisions the deceased sitting in an empty chair, engages in a conversation with that person, and then switches chairs so that the bereaved, acting as if they were the deceased, may respond. In the client's monologue, the therapist aids the person to experience the full range of emotion with appropriate comments: "Tell the deceased you know she's not returning," "Let that [crying] out," and "Make sound" (p. 77).

One uncontrolled study by Hodgkinson (1982) offered a gestalt treatment program totaling 6 to 20 sessions, 2-3 times per week (N=10). Using a stimulation and exposure model, the author assessed where in the process the client had come to a halt and what in the style of "one's emotional responding, the circumstances of the death, or nature of the relationship with the deceased" the blockage was related (p. 29). Thus, the therapist helped the client to talk about the death in detail, determined where in the sequence of events the client was fixated, and taught the participant that emotions are containable, and release and confrontation necessary. Linking objects, or items that serve to elicit an emotional reaction from the bereaved were used in the evocation of affect. Ritualized behavior, such as stroking a picture or kissing the bereaved's clothes, was discouraged because such behavior was viewed as a reinforcement of the fixation and a failure to relinquish the deceased. The "third chair" technique (presumably equivalent to the empty chair technique) was employed in the final treatment phase. Although the author reports

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"positive outcomes" based on the author's subjective evaluation, no validated measures were reported. This study fails to demonstrate the efficacy of gestalt therapy.

In conclusion, gestalt therapy is a technique that is perceived as an aid in the therapeutic setting for expression of true affect. As with Barbato and Irwin's (1992) review, Smith (1985) fails to offer the reader an interpretation as to why this expression is so intimately tied to recovery, nor is this intervention reported to stem from empirical work, field studies or clinical observation. The only application of gestalt theory in the grief literature is Hodgkinson's (1982) study which excludes basic information on methods and procedure, preventing a valuable assessment of this model. Thus, although other theories support the expression of affect, client-centered and gestalt interventions do not provide the clinician with a comprehensive framework from which to guide therapy, nor do they offer empirical work to defend its value.

SOCIAL SYSTEMS

Only one study has evaluated the efficacy of a social systems framework in the treatment of bereaved families. A controlled study conducted by Polak, Egan, Vandenbergh and Williams (1975) examined the benefits of a crisis intervention with families within two hours after the death of a member (bereaved, treatment, n=39 families; bereaved, no treatment, n=66; not bereaved, no treatment, n=56). Accompanying medical examiners to the home, therapists facilitated grief work, supervised children and assisted in notifying relatives of the loss. Phone and home visit contact lasted between one and six hours; each family received between two to six sessions in the following one to ten weeks.

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Treatment was randomly assigned and the goal was to increase the effectiveness of the family in coping with feelings, decisions, problems, values and boundaries.

Preliminary data analysis revealed significant differences among all the groups. First, the experimental group had a significantly greater number of deaths due to suicide or that were sudden, in comparison to the bereaved control group. In addition, the non-bereaved control group had significantly better social and personal adjustment than the bereaved groups prior to participation in this project ($p<.001$). Based upon data collected at six and eighteen months by an independent research team using examiner-evaluator ratings, questionnaires and self-report methods, both of the bereaved groups had a higher incidence of psychiatric illness compared to the non-bereaved control group. In conclusion, the systematic differences among the groups prior to treatment compromise the results thereby limiting interpretations of the systems treatment modality as a reliable form of intervention with bereaved families. That the bereaved groups had an elevated pathology level compared to the control, non-bereaved group post-treatment suggests the social systems approach administered in this format may be unhelpful, or even potentially harmful, to the bereaved client.

FEMINIST

Blieszner (1994) discusses widowhood from a feminist-socialist theoretical viewpoint. The author highlights the importance of examining gender, class and race/ethnicity in the analysis of widowhood, and expresses concern for the "absence of attention in the literature paid to capitalism and patriarchy" in loss (p. 172). She encourages the reader to consider the differential aspects of widowhood depending upon

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one's gender. She surmises that traditionally role-defined men suffer after loss in the ability to care for oneself; these men are not as accustomed to cooking, cleaning or caring for themselves in the domestic ways that their wives may have provided. Campbell and Silverman (1996) suggest that in the past, "men have been content to let their women handle the emotional work in life, along with the housework, the social work, and the work in raising the children" (p. 227). Contrary to men, women experience a critical loss of income with the death of their husbands, and may not be able to maintain the life style to which they were accustomed. These economic and social factors thus impact the bereavement process for traditional, heterosexual couples.

Blieszner also notes that for women, the opportunity to attain a level of economic independence and to push themselves to achieve may be a source of confidence that women alone have; men, not deeming domestic matters with as much status as economic self-sufficiency may not find autonomy in that area as rewarding as the woman who is able to become her own provider. The author concludes that the consequences of widowhood are inextricably linked to "the interactions of private and public spheres that influenced past labor market experiences and gender-based power relations in the home" (p. 178).

Only in Barrett's (1978) study is a feminist approach employed in the treatment of bereavement. Treatments were designed based on the premise that widowed women would be able to help each other cope with the stresses of their situation. It was further postulated that a number of the stresses of widowhood derive from sex roles operative both in marriage and after loss, thus giving dimension to the "consciousness raising group"

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treatment condition. Barrett's study reflects an unique impetus compared to most of the bereavement literature.

Women were randomly assigned to either the self-help, consciousness raising, confidant or wait list/control group (N=70). Treatment consisted of seven, weekly, two hour sessions at the University of Southern California. In the self-help groups, members initiated all topics of discussion; explored the specific problems of widowhood; and, helped one another find solutions to problems (n=8, 10). The purpose of the confidant groups was to facilitate the development of close friendships through pairing off, sharing personal concerns and making explicit requests for help from others (n=8, 7). Modeled after the Consciousness Raising Committee of the Los Angeles chapter of the National Organization for Women, the consciousness raising groups were provided with sex role topics relevant to widows and discussed roles of women in society (n=11, 9).

Based on comprehensive pre-treatment, post-treatment and follow-up (14 weeks post-treatment test) measures of mental health, perceived benefits, attitudes, physical health, social adjustment and grief, the treatment participants showed more positive change in five year health predictions and less "other-orientation" than the control group at post-treatment. At follow-up, the treatment participants reported greater self-esteem, greater negative attitudes toward widowhood and remarriage, less other-orientation, and *greater* grief intensity than the control group. In summary, treatment was effective on measures of physical and mental health for the treatment groups at post-treatment and follow-up. There were also negative or non-beneficial results on measures of grief and attitudes post-treatment. The study did not state results for each of the treatment

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conditions separately. This absence of information *suggests* that there were no significant results to report. This study was strong in its explicit description of treatment modalities and the assessment of participants at a follow-up point.

INTERPERSONAL

A controlled study for conjugally-bereaved participants was conducted by Lieberman and Yalom (1992) to assess the value of a brief, group therapy for clients in their mid- to late-life, as well as the relative value of this treatment for "at-risk" clients versus less distressed individuals. All participants had lost their spouse due to cancer in the preceding four to ten months (after attrition: treatment, $\underline{n} = 34$; control, $\underline{n} = 19$), and 41% were deemed to be "at-risk" based on the Mellinger-Balter algorithm (1983; in Lieberman & Yalom, 1992) indicating signs of psychiatric disorders. Predominantly middle-upper class and 73% female, all clients were Caucasian and three dropped out of the study. Randomly assigned to the treatment and control conditions, participants in the experimental group were again randomly assigned to one of four groups within the experimental condition, each group convening for eight, 80-minute sessions led by a co-therapy team (Yalom, and either a psychiatric resident or a bereavement counselor). The control group's only contact with the researchers was to complete the battery of questionnaires at the beginning of the study, and one year later.

Compelled by the common complaint of "loneliness and isolation" of the elderly, Lieberman and Yalom designed a process-oriented group that focused on norm setting, the present and future, and relevant topics to bereavement including being single, fears of betraying the deceased spouse, social expectations and existential issues triggered by the

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death of their spouse. In describing the "therapy intervention," the authors state that "group psychotherapy is particularly suited to addressing problems of social isolation and the development of new social networks. Group participants often experience relief through sharing, feeling accepted by a group, realizing that others share their dilemmas, being inspired by others who have found ways of surviving..." (p. 123). Judging from these statements, it can be understood that Lieberman and Yalom adamantly promote the interpersonal approach. However, literature is not cited that supports their belief that "group psychotherapy is particularly suited" or that "the group participants often experience relief." Thus, one critique of this article may be strongly-worded support for a type of treatment that, at least in this article, is not adequately documented to be indicated by earlier studies, field work, or clinical observation.

Based on five validated, self-report measures of psychological states, social roles, and mourning, differences among the four experimental groups were not significant and so were grouped as one. In this true experimental design, there were two significant results on measures of positive mental health and negative social adjustment; the treatment group showed a significantly greater level of self-esteem and lower level of single role strain compared to the control group at post-treatment. There were not significant results between the high- and low-risk participants. There was overall improvement over time in health, guilt, and anger for all participants. In conclusion, this study lends initial support that interpersonal group therapy can help bereaved patients with issues of self-esteem and single role strain.

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ATHEORETICAL STUDIES

Four studies have been conducted without the specific use of a well-defined theoretical orientation. Three of these studies (Constantino, 1981; Flatt, 1988; Parkes, 1981) found empirically interesting results where treatment condition clients improved on measures of social adjustment, depression, reduced substance abuse and reduced levels of autonomic activity. Similar to earlier models and treatments reviewed in this paper, three of the studies in this section focused on the effects of treatment for participants at "high-risk" for pathological reactions. Most of these studies present some serious methodological problems. For example, procedural detail that would facilitate the replication of the studies is omitted; information on treatment orientation, length and duration is unclear; and, factors about recruitment, inclusion and exclusion criteria, diagnoses and supervision of treatment providers is insufficiently elaborated. Thus, these studies are weakened due to the lack of critical information.

In Jones' (1979) controlled dissertation study on conjugal loss (N=36), the treatment consisted of an eight week, three hours per week psychotherapy group aimed at helping clients accept and adjust to loss (89%=female, 11%=male). Using the SCL-90 and Personal Orientation Inventory, no significant differences were found between the treatment and control groups immediately post-treatment. However, based on a pre- and post-treatment questionnaire, the participants' response to group was "overwhelmingly positive" suggesting that the standardized instruments may have failed to detect the treatment progress made by the clients; or, demand characteristics or expectation biases influenced the clients' subjective assessment of the intervention.

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Investigating the levels of depression and social adjustment for widows, Constantino (1981) conducted a controlled study with a bereavement crisis intervention group (n=7), socialization group (n=10), and control (n=10). The bereavement crisis intervention group, co-facilitated by masters-level clinicians, was described as giving specific support and encouragement for mourning, although the length of treatment is not reported. The socialization group provided a forum for widows to gather and partake in social activities; participants convened at the investigator's home the first two times, and it served as the point of departure for the final four meetings. ANOVA yielded a significant increase in depression post-treatment (specific time not reported) for control groups, compared to the treatment conditions; the bereavement crisis intervention participants also improved significantly on the social adjustment scale. In summary, although this study demonstrates the value of encouraging expression of grief in bereaved women, the treatments are not replicable because of the omission of basic procedural information including the length of treatment and specifics about the bereavement crisis intervention model. In addition, this study had very few participants.

In a retrospective study of participants (N=260) at a funeral home's "Grief Recovery of Widowed" (GROW) program in which groups met two hours per week for six weeks, Flatt (1988) analyzed people's pre- and post-scores on an unvalidated measure of grief, depression and quality of relationships. GROW is described as a relatively structured group therapy service "yet loosely organized to allow for discussion of what is on the heart of each participant" (p. 43). The article did not indicate whether a professional was present during the group sessions. Although significant positive change

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was found in seven of the eight components of the scale, there was a 50% attrition rate for those who participated in GROW and no explanation for this is offered by the author. In conclusion, this article omits relevant detail about the sample population, nature of the treatment, and does not use a control group.

Parkes' (1981) longitudinal, controlled study with families (N=302 before attrition; N=57 after attrition) from a London Hospice evaluated high- and low-risk participants in a treatment condition in which families were offered the services of a volunteer bereavement counselor. Sixty-five percent of the sample population were widows, and 45% of the group was unable to be reached by an independent evaluating interviewer at the 20 month follow-up time. Participants were randomly assigned to the treatment or control condition. A questionnaire assessing depression, substance abuse, health, and anxiety administered pre- and post-treatment revealed significant, positive differences between the treatment and control high-risk participants on indices of autonomic activity and substance abuse. Because of the use of only one measure and the omission of information about the treatment, sample population, and operational definition of high- and low-risk participants, the application and validity of these results is highly compromised. However, the use of a 20 month follow-up assessment time is an important strength of this article, and sets it apart from much of the other bereavement literature.

SELF-HELP AND PEER COUNSELING

Some studies have tested the efficacy of self-help from other people who have experienced loss. These investigations seek to explore the potential for people to work through loss without professional help, although such groups may serve as an adjunct to

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ongoing individual psychotherapy. Lieberman's (1996) extensive review of interviews with over 600 widows concludes with a definitive endorsement of bereavement support groups: "Regardless of their backgrounds, ages and circumstances, widows who joined support groups recovered much faster" (p. 125) based on measures of depression, use of medication and alcohol, anxiety, well-being, and self-esteem. One limitation of this method may be that peers are not always capable of handling the degree of emotion that someone in crisis may exhibit. Rynearson suggests that self-help work may be only appropriate for general support of uncomplicated grievers (1987, p. 494). One self-help study conducted by Vachon, Lyall, Rogers, Freedman-Letofsky, and Freeman (1980) demonstrates the value of this approach. However, all eight articles reviewed have a variety of methodological limitations and problems due to omission of relevant information.

Ineffective Studies

A short-term and long-term self-help model employed by Caserta and Lund (1993) evaluated men and women's perceived interpersonal resources (self-esteem, competencies, and life satisfaction) on outcome measures of grief and depression. In an effort by the authors to examine the effects of length of treatment upon participants, two experimental conditions were designed. The long-term treatment condition entailed eight weekly sessions and ten additional monthly meetings, while short-term group condition involved eight weekly sessions only. Participants were randomly assigned to either treatment condition (n=188) or a control group (n=98). Measures were administered at four times: two months post-death, after eight weeks of treatment, ten months later, and immediately

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following the second anniversary of the death. No significant treatment results were realized. The authors suggested that the respondents' lack of change over time on these measures may be a result of the absence of pathology at the start of treatment. Therefore, this self-help model treatment was not found to be efficacious for this adult, bereaved sample.

To assess the efficacy of a mutual help group intervention with older widowers deemed to be at "normal risk for morbidity," Tudiver, Hilditch, Permaul and McKendree (1992) offered nine semi-structured, 90 minute, weekly sessions to the treatment group (n=43) and to the wait list/control group (n=26). During group, members could raise individual concerns and also discuss formal topics including legal matters, life style changes, relationships, nutrition and exercise. Two trained facilitators with experience in counseling the bereaved were taught group process issues and provided with manuals on conducting sessions with between five and twelve members per group. Measures administered at 2 (end of treatment), 8, and 14 months assessed depression, health, anxiety, social support and social adjustment. ANOVA yielded no significant differences between the two groups over the fourteen month observation period. Thus, this treatment approach failed to demonstrate utility for bereaved widowers.

Interestingly, a follow-up, retrospective study of the same group of participants was conducted by Tudiver, Permaul-Woods, Hilditch, Harmina and Saini (1995). Matching participants with married cohorts and tracking all participants' use of the medical providers of the Ontario Ministry of Health, the authors noted that rates for visits to family physicians significantly declined after the intervention for the treatment group,

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but kept rising among the controls; the married cohorts' visit rates remained constant. These results suggest that those who take part in a mutual support program decreased health care utilization. That this article detected changes that Tudiver, Hilditch and Permaul (1991) did not assess is testimony to the importance of using multiple measures which evaluate a wide range of factors.

In a controlled, outcome study, Lieberman and Videka-Sherman (1986) evaluated the benefit of a one year self-help group (THEOS, "They Help Each Other Spiritually") for conjugally bereaved adults (N=502). Four groups were discerned from the sample population: (a) *Nonmembers* (n=100) had attended two or fewer THEOS meetings and considered themselves nonmembers; (b) *Meeting attenders only* (n=133) attended regular monthly meetings but had not developed significant social linkages with the group as might be assessed by degree of contact with members outside the group or by number of members considered to be "close friends;" (c) *Low-social linkage members* (n=117) attended regular meetings, and, either considered some members to be their "best friends," or gave and received support outside the group meetings; and, (d) *High-social linkage members* (n=126) both attended regular meetings, had regular contact with members outside the group, and gave and received social support outside of the regularly-scheduled meetings. (The number of sessions attended was not listed for any of the four groups.)

Based on measures of social functioning, attitudes and mental health, individuals demonstrated significant improvements on most variables over the duration of the self-help treatment compared to a probability group (a sample of widow and non-widow respondents who were matched to the THEOS sample according to race, age, education

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and sex). The additional comparative steps necessary in the use of a probability sample evidences the authors' statistical and methodological thoroughness in this study. Despite these efforts, widows in the THEOS sample were significantly more distressed at pre-test than those in the normative sample. Thus, the demonstrated value of this treatment is limited by systematic differences in levels of pathology between THEOS and normative sample group members.

Walls and Meyers (1985) also employed a self-help model in their controlled study with participants assigned to one of four conditions including cognitive restructuring, behavioral skills, self-help or the delayed treatment/control group (N=38 widows, before attrition; N=21, after attrition). The self-help group met for ten, weekly 90 minutes sessions in an unstructured environment where members were encouraged to support one another and share problems and methods of coping with stress. Assessed on measures of depression, beliefs, anxiety, and life satisfaction, two significant results were found; on a measure of negative social adjustment, there was a group by time interaction with post-hoc analyses suggesting that the cognitive restructuring group improved over the other two treatment conditions at post-test. On a measure of positive social adjustment, post-hoc analyses indicated that the cognitive restructuring and behavioral skills groups *decreased* significantly on a measure of potential for pleasurable activities compared to the self-help and control group conditions at post-test. In summary, there were significant beneficial and non-beneficial results for the treatment condition participants. Low statistical power may have contributed to the inconclusive findings of this study.

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In a controlled experiment by Sabatini (1988), self-selected participants (N=50) were placed in either a crisis intervention study offered by the American Red Cross program, First Step, or the wait list/control group. A majority of the participants were Caucasian. Led by a former widowed person and mental health professional, the treatment group consisted of fourteen, weekly two hour sessions during which the goal was to restore the clients to their prior level of physical and emotional functioning. Initial sessions were psychoeducational where leaders taught clients about the dynamics of grief and the recovery process. This less-structured support group allowed members to raise relevant concerns and receive validation for their experiences and feelings. Five central tasks included accepting the reality of the loss; helping in the development of new, modified self-concepts, such as "single" versus "married;" learning how to manage mood changes and feelings; avoiding deification of the deceased; and, starting a new life.

One validated measure of grief administered pre- and post-treatment yielded non-significant differences between the treatment and control conditions, although all clients evidenced significant improvements at the post-treatment assessment time (14 weeks). Recovery was, however, significantly influenced by systematic, pre-treatment differences between group members on measures of "circumstances of spouse's death and amount of time since death." The value of this study is weakened by the omission of information on attrition and the use of only one measure which may or may not have captured relevant variables for this sample population. Furthermore, this study provides no information on the diagnoses or symptomatology of the participants.

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Marmar, Horowitz, Weiss, Wilmer and Kaltreider (1988) conducted an controlled experiment for widows with stress response syndrome using individual, brief dynamic therapy and mutual help groups (before attrition: treatment, n=31, mutual help group, n=30). Participants (mean age=58 years) were screened from 300 callers, and selection was based on prolonged distress and symptomatology. Two independent clinicians reviewed the pre-treatment evaluation to verify the presence of common grief reactions including depression, anxiety, anger, guilt, intrusive thoughts, avoidance, denial, and sleep disturbances. A significantly greater number of participants dropped out of the mutual-help group than the treatment group.

Each treatment condition consisted of twelve, weekly 90 minute sessions. The support group, led by five bereaved, non-clinicians who received common training and a manual on leading sessions, was defined as a "group in which people come together for mutual support and constructive action leading to achievement of shared goals" (p. 204). Based on multiple clinician and self-report measures, ANOVA yielded a significant improvement for those who received individual psychotherapy on the Symptom Checklist-90 at the four month follow-up time period compared to the mutual-help group: all clients improved on measures of intrusion and avoidance, general anxiety and depression. In summary, the value of this study is limited by the lack of a "true" control group, steep attrition rate of over 50%, and a systematic relationship between attrition and group assignment which resulted in poor statistical power. Another consideration is the degree to which the group leaders had resolved their own bereavement issues and how this may have affected the participants and mutual help group process.

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Effective Study

Only one article, a controlled study involving widow-to-widow support by Vachon, Lyall, Rogers, Freedman-Letofsky and Freeman (1980) demonstrates the efficacy of the self-help model. Participants were interviewed at 1, 6, 12, and 24 months after the loss of a spouse (before attrition: treatment, n=68; control, n=94). Despite random assignment, treatment members were significantly more likely to have lost their husband due to cancer, have at least two people who were emotionally supportive, and talk to their spouse as if alive. There were no significant differences between the intervention and control groups' attrition rates or characteristics of participants lost to follow-up.

Each patient was assigned one of six "widow-contacts," and both the patient and widow contact could initiate phone calls, face-to-face contact, referral advice for locating community resources, and small group meetings. On a measure of positive social adjustment, the treatment group was significantly more likely to experience intrapersonal benefits than the control group on one *test item* at post-test. At follow-up, the treatment group was significantly more likely to experience interpersonal benefits than the control group on three *test items* on a measure of positive social adjustment. High distress participants (those who scored 5+ on the Goldberg General Health Questionnaire, 1978) were significantly more likely to have shifted to low distress than high distress participants who had not received treatment. The treatment is not replicable due to lack of detail on number and length of contacts within the pairings of widows. In conclusion, this article offers a tentative demonstration of the value of widow-to-widow pairings for the treatment of conjugally bereaved clients.

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Summary of Self-Help Literature

In summary, seven of the eight self-help group studies involved the use of control groups, and samples ranging from 28 to 502 participants, with larger samples occurring more often. Treatment approaches ranged from formal group formats with pre-scheduled meetings, to widow-to-widow pairings where widows are given a "widow-contact" to meet with at their own pace. Although several studies demonstrated positive significant differences between the treatment and control conditions (Lieberman and Videka-Sherman; Marmar et al.; Vachon et al.), two had significant pre-treatment differences in participants' symptoms between the groups (Lieberman and Videka-Sherman; Sabatini), and one had a systematic relationship between attrition and group assignment (Marmar et al.). Attrition was deemed a significant problem in two studies (Marmar et al.; Vachon et al.). Despite a the 61% attrition rate and the omission of details relating to the intervention, Vachon et al. (1980) present the only tentative support for the self-help model; the experimental group demonstrated significant improvements on a measure of general health compared to the control group one year post-loss. Overall, studies of self-help interventions were compromised by methodological weaknesses, as well as the simple omission of information that would facilitate replication of these studies, such as a detailed description of the intervention. In general, the studies do not demonstrate the efficacy of this type of treatment for patients.

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COGNITIVE-BEHAVIORAL

Cognitive-Behavioral Theory

Cognitive-behavioral theory is discussed widely in the grief literature. Based on the premise that that which is learned can be unlearned, cognitive-behavioral theories (CBT) explain grief as the natural consequence of operant and classical conditioning, desensitization and incubation. CBT proposes that depression-related mourning may be a natural response to the loss of a loved one as a result of environmental circumstances and individual behaviors and cognitions. Thoughts such as "I'll never make it alone," "A part of me has died," and "It should have been me" contribute to a sense of hopelessness, failure, and loneliness. Common cognitive-behavioral conceptualizations of grief explain the bereaved's behavior as actions that are environmentally reinforced. For example, the widower may experience an initial increase of affection, phone calls and visits from family and friends if he is quiet, withdrawn and tearful. These behaviors elicit the social support which he may need at that time. Or, dysphoria when talking about the loss may evoke a negative social response (i.e., punishment), and therefore may precipitate a decrease in the frequency of mourning behaviors. In the following section, theories of grief based on cognitive and behavioral models will be reviewed.

Gauthier and Marshall (1977) and Ramsay (1977; 1979) were among the first theorists to develop cognitive-behavioral models in the treatment of bereavement. Gauthier and Marshall stressed environmental influences in the bereavement reaction, while Ramsay focused on behaviors of the patient, such as avoidance and escape.

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In the development of grief, Gauthier and Marshall suggest two primary contributing factors. The first is when attempts to inhibit the mourning produce ideal conditions for the cognitive "incubation," or continued internalized mental activity about the grief when the bereaved has a desire to talk openly about his or her feelings, thoughts and fantasies. Grief may be additionally maintained by the concurrent lack of reinforcers for behavior other than the mourning behavior.

As part of this incubation, Gauthier and Marshall coined the term, "conspiracy of silence" (p. 41). Afraid to "bring up such a sensitive topic," family and friends may avoid any mention of the deceased in the presence of the bereaved. Consequently, the bereaved may feel encouraged or socially reinforced *not* to talk about the loss. Alternatively, the bereaved may interpret people's willingness to spend time with them as a reinforcing consequence for not outwardly mourning. Together, these environmental factors contribute to the grief reaction. Several additional factors could explain individual variations, including the history and "constitutional" specifics of the griever, abruptness of the loss, significance of the loss, availability of replacements for the loved one, and environmental events after displays of grief.

The authors implicate classical conditioning in their conceptualization of the grief reaction as a product of incubation. Prior studies demonstrate that "following a single pairing of a conditioned stimulus (CS) and an aversive unconditioned stimulus (UCS), repeated brief presentations of the CS alone at full intensity produced an increase in blood pressure, an unconditioned response (UCR)" (p. 41). Although the authors fail to make explicit what they are labeling as the CS, it may be inferred that thoughts of the deceased

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act as the conditioned stimulus, and the actual death the unconditioned stimulus. The authors suggest that a pathological grief response may occur if the bereaved experiences "unpleasant feelings when reminded of the deceased" and is socially conditioned to believe that "talking about the deceased is improper and should be suppressed." As a result, each time the bereaved is reminded of the loss, the increased arousal of those feelings helps to intensify the grief reaction.

Comparing grief avoidance with the treatment of phobias, the authors indicate that avoiding internal or external stimuli associated with the death intensifies the aversiveness of these stimuli, and prevents successful adaptation to the event. Consequently, Gauthier and Marshall suggest a re-construction of this social reinforcement schedule whereby the patient is reinforced for talking about their grief, and "social reinforcement is not consistently given for alternative behavior" (e.g., having a good time, talking about inconsequential matters, pursuing hobbies) (p. 42).

Although Gauthier and Marshall make some interesting and useful connections between the grief reaction and cognitive-behavioral concepts, such as incubation and social reinforcements, the comparison of classical conditioning with the grief response is not elaborated upon sufficiently, nor is it explained how classical conditioning is implicated in the social reinforcers discussed earlier in the article. Further, the authors do not adequately explain how "guilt" is accumulated as a result of "grief incubation." A final concern is the distressing nature of the flooding intervention. Ramsay (1979, p. 228) states, "for grief, there is no gentle equivalent [to flooding]; the therapist can grade the confrontation in a roughly hierarchical fashion, but the emotional reactions, when they

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occur, are usually intense." Thus, Gauthier and Marshall's support of this technique may not appeal to individuals simply by nature of its in-the-moment discomfort, despite its proven benefits.

Reminiscent of Gauthier and Marshall's work, Ramsay's (1977; 1979) theory is based on a comparison of pathological grief to phobia. Phobia, the authors notes, "involves a single or series of traumatic events resulting in a conditioning of previously neutral stimuli which becomes cathected with an unconditioned stimulus" resulting in an unconditioned response. In the case of grief, a relatively non-compelling item before death, such as the deceased's blue sweater (CS) is paired with the death (UCS), resulting in an unconditioned response of sadness and depression (UCR) upon presentation of the blue sweater (CS). In both phobias and avoidant bereavement responses, the patient is motivated to escape "objectively harmless situations" (Ramsay, 1979, p. 227), ones that in the case of mourners are the exact triggers for grief work that can precipitate the extinction of the conditioned response.

Consequently, Ramsay states that flooding and prolonged exposure to the conditioned stimuli, which arouse the conditioned emotional responses, can be as effective for pathological mourning reactions as it is for the treatment of phobia. Using objects that elicit large enough emotional reactions, clients are prompted to "stay with the emotion" and discuss appropriate feelings given the context. This model of confrontation with the loss, catharsis, and re-integration -- the process of "putting the resolution and acceptance into practice in everyday life" (p. 224), and breaking habits such as watching the partner's favorite television program or purchasing their preferred grocery item -- is considered

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suitable for "embedded" or phobic grief reactions. The treatment is designed for those strong enough to endure the treatment, particularly, those with a reliable social network and the "possibility of making a new life" (p. 229).

Ramsay explains the benefits of this approach as breaking a pattern of avoidance of aversive stimuli on the part of the bereaved, the very cycle which prevents the necessary confrontation with the fear and consequent extinction. This article is strong in its ability to clearly link the similarities between phobic and grief reactions, both characterized by anxiety and avoidance of objectively harmless situations. Support for this theory is evidenced in studies that document the value of flooding for the bereaved patient.

In 1984, Brasted and Callahan reviewed the learning theories in the treatment of grief including respondent or classical conditioning, adaptation and sensitization. Stating that the operant formulations provide only "partial explanations for the grieving process" (p. 535) the authors highlight the relationship of classical conditioning to bereavement, and emphasize the impact of interpersonal variables.

In the authors' discussion of respondent conditioning, it is stated that a "neutral stimulus [unemotionally charged stimulus] acquires conditioned aversive properties resulting in the suppression of behavior upon presentation of the conditioned stimulus (e.g., tone or light) and in the absence of an aversive event (e.g., shock)" (p. 535). Brasted and Callahan compare the behavior of a rat after shock treatment, the initial flinching followed by attempts to escape the aversive stimulation, to the experience of the bereaved individual when they are unable to avoid the aversive stimulus. Consequently, the authors compare the grief reaction to any phobic disorder marked by agitation and a

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desire for withdrawal from the "noxious stimuli." One concern with this theory is the degree to which results from animal studies can be generalized to human behavior.

Similar to Gauthier and Marshall, and Ramsey, Brasted and Callahan promote the applicability of flooding interventions to anxiety. However, contrasted to Gauthier and Marshall, and Ramsey, who focus on the pathology of grief, Brasted and Callahan emphasize the normalcy of the grief reaction, and how it is similar to any avoidance behavior of evocative material.

Conceptually, the grief reaction of elderly populations is congruent with Brasted and Callahan's focus on learning histories. Typically, older people have experienced a greater number of losses as a result of natural complications that occur later in life. Such losses may familiarize the elderly person with the experience of loss, resulting in their easier adaptation to it, which is in fact the case (Parkes, 1964). Alternatively, premature experience with loss, such as the loss of a mother or father as a child, theoretically may results in a heightened sensitivity to future loss, although this would depend on the degree to which such a loss is resolved adaptively. But clearly, one's learning history, either adaptation or sensitization, is a mechanism which conditions one's course of grief.

Based on these learning models, pathological grief is defined as a function of the individual's successful or partially successful attempts to avoid normal grief; "this response fosters an inability to cope with an environment replete of cues of the deceased" (p. 539). Learning models emphasize the powerful impact of the behavior of friends and relatives upon the course of the bereaved's grief reaction, especially in pathological mourning. The learning model implies that confrontation with the loss such as planning

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the funeral, viewing pictures of the deceased, and talking about the death result in a healthier adaptation to the loss.

One caveat raised by the authors relates to the applicability of operant conditioning in understanding grief reactions in the elderly and in women who have spontaneous abortions, based on the length of their learning history *with the lost person.* Based on a lifetime of intimacy with the deceased, the elderly widower should have a grief reaction with deep emotional ramifications compared to a young widow, less accustomed to life with one's partner (p. 535). However, as the literature demonstrates (Skelskie, 1975 in Brasted & Callahan, p. 534), in fact, it is elderly people who have healthier adaptations to loss. Likewise, operant conditioning predicts that the woman with limited interactions with her developing fetus, who experiences an abortion, would have a shortened grief reaction because she has had limited rewarding and reinforcing interactions with her child. As with the young widow, a woman who has a spontaneous abortion often experiences a large amount of grief despite the absence of long-standing behavioral patterns involving the child (Stack, 1980). Thus, social learning theory unsuccessfully explains these two grief reactions; the older woman with a longer social history with her deceased husband fares better than expected, and the expectant mother with limited history with her child and who loses her pregnancy can be greatly impacted.

These examples indicate the presence of additional mechanisms that may contribute to the experience of bereavement. One such mechanism might be the role of expectations and anticipation of life with one's child or partner. The cognitions around an hoped-for lifestyle, not yet experienced but intended may impact the bereaved upon the

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death of these unrealized dreams. In conclusion, this article offers a comprehensive review of cognitive-behavioral theories, integrates operant and classical mechanisms, and discusses important limitations of social learning theory to a conceptualization of grief.

As specified by earlier theorists, exposure to the stimulus associated with the loss is thought to be a "critical ingredient" in overcoming pathological grieving and PTSD (Fairbank & Brown, 1987). In 1989, Callahan and Burnette presented the exposure paradigm as intended to help the pathologically bereaved "relive the trauma" through guided imagery. Similar to other theorists, these authors propose that it is the successful avoidance of reminders of the deceased that exacerbates the bereavement reaction, and inhibits recovery.

Cognitively based behavior modification techniques such as guided imagery or cognitive restructuring is also described by Clegg (1988) and Melges and Demaso (1980). Based on Kelly's Construct theory which states that all people engage in a continual attempt to predict and control behavior (Kelly, 1955; in Clegg, 1988), Clegg suggests that loss is an assault on a person's perceived ability to anticipate and plan events. Consequently, guided imagery is a method whereby visualization is used to restructure the memory of emotional events, and the therapist may aid the client in a fantasy that includes more control over the traumatic event, "especially when strong feelings of helplessness are evoked." Likewise, Melges and Demaso state that the way people construe death is central to the whole structure of their cognitive system; guided imagery aims to reconstruct the individual's sense of failure and enable one to "re-experience the loss with prior obstacles removed" (p. 59).

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Fairbank and Brown (1987) compare loss to other traumas, such as sexual abuse and combat-related events. It is proposed that PTSD symptoms are a consequence of a learned response to a traumatic conditioning event. "A wide range of previously neutral stimuli become conditioned (CS) as a function of pairing with an aversive stimulus (UCS)" (p. 58). Because a learned response exacerbates and maintains the grief reaction, the authors employ Mowrer's Two Factor Theory. Factor one involves the CS and UCS pairing; factor two entails the reinforcement of avoidance by reduction of anxiety. According to Mowrer's theory, "treatment involves (a) exposure to the fear-eliciting conditioned cues, and (b) the prevention of responses (e.g., withdrawal, avoidance, anger) that typically result in short-term anxiety reduction but also maintain the affect-inducing potency of these stimuli" (p. 63). This conceptualization builds upon the work of other theorists, including Gauthier and Marshall, and Ramsay. Fairbank and Brown do not, however, take into account cognitive responses; is anxiety reduction accomplished purely by the process of extinction, or do changes occur in the manner in which a client thinks and re-thinks about the event?

Kavanagh (1990) proposes a cognitive-behavioral model of grief based on depression and anxiety models. The author highlights how past studies' focus on phobic reactions have failed to address grief's analogy to depression. For example, phobia is less common after loss whereas depression is common; delayed or inhibited grief is only one kind of response to loss; and chronic grief conflicts with the phobic model, which relies on habituation and counter-conditioning to explain recovery. Grief fails to conform to the phobic model because it is an "extensive series of exposure trials to multiple stimuli that

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fail to produce generalized reduction of distress" (p. 374). Rather, Kavanagh proposes that chronic grief is the result of an "emotional feedback loop." Initial sadness is reinforced by the negative conditions, behavior and physiological processes it triggers, and which serve to "maintain and deepen" the depression.

Following from Kavanagh's conceptualization of the grief phenomenon, the author suggests interventions which resemble the more modern approaches to depression, combined with flooding and exposure techniques. The author suggests helping the client to address self-efficacy issues, anticipate high-risk situations, increase involvement in activities that provide "temporary distraction and relief," and confront negative triggers (such as pictures of the deceased, wedding memorabilia and other tokens that remind the bereaved of the deceased). Kavanagh legitimizes "controlled distraction," and explicitly includes cognitive therapy and skills training; as with most treatments of depression, the resumption of activity is seen as central in this treatment strategy. Although Kavanagh successfully addresses the depression component of grief, the author fails to explain the origins and basis for the "emotional feedback loop." The questions raised by this approach include, what evidence is there for the maintenance and deepening of the initial sadness? What explains why some individuals slide into a deeper depression while others recover? For those who do enter a declining depression, how do these clients eventually improve in their mood presentation?

Cognitive theory assumes that problematic affect stems from the manner in which one structures an experience in the world. Barbato and Irwin (1992) review the purely cognitive theories of grief, but only one controlled study (Walls & Meyer, 1985) employs

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a strictly cognitive approach as an experimental condition. The patients assigned to the cognitive restructuring group are taught how their thoughts, beliefs, self-statements, and perceptions affect their emotions, as well as helped to identify negative beliefs, modify irrational thoughts, and practice positive self-talk. In general, cognitive-based techniques might include understanding how one's thoughts impact one's feelings; examining thinking errors such as minimization, catastrophizing and black and white thinking; substituting positive thoughts for harmful ones; and, practicing self-talk (Barbato & Irwin, p. 25; Kavanagh, 1990, p. 380).

Barbato and Irwin review the work of Ellis (1981), Rowe (1984) and transactional awareness (Berne, 1964). Ellis suggested that harmful emotions are the consequence of a destructive thought system. Rational emotive therapy was designed to heighten the patient's awareness of irrational thoughts and demonstrate their harmfulness to the individual. He proposed that people manufacture negative affect, including helplessness, anger, anxiety and depression by way of information processing that creates an "irrational belief system." Similarly, Rowe believed that irrational thoughts predispose a person to more complicated grief reactions. For example, if one views the self as bad or one's feelings as "wrong" or "unforgivable," this may exacerbate pathology. Transactional awareness teaches the individual to think in rational ways, develop awareness of destructive thought patterns, and recognize mature and immature levels of thinking.

Summary of Theory

In conclusion, bereavement theorists have applied a wide range of cognitive-behavioral concepts in the conceptualization of the grief reaction, its maintenance and

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treatment. Classical and operant conditioning offer useful ideas for understanding bereavement. Likewise, flooding, exposure, desensitization and social skills training are advocated as suitable treatments. This body of theory is able to explain the development of phobic-like symptoms in the bereaved based on classical conditioning, as well as depression based on a deficit in positive reinforcement schedules.

Cognitive-Behavioral Treatment

Nine studies have been conducted that employed cognitive-behavioral therapy in the treatment of bereaved individuals. Schut, Stroebe, van den Bout and de Keijser (1997), Walls and Meyers (1985) and Brom, Kleber and Defares (1989) employed a control group that did not receive any professional treatment until after the collection of data. Mawson, Marks, Ramm and Stern (1981) and Sireling, Cohen and Marks (1988) used an exposure and anti-exposure groups in which the anti-exposure group received an equal amount of professional contact, while Schut, de Keijser, van den Bout and Stroebe (1996)'s employed a grief therapy control group in comparison to the behavioral/art therapy intervention group. Two uncontrolled studies, Lieberman (1978) and Debor, Gallagher and Lesher (1983) were weak on methodology and measurement. Of all the studies, a controlled experiment by Reich and Zautra (1989) was by far the most complex with a 12-cell design involving two at-risk groups, bereaved and disabled, and additional conditions for matched controls, placebo groups and no-contact control groups. Overall, the studies employed a wide range of interventions, including cognitive restructuring, exposure and guided mourning. In part due to a variety of methodological problems,

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cognitive-behavioral interventions demonstrate limited therapeutic value in the treatment of the bereaved.

In Schut, Stroebe, van den Bout and de Keijser (1997) study, differential treatments for widows (n=23) and widowers (n=23) were compared to a non-treatment control group (n=59) in The Netherlands. Conjugally bereaved adults under the age of 65 were contacted through obituary notices. Based on an initial interview, participants with moderate to high levels of distress on a measure of general health were invited to partake in the study. There were two treatment groups, an emotion focused and problem focused group. The control group participants were selected from a prior study (Schut, 1992) and chosen to match the treatment group participants at baseline on levels of distress, gender and cause of death. The problem focused group participants had a significantly higher level of income at baseline than did the other groups at baseline ($p<.01$). Participants were bereaved an average of eleven months.

Based on Worden's (1991) work, the treatment group conditions involved gradual exposure, systematic desensitization and rational emotive therapy aimed at "tackling behaviors and cognitions that complicate the grieving process such as rumination and social withdrawal" (p. 66). For each treatment group, seven counselling sessions were conducted within ten weeks between 14 and 17 months after bereavement. The individual treatment sessions were conducted by one of 26 experienced social workers trained in either the problem or emotion focused treatment modality.

In this quasi-experimental, non-equivalent control group design, assessment occurred at baseline and 18 and 25 months after the loss. Based on a measure of general

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health (GHQ, General Health Questionnaire: Goldberg & Hillier, 1979), all three groups showed a significant linear decline in GHQ scores of the participants over time ($p<.001$) in a MANOVA over repeated measures. Univariate tests suggest a significantly smaller decrease in distress in the control group ($t_{linear}=2.29$, $p<.05$). Cross-sectional ANOVAs only revealed a significant group difference in GHQ scores during follow up ($F(2,102)=3.57$, $p<.05$) with a Scheffe test indicating that this was due to the difference between the control group and problem focused group.

Schut, de Keijser, van den Bout and Stroebe (1996) conducted a controlled study with an inpatient, bereaved population in The Netherlands. Integrating behavior and art therapy, the investigators administered to one group ($n=52$) "cross-modality grief therapy" (CMGT), while the second "control" group ($n=17$) received the "regular Health Care Center therapy for complicated bereavement." The only significant pre-treatment difference between the two groups was that the level of education was higher for participants in CMGT compared to those in the regular grief program ($p<.05$). CMGT comprises an introduction, an individual-oriented, a social-surrounding-oriented, and a completion phase, and includes psychoeducation, cognitive restructuring, gymnastics, relaxation training, thematic group discussions, and arts and crafts activities. The focus during group was on "accepting the reality of the loss, working through emotions and adjusting to the new social situation" (p. 358). The "control" group treatment program was not described.

Employing a quasi-experimental, non-equivalent control group design, data were collected at intake, entrance (baseline), directly after discharge (post-treatment) and three

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to four months after discharge (follow-up) using a measure of general health (Goldberg & Hillier, 1979). A total of 19 participants did not complete the study. MANOVAs over repeated measures showed decreasing distress over time for both groups $F(3,46)=33.7$ ($p<.001$). On a measure of negative mental health, the treatment group improved more so than the control group at post-test. Trends indicated that the magnitude of effect for participants in CMGT was greater than for the regular grief therapy participants.

In an uncontrolled study by Debor, Gallagher and Lesher (1983), the authors treated 20 self-referred patients between the ages of 55 and 81 (30% male) with mild to moderate post-bereavement stress. No pre-test measure was used, and participants were asked to complete a subjective, self-report questionnaire (no further description given) one month post-counseling. The treatment consisted of group therapy with five to seven members per group for eight weeks. Participants were encouraged to express feelings of loneliness and invited to generate solutions to members' problems. Experiences were framed in terms of a transitional period, noting that "discomfort would probably exist until new patterns were developed" (p. 85). Social activity was encouraged, and relaxation techniques taught and practiced. Cognitive interventions included negative thought tracking, developing more flexible thinking patterns, and having members push their feelings and thoughts to both positive and negative extremes, resulting in more reality-based perceptions.

All participants reported that the group provided them with better understanding of the grief process; facilitated learning through sharing in experiences of others; provided a safe place to talk; and, enabled them to cope much better with stress. On a scale of

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helpfulness, clients averaged a mean score of five (1 = not very helpful; 7 = extremely helpful). Two areas were reported not to have been affected, including the resolution of conflicted family relationships and the levels of daily activity. This experiment has a number of weaknesses including the lack of a control group, no pre-test measures, and an unvalidated questionnaire which may have been affected by demand characteristics. Its strengths are its detailed description of the treatment approach, and a more circumscribed sample.

Lieberman (1978) examined the effects of a forced mourning procedure on 19 individuals who presented at a severe level of one of thirteen indicators of morbid grief, including "absence of expected response; delayed response; identification with symptoms present in the last illness of the deceased; and identification with personal traits present in the deceased" (p. 161). All participants were on medications and diagnoses included schizophrenia, depression, alcoholism, and personality disorder. The forced mourning procedure follows behavioral principles, including systematic desensitization, implosion (e.g., write a letter to the deceased member, fantasize communication of feelings toward the deceased, view pictures, discuss feelings relating to this imagery), and family involvement in order to facilitate the transfer of progress made in therapy to the home and workplace. This three stage treatment model included: (a) explaining client's diagnosis; (b) exploring client's relationship with the deceased and encouraging strong emotion; and, (c) acknowledging the completion of the treatment when the individual is able to "review the total relationship with the deceased, acknowledge positive and negative aspects of the relationship, develop new relationships, and discuss termination of therapy" (p. 160).

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Based on the author's assessment of improvement on a scale of one to five, Lieberman concluded that for sixteen of nineteen participants, the use of "forced mourning procedures resulted in major relief or disappearance of referral symptoms" (p 161). Social class was associated with general outcome; twelve of the sixteen participants in social classes I-III (not defined), versus one of three in class IV, improved. Twelve of thirteen participants in which families were involved benefited, whereas only three of six members whose families did not participate in treatment, improved.

Clegg (1988) states that this treatment may be beneficial only when family members can be incorporated into the treatment procedure, but that "forced mourning is not indicated when a bereaved individual lacks social support, has concurrent financial problems, or is experiencing other significant stressors" (p. 71). Given the significant diagnoses of the nineteen members, Clegg's statement regarding "other significant stressors," may be unfounded. Omission of the length of treatment, the absence of test measures, the absence of a control group, and the use of an unvalidated, subjective measure created and used by the author detract from the value of these results. The study also fails to define the socio-economic classification system used rendering the significant results without interpretative value for the reader.

Comparing unresolved grief to other forms of phobic avoidance treated with exposure, Mawson, Marks, Ramm and Stern (1981) used guided mourning in a very small, controlled study (exposure, $\underline{n}$ = 6; anti-exposure, $\underline{n}$=6). All individuals had grief distress for more than one year plus two or more other indications of pathological grieving (e.g., increased alcohol, drug, or cigarette consumption, an anniversary reaction, excessive guilt

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toward the deceased). Treatment consisted of individual therapy three times per week for two weeks, with sessions lasting between 60 and 90 minutes. Participants were randomly assigned to one of two treatments and assessed at 28 weeks post-treatment. The treatment employed was "directive although each step was mutually acceptable" (p. 186) to therapist and participant.

The guided mourning group (n=6) was exposed to avoided and painful memories, ideas, situations both in imagination and real life, relating to the loss. The therapist focused on those areas "most difficult for the participant to describe" using strategies such as "saying good-bye" (p. 187), completing written homework, and visiting the cemetery. The treatment goal was to maximize exposure to avoided stimuli at a pace tolerable to the individual. Participants were instructed to "Write at least one page daily about your relationship with the deceased, think about the relationship with the deceased, and think about that lost person as often as you can. Force yourself to face grief. Look at a photo of the deceased daily" (p. 186). The alternative anti-exposure intervention was labeled in the study as a "control" group (n=6), and individuals were encouraged to avoid thoughts of the deceased, give little attention to painful memories, and explore distraction methods. This group was taught relaxation skills, and encouraged to think about current and future concerns. Participants were instructed to "Write at least one page daily about your relationships with other friends and relatives who mean a lot to you; think about them as often as you can. Give yourself a break and you'll feel better. Look at photos of friends and relatives" (p. 186).

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Between groups analyses at week four concluded that guided mourning participants improved significantly more than anti-exposure participants on total phobic avoidance and on the bereavement avoidance task performance, with supporting trends in the same direction on four additional measures of grief, anxiety-depression and global phobia. This experiment did not involve a no-treatment "control" group, and patients ranged widely in ages (28-61). Furthermore, the authors did not explain how the inclusion criteria, "delayed or abnormal onset of grief, or excessive guilt and hostility" (p. 192) were operationally defined. In conclusion, this study demonstrates the partial efficacy of short-term, individual guided mourning for morbid grief within the first month after treatment. These benefits were not maintained at the five month follow-up.

Sireling, Cohen and Marks (1988) replicated Mawson et al.'s (1981) study with moderate changes. Sireling et al. used a larger N of 20 participants, and increased treatment to ten sessions over the course of 14 weeks instead of six over two weeks. Both the exposure and anti-exposure groups were given more systematic advice and support concerning relationships, work, and leisure activities. They improved the study with a masked assessor and broader range of measures. A larger follow-up was conducted at one, three and nine months post-treatment, versus five.

Morbid grief was defined as "avoidance of people, objects, places or conversations concerning the deceased, or of saying a final good-bye to the deceased" (p. 123). Symptoms had to have begun after the loss, and persisted longer than one year. Participants evidenced no psychotic symptomatology. For the exposure group, therapists explained healthy grief and why the individual's symptoms were unhealthy. Avoidance of

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cues was identified, and clients were encouraged to confront avoided cognitive cues (thoughts), affective cues, and behavioral cues (e.g., books/photos, shoes and jewelry from the deceased, grave of the deceased). The anti-exposure group was encouraged to "get on with living," avoid thinking about the loss, think about the future, remove reminders associated with anniversary dates, turn off radio when songs reminded individual of the deceased, and distract themselves from these thoughts (e.g., polish silver). Homework was assigned to each group.

Analyses of five behavioral and self-report measures indicated that guided mourning was significantly superior to anti-exposure on only one variable, the bereavement avoidance task at three months post-treatment. As might be predicted, the article demonstrates that interventions which desensitize an individual to memories of the deceased produces a greater willingness to expose oneself to memories of the deceased. The lack of improvements on any measure of grief, physical symptoms, hostility, anger or guilt indicates that this treatment was effective only for behavior, and not emotional adjustment. The results of this study were similar to the first by Mawson et al. In both studies, exposure techniques resulted in participants' reduced avoidance of stimuli associated with the deceased.

A controlled treatment study was conducted in the Netherlands also by Brom, Kleber and Defares (1989). The sample averaged 42 years of age (range=18 to 73), and included people with a traumatic incident in the past year (e.g., traffic accidents, violent acts, bereavement, etc.) and diagnosed with PTSD (before attrition: N=112). Participants were randomly assigned to either trauma desensitization, hypnotherapy, brief

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psychodynamic individual therapy, or a wait list/control group. The trauma desensitization therapy program was based on work by Fairbank and Brown (1987), and lasted an average of 15 sessions with follow-up at three months. Clients were taught relaxation techniques, encouraged to reexperience the event, exposed to the avoided stimuli, and taught to strengthen their feelings of control over the stimuli.

Based on measures which assessed symptom level, anxiety, anger, and personality variables, a multivariate ANOVA demonstrated clinically significant improvements in 60% of the treatment group participants and in 26% of control participants. Therapies were found to be equally effective but were significantly more so than the control group. Given the large number of participants and multiple measures, this study demonstrates the efficacy of intervention with people experiencing more severe symptoms after a traumatizing event, such as being a victim of a violent crime, or loss by murder, illness, or traffic accident. Although some of the participants were bereaved, it is not clear whether this would be an effective intervention for a bereaved population, specifically.

In a cognitive treatment study of older adults, Reich and Zautra (1989) compared two at-risk populations, recently disabled ($\underline{n}$=61) and recently bereaved ($\underline{n}$=62), with matched non-risk controls (not bereaved, not disabled, $\underline{n}$=123). Participants were randomly assigned to a placebo-contact group, a no-contact control group, or a four-session, ten-week intervention focused on enhancing perceived control. After attrition and elimination of participants due to matching restrictions (matched on age, sex and socioeconomic status), twelve conditions composed the study: (a) *disabled participants*, intervention=19, placebo=6, no contact=32; (b) *bereaved participants*, intervention=19,

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placebo=9, no contact=29; (c) *control participants matched with disabled*, intervention=19, placebo=6, no contact=32; and, (d) *control participants matched with bereaved*, intervention=20, placebo=9, no contact=27.

Intervention sessions lasted from 30 to 60 minutes each and were conducted in a "warm, open, and empathic manner" (p. 417). Interveners were seven older women recruited for their work with human services (teaching, counseling, etc.), and deemed therefore to have personal skills and interests in working with this older population. For training purposes, the interveners attended a workshop on cognitive-behavioral control processes, interview skills and assessment instrument administration. In the sessions, the goal was to engage the participant in a review of their lives and the opportunities for control they actually have, that is, to make them "mindful" of control in their lives. "The intervener sought active participation by using the participant's own examples, experiences and reminiscences; although the focus was on enhancing the cognitive understanding of the role and importance of cognitive control, a prominent theme also involved the emotional side" (p. 417) of one's competence and perceived control. Placebo-contact control participants received social visits for the same length and frequency as the experimental group. No-contact participants did not know about the experiment.

Measures of personal mastery, psychological well-being and distress, positive and negative affect, and of daily events and activities were assessed monthly for six months; the intervention occurred during months three through six. Compared with participants in the two control conditions, participants who received the intervention experienced

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significantly increased personal mastery by month four and lower psychological distress at month five (during the intervention). Also, they had significantly lower negative affect by the third session, and they were engaging in higher desire event responses by the final session. Interestingly, even though all planned comparisons did not reach statistical significance, mean differences nearly always favored those who received the intervention.

The most methodologically sophisticated study of cognitive-behavioral treatment is Walls and Meyers (1985). Sessions lasted 90 minutes, and were held once per week for ten consecutive weeks. Participants (N=38 females between 30 and 65 years old) were widowed between 25 months and 3 years prior to treatment, and were randomly assigned to one of four treatment modes: (1) cognitive restructuring, (b) behavioral skills, (c) self-help, and (d) delayed treatment control group.

The cognitive restructuring group educated participants on how thoughts effect emotions, helped clients to identify and modify irrational thoughts, practice self talk, problem solve, and examine catastrophic thinking, such as self-statements about being alone, fear of failure when undertaking new, more masculine tasks, exaggerated social anxiety, negativism and hopelessness about the future. The behavioral skills group, based on Lopata (1973) and Lewinsohn (1973), addressed the reduced social roles and isolation resulting from widowhood. This group increased social reinforcement to decrease depression, increased the frequency of enjoyment of activities on a weekly basis, taught assertive communication and social skills, informed participants how to get involved as a volunteer in the community, and also educated clients to re-enter the job market. The self-

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help group participated in unstructured sessions which encouraged members to support one another and share problems and methods of coping with stress.

All groups completed measures at pre- and post-treatment, and one year follow-up. On a measure of social adjustment, there was a group by time interaction; post-hoc analyses showed that the cognitive restructuring group improved over the behavioral skills, self-help and control groups. There were also significant, non-beneficial results; on a measure of positive social adjustment, there were two group by time interactions. Post-hoc analyses indicated that the (a) cognitive restructuring and behavioral skills groups were significantly decreased on a measure of potential for pleasurable activities compared to the self-help and control groups; and (b) the control group significantly increased on a total score of potential for pleasurable activities and the cognitive restructuring group decreased significantly on a total score of potential for pleasurable activities compared to the behavioral skills and self-help groups at post-test.

In understanding these results, several hypotheses are offered by the authors. The use of inexperienced therapists (psychology students) may have impacted statistical significance. Second, group cohesion via group process has been demonstrated to be significant in the therapeutic process (p. 142). However, the cognitive-behavioral approach does not facilitate those processes found to promote change, including self-disclosure, acceptance of cohesiveness, group interaction and interpersonal learning, insight into behavior, universality or mutual guidance. A final concern was the attrition of 10 participants resulting in a total sample of 28 participants, and there was a significant relationship between age and attrition. Those who remained in the study were

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significantly older than those who dropped out. Further, only 21 people completed the follow-up questionnaire. These low numbers impacted the study's statistical power. Although Walls and Meyer base treatment modalities on prior studies, employ a control group, and have a homogenous sample population, the study fails to demonstrate the value of cognitive restructuring and behavioral skills group therapy for bereaved populations.

Summary of Treatment

Based on these seven studies, cognitive-behavioral treatments have limited effectiveness. Three studies employed a no-treatment control group, and only Brom, Kleber, and Defares found those participants who received trauma desensitization to improve significantly more than the control group. To the credit of these three studies, each was based on prior theoretical work. Overall, the studies suffered from low power (N ranged from 12 to 38, with only Reich and Zautra and Brom et al. employing more than 100 participants) and the use of too few measures; in fact two studies, Debor, Gallagher and Lesher (1983) and Lieberman (1978) employed only one, unvalidated, self-report measure. Only Reich and Zautra's study demonstrated significant treatment benefits at follow-up. As might be predicted, studies which flooded patients with material that desensitized them to aversive stimuli, demonstrated just that: significant results that indicated patients' greater facility to expose themselves to triggering stimuli. However, no significant decreases in depression, grief, anger or anxiety resulted from behavioral treatment.

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PSYCHODYNAMIC APPROACHES

Psychodynamic Theory

Central to dynamic understanding of loss are the working through of ambivalent feelings and the "decathexis" of the lost object. This gradual process of de-cathecting -- of resolving psychic energy directed toward or attached to a mental representation of a person -- is a significant component of psychoanalytic understandings of grief. Dynamic interventions have been employed in a variety of controlled and uncontrolled studies with both individuals and groups. Dynamic therapy has been found to be an efficacious form of therapy for grieving adults.

Freud's Totem and Tabu (1913), Mourning and Melancholia (1917), and Symptoms, Inhibitions and Anxiety (1929) state that the only cause of "abnormal grief" is the presence of unconscious ambivalent feelings towards the loved object, and categorizes bereavement reactions as a member of the group of narcissistic neuroses because of its emphasis on identification with the deceased and need for decathexis from the deceased. Freud believed that grief resolution required a thoughtful examination of these feelings and psychic energy directed toward the loved one. Complicated grief according to Freud is the internalization of negative feelings directed at the deceased resulting in depression, and decreased self-esteem, which in extreme cases may reach delusional proportions.

Adaptive mourning is considered to be the process by which one's unconscious thoughts regarding the lost object become conscious. When this process is completed, "the ego is free again." Although the individual may still experience residual thoughts and emotions about the significant lost person, they will not be of the same intensity or

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debilitating nature as they were before this course of treatment. In the case of pathological mourning, the bereaved's degree of identification with the deceased is assumed to contribute in large part to the intensity of the grief. In Krupp, Genovese and Krupp's (1986) interpretation of dynamic theory, "it is precisely that individual with an incomplete (non-autonomous) self-identity who is more likely to develop pathological identifications" (p. 340). Thus, the defense mechanism of identification aids in dynamic theory's distinction between normal and pathological grief.

Dynamic theorists post-Freud expanded upon his theories. In Lindemann's (1944) study of the Coconut Grove fire and loss due to war (N=101), he proposed that a central component of grief recovery is the "emancipation from bondage of the deceased." By emancipation, the author is implying an emotional freedom from obsessions, ruminations, or excessive focus on the deceased. The premise that it is necessary for people to "release themselves" from significant others relates to Freud's stated belief that complicated grief requires a working through of ambivalent feelings toward the lost, significant person.

Lindemann hypothesized that bereavement reactions consist of five components: somatic disturbance, preoccupation with the image of the dead, guilt, hostility, and disorganized behavior. Recovery for both abnormal and normal grief requires the completion of "grief work." He proposed that grief work can be accomplished through readjustment to the environment, formation of new relationships, and the "analytic working through" of feelings such as fear or hostility; and the expression of feelings of loss and guilt. Lindemann does not detail what is meant by "analytic working through," nor clarify whether this necessitates verbal or non-verbal expression.

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In Attachment and Loss (1980), Bowlby offers a conceptualization of grief that integrates both dynamic and biological components, and suggests that grief is the natural consequence of separation. One's approach toward relationships is based on an integration of one's personality and prior attachment patterns. The author states that human beings instinctually work to develop strong emotional connections, and that when these relationships terminate or are threatened, they may experience a wide variety of emotions or behavior change (p. 39). Attachment theory presupposes an individual's desire to remain close to the loved one either through symbolic attachment or an ongoing searching behavior. Breaking from psychoanalytic theory, Bowlby does not grant the process of identification a prominent role; and when it is, according to Bowlby, it may indicate pathology. Further forms of pathological grief include displacement, where the bereaved directs anger away from the lost person onto someone else; or, as in the case with repression, splitting or dissociation, where the emotional components of grief become intellectually disconnected from the loss.

Bowlby's conceptualization of pathological mourning stems from abnormal psychological development in infancy, childhood or adolescence, and represents an intensification of the normal grief process (p. 217). In fact, Bowlby states that defenses interfere with, divert or exacerbate bereavement and render it pathological. Intimately tied to these defense mechanisms are the idiosyncratic attachment processes of the adult developed as a consequence of the relationship between the child and caretaker. In keeping with the disease model of bereavement, he states, "any system is capable of effective operation only when the environmental conditions relevant to its operation

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remain within certain limits. When they do not, the system becomes over-stretched and eventually fails" (p. 42). Thus, the childhood bond serves as a template for future interactions which, if tested beyond its capabilities become vulnerable to inoperation. Different from classical psychoanalytic theory which views deviant attachments as the result of "fixation" or "regression" to an earlier stage, Bowlby's theory locates the source of problems in the early formative and immature years of the person's life. Mourning therefore begins with protest, despair and detachment, and is resolved either when the lost person is found, or in a process of gradual emotional and cognitive resolution of the loss.

Bowlby's theory is distinct in its overt rejection of some of Freud's work, including the deemphasis of identification and libido theory. In contrast with Freud's implication of identification as a substitute for a libidinal bond, Bowlby suggests that "identification is almost certainly independent of orality" (p. 26). A theoretical problem is that Bowlby's equation of separation anxiety with grief has not been tested; pain and anguish is a reaction common to most upsets, not just loss. One significant issue raised by Shackleton (1984) is Bowlby's main tenet, that grief is separation anxiety. Even though the bereaved person might appear to display similar affect as a small child suddenly separated from its parent, it does not necessarily imply that the two events are psychological or developmental equivalents (p. 166). Although Bowlby's work is largely based on conjecture regarding the similarities between separation anxiety and loss, Bowlby expands the dynamic interpretations of bereavement and questions analytic work by his predecessors, thus sparking new discussion in our conceptualization of grief.

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The practical implications of Bowlby's work are generally similar to those offered by other theorists, with emphases on creating a safe and trusting environment for the client; reviewing circumstances around the death; and, exploring the course of the relationship with the lost loved one. As suggested by Sable (1992), the emphasis for Bowlby however dwells in issues of abandonment and separation with the lost person and other significant people in the bereaved's life.

Like Bowlby, Parkes conceives of mourning as similar to the searching behavior of young children. Biological motives to find and reunite with the lost caretaker are instinctual drives (Parkes & Weiss, 1983, p. 3). The various behavioral components evidenced after grief serve adaptive functions. Crying, for example, may aid in eliciting emotional or practical support from others. In normal grief, Parkes suggests there is an initial degradation of the capacity to work and function followed by the growing ability to return to the prior level of activity. When this recovery process is stalled, Parkes suggests that it is abnormal, and may be further characterized as either "chronic," "inhibited" or "delayed" (Parkes, 1965, p. 14). The label of "illness" is reserved for instances where abnormal grief results from pre-existing psychological problems, and produces long-lasting inabilities to function; bereavement is but one precipitant to the ensuing problems.

In the course of recovery, the bereaved must progress through three stages: (a) the intellectual acceptance of the loss, (b) the emotional acceptance of the loss, and (c) the matching of the person's perception of the self and the environment with their new reality. Similar to Horowitz (1984), Parkes (1971) suggests that grief is the process of letting go of one set of assumptions and the adoption of a new and more appropriate set; both

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authors emphasize the integration of the bereaved's schemas about the world prior to the loss and after, as well as pre- and post-loss perceptions of self and the self in relationship. Because these internal concepts have implications for how one operates in the world (e.g., friendships, finances or travel) the modification of these unconscious and conscious worldviews are critical for healthy adaptation. In the three phases, the bereaved will repeatedly review all their associations around the loss with special emphasis on answering the question "why did this person die?"

Margaret Mahler's work on the psychological development of the infant (1975) also contributes to the comprehension of the bereavement process. Her emphasis on the child's separation-individuation phase is similar to Bowlby and Parkes' comparison of childhood separation anxiety to bereavement. Mahler suggests six developmental stages that the child experiences in the first three years including: (a) the autistic phase (birth through six weeks), (b) symbiotic phase (six weeks to five months), (c) differentiation subphase (five to nine months), (d) practicing subphase (nine through 16 months), (e) rapprochement subphase (16 to 24 months), and, (f) "on the way to the libidinal object constancy" subphase (24 to 36 months). These phases together help to move the child from a state of dependency on the caretaker for emotional and physical well-being to a place where the child can provide that comfort to itself. Ideally, the child will have internalized a positive and healthy image of the caretaker that facilitates self-soothing and self-loving throughout its life.

The critical component of this theory in relation to grief is the emphasis on the child's ability to develop an image of its primary caretaker as an integrated "good" and

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"bad," and not strictly one or the other. Mahler suggests that it is the child's skill in developing a sense of its primary caretaker as a consistent, stable internal image that contributes to the child's sense of sustenance, comfort and love. If the child integrates the good and disappointing qualities about the caretaker into one image, this facilitates healthier relationships with people, and thus, perhaps, a healthy adaptation in the case of loss. If, on the other hand, the child "splits" the images of the caretaker into "good" and "bad," the child may not have any consistent, internal images to support her or himself, especially if she or he loses a loved one in a sudden or premature manner. The way in which the child attaches to her or his primary caretaker in infancy thus, contributes to the template for attachment patterns throughout one's life, and may have potentially serious consequences in the case of bereavement.

Krupp (1986) and Marris (1958; 1974) also expanded upon the theories of their predecessors, stating that the bereaved individual maintains a level of energy or preoccupation with the deceased by the processes of introjection (unconscious fantasy of union with another) or identification until that grief is either re-channeled or released. Krupp emphasizes the self-soothing process of identification with the deceased; the unconscious process whereby the individual takes observable qualities of the deceased, namely, behaviors, attitudes, emotions, into the internalized representation of that lost person, and assumes those manners as one's own. For example, upon losing one's spouse, the bereaved may watch the deceased's favorite television show despite never having enjoyed it before; in this way, the bereaved retains a sense of connection to the deceased.

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Marris also highlights the significance of the death of a loved one as it relates to the loss of that which is irretrievable, familiar, and predictable. In this discourse, Marris expands the understanding of loss. For most, death only seems "fair" if it comes at the end of a full and rich life. Bereavement that results from sudden death, chronic illness, murder, suicide, or accident feels frustrating and illogical. Consequently, one does not lose "only" a lover, a spouse or a friend, but also the naive safety that life is somehow predictable or controllable. It is this secondary existential loss that can complicate the psychological resolution of bereavement.

Summary of Theory

In recent years, dynamic or analytic-oriented treatments of bereavement often include the exploration of intense affect and ambivalent feelings toward the deceased spouse, especially those who are abusive or violent. The expression of affect is encouraged, and little structure is imposed in the sessions. Dynamic psychotherapy "aims to change not only symptoms but problems of recurrent maladaptive interpersonal relationships and of self-esteem, through resolution of intrapsychic conflict" (Horowitz, Marmar Weiss, et al., 1986, p. 583). Crucial to treatment is the exploration of dreams, transference, termination issues and ambivalence towards the deceased in the course of treatment. All theorists have viewed awareness and expression of affect as a necessary part of "grief work."

Commonly the dynamic treatments expand their sample populations to include participants who have experienced a variety of trauma-type events, including war-time events, natural disasters and sexual trauma. The rationale for grouping people with these

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types of experiences with those with those who are bereaved is not fully explained. In their use of this greater range of clients, the dynamically based theories differ markedly from cognitive-behavioral based studies whose samples were restricted to participants who are bereaved. Although certain dynamic studies addressed populations with significant distress or PTSD diagnoses, each excluded patients with severe personality disorders, substance abuse, or prior histories of hospitalization.

Psychodynamic Treatment

Four controlled psychodynamically oriented studies have been conducted with individual and group treatment modalities. Raphael (1977; 1978) investigated pathological mourning with "high-risk" populations, or people who perceive their support systems as inadequate. The two studies conducted in Canada at the University of Alberta Hospital also employed a population deemed to have pathological grief. Raphael's sample was restricted to bereaved patients. In the Alberta studies, patients had experienced loss due to death, divorce/separation, or both. All studies encouraged the expression of affect as the primary variable in the facilitation of grief work. Each study evidenced significant and positive results for the treatment condition relative to controls demonstrating the efficacy of psychodynamic treatment for bereaved adults with complicated grief reactions.

Involving only high-risk bereaved women as defined by degree of perceived social support, Raphael (1977) conducted a controlled, psychodynamic therapy study to assess the treatment benefits of a preventive intervention for the recently bereaved (before attrition: experimental group, n=31; control, n=33). High-risk participants were those with a perceived level of non-supportiveness from their social network; a prior ambivalent

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relationship with the deceased; and/or (study does not specify) the presence of at least three concurrent life stressors, "as rated by three clinician raters" (p. 1250). The treatment was conducted in the widow's home and sessions lasted for two or more hours. Depending upon the specific needs of each woman, sessions varied in length and frequency. The range of frequency of sessions was not specified in the article. Treatment offered ego support through the facilitation of affective expression including expression of sadness, anxiety, hopelessness, despair and through the review of positive and negative aspects of the lost relationship. All treatment was concluded within the first three months of bereavement. Follow-up was conducted 13 months following the completion of treatment with one measure of general health.

The experimental group improved significantly more than the control on a measure of general health. The results suggest that those who perceive a high level of non-supportiveness in their social network are likely to benefit from treatment. However, this study is limited in its failure to include important procedural details, such as the average number of treatment sessions, exclusion criteria, and information on the outcome variable. A critical weakness of this study is its failure to explicate the treatment provided.

Working with a sub-sample of an earlier study (Raphael, 1976; 1977), Raphael (1978) continued her work with bereaved women (experimental, $\underline{n}$=12; control, $\underline{n}$=10) using a procedure similar to that used in her 1977 study. Individuals who were rated as having a "pathological marital relationship," and who did *not* fall into the category of high-risk in terms of ten or more areas of perceived non-supportiveness, were randomly

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allocated along with high-risk participants (i.e., due to traumatic circumstances of the death, concurrent crisis, alcoholism, marked dependence or antagonism).

Experimental group participants were seen for one or more sessions (no maximum indicated) in their homes, and encouraged to express affect, grief, perceived deficits in their social networks, and ambivalence toward the lost spouse. "In particular, participants were directed to work through ambivalent aspects of the mourning process: the acceptance, expression and facing of ambivalent affects and their origins, and the gradual going-over and decathexis of negative as well as positive memories of the dead husband" (p. 305). A follow-up questionnaire distributed 13 months post-loss was rated by an independent evaluator unaware of group status. The experimental group showed significantly better general health and significantly fewer depressive symptoms than the control group post-treatment. The measure used to assess these areas was not specified.

Although the results of this study are encouraging, its value is limited by the lack of demographic information on participants (e.g., age, socio-economic status, or ethnicity), and poorly specified treatment techniques and duration. As a result of its use of a sub-group from a previous study, Raphael's (1978) study cannot be regarded as independent evidence of the therapeutic value of this kind of treatment. As in the (1977) study, it is unclear whether participants in this study needed all three of the inclusion criteria or just one. A serious consideration in both studies by Raphael is the reliance on a single measure to detect relevant changes. Although Raphael's work highlights and promotes the importance of treating those individuals with "complicated" grief reaction,

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its impact in the treatment of bereavement is limited by the omission of potentially critical details.

Conducting a controlled investigation of a short-term psychoanalytically-oriented group therapy, McCallum and Piper (1990) worked with psychiatric outpatients experiencing difficulty with loss through divorce, separation, death, or a combination. Approximately 80% of the participants were bereaved, or both bereaved and divorced/separated (immediate treatment, n=20; wait list, n=28). Based on psychodynamic theory, the authors believed that "recurrent internal conflicts are largely unconscious and serve to perpetuate maladaptation" (p. 436). Facilitators helped participants (a) recognize the relationship between current difficulties and unresolved intrapsychic conflicts, and (b) explore transferential issues within the group. Given the short-term format and wish to minimize attrition, techniques included the encouragement of rapid group cohesion, maintenance of clear and specific goals, emphasis on the awareness of time, an active therapist role, and a focus on current relationships and behaviors, including those in the group.

Eight separate groups (four immediate treatment, four wait list) attended a 12-week long intervention with the same two therapists. The outcome battery was administered before and after the wait period (not defined), before and after treatment (not defined), and at six month follow-up. Forty-nine percent of the participants were taking antidepressants or anxiolytics. Fifteen of the 54 participants dropped out of the study. No significant differences between the immediate treatment and control conditions were detected on demographic characteristics, pre-test outcome levels, medications used, or

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factors relating to their personal losses. Attrition was not significantly related to condition assignment. However, dropping out of treatment was found to be significantly and positively related to level of psychologically-mindedness (i.e., capacity for insight). Therefore, this type of treatment may be less useful for low psychologically-minded individuals. Those who are more inclined to explore links between unconscious issues and current difficulties, and to examine their role in problems are more likely to remain in a dynamic-oriented treatment group.

Using a wide variety of measures, a MANOVA revealed a significant main effect for treatment ($p<.02$), and ANCOVAs yielded eight significant main effects of 17 outcome variables at post-treatment. The ANCOVA removed any possible confounding effects resulting from the relationship between pre- and post-outcome scores. Participants who were "treated improved significantly more on outcome measures than matched counterparts on the wait list" (p. 441). The results support the efficacy of short-term group therapy in areas of interpersonal functioning, psychiatric symptoms, self-esteem, and general life satisfaction. For all outcome variables, treatment benefits were maintained over the follow-up period of six months; three variables -- work, intrusion, emotional reliance -- significantly improved over this time. In summary, this is a strong, controlled study which demonstrates the benefits of short-term psychoanalytic group psychotherapy for the treatment of loss through separation/divorce, death, or a combination.

In Canada, Piper, McCallum and Azim (1992) conducted a controlled outcome study on a sample population that included people with losses due to death (29%), separation/divorce (12%) or both (59%). The study involved 154 patients in 16 groups in

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a time limited psychotherapy group treatment program at the University of Alberta Hospital. The loss group program was deemed appropriate for adults experiencing a pathological reaction to loss, as determined by the evaluating clinician at the University Walk-in Clinic. Patients with suicidal ideation, psychosis, addiction, sexual deviation, sociopathic behavior, or currently in therapy were excluded. After attrition, 76 patients (36 immediate treatment, 40 control/wait list) completed treatment; treatment dropout percentages for immediate and delayed treatment conditions did not differ significantly.

Employing a psychoanalytic orientation, the authors conceptualized patients' grief as the result of a "reintensification of unconscious conflicts." For pathological grievers, although the initial shock may have subsided, the "loss continues to interfere significantly with the patient's ability to enjoy a satisfying and productive life. The grief may be absent (masked), delayed, or excessive and prolonged" (p. 43). Treatment consisted of 12 weeks of group therapy with sessions once per week for 90 minutes. Each group was composed of seven or eight patients, and conducted by either one staff therapist or a cotherapy team with extensive experience in group therapy. In session, patients were offered the opportunity to explore and negotiate a new resolution to their conflicts. Termination is a critical component of this intervention; it requires the client to confront the current loss and unresolved ones from the past.

Based upon measures of dependency, symptom level, self-esteem, and life satisfaction, the immediate treatment condition evidenced significant and positive changes relative to controls. Further, significant treatment effects were found for ten of 16 variables, including self-esteem, avoidance, intrusion, depression, overall symptom

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severity, social skills, sexual activity, and life satisfaction. Piper, McCallum and Azim's controlled study demonstrates the efficacy of the dynamic group treatment model for bereaved adults.

Summary of Treatment

In the preceding section, four studies were reviewed that employed psychodynamic theory. Each article evidenced significant improvements for the target population, relative to the control. Raphael's work investigated the relevance of perceived social network and found a significant, positive relationship, but was marked by a number of methodological limitations. McCallum and Piper demonstrated the value of short-term dynamic group psychotherapy in the treatment of pathological grief in two separate studies but not all participants were bereaved.

Dynamic treatments, as well as work by Horowitz and colleagues (described below) suggest the value of treatments aimed towards clients with pathological grief reactions as opposed to those undergoing normal bereavement. This perspective is held by other researchers as well. In Potocky's (1993) review of nine studies on conjugal loss, conducted between 1974 and 1990, three of the five studies deemed "effective" were with clients identified as "high-risk" compared to only one of four of the "ineffective" studies. The data, combined with the results of the dynamic literature, suggest that studies that restrict their samples to more distressed clients are more likely to detect treatment benefits than those with heterogeneous symptom level participants.

Although each of the psychodynamic studies was a controlled experiment, two were conducted by Raphael, and two by McCallum, Piper and colleagues. According to

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Chambless and Hollon (1998), empirically supported treatments are those found to be valuable by at least two independent research teams. Thus, although these authors demonstrated treatment efficacy in two studies, the independent investigator criteria was not met and the treatments cannot be classified as empirically supported therapies (p. 8). In conclusion, dynamic treatment approaches have demonstrated preliminary efficacy in the treatment of individual's experiencing pathological responses to loss (not specific to bereavement).

HOROWITZ'S STRESS RESPONSE SYNDROMES

Over the past two decades, Mardi Horowitz has developed a theory and treatment approach of grief. Because this approach combines components of both cognitive and dynamic theory, it is allocated its own section in this paper.

Horowitz's Theory of Stress Response Syndromes

Horowitz (1976; 1986; 1997) theory on stress response syndromes is stated to be a universal response following all stressful events, including rape, abortion, mastectomy, car accidents, miscarriage, and complicated bereavement. Based on experimental, field and clinical studies, Horowitz developed some initial premises detailing the process of grief. The experience of flashbacks or vivid memories relating to the event are a source of great distress to the patient. The author focused on the process by which these "intrusive episodes" become less and less frequent, or less and less painful. The cognitive memory process is the mechanism most intimately tied to the evolution of the emotional charge of the disturbing, internal images. According to Horowitz, there is a "gradual integration of both memories and associations activated by the incident" (Horowitz, 1993, p. 727). Until

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then, the event and attitudes towards the event are held in active memory where the material is repeatedly reviewed. Since these "unbidden images" are disturbing, the patient erects defenses or "inhibitory controls" to attempt to limit the degree of consciousness. It is the resulting interplay between the push for consciousness of the event by the active memory system and the press for repression by the defenses that creates tension: as a consequence, the client experiences the images as "intrusive."

Trauma-evoked affect is generated from the discrepancy between one's prior perception of events, and the new one, a result of the death. Over time, the patient develops new ways of understanding the event, and the inner schemata reach closer approximations of reality. This integrative process essential for recovery is called the completion tendency. As new cognitive schematic structures are established, the news about the individual's revised circumstances becomes part of long-term memory and the coding behavior in active memory decays. In normal grief, a combination of time and information processing (e.g., comparison of old information to new) contribute to the successful adaptation to revised life circumstances. In fact, a healthy balance of intrusion and denial is ideal.

Phases of the Stress Response Syndrome

The phases of recovery are self-modulated through what Horowitz terms, "controls," the ability of the client to increase or decrease the degree of intrusive thinking. Ideally, one "doses" oneself with memories of the event at a tolerable rate, enabling the succession through the stages. For example, survivors may allow themselves to recall a particularly compelling memory, perhaps of sentimental value or import. Depending on

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the individual, after several minutes this sudden memory may evoke tears or sadness. Moving into the denial phase, they may "forget" that image, and focus on caring for a pet or returning to work activities. In this way, clients move back and forth between the denial and intrusive phases at a pace that is optimal to recovery and functioning.

According to Horowitz, typically there is an initial period of extreme distress and alarm that may be an internal emotional experience or an external, more observable event that may include hysteria and crying (Horowitz, 1986, p. 242). Deep emotion may reach pathological levels, and be characterized as rageful, panicked, or destructive. Afterward, the patient may enter into alternative phases characterized by denial and then intrusion, and then back and forth. The intrusion state is described by unbidden ideas, "rushes" of feeling and compulsive actions; the denial state by refusal to face the event, the forgetting of important issues, and emotional experiences described as "numbing, withdrawal and constriction" (p. 242). As explained before, this switching from one state to another is adaptive, and helps the client modulate their grief. Abnormal denial is extreme avoidance that may be facilitated by substance abuse or thrill-seeking behavior. The intrusive phase may also reach pathological levels, resulting in hypervigilance, startle reactions, illusions and flooding.

The recovery phases begin with a working through stage, followed by that of completion. Working through involves a reappraisal of the serious life event, and its meanings. One also explores the relationship between the event and one's own personality. The client may continue to exhibit symptoms at the completion phase, but one's reactions and emotions related to the event should be at a manageable level.

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Pathological Grief

Trauma survivors experience transient states of alarming sadness caused by revised life circumstances. Those predisposed to pathological grief cannot readily complete the review of such self-images and new information. Instead, the state during the review becomes "unusually intense and interminable or excessive controls prevent review of activated role relationship models, so that mourning is never completed" (Horowitz, Wilner, Marmar, & Krupnick, 1980, p. 1162). As a result, pathological grief takes two forms. The first is in the case of weak controls or excessive intrusion. If a patient is unable to dose himself slowly with memories of the event, he will experience a flood of emotion and retraumatization. A second source of pathological grief is excessive controls, or extreme denial. Since it is the repeated comparison of new information with old that enables recovery, the failure to allow for this comparison prevents one's inner models from being revised. This inhibition results in a trauma never worked through or resolved.

In Horowitz, Wilner, Marmar et al. (1980), Horowitz expanded his theory by incorporating the idea of relationship models and how those are disrupted by trauma. Just as in the original theory, it was the new information and the requirement for modified schematic structures that gave strength to painful emotion. In the expanded development of Horowitz's theory, it is suggested that information specific to one's self-images and role relationships are what gives force to the distress evoked by the loss. A patient may regress to earlier (pre-loss) self-perceptions, or the event itself creates new, undesirable role relationships (p. 1159). For example, partnership with one's spouse may keep in check feelings of low self-worth. With the death of one's partner, the bereaved

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experiences a re-emergence of dormant schema such as "I am unlovable" and "No one would want to be in a relationship with me." Here, Horowitz distinguishes the theory from more traditional dynamic theory which postulates that it is the internalization of ambivalent attitudes toward the deceased that propels complicated grief reactions. Instead, Horowitz highlights the creation or re-emergence of disrupted self-images and role relationship models.

Treatment Indicated by Stress Response Syndromes Approach

The 12-session treatment program that follows from the stress response syndromes theory is an effort to assist patients in their own "natural completion process" (Horowitz, 1993, p. 728). As part of this treatment, the therapist aids the client in the gradual integration of one's new reality with the old. For example, the patient may have to adjust their self-view from husband to widower; from "I am part of a team" to "I am a single person who functions and make decisions independently." Obviously, these changed perspectives are far-reaching and multi-layered with all their associated implications, dynamic conflicts and emotions. For many bereaved individuals, the death elicits a radical shift in one's self-perception and worldviews that impacts all of life, including work, home, family and friendships.

Therapy emphasizes the establishment of a safe and communicative relationship that enables the client to alter their defenses. Those with rigid defenses may slowly allow thoughts of the trauma to reach consciousness; for patients flooded with intrusive thought patterns, therapy may aid in the tightening of the controls which enables optimal dosing of distressful memories. At different points in treatment, the client may be ready to examine

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different aspects of the new information, including survivor guilt, fear of the trauma occurring again, or fears of the trauma happening to a close relative, child or friend. Horowitz suggests nine themes in particular that may emerge over the course of treatment. These include: fear of repetition, fear of merger with victims, shame and rage over vulnerability, rage at the source, rage at those exempted, fear of loss of control of aggressive impulses, guilt and shame over aggressive impulses, guilt and shame over surviving, and sadness over losses (Horowitz, 1997, p. 17). Consequently, therapy facilitates the client's repeated reappraisal of stressful events and their meanings as the client explores different aspects evoked by the traumatic event.

In Table 1, Horowitz delineates the specific nature of the treatment session by session. Horowitz's approach highlights the relational aspect of therapy in the first column of the table which is devoted to feelings the client may have toward the therapist. The therapist's activities are largely dynamic in focus with an emphasis upon interpretation of resistances, recognition of the transference and clarification of central conflicts and termination issues.

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Table 1

Time Limited Brief Psychotherapy

Session	Relationship Issues	Patient Activity	Therapist Activity
1.	Initial positive feelings for helper	Patient tells story of stressful event	Preliminary focus discussed
2.	Lull as sense of pressure reduced	Event is related to life of patient	Psychiatric history taken
3.	Patient tests therapist, place therapist in role of rescuer, victim, victimizer. Is it safe to share horrendous details of the story, to see if therapist is strong enough to hear the story.	Patient adds associations	Realignment of focus; interpretation of resistances; empathic recognition of transference and reasons why they are currently reasonable based on past relationships
4.	Therapeutic issues	"	Further interpretation of defenses and warded-off content, linking latter to personal meaning of stressful event
5.	"	Work on what has been avoided	"
6.	"	"	Time of termination discussed
7.-11.	Transference reactions interpreted and linked to other configurations	Continued working through of central conflicts and issues of termination as related to the life event and reactions to it	Clarification and interpretation related to central conflicts and termination; clarification of unfinished issues and recommendations
12.	Saying good-bye	Realization of work to continue on own	Acknowledgment of real gains and real future work in continued mourning and formation of new schemata

Source: Horowitz (1993)

In therapy, Horowitz's theory promotes three goals to restore the bereaved's positive self-images. First, the patient should be aided in retaining a sense of competence and self-worth. This requires the client's gradual acceptance of the changed life circumstances without a sense of hopelessness or deep assault on the view of the future. Second, the client should continue to pursue life actively; that is, the bereaved person

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should maintain relationships, develop new ones, and continue in other hobbies, work activities and responsibilities. A third and final goal of the Horowitz treatment program is that the client experiences the trauma as growthful, an opportunity to learn and strengthen the self (Horowitz & Kaltreider, 1980). The therapist may help the client focus on the event, reconstruct the client's understanding of it, review self-images, and modify role relationships by way of questions, reflections and clarifying comments. Not only is it important that the client articulate these changes and the process by which they are making them, but the client must also practice these new beliefs. For example, the widower may discover himself capable of deciding how to invest money without the help of his deceased wife, thus applying what is discussed in therapy in his daily life. Ideally, these behaviors will become automatic and occur without a concurrent sense of loss or distress. As a result, intensive, brief therapy can lead to developmental progress as well as altering the symptomatic response to stress.

Theory Evaluation

Following its genesis in 1976, Horowitz's theory of stress response syndromes has been expanded upon and revised in numerous papers (e.g., Horowitz, 1986; Horowitz, 1993; Horowitz, 1997; Horowitz, Field & Classen, 1993; Horowitz & Kaltreider, 1980; Horowitz, Krupnick, Kaltreider, Wilner, Leong & Marmar, 1981; Horowitz, Wilner, Marmar, & Krupnick, 1980; Weiss & Marmar, 1993; Windholz, Marmar Horowitz, 1985). It has a strong foundational basis in clinical observations on intrusive thinking, experimental work on the perception of distressful stimuli, and field studies on reported stress, and has been tested as a treatment in uncontrolled and controlled studies (e.g.,

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Brom, Kleber & Defares, 1989; Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984a; Jones, Cumming & Horowitz, 1988; Marmar, Horowitz, Weiss, Wilner, & Kaltreider, 1988; Windholz, Weiss, & Horowitz, 1985). In its degree of development, research and application in empirical studies of grief, this theory and treatment model approaches the level of establishment of the two most predominant theories of grief, cognitive-behavioral and psychodynamic.

The beauty of Horowitz's theory is its ability to explain multiple aspects of the grief reaction. Relying on ego functions including memory, information processing, affect and defenses, it offers a coherent body of mechanisms that explain normal and pathological grief, individual variation, traumatic symptoms, and the process of recovery and resolution of grief. Its appeal is broadened by a combined reliance upon cognitive functions and intrapsychic mechanisms.

Horowitz's investigative studies have demonstrated that intrusive thoughts and avoidance follow multiple types of trauma, including war events, sexual molestation, and bereavement. His work further suggests that heightened defenses block cognitive processes necessary for recovery. However, it is not clear from the literature what will be the consequence if these cognitive tasks are obstructed; will the patient's depression deepen? Will one develop a substance abuse or obsessive-compulsive disorder? If Horowitz is relying upon dynamic theory to explain the problem that occurs with excessive controls, i.e., ego functioning is disturbed because energy is malappropriately directed to suppress the conscious memory of the event, then this needs to be articulated and not assumed.

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Horowitz's Stress Response Syndromes Treatment

Five studies employed Horowitz's theory of stress response syndromes in the treatment of bereaved adults, and often included participants with traumatic reactions due to events other than bereavement. Three studies were uncontrolled, and all reported significant improvements for the treatment condition. Compared to psychodynamic and cognitive-behavioral treatment studies, studies based on Horowitz's theory typically involve larger samples (ranging from N=41 to 112) and employ a twelve-week long treatment model.

In an uncontrolled study, Jones, Cumming and Horowitz (1988) examined the effects of individual therapy based on Horowitz's theory of stress response syndromes for participants (N=40 women) who have experienced rape, robbery, mastectomy, abortion, automobile accidents, or bereavement (n=28). All clients evidenced PTSD symptoms (intrusive ideation, insomnia, nightmares, illusions, signs of avoidance) upon initial interviews. No data on attrition were provided.

Twenty-one therapists ranging in experience from 3 to 20 years were provided with a manual outlining the prescribed treatment model. In a 12-week long therapy program, therapists helped participants explore the loss and its meaning; facilitated the normal grieving process; provided a supportive environment; informed clients about PTSD symptoms to alleviate patterns of fear; explored the therapeutic relationship, transference issues, and termination; facilitated the discussion of new plans and decisions; and provided an opportunity to practice these intentions.

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Clients were assessed via self-report, therapist and independent evaluator at pre- and post-treatment, and at four months after the completion of treatment on measures of symptom level, global severity of symptoms, impact of event and multiple indicators of level of stress. All six scales showed significant improvement for participants between pre-therapy, post-therapy and follow-up ($p<.001$). A large effect of .80 was demonstrated on all measures. The authors concluded that "therapy must address the conflicts of the participant triggered by the experience of a severely disruptive life event and aim toward mastery of the experience" (p. 52). Despite the positive findings, this study's application to the treatment of bereavement is limited by the absence of a control group and the use of participants who had experienced traumatic events other than loss.

Marmar, Horowitz, Weiss, Wilmer and Kaltreider's (1988) study compared individual, brief therapy based on Horowitz's stress response syndromes approach ($n=31$) and mutual help groups ($n=30$) in the treatment of widows. Randomly assigned participants (mean age=58 years) were screened from 300 callers, and selection was based on prolonged distress and symptomatology. Two independent clinicians reviewed the pre-treatment evaluation to verify the presence of common grief reactions including depression, anxiety, anger, guilt, intrusive thoughts, avoidance, denial, and sleep disturbances. Twenty-three members of the mutual help group and ten treatment group members dropped out of the study.

Each treatment condition consisted of twelve weekly sessions. The dynamic psychotherapy sessions were led by clinically trained faculty (psychologists, psychiatrists, and psychiatric social workers). They focused on stress response syndromes by reviewing

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conflicts involved in the participants' relationships with the deceased spouses that might impede mourning. The support group, led by five bereaved non-clinicians who received common training and a manual on leading sessions, was defined as a "group in which people come together for mutual support and constructive action leading to achievement of shared goals" (p. 204).

Based on clinician ratings and self-report measures of adjustment, work/interpersonal functioning, depression, symptomatology and stress, ANOVA yielded a significant improvement for the dynamically treated group compared to the mutual help group on the Symptom Checklist-90 at four months and one year follow-ups; all clients improved on measures of intrusion and avoidance, general anxiety and depression. In summary, this study is weakened by its lack of a no-treatment control group, steep attrition rate of over 50% which resulted in poor statistical power, and a systematic relationship between attrition and group assignment. Also, there were differences in experience and training between the therapists in the two treatment conditions.

One of the more unique assessments of psychodynamic treatment with bereaved adults was conducted by Horowitz and his colleagues (Horowitz, Weiss, Kaltreider, Krupnick, Marmar, Wilner, & DeWitt, 1984; follow-up study by Horowitz, Marmar, Weiss, Kaltreider & Wilner, 1986) in which patients were assessed on a multitude of indices, some less typically used in the empirical literature. Responding to the methodological limitations that plague most clinical research, these authors investigated symptom levels using four perspectives: patient, evaluating clinician, treating clinician and independent judges. In addition, the authors examined data on symptom levels by using

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group means as well as "categories of clinical relevance;" in this way, the researchers contrasted "clinical" and statistical significance, and recognized that the two are not always identical.

Working with a pathologically grieved adult population (experimental, n=35; control, n=37), clinically trained therapists who had completed either a psychiatric, clinical psychology or psychiatric social work degree conducted twelve individual therapy sessions with clients based on Horowitz's theory and treatment of stress response syndromes. Clients with a history of psychiatric hospitalization, concurrent mental health treatment, psychotic symptoms, or severe alcohol or substance abuse were excluded from the study. Each client had lost a parent, and were evaluated before treatment, at follow-up five months and again at one year after the completion of the treatment. Therapy aimed to review the conflicts involved in the relationship with the deceased parent that might impede mourning and self development, as well as the personal meanings of loss.

Outcome measures were used to assess not only the dimensions of symptoms but also those of interpersonal functioning, including work identity, intimacy and self-esteem. Symptom measures derived from scales of psychiatric ratings, stress, intrusive thinking, and global assessment were rated by patients, therapists, and evaluating clinicians. Patients answered measures of general symptom level, impact of events, and stress. To assess a patient's status in terms of "overall clinical condition (excellent, good, fair, or poor)," a composite symptom rating composed of key distress variables, including five patient self-reports and two clinician ratings, was developed. Based on cut-off points, a patient could be categorized as being low, medium or high level of distress. These distress

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measures were entered into a decision rule algorithm that produced an overall categorization of the patient's condition at one of the four levels. Independent judges reviewed videotapes of pretherapy and the first follow-up evaluation interviews and rated self-regard and work and interpersonal functioning in addition to ratings of assertiveness, work identity, relationship with surviving parent, relationship with siblings, relationships with same-sex persons, and capacity for intimacy (as rated on seven-point scales).

Based on these assessment instruments, treated patients were significantly improved on trauma and mental health symptoms at five months and one year follow-up times. As for change in general adaptation, relationships and self-concepts, no significant changes occurred except for on the measure of assertiveness. Based on the results of the algorithm to assess "clinical relevance" (p. 587) clients also improved. At pre-therapy evaluation, the majority (32 of 35) of clients had a status in the fair-to-poor range. By first follow-up, the majority of the sample (21 of 35) were characterized in the excellent-to-good range, and at the second follow-up, 21 of 26 participants were in the excellent-to-good category. A limitation to this study is that most (33 of 35) of the patients were female thus restricting generalizability. The relatively smaller effect size for adaptive functioning, thought to assess change as a result of dynamically-oriented treatment, suggests that brief dynamic therapy is not as effective in helping interpersonal and self-related issues as it is in reducing symptom levels. The results may also suggest that brief therapy is insufficient, and that to detect changes in adaptive functioning, longer-term work is necessary.

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In a second uncontrolled study Horowitz, Marmar, Weiss, DeWitt and Rosenbaum (1984) explored the relationship between dispositional, process and outcome variables with time-limited, dynamic therapy for bereaved adults (n=50 women; n=2 men). Elapsed time since the loss ranged from two weeks to three years, and diagnoses included adjustment disorder (28), PTSD (14), major depression (5), both major depressive disorder and PTSD (2), uncomplicated grief (2), and panic disorder (1). Those with past or present psychoses, previous hospitalization, history of substance abuse, or concurrent psychological treatment were excluded.

The 12-week long individual treatment intervention helped patients establish trust; confront, clarify, and interpret conscious and unconscious conflicts that impede life skills and mastery; interpret impulsive behavior and threats of acting on impulses and defenses; interpret relationship conflicts that arise with the therapist and others; and focus on themes of separation and loss by virtue of the time-limited treatment. Patients were evaluated through self-report and clinician ratings at pre- and post-treatment on measures of stress, anxiety, avoidance, intrusion, depression, general psychiatric symptoms and work/interpersonal functioning. Compared to pre-therapy scores, clients' post-therapy results were significantly improved on all outcomes. Despite the comprehensiveness of the measures used in this study, the absence of a control group limits the demonstration of treatment effectiveness and the disproportionate number of widows and widowers is also a limitation.

In the Netherlands, Brom, Kleber and Defares (1989) conducted a controlled experiment where participants were randomly assigned to the following individual

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treatment group conditions: trauma desensitization, hypnotherapy, Horowitz's stress response syndromes therapy, or a control/wait list group. Brom et al.'s sample population was broadened to include individuals who experienced a traumatic incident in the past year (e.g., traffic accidents, violent acts, or bereavement); in addition, each of the participants (N=112) was diagnosed with PTSD. Treatment was conducted by seven therapists each with more than ten years of experience; each therapist worked from the orientation which they preferred and was supervised by a senior advisor to help ensure adherence to experimental procedures, although this was not assessed formally by any measure or independent analysis of taped sessions.

The treatment program employed in the dynamic group blended cognitive stress theories and psychoanalytic theory as described in Horowitz (1976) and lasted for 18 sessions with follow-up at three months. This treatment aimed to "resolve intrapsychic conflicts resulting from trauma, with the therapist playing an active role" (p. 607). It is distinguished from most dynamic treatments in its aim to reduce current disorders, and not to alter long-standing personality traits.

Using measures that assessed for symptom level, anxiety, anger and personality characteristics, a MANOVA was conducted and determined that treatment yielded clinically significant improvements in 60% of participants in the treatment condition and in 26% of the control participants. Therapies were found to be equally effective but were all more effective than the control group. Consequentially, given the large number of participants and multiple measures, this study demonstrates the efficacy of intervention with people experiencing more severe symptoms after a traumatizing event such as being a

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victim of a violent crime, or loss by murder, illness, or traffic accident. Each therapist may work differently, have a different therapeutic style or possess alternative clinical strengths and weaknesses. Although some of the participants were bereaved, it is not clear whether this would be an effective intervention for a bereaved population, specifically.

Summary of Treatment

In conclusion, studies based on Horowitz's stress response theory demonstrate preliminary efficacy in two controlled and three uncontrolled studies. The work is strengthened by the multiple replications involving sample populations that are homogenous across studies. Similar to the treatments based on the psychodynamic model, some studies based on the stress response syndromes theory involved participants with traumatic histories not exclusively due to loss (Jones, Cumming, & Horowitz, 1988; Brom, Kleber, & Defares, 1989). Additional controlled treatment studies based on Horowitz's model would enrich the literature on the treatment of bereavement using pure-bereaved samples.

SUMMARY OF LITERATURE

This literature review has discussed the different theories and treatments of bereavement, including atheoretical studies, client-centered, cognitive-behavioral, dynamic, feminist, Horowitz's stress response syndromes approach, interpersonal, and self-help models. This preliminary look at the body of literature suggests that CBT, psychodynamic theory, and Horowitz's approach are more well-developed than others, such as client-centered, gestalt, interpersonal and self-help models. In addition, CBT,

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psychodynamic, Horowitz's approach, and self-help models have been applied more often, and with stricter empirical methodology than other theories.

Despite the quantity and variety of studies with adult, bereaved populations, there are still contradictory and inconclusive findings regarding the efficacy of psychotherapy for bereaved people. The controlled studies display a variety of methodological flaws, including low attrition rates, low power (n), systematic differences between the control and experimental groups before treatment, the use of unvalidated measures (or no measures at all) and a disproportionate number of male patients to female in the samples across studies. It is also interesting that some of the studies demonstrate efficacy while others do not. For example, only one of the eight studies using a self-help model demonstrated clear treatment benefits. Can this be solely explained by its failure to use a theory? And, how is it understood that three of the seven studies based on cognitive-behavioral theory were found to be efficacious? How does the researcher explain these differing outcomes? Given the methodological variation and limitations, how does the clinician understand what is most appropriate for one's patient? Answers to these questions will be explored in Chapter II. Additional issues that emerge from this preliminary literature review and that will be addressed in Chapter II include:

1. Is there a relationship between group versus individual treatment and outcome?
2. Is there a relationship between participants' level of risk and outcome?
3. Is there a relationship between recency of loss and outcome?
4. Is there a relationship between length of treatment and outcome?

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5. Is there a relationship between "patient" or "non-patient" status of participants and outcome? ("Non-patient" is defined as those participants who were recruited into the study, whereas "patients" are those who sought treatment on their own.)
6. Is there a relationship between qualifications of clinicians and outcome?
7. Is there a relationship between theory-based or non-theory based studies and outcome?
8. How do studies define "self-help" and is there a relationship between self-help treatments and outcome?
9. Do any studies support the efficacy of a given treatment based on Chambless and Hollon's (1998) definition of efficacy: "for a treatment to be efficacious, it must demonstrate efficacy in at least two studies by independent research teams" (p. 7)?
10. Do any studies demonstrate benefits on measures directly related to the theories (e.g., intrusion for Horowitz or exposure for CBT)?
11. How do the eighteen controlled treatment outcome studies compare to the methodological "Gold Standards" delineated by Foa and Meadows (1997)?
12. What areas can be improved upon in future studies?

Wide differences in methodologies, parameters and designs impede comparability. Inadequate and disparate operational definitions of grief types (prolonged, delayed, "high-risk," normal, etc.) make it difficult to compare studies. Thus, the researcher is unable to draw firm conclusions about the value of the different kinds of grief intervention, and is

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unsure in making clinical recommendations to clients with problems believed to be related to a significant loss.

Treatment Outcome Review Articles

Despite this impressive body of literature in journals and books containing numerous theoretical discussions of grief and over 30 treatment outcome studies, only a few articles have been written that review the bereavement treatment literature (Fulton & Gottesman, 1980; Shackleton, 1984; Windholz, Marmar & Horowitz, 1985; Zimpfer, 1991). The review article by Fulton and Gottesman was limited to an exploration of studies on the effects of anticipatory grief, which included a critique of methodological concerns. However, the authors did not examine treatment outcome literature so much as they investigated whether forewarning of death is helpful to the bereaved person. In 1984, Shackleton produced a more comprehensive article reviewing the theories of grief and relating them to descriptive data such as "factors occurring after the death" and "expression of affect." Although Shackleton included a table of five articles (table headings included: participants, treatment type, assessment, non-statistical results, and methodological flaws), only two broadly-stated critiques are offered; there is a "paucity of theoretical writing" and "serious methodological flaws" (p. 197) within the outcome literature.

Similar to Shackleton (1984), Windholz et al. (1985) reviewed descriptive data concerning bereaved individuals. However, Windholz et al. finished their paper with a review of five treatment studies of conjugal loss only. The final review article by Zimpfer (1991) discussed only seven articles employing a group treatment for adult loss, and the

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author concluded that the "professional literature on bereavement group work has just scratched the surface" (p. 54). Thus, Windholz et al. and Zimpfer come closest to reviewing the treatment outcome literature, although the number of studies is smaller than what I intend to include, and the authors restrict their studies to group modalities and conjugal loss respectively.

Goals of the Dissertation

The goals of this dissertation are to organize the literature in table format that is easily read by the clinician and academician, and also to provide comprehensive statistical information that an interested party can quickly glance at, and discern the potential treatment benefits specific to the model employed. One example of this type of "table" analysis and critique was published by Jensen, Turner, Romano and Karoly (1991) on chronic pain. In Chapter II, I conduct a similar review with the controlled outcome treatment literature on adult bereavement.

After organizing the literature, I discuss answers to the questions listed above, further integrating, clarifying and sifting though some of the complexity within the bereavement literature given its methodological diversity and shortcomings. As discussed in the beginning of this chapter, articles are assessed based on the "gold standard" criteria (Foa & Meadows, 1997, p. 7) and Chambless and Hollon's (1998) operationalized definition of "empirically supported therapies." Studies with mixed populations (e.g., war trauma, rape, mastectomy, etc.) are excluded from the review. And with the exception of articles on loss due to SIDS and AIDS, this dissertation yields a comprehensive qualitative analysis of the controlled articles on the treatment of adult bereavement.

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While quantitative outcome research is helpful, there are some practical limitations. First of all, research procedures are standardized, and thus less able to accommodate the modifications in treatment that can occur in a clinical setting. Also, measures that are administered pre- and post-treatment do not necessarily capture the relevant dimension to the treatment (e.g., intrusion and avoidance for Horowitz's model, exposure for CBT). Alternatively, therapy may propel a client toward a transformation that is realized over a period of time that surpasses even the longest follow-up time of twenty months (Parkes, 1981) in all of the bereavement outcome literature. Further, while statistics indicating group averages may facilitate generalizability, they may also hide individual differences or the benefits realized by a sample sub-group. A final difference between treatment research and clinical work is that participants in research are often excluded, especially within the bereavement literature on the basis of co-morbidity, substance abuse and dependence, and personality disorders. As a consequence, clinical procedures may be artificially effected within the laboratory. As a result, my qualitative review yields some additional, relevant clinical information not discerned by the qualitative data alone. Within the discussion of the results of Chapter III, I explore the changes the three bereaved women realized that complement or diverge from Horowitz's stress response syndromes theory and treatment model.

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CHAPTER II

TABLE ANALYSIS

To conduct the synthesis of the treatment outcome literature, the ERIC, MEDLINE, PsychINFO, and PsychLIT databases were searched for bereavement treatment outcome studies in journals and books. Database search terms were combinations of the following words: mourning, grief, bereavement, loss, adult, complicated, uncomplicated, pathological, treatment, outcome, psychosocial, intervention, therapy, uncontrolled and controlled. The bibliographies of the articles and books obtained were also scanned for additional articles. Some study designs had samples that contained a mixture of bereaved and other-trauma participants (e.g., rape, mastectomy, automobile accident, divorce, etc.). Barring one exception, only articles that reported results separately for bereaved patients were included in the review; Brom, Kleber and Defares (1989) was used because 80% ($n \approx 80$) of its sample population were bereaved. Only articles that employed a true experimental or non-equivalent (quasi-experimental) control group design were used. As of April 15 1999, 18 studies were in this category.

To facilitate comparison of methods and treatment techniques, the studies are organized into two tables based on type of treatment: group therapy (Table 2) and individual psychotherapy (Table 3). The articles are arranged from weakest to strongest based on issues of methodology and statistical significance. For example, a study that trains its treating therapists with a treatment manual or seminar is superior to one that

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equivalent control group" designs. The final row is the "Results" column which reports all specific outcome variables and categorization of outcomes by construct. It also contains the statistical method employed (e.g., correlational analysis, multiple regression analysis, MANCOVA, t-test, etc.) and statistics to permit future calculation of effect sizes (t, F, r, df, direction of effect or group means and standard deviations if no statistics are cited) for each outcome measure. It also notes which group did better and at what time frame (post-test, follow-up, etc.). The final row entitled "Summary" describes the significant between and within group analyses in written form.

In preparing the tables for a potential future meta-analysis, I focused on comparisons between the treatment and control groups. Thus, a comparison of the whole sample at pre-test to the whole sample at post-test to assess generalized change is not relevant, and was excluded from the table. Also, the tables focus on ANOVA results from one dependent variable at a time, rather than MANOVA results; individual ANOVAs allow the assessment of the effects of treatment on specific dependent variables. As part of this dissertation work, I also examined the relevance of "high-risk" or "pathologically-bereaved" participants in treatment efficacy. Therefore, for articles that evaluated treatment for a subgroup of "high-risk" participants, a small section at the end of the Results row delineates "Sub" and reports those results. Please refer to the "Key" to aid with table interpretation.

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KEY

-	information not provided
↑	increase
↓	decrease
*	measure developed for the purpose of this study
>/<	statistically significant greater/lesser difference
abr	abbreviation
AT	whether the article trained its assessors; and if methods were used to ensure homogenous assessment procedures
Att	attrition data
Attd	attitudes
B	type of administration of measure; behavioral measure
Beh	negative health behaviors (smoking, drinking, health care utilization, medication abuse, etc.)
Beneficial	favors treatment condition
Ber	bereavement
C	construct
Char	sample characteristics
CR	clinician rating is the mode of assessment
F/U	follow-up
Grief	grief
IE	independent evaluator, masked assessor
IQF	intellectual functioning
Mod	moderator variables
Mode	mode of assessment (self-report, clinician rating)
N/n	# of participants (total/sample) after attrition
NMH	negative mental health
NPH	negative physical health
NS	not significant
NSA	negative social adjustment; the higher the score, the less social adjustment the S experienced
Over	overall; a measure that assesses overall functioning covering multiple constructs
P	pre- or post-test
patient	Ss sought tx at an agency (vs. Ss responding to research advertisement)
PB	perceived benefits
PH	physical health
PHB	positive health behavior (e.g., exercise)
PMH	positive mental health
PPH	positive physical health
PSA	positive social adjustment
Pre-tx	pre-tx differences
Q	qualifications of clinicians providing treatment
R/IC/TR	reliability, internal consistency, test-retest
SA	social adjustment, quality of life, adjustment to social role & social activities
SES	financial related issues and concerns
SR	self-report
Ss	participants
SRS	Horowitz's theory of stress response syndromes
Sub	subgroups within samples
TH	theoretically based treatment program
TI	treatment integrity; efforts by article to ensure tx integrity, i.e., supervision, review of audio or videotape, etc.
T/M	training and/or use of manuals for clinicians providing treatment in studies
TOTAL	final # of participants remaining after attrition
TS	measure of intrusion and avoidance
tx	treatment
type	individual, family or group intervention
V/C/D/P	validity, convergent, discriminant, predictive
Y	yes

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	PSA	Quality of life	NS	NS
		No. of group meetings	NS	NS
		No. members contactd	NS	
		Total no. of contacts	NS	
		Social life	NS	NS, p=.08, ABC greater social role involvement than D
	Grief	Intensity of grief	NS	F(1,41)=23.7, p<.001, ABC greater grief intensity than D

MEAN PRE-POST CHANGE IN SELECTED VARIABLES

Variable	Consciousness Raising	Confidant	Self-help	Control
Self-esteem	2.53	2.78	1.29	3.82
Grief intensity	6.46	5.57	1.71	4.58
Health prediction	.20	.14	-.06	-.24
Remarriage	-.47	-.86	-.47	-.65
Other-orientatn	-1.83	-1.53	-2.38	.29
Self-orientatn	.67	.47	1.31	1.29
Rad vs. Cons	.28	2.13	-.69	1.00

MEAN EVALUATION SCORES BY TREATMENT AT T2 AND T3

Variable	Time	Consciousness Raising	Confidant	Self-help
Helpfulness	T2	5.75	5.34	4.39
	T3	5..55	5.00	4.06
Educational Value	T2	5.75	5.54	4.34
	T3	5.85	5.57	4.70

GROUP MEANS FOR BEHAVIORAL MEASURES AT T3

Variable	Therapist	Consciousness Raising	Confidant	Self-help
No. persons contacted	1	1.82	4.12	43
	2	1.33	.50	.80
No. contacts	1	2.82	13.00	22.57
	2	5.33	1.00	1.50
Group meetings	1	.82	1.25	14
	2	.00	.00	.90
Life change	1	4.09	2.88	3.14
	2	4.44	4.17	3.40

Summary

Between

T1 to T2, 2 significant results:

- Beneficial. On a measure of positive physical health, the treatment groups (ABC) showed more positive change in five year health predictions than the control group (D)
- Neutral. On a measure of attitude, ABC showed less "other-orientation" than the D.

T1 to T3, 4 significant results:

- Beneficial. On a measure of positive mental health, ABC showed greater self-esteem than D.
- Neutral. On a measure of attitudes, ABC showed greater negative attitudes toward widowhood and remarriage than D, as well as were less other-oriented than D.
- Not Beneficial. On a measure of grief intensity, ABC showed *greater* grief intensity than D.

Within Group

No analyses.

Sub

No risk assessment.

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Article	Walls & Meyer (1985)					
Abstract	10-weekly, 90-minute group sessions with three experimental conditions (cognitive, behavioral, self-help) and one control group demonstrated one significant beneficial and two non-beneficial between group differences post-treatment.					
Sample	**Group**	**Name**	**TH**	**n@T2**	**n@T3**	**N**	**Assignment**
	A	cognitive restructuring	cog	7	7		stratified sampling procedure based on age & length of widowhood
	B	behavioral skills	beh	6	5		"
	C	self-help	no	8	5		"
	D	control	no	7	4		"
	TOTAL					T2=28 T3=21	
	Matched	-					
	Char	spousal loss; avg length of bereavement = 11.80 mos; females only; avg age=52.5 yrs; non-patients; no risk assessment					
	Att	17 of 38 original Ss did not complete the study					
	Pre-tx	none					
Method	A, B, C	10 wkly, 90-minute sessions; led by female clinical psychology doctoral student					
	D	delayed tx control group					
	Q	clinical psychology doctoral student					
	T/M	no					
	AT	-					
	TI	-					
	IE	-					
Measure	**C**	**Name (abr)**	**Mode, Author (year)**			**R**	**V**
	NMH	Beck Depression Inventory (BDI)	SR, Beck & Beck (1972)			-	-
	PMH	Life Satisfaction Index (LSI)	SR, Neugarten et al. (1961)				
	Attd	Irrational Beliefs Test (IBT)	SR, Jones (1969)			-	-
	NSA	Social Anxiety and Distress Scale (SADS)	SR, Watson & Friend (1969)			-	-
	PSA	Pleasants Events Schedule (PES)	SR, MacPhillamy & Lewinsohn (1975)			-	-
		1. frequency subscale					
		2. pleasantness subscale					
		3. cross-product subscale					
Assessment Time	T1	pre-tx					
	T2	ten wks after T1					
	T3	one yr after T1					
Design	True Experimental (pretest-posttest control group, ROXOO)						
Results	**C**	**Name**	**BETWEEN GROUPS: A vs. B@T2**				
	NMH	BDI	NS				
	PMH	LSI	NS				
	Attd	IBT	NS				
	NSA	SADS	$F(3, 24)$, $p<.05$, group by time interaction; post hoc ANOVA showed group A demonstrated greater pre-posttest improvement $F(1,25)=5.88$, $p<.05$				
	PSA	PES	-				
		1. frequency	NS				
		2. pleasantness	$F(3, 20) = 4.28$, $p<.05$, group by time interaction; post-hoc ANOVA indicated that A ($F(1,20)=6.41$, $p<.05$) and B ($F(1,20) = 12.97$, $p<.01$) reported significant decrease in potential for pleasurable activities at posttest				
		3. cross-product	$F(3,20)=5.42$, $p<.01$ significant group by time interaction; post-hoc ANOVA revealed a significant decrease in cross-product scores for A, $F(1,20)=7.55$, $p<.01$; and significant increase in cross-product scores for D, $F(1,20)=6.57$, $p<.05$				
	C	**Name**	**BETWEEN GROUPS: A vs. B@T3**				
	NMH	BDI	NS				
	PMH	LSI	NS				
	Attd	IBT	NS				
	NSA	SADS	NS				
	PSA	PES	-				
		1. frequency	NS				
		2. pleasantness	NS				
		3. cross-product	NS				

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GROUP MEANS (SD'S) AT T1 & T2 ON THE BDI, SADS, IBT, LSI & PES

Tx Grp	BDI Pre/Post	SADS Pre/Post	IBT Pre/Post	LSI Pre/Post	PES freq. Pre/Post	PES pleasant Pre/Post	PES cross Pre/Post
A	5.29/5.43	6.14/7.57	301/303	10.86/10.71	0.59/0.52	0.86/0.67	0.84/0.69
n=7	(3.30/3.74)	(4.02/5.94)	(17/19)	(2.85/3.99)	(0.21/0.15)	(0.28/0.26)	(0.38/0.22)
B	8.17/6.67	13.0/19.0	283/300	10.83/12.06	0.60/0.51	0.98/0.66	0.97/0.68
n=6	(7.14/6.71)	(5.97/7.10)	(23/18)	(4.13/3.98)	(0.15/0.15)	(0.23/0.36)	(0.30/0.31)
C	11.0/8.0	9.75/12.58	295/293	11.13/12.25	0.64/0.66	0.68/0.72	0.74/0.78
n=8	(6.87/6.93)	(6.67/7.21)	(20/11)	(4.61/4.46)	(0.10/0.22)	(0.18/0.21)	(0.22/0.28)
D	7.00/6.29	11.85/11.85	290/296	10.85/11.14	0.63/0.71	0.87/0.87	1.00/1.27
n=7	(4.86/5.65)	(11.20/10.59)	(29/39)	(6.12/6.81)	(0.29/0.24)	(0.35/0.27)	(0.57/0.47)

GROUP MEANS (SD'S) AT T1, T2, & T3 ON BDI, SADS AND LSI

Tx	BDI			SADS			LSI		
Group	Pre	Post	F/U	Pre	Post	F/U	Pre	Post	F/U
A	5.28	5.43	4.71	6.14	7.57	8.42	10.67	11.17	11.33
n=7	(3.30)	(3.74)	(2.81)	(4.02)	(5.94)	(7.39)	(3.08)	(4.17)	(4.27)
B	7.60	7.00	7.40	13.40	10.40	11.60	10.60	12.80	11.00
n=5	(7.83)	(7.45)	(3.64)	(6.58)	(6.95)	(8.91)	(4.56)	(4.44)	4.72
C	9.6	7.20	10.20	9.20	9.60	9.40	12.80	13.80	10.40
n=5	(8.54)	(7.98)	(12.26)	(6.61)	(7.45)	(5.94)	(4.66)	(4.71)	(5.55)
D	7.5	6.00	6.00	7.00	8.00	7.50	11.75	14.25	11.50
n=4	(5.45)	(6.38)	(8.72)	(9.41)	(8.90)	(7.23)	(7.14)	(6.70	(6.76)

Summary

Between

T1 to T2, 3 significant results:

- Beneficial. On a measure of negative social adjustment, there was a group by time interaction; post-hoc analyses showed that the cognitive restructuring group (A) improved over the behavioral skills (B), self-help (C) and control groups (D).
- Not Beneficial. On a measure of positive social adjustment, there were two group by time interactions; post-hoc analyses indicated that the A and B significantly decreased on a measure of potential for pleasurable activities compared to the C and D. Additional post-hoc analyses indicated that the D significantly *increased* and A significantly *decreased* on a total score of potential for pleasurable activities compared to B and C

T1 to T3, 0 significant results

Within

No analyses.

Sub

No risk assessment.

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Article: Schut, de Keijser, van den Bout & Stroebe (1996)

Abstract: 12-weekly, two hour group sessions with one experimental condition (cross modality grief therapy) and one control group (grief therapy) demonstrated one significant beneficial between group difference at follow-up.

Sample

Group	Name	TH	n	N	Assignment
A	CMGT	beh/art	38 (3-5 Ss per grp)		agreed to participate upon admission
B	therapy	-	12		participated in B one year earlier
TOTAL				50	

Matched Char: A=54% spousal loss, avg yrs since bereavement=3.9; 88% women; mean age=51.6. B=63% spousal loss, avg years since bereavement=2.2, 87% women, mean age=54.9; inpatients; [my determination: high risk]

Att: 19 of original Ss did not complete the study

Pre-tx: group A Ss had significantly higher level of education than B ($t(64)=2.31$, $p<.05$)

Method

A: 12, 2 hr behavior therapy sessions and 8, 2 hr art therapy sessions over the course of Ss 3 mo stay at the center; "cross-modality grief therapy"

B: regular health care center therapy for complicated bereavement; individual tx was combined with group therapy for relaxation, social skills training and thematic discussions

Q: 3 psychotherapists and an art therapist

T/M: 3-day training course

AT: -

TI: -

IE: -

Measure

C	Name	Mode, Author (year)	R	V
NMH	General Health Questionnaire (depression, somatic complaints, anxiety, sleep disorders, problems with daily functioning)	SR, Goldberg & Hillier (1979)	-	-

Assessment Time

T1: at intake
T2: entrance (baseline or pre-tx)
T3: directly after discharge (post-treatment)
T4: 3 to 4 mos after discharge (follow-up)

Design: Quasi-Experimental (non-equivalent control group, OOXOO)

Results

GHQ TOTAL SCORES BY CONDITION

		T1		T2		T3		T4	
Group	N	M	SD	M	SD	M	SD	M	SD
A	38	18.5	6.5	20.1	6.0	6.5	6.8	10.5	7.9
B	12	21.1	4.2	18.5	8.5	7.3	7.3	15.3	6.5

$F(3,46)=33.7$, $p<.001$, groups evidenced a significant GroupXTime interaction

COHEN'S d COEFFICIENTS FROM T2 VS. T4 CHANGE ON GHQ SUB-SCALES BY CONDITION

	d, magnitude of change*	
Subscale	A	B
Total GHQ	1.43	.42
1. problems with daily functioning	1.52	.39
2. anxiety/insomnia	1.38	.22
3. severe depression	.60	.33
4. somatic complaints	.94	.45

*d: .2=small; .5=medium; .8=large, B leads to no more than small to medium improvement; A changes range from medium to very large

Summary

Between
T1 to T4, 1 significant result.

- Beneficial. On a measure of negative mental health, the treatment group (A) improved more so than the regular therapy group (B); on the five subscales, estimates of effect size indicated more improvement in A than B.

Within
No analyses.

Sub
All Ss inpatient.

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Article	Polak, Egan, Vandenbergh & Williams (1975)
Abstract	2-6 phone or home visits to a family over the course of one to ten weeks with one experimental condition (crisis intervention) and one control group demonstrated one significant non-beneficial between group difference post-treatment.

Sample

Group	Type	TH	n (families)	N	Assignment
A	crisis intervention	systems	39		
B	control	no	66		
TOTAL				105	random

Matched Char: for age, SES, education, location
Char: type of loss not provided; avg length of time since bereavement=1-2 hrs; excluded families who had experienced another death within the prior 2 yrs; non-patients; no risk assessment
Att: -
Pre-tx: A had greater number of suicides ($F=5.1$, $p<.025$) and sudden deaths ($F=9.8$, $p<.002$) than B

Method

A	2 to 6 phone or home family sessions over the course of 1 to 10 wks
B	no tx
Q	-
T/M	no
AT	-
TI	-
IE	yes

Measure

C	Name (abr)	Mode, Author (year)	R	V
PH	Cornell Medical Index (CMI)	SR, Brodman et al. (1949)	-	-
NMH	MMPI	SR, -	-	-
	Stirling County Questionnaire	SR, MacMillan (1957)	-	-
	Beck Depression Inventory (BDI)	SR, Beck et al. (1961)	-	-
	Parts of Boston Bereavement Project (BBP)	SR, Parkes & Brown (1972)	-	-
SA	Unrevealed Differences Technique (UDT) (family functioning)	SR, Ferriera & Winter (1965)	-	-
	Bodin Free Drawing Technique (BFDT) (family functioning)	SR, Bodin (1968)	-	-
	Social Cost Questionnaire (income, expenses, indirect costs and losses)	SR, *	-	-
Grief	Stress Questionnaire (crisis coping)	SR, *	-	-
IQF	Harvey's Conceptual Systems Test	SR, Harvey et al. (1961)	-	-

Assessment Time	T1: 6 months post-loss T2: 18 months post-loss
Design	True Experimental (posttest-only, control group, RXOO)

Results

C	Name	BETWEEN: A vs. B@T1	A s. B@T2
PH	CMI	NS	-
NMH	MMPI	NS	-
	Stirling County	NS	-
	BDI	NS	-
	BBP	NS	-
SA	UDT	NS	-
	BFDT	NS	-
	Social Cost Q	$p<.004$, B exhibited less concern over SES and social well-being than A	-
Grief	Stress Q	NS	-
IQF	Harvey's	NS	-

Summary

Between
T1 to T2, 1 significant result:
- Not Beneficial. Based on a measure of social adjustment, the control group (B) exhibited *less* socioeconomic concern and social well-being than did the treatment group (A).

T1 to T3, results not reported.
Within
No analyses.
Sub
No risk assessment.

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Article: Lieberman & Yalom (1992)

Abstract: 8 weekly, 90-minute group sessions with one experimental condition (interpersonal) and one control group demonstrated two significant beneficial between group difference at follow-up.

Sample

Group	Type	TH	n	N	Assignment
A	tx	interpersonal	34 (each≅10)		
B	control	no	19		
TOTAL				53	random

Matched	-
Char	spousal loss due to cancer; bereaved between 4 and 10 mos; mean age=56.7; 73% female; all Caucasian; predominantly middle-upper SES; non-patients; no risk assessment
Sub	"at-risk" clients compared to "no-risk clients" ("at risk" defined as "impoverished social resources, limited psychological resources, and presence psychiatric illness")
Att	3 of 56 original Ss did not complete the study
Pre-tx	no

Method

A	8, 90-minute, interpersonal, group tx sessions (duration of tx not provided), led by cotherapists
B	no tx, no contact
Q	psychiatrist and "experienced bereavement counselor" or psychiatric resident
T/M	no
AT	assessor training information not provided; did however use the Mellinger-Balter (1983) algorithm to classify sample (the M-B approach has high validity: significant relationship between classifications and subsequent visits to psychiatrists, psychiatric hospitalization, utilization of psychotropic medication)
TI	no
IE	-

Measure

C	Name (abr)	Mode, Author (year)	R	V
NMH	Hopkins Symptom Checklist	SR, Pearlin et al. (1981)	-	-
	1. depressn subscale		.87	-
	2. anxiety subscale		.82	-
	3. somatic subscale		.74	-
	Bradburn Affect Balance Scale	SR, Bradburn (1974)	-	-
	1. negative well-being subscale		.92	-
PMH	2. positive well-being subscale		.91	-
	Coping Mastery Scale	SR, Pearlin et al. (1981)	.53	-
	Rosenberg Self-esteem Scale	SR, Rosenberg (1965)	-	-
	Overall MH	-	-	-
MH	Bradburn 3. total	SR, Bradburn (1974)	-	-
Beh	Medication/Alcohol Abuse	SR, Lieberman & Videka-Sherman (1986)	-	-
NSA	Single Role Strain	SR, Pearlin et al. (1981)	.82	-
	Stigma	SR, Lieberman & Videka-Sherman (1986)	.68	-
Grief	Mourning	SR, Lieberman & Videka-Sherman (1986)	.68	-
	1. intensity of grief			
	2. grief preoccupation			
	3. anger			
	4. guilt			
	Grief-related distress	SR, Battle (1966)	-	-

Time of Assessment: T1 pre-tx; T2 one year after T1

Design: True Experimental Design (pretest-posttest control group, ROXO)

Results

C	Name	BETWEEN GROUPS A vs. B@T2	Mean Scores (SD) A@T1	A@T2	B@T1	B@T2
NMH	Hopkins					
	1. depressn	NS	2.1(.70)	1.8(.61)	1.9(.71)	1.7(.50)
	2. anxiety	NS	1.5(.43)	1.45(.46)	1.5(.50)	1.31(.30)
	3. somatic	NS	1.74(.53)	1.5(.43)	1.54(.41)	1.46(.31)
	Bradburn - negative	NS	-	-	-	-
PMH	Bradburn - positive	NS	-	-	-	-
	Coping Mastery	NS	4.24(.99)	4.46(1.43)	4.30(1.42)	4.7(1.03)
	Rosenberg	F=4.24, p<.05, A more self-esteem than B	4.56(.68)	4.81(.82)	4.38(1.36)	4.5(.51)
	Overall MH	NS, F=.62	2.01(.91)	2.1(.89)	2.0(1.0)	1.96(.92)
MH	Bradburn - Total	NS	3.5(1.26)	3.75(1.0)	3.33(1.56)	3.90(1.48)
Beh	Med/Alcohol Abuse	NS	1.72(3.18)	1.33(2.2)	2.3(4.26)	1.24(3.3)
NSA	Stigma	NS	2.13(.59)	2.82(.58)	2.10(.53)	2.95(.48)
	Single Role Strain	F=5.37, p<.05, A less single role strain than B	1.83(.34)	1.48(.39)	2.10(.40)	1.36(.45)

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	Grief	Mourning	NS, F=.16	-	-	-	-
		1. intensity of grief	NS	-	-	-	-
		2. preoccupation	NS	2.65(.73)	2.31(.93)	2.55(1.0)	2.11(1.1)
		3. anger	NS	1.58(.44)	1.64(.44)	1.68(.58)	1.62(.52)
		4. guilt	NS	1.44(.41)	1.58(.49)	1.31(.42)	1.68(.58)
		Grief-related distress	NS	-	-	-	-
	Sub	At-risk vs. no-risk	NS treatment-pathology interaction				
Summary	**Between** T1 to T2, 2 significant results: • Beneficial. On a measure of positive mental health, the treatment group (A) showed a significantly greater level of self-esteem than the control group (B). On a measure of negative social adjustment, A decreased significantly in its level of single role strain compared to B. **Within** No analyses. **Sub** Sub-group of at-risk Ss compared to no-risk Ss; 0 significant results.						

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Article: Constantino (1981)

Abstract: Time-limited group therapy with two experimental conditions (bereavement crisis intervention, socialization) and one control group demonstrated two significant, beneficial between group difference post-treatment.

Sample

Group	Type	TH	n	N	Assignment
A	bereavement crisis intervention	no	7		first 7
B	socialization	no	10		last 10
C	control	no	10		if cound not participate in A or B
TOTAL				27	

Matched -
Char: spousal loss; people with spouses who had died due to malignancy/heart disease within 6 months prior to study; female only; mostly Caucasian; age=between 30 and 69 yrs; exluded if hx of psychiatric illness and if currently medicated; non-patients; no risk assessment
Att -
Pre-tx -

Method

A, B: planned, time-limited phase-specific group intervention (duration of tx not provided), led by 2 nurses
C: no tx
Q: female psychiatric mental health nurses with masters degrees
T/M: no
AT -
TI -
IE -

Measure

C	Name (abr)	Mode, Author (year)	R	V
NMH	Deprssn Adjective Chcklst-Form E (DACL)	SR, Levitt & Lubin (1975)	IC=.83 males, .88 fem.	-
NSA	Social Adjustment Scale (SAS-SR)	SR, Edwards et al. (1978)	TR=.778; IC= 737	-

Assessment Time: T1 pre-tx (time frame not provided); T2 post-tx

Design: Quasi-experimental (non-equivalent control group, OXO)

Results

BETWEEN GROUPS
T2 ANOVA, *change* scores

C	Name	pre-post b/t 3 grps, Scheffe post-hoc	Means: Group	@T1	@T2
NMH	DACL	F(2,24)=46.10, p<.05, A less depression than BC	A	19.43	8.57
			B	15.20	14.00
			C	18.20	18.90
NSA	SAS-SR	F(2,24)=11.63, p<.05, A less negative social adjustment than BC	A	2.70	1.94
			B	2.15	2.03
			C	2.09	2.19

Summary

Between
T1 to T2, 2 significant results:
- Beneficial. On a measures of negative mental health and social adjustment, the treatment group (A) showed less depression and less negative social adjustment than the control group (B).

Within
No analyses.

Sub
No risk assessment.

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Article: Lieberman & Videka-Sherman (1986)

Abstract: Group therapy study which compared self-help treament to a bereaved normative group demonstrated two significant beneficial between group difference at follow-up.

Sample

Group	Name	TH	n	N	Assignment
A1	non-members: 2 or fewer mtgs	no	100		
A2	mtg attenders only: attended regularly	no	133		
A3	low social linkage: A2 & had close in-group contact	no	117		
A4	high social linkage: A3 & had close out-grp contact	no	126		
A TOTAL			476		self-selected
B	bereaved normative (from Pearlin & Lieberman, 1979)	-	?		not provided
TOTAL				?	

Matched -
Char spousal loss; avg length of bereavement=43 mos; 36 widowers, 466 widows; 93% had children; non-patients; no risk assessment
Att 26 of 502 original Ss in Group A did not complete the study; attrition for group B not reported
Pre-tx A234>A1: lost spouses more recently; slightly more likely to be employed outside their homes; tended to turn more to their friends for help; and were more socially active in organizations and clubs (significance level not indicated); A significantly more distressed than B

Method

A1-4 self-help "THEOS" (They Help Each Other Spiritually) mutual support groups (duration of tx not provided)
B not described
Q -
T/M no
AT -
TI -
IE -

Measure

C	Name (abr)	Mode, Author (year)	R	V
NMH	Hopkins Symptom Checklist	SR, Derogatis et al. (1974)		
	1. depression -		alpha.87	-
	2. anxiety		alpha.82	-
	3. somatization		alpha.74	-
PMH	Rosenberg Self-esteem	SR, Rosenberg (1965)	-	-
	Mastery scale	SR, Pearlin et al. (1981)	alpha.53	-
	Well-being	SR, Bradburn (1969)	-	-
	Life Satisfaction	SR, Neugarten et al. (1961)	-	-
Grief	Target Problem	SR, Battle et al. (1966)		-
	-			
Beh	Psychotropic drugs and alcohol	-	alpha.65	-

Assessment Time: T1 pre-treatment; T2 12 mos after T1

Design: Quasi-Experimental (pretest-posttest control group, OXO)

Results

MEAN SCORES IN WIDOWED MENTAL HEALTH MEASURE AT T1 & T2 FOR SELF-HELP PARTICIPANTS (A234), NON-PARTICIPANTS (A1) & NORMATIVE SAMPLE (B)

Name	Time	A2-4	A1	B
depression	T1	2.00	2.10	1.42
	T2	1.79	1.94	1.50
anxiety	T1	1.62	1.64	1.27
	T2	1.49	1.157	1.45
somatization	T1	1.69	1.72	1.44
	T2	1.64	1.66	1 56
self-esteem	T1	4.81	4.89	5.42
	T2	5.09	5.21	5.16
mastery	T1	4.63	4.54	4.40
	T2	4.75	4.67	4.00
medications	T1	1.54	2.37	-
	T2	1.34	2.40	-
well-being	T1	1.20	1.39	-
	T2	1.56	1.20	-

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COMPARISONS OF MENTAL HEALTH CHANGES FROM T1 TO T2 AMONG THEOS MEMBERSHIP GROUPS AND NORMATIVE WIDOWS WITH DEMOGRAPHIC DIFFERENCES CONTROLLED

Group	Deprssn	Anxiety	Somatizatn	Well-being	Coping	Self-esteem
A. THEOS						
A1	2.55	1.53	1.50	2.21	5.14	5.09
A2	2.55	1.53	1.51	2.07	4.94	4.77
A3	2.40	1.40	1.48	2.51	5.26	5.10
A4	2.43	1.50	1.50	2.65	5.15	5.10
B. NORMATIVE SAMPLE						
	1.96	2.05	1.82	-1.85	3.93	2.27

• A1234 were statistically different from B on multivariate tests on these simple contrasts ($p<.01$)

THEOS PARTICIPATION AND PROFESSIONAL MENTAL HEALTH ASSISTANCE AS PREDICTORS OF CHANGE IN MENTAL HEALTH

C	Name	Adjusted T2 Scores A1	A2	A3	A4	BETWEEN GROUPS A1 vs. A234@T2, $p<.05$
NMH	Hopkins					
	1. depression	1.96	1.95	1.78	1.84	A1 more depressed than A234
	2. anxiety	1.62	1.61	1.46	1.55	NS
	3. somatization	1.68	1.70	1.55	1.71	NS
PMH	Well-being	0.99	0.97	1.49	1.54	NS
	Self-esteem	5.07	4.76	5.08	5.05	NS
	Mastery	4.58	4.45	4.75	4.57	NS
	Life Satisfaction	2.45	2.36	2.24	2.17	NS
Beh	Drugs & alcohol	2.19	1.87	1.44	1.49	A1 used more drugs/alcohol than A234
Grief	Target Problem	5.69	5.47	6.38	6.43	NS

Summary

Between

T1 to T2, 2 significant results:

- Beneficial. On a measure of negative mental health, nonmembers (A1) were more depressed than participants (A234). On a measure of behavior, A1 used more drugs and alcohol than A234.

Within

No analyses.

Sub

No risk assessment.

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Table 3

Individual Treatment

Article	Parkes (1981)					
Abstract	Individual therapy with one experimental condition (high-risk treatment) and one control group (high-risk non-treatment) demonstrated three significant beneficial between group differences at follow-up.					
Sample	Group	Name	TH	n	N	Assignment
	BE	high-risk experimental	no	28		if 18+ on Health Questionnaire,
	BC	high-risk control	no	29		randomly assigned to either BE or BC
	TOTAL B			57		
	Matched	-				
	Char	65% widows, 22% widowers, 13% non-spousal loss; avg length of bereavement=20 mos.; avg age=66; non-patients; group B=high-risk based on interviewer's assessment				
	Att	143 of 302 original Ss did not complete the study				
	Pre-tx	-				
Method	BE	"offered the support of a volunteer bereavement counselor;" (duration of tx not provided)				
	BC	no support offered				
	Q	home care nurse or volunteer counselor, sometimes social worker, clergyperson or psychiatrist if deemed necessary by nurse or counselor				
	T/M	no				
	AT	-				
	TI	-				
	IE	-				
Measure	C	Name (abr)			Mode, Author (year)	R V
	Over	Health Questionnaire (HQ, from Harvard Ber Study)			CR, Parkes & Brown (1972)	- -
	PH	1. physical symptom subscale				
	NMH	2. depression subscale				
		3. autonomic symptom subscale				
		4. worry (external anxiety) subscale				
	Beh	5. habit change (↑ drugs, alcohol, tobacco) subscale				
		6. healthcare (utilization) subscale				
Assessment Time	T1	pre-tx				
	T2	20 month after T1				
Design	Quasi-Experimental (non-equivalent control group, OXO)					
Results			BETWEEN GROUPS			
	C	Name	BE	BC	p	
	Over	Health Questionnaire	2.78	3.93	.03, BC worse health than BE	
	PH	1. physical	2.2	2.5	.44, NS	
	NMH	2. depression	5.5	7.9	.14, NS	
		3. autonomic sx	2.2	3.5	.05, BC more sx's than BE	
		4. worry	1.25	1.83	.46, NS	
	Beh	5. negative habit change	.36	.85	.02, BC inc'd habits than BE	
		6. healthcare	1.30	1.59	.17, NS	
Summary	**Between** T1 to T2, 3 significant results: • Beneficial. On the measure of health, the high risk control group (BC) demonstrated worse health than the high-risk experimental group (BE). Further analyses on subscales of the measure of health indicate that BC demonstrated greater number of autonomic symptoms and greater number of negative health behaviors than BE. **Within** No analyses. **Sub** All group B (BE & BC) Ss high-risk.					

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Article: Vachon, Lyall, Rogers, Freedman-Letofsky & Freeman (1980)

Abstract: Individual support with one experimental condition (widow-to-widow) and one control group demonstrated one significant, beneficial *item* result at post-treatment and two at follow-up.

Sample

Group	Name	TH	n	N	Assignment
A	tx	no	24		
B	control	no	38		
TOTAL				62	random

Matched: -

Char: spousal loss; females only; 81% of husbands had died of chronic diseases and were 67 years or younger; median length of final illness=6 mos; mean age=52 years; range=22-69; 75% Protestant; 68% Canadian-born; 71% housewives; non-patients; no risk assessment

Sub: at T1, Ss who scored 5+ on GHQ were considered to be experiencing "high distress"; 4- = "low distress"

Att: 100 of original 162 Ss did not complete the study

Pre-tx: A significantly more likely to have lost husbands due to cancer, have at least 2 ppl who were emotionally supportive, and talk to spouse as if still alive

Method

A: widow-to-widow contact could be initiated by the widow or "widow contact;" (duration of tx not provided). contact gave practical help locating community resources, supportive phone calls, face-to-face mtgs

B: no tx

Q: widowed, female, "resolved their own bereavement reactions"

T/M: participated in a training seminar that examined problems of bereavement, provision of supportive counseling, and the spectrum of community resources likely to be helpful to new widows

AT:

TI: no

IE: -

Measure

C	Name (abr)	Mode, Author (year)	R	V
NMH	Goldberg General Health Questionnaire (GHQ)	SR, Goldberg (1978)	-	-
PMH	Intrapersonal Adaptation Index	-	-	-
PSA	Interpersonal Adaptation Index	-	-	-

Assessment Time

T1: 1 mo post loss
T2: 6 mos post loss
T3: 12 mos post loss
T4: 24 mos post loss

Design: True Experimental (pretest-posttest control group, ROXOOO)

Results

C	Name	Time	BETWEEN GroupXTime (Chi-square test, p<.05 between individual items)
NMH	GHQ	T2	NS
	by item	T3	NS
		T4	NS
PMH	Intra	T2	A significantly more likely to perceive health as better than avg. to feel "better" than they did at time of husband's death, less likely to be seeing old friends as much, and less likely (p<.01) to anticipate difficulty adjusting to widowhood, than B
		T3	NS
		T4	NS
PSA	Inter	T2	NS
	by item	T3	A significantly more likely to feel "much better" than at the time of their husband's death, to have made new friends, and to have begun new activities than B; A significantly less likely to feel anxious "often" or "almost always" or to need to keep up a front rather than express true feelings
		T4	NS

PERCENT OF WIDOWS IN TREATMENT (A) & CONTROL (B) GROUPS WHO SHOWED POSITIVE, NEGATIVE, & NO CHANGE (for each women, T1 score was subtracted from T2, T3 or T4 score respectively)

Index	Mos after Loss	% of Widows A (N=24)	% of Widows B (N=38)
Intrapersonal Adaptation	6 mos		
Negative change		8	24
No change		38	24
Positive		54	53
Interpersonal adaptation	12 mos		
Negative change		0	10
No change		8	24
Positive		92	66
GHQ	24 mos		
High-high (no change)*		17	26
Low-low (no change)*		25	40
High-low (positive)*		58	34

*a shift from 1-month high distress to 24 month high distress
a shift from 1-month low distress to 24 month low distress
a shift from 1-month high distress to 24 month low distress

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	Sub	**Time**	**Result on GHQ**
		T1	-
		T2	NS
		T3	NS
		T4	high distress Ss who received tx were significantly more likely to have shifted to the low distress group than high-distress participants who had not received intervention: for high distress Ss. "number of people to count on" was strongly and negatively related to their T4 GHQ score, i.e., the more people to rely on, the better their general health score ($p<.02$)
Summary	**Between** (by test items only) T1 to T2, 1 significant *item* result: • Beneficial. On a measure of positive social adjustment, the treatment group (A) was significantly more likely to experience intrapersonal benefits than the control group (B) on one test item. T1 to T3, 2 significant *item* results: • Beneficial. On a measure of positive social adjustment, A was significantly more likely to experience interpersonal benefits than B on three test items. **Within** No analyses. **Sub** High distress Ss who received treatment were significantly more likely to have shifted to the low distress group than high-distress participants who had not received intervention.		

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Article: Mawson, Marks, Ramm & Stern (1981)

Abstract: 6, 90-minute individual therapy sessions in two weeks with one experimental condition (guided mourning) and one control group (anti-exposure) demonstrated seven significant beneficial between group difference post-treatment.

Sample

Group	Name	TH	n	N	Assignment
A	guided mourning	beh	6		
B	anti-exposure	beh	6		
TOTAL				12	random

Matched: -

Char: type of loss not provided; avg length of bereavement not provided; avg age for A=42, for B=54; cause of death was neoplasia in 11, heart attack in 1; 4 patients in each were on psychotropic medications; excluded if received prior behavioral tx; patients; all Ss complained of "persistent distress" of over one year's duration since loss, plus 2 or more other indications of pathological grief: delayed or abnormal onset of grief after death; increased alcohol, drug or cigarette consumption; anniversary reactions; excessive guilt toward the deceased; identification with the deceased; psychoneurotic reactions arising since death; avoidance behavior concerning the deceased

Att: all 12 Ss completed tx to T3; 11 to T4; 6 to T6

Pre-tx: no

Method

A: 6 (3 per wk), 1-1.5 hr individual therapy; pt encouraged to think about the deceased

B: 6 (3 per wk), 1-1.5 hr individual therapy; pt encouraged to think not about the deceased

Q: 3 psychiatrists, 2 nurse therapists

T/M: no

AT: no

TI: -

IE: -

Measure

C	Name (abr)	Mode, Author (year)	R	V
NMH	Wakefield Depression Questionnaire (WDQ)	SR, Snaith et al. (1971)	TR.68	-
	Anxiety	SR, Watson & Marks (1971)	-	-
	Fear Questionnaire	SR, Marks & Matthews (1979)	-	-
	Compulsive Activity Checklist (CAC)	SR, Philpott (1975)	-	-
	Hostility-Anger-Guilt (HAG)	SR, *	-	-
SA	5-item scale	SR, Watson & Marks (1971)	-	-
Grief	Bereavement Avoidance Tests (BAT)	SR, *	-	-
	1. performance (could task be done?)			
	2. distress (how much distress produced by task?)			
	Texas Inventory of Grief (TRIG)	SR, Faschingbauer et al. (1977)	-	-
NPH	Physical Symptoms of Grief	SR, Maddison & Viola (1968)	-	-
Attd	Attitude to	SR, *	-	-
	1. self (direction not indicated)			
	2. deceased (the higher the score, the more difficulty thinking about deceased)			

Time of Assessment

T1: 0 wks (pre-tx)

T2: 2 wks post T1 (pre-tx)

T3: 4 wks post T1 (post-tx)

T4: 8 wks post T1

T5: 12 wks post T1

T6: 28 wks post T1

Design: True Experimental (pretest-posttest control group, ROOXOOOO)

Results

C	Name	BETWEEN: ANCOVA (covariates not stated). Compared T1/T2 pooled means with T3 for A vs. B	WITHIN: 2-tailed t-tests Compared T1, T2, T3 and T5 T1vsT2	T2vsT3	T2vsT5
NMH	WDQ	NS	NS	NS	NS
	Anxiety	NS	NS	NS	NS
	Fear	NS	NS	NS	NS
	1. total phobia	p<.03, A less total phobia than B	NS	NS	NS
	2. anx-depr	p<.08, A less anx/depr than B	NS	NS	NS
	3. global phobia	p<.1, A less phobia than B	NS	NS	NS
	CAC	NS	NS	NS	NS
SA	5-item	NS	NS	NS	NS
Grief	BAT	NS	NS	NS	NS
	1. performance	p<.02, A more tasks than B	NS	NS	NS
	2. distress	p<.03, A no change, B signif. worse	NS	NS	NS
	HAG	NS	NS	NS	NS
	TRIG	p<.06, A less grief than B	NS	NS	A less grief, p<.05
Phy	Physical	NS	NS	NS	NS
Attd	Attitude	NS	NS	NS	NS
	1. self	NS	NS	NS	NS
	2. deceased	p<.07, A less difficulty thinking about dec'd than B			

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MEANS AND STANDARD ERRORS OF SCORES

C	Measure	Score Range	Group	Mean/SE T1	Mean/SE T2	Mean/SE T3	Mean/SE T4/T5 avg
NMH	WDQ	0-36	A	25.5/2.4	27.0/2.0	20.8/3.8	18.8/4.6
			B	4.5/3.0	24.7/2.8	21.8/2.2	22.2/3.3
	Anxiety	0-8	A	5.5/1.2	5.8/0.8	5.0/0.8	4.2/1.0
			B	5.0/1.1	5.0/1.1	4.3/1.1	4.5/1.4
	Fear Questionnaire						
	1. total phobia	0-136	A	36.8/8.6	44.7/11.7	32.2/8.2	29.2/0.5
			B	34.8/13.0	29.2/10.3	34.2/12.0	34.9/15.6
	2. anx-depr	0-48	A	26.5/1.6	25.3/2.1	17.8/3.8	14.2/4.3
			B	20.3/6.1	19.3/5.7	21.5/5.9	20.8/6.4
	3. global phobia	0-8	A	4.7/1.2	2.7/1.0	2.2/0.7	1.7/0.7
			B	3.7/1.5	3.7/1.5	3.5/1.5	4.5/1.6
	CAC	0-117	A	20.0/5.4	20.3/5.9	18.8/6.3	13.5/5.6
			B	22.5/7.7	28.0/10.0	32.5/13.0	23.2/12.1
SA	Work	0-8	A	2.8/1.4	3.8/1.1	2.8/1.1	2.7/1.0
			B	4.3/1.1	2.8/0.9	4.3/1.2	4.1/1.5
	Leisure	0-8	A	3.7/1.4	4.8/1.0	3.3/1.2	4.1/1.4
			B	4.3/1.3	2.8/0.9	4.3/1.2	4.8/1.4
	Relationship/family	0-8	A	4.0/1.8	2.3/1.2	2.5/1.3	2.8/1.1
			B	1.3/1.0	1.8/1.0	2.0/1.0	1.4/0.9
	Social Relations	0-8	A	2.2/1.2	3.3/1.6	1.8/0.9	2.2/1.2
			B	2.0/1.0	2.0/0.5	2.3/0.9	3.0/1.3
Grief	BAT						
	1. performance	0-5	A	2.2/0.3	1.5/0.3	0.2/0.2	0.8/0.3
			B	2.8/0.6	1.7/0.3	1.7/0.4	1.8/0.5
	2. distress	0-10	A	6.2/1.0	5.7/1.4	6.5/1.3	4.8/1.0
			B	4.7/1.8	4.8/1.4	6.5/1.3	7.8/1.3
NPH	Physical Symptoms	0-39	A	10.0/2.6	9.3/1.8	7.0/1.2	5.8/1.4
			B	9.5/3.0	9.5/3.0	9.0/1.8	8.7/1.6
	HAG	0-10	A	4.5/0.3	5.0/0.7	3.3/0.5	3.3/0.6
			B	4.5/1.0	3.8/0.9	3.5/1.0	3.6/1.3
	TRIG	0-35	A	18.2/1.4	19.3/1.3	14.3/1.7	11.6/2.9
			B	19.7/2.0	20.0/1.9	19.6/1.6	19.5/1.9
Attd	Attitude to:						
	1. Self evaluative	0-12	A	6.5/1.4	9.0/1.1	6.8/1.9	7.0/2.1
			B	5.0/0.8	4.5/1.0	4.3/0.7	5.0/1.6
	anger	0-12	A	8.7/1.1	9.1/1.0	8.3/1.3	7.0/1.9
			B	5.2/2.1	6.0/1.9	6.3/1.6	4.5/0.9
	2. Dec'd evaluative	0-12	A	3.7/2.0	5.8/1.6	3.6/1.8	4.2/1.4
			B	1.3/0.6	5.7/2.0	4.8/1.9	1.9/0.7
	thought-difficulty	0-6	A	5.8/0.2	4.3/1.0	2.2/1.1	2.9/1.2
			B	2.71.1	3.5/0.9	2.7/1.1	3.4/1.5

Summary

Between

T1/T2 (pooled means) to T3, 7 significant results:

- Beneficial. On a measure of negative mental health, the guided mourning group (A) experienced three significant benefits compared to the anti-exposure group (B). On a measure of grief, A experienced three significant benefits compared to B. And on a measure of attitudes toward the deceased, A experienced one significant benefit compared to B.

Within

T1-T5, 1 significant result:

- Beneficial. Compared to T2, A improved at T5 on a measure of grief.

Sub

All Ss high-risk.

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Article: Sireling, Cohen & Marks (1988)

Abstract: 10-weekly, 90-minute individual sessions with one experimental condition (guided mourning) and one control group (anti-exposure) demonstrated one significant beneficial between group difference post-treatment and 14 at follow-up.

Sample

Group	Name	TH	n	N	Assignment
A	guided mourning	beh	11		
B	anti-exposure	beh	9		
TOTAL				20	random

Matched: -
Char: mixed spousal, sibling and child loss; age range=16-70; patients; presence of morbid grief ("most prominent symptoms had to relate in time and content to the loss of a significant other, having started after it and persisted longer than a year" p. 123); avoidance of people, objects, places or conversations concerning the deceased, or of saying a final goodbye to her/him (accepting that oneself would never return to be communicated with as before); no evidence of psychosis
Att: 6 of 26 original participants did not complete the study
Pre-tx: A Ss had had more past psychiatric tx ($p<.05$) and cried more frequently at T2 ($p<.05$)

Method

A: 10 wkly, 1-1.5 hr sessions; 4-wk interval b/t sessions 9 and 10; pt encouraged to think about deceased
B: 10 wkly, 1-1.5 hr sessions; 4-wk interval b/t sessions 9 and 10; pt encouraged to not think abt deceased
Q: -
T/M: no
AT: -
TI: -
IE: masked assessor

Measure

C	Name	Mode, Author (year)	R	V
NMH	Wakefield Depression Inventory (WDI)	SR, Snaith et al. (1971)	-	-
	Fear Questionnaire (FQ)	SR, Marks & Mathews (1979)	-	-
	Hostility-Anger-Guilt (HAG)	SR, Mawson et al. (1981)	-	-
	Beck Depression Inventory (BDI)	SR, Beck et al. (1974)	-	-
	Hamilton Depression Questionnaire (HDQ)	CR, Hamilton (1969)	-	-
NPH	Physical Symptoms of Grief (PS)	SR, Mawson et al. (1981)	-	-
	Global Severity of Illness (GSI)	CR, -	-	-
NSA	Anxiety and Social Adjustments (ASA) (anxiety, work, leisure, relationships)	CR & SR, Marks et al. (1986)	-	-
Attd	1. toward self	SR, -	-	-
	2. toward deceased	SR, -	-	-
Grief	Texas Inventory of Grief (TRIG)	SR, Faschingbauer et al. (1977)	-	-
	Bereavement Avoidance Tests (BAT)	SR, -	-	-
	Grief Activity and Avoidance (GAA)	SR, Lieberman (oral communication)	-	-
Over	Global Improvement (GI)	CR, -	-	-

• for all measures, lowest score indicates absence of pathology

Assessment Time

T1: 0 weeks, pre-tx
T2: 2 weeks, pre-tx
T3: 14 weeks-18 weeks, post-treatment
T4: 28 weeks
T5: 54 weeks

Design: True Experimental (pretest-posttest control group, ROOXOOO)

Results

		BETWEEN GROUPS	WITHIN GROUPS	
C	Name	A vs. B@T3	A@TX	B@TX
NMH	WDI	NS	less depr (T3, T4, T5, $p<.05$)	less depr (T4, T5, $p<.05$)
	FQ	NS, $p<.10$, A less phobic avoidant than B	NS	NS
	HAG	NS	NS	NS
	BDI	NS	less depr (T3, T4, T5, $p<.05$)	less (T3, $p<.05$)
	HDQ	NS	less depr (T3, T5, $p<.05$, clinician rating)	less depr (T3, $p<.05$, clinician rating)
NPH	PS	NS, $p<.10$, A less physical sx's than B	less physical sx's (T3, $p<.05$; T4, $p<.01$)	NS
	GSI	NS	less severe (T3, T4, T5, $p<.001$)	less severe (T3, T4, T5, $p<.01$)
NSA	ASA	NS, $p<.10$, A better relationships with family and friends than B (self report); NS, $p<.10$, A better relationships with family (clinician rating); NS, $p<.10$, A more leisure activities than B	better adjustments with friends (T4, $p<.05$); more work (T3, $p<.05$); more leisure (T3, $p<.05$); less anxiety (T3, T4, $p<.01$)	more work (T3, $p<.01$) and more leisure (T3, $p<.05$) and less anx (T4, $p<.01$)

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	Attd	1. self	NS, $p<.10$, A evaluated self better than B	NS	NS
		2. dec'd	NS	NS	NS
	Grief	TRIG	NS	less grief (T3, $p<.05$; T4, T5, $p<.01$)	less grief (T3, T5, $p<.01$; T4, $p<.05$)
		BAT	$p<.05$, A avoided less bereavement tasks than B	less task avoidance (T3, $p<.05$; (T5, $p<.01$); less distress during tasks (T3, T4, T5, $p<.05$)	NS
		GAA	NS	less crying over dec'd (T3, $p<.05$); less crying for no reason (T3, T5, $p<.05$)	NS
	Over	GI	NS	-	-
Summary	**Between** T1 to T3, 1 significant results: • Beneficial. On a measure of grief, the guided mourning group (A) avoided bereavement tasks less so than the anti-exposure group (B). **Within** T1 to T5, 14 significant results for A: • Beneficial. On measures of negative mental health, A decreased on depression. On a measure of negative physical health, A decreased its level of physical symptoms and global severity of illness. On a measure of negative social adjustment, A improved relationships with friends, increased work and leisure behavior, and decreased anxiety as related to social adjustment. On measures of grief, A decreased on level of grief, avoided bereavement tasks less, experienced less distress during bereavement tasks, cried less over the deceased, and cried less for no reason. **Sub** All Ss high-risk.				

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Article: Brom, Kleber & Defares (1989)

Abstract: 14 to 19-weekly, individual sessions with three experimental conditions (trauma desensitization, hypnotherapy, psychodynamic) and one control group demonstrated 21 significant beneficial between group differences post-treatment and 27 at follow-up.

Sample

Group	Name	TH	n	N	Assignment
A	trauma desensitization	CBT	28		
B	hypnotherapy	CBT	26		
C	psychodynamic therapy	dyn	26		
D	control	no	20		
TOTAL				100	random

Matched: -
Char: 83 lost loved one; 19 experienced violent crime; 4 had traffic accident; no more than 5 yrs elapsed since mourning event; 79% women, 21% men; mean age=42; 59% married; 24% widowers; 15% single; 51% employed; patients; "crisis-like symptom" and "suffering from PTSD" (p. 608)
Att: 12 of original participants did not complete the study
Pre-tx: no

Method

A	avg of 15 wkly individual sessions (duration of session not provided); 3 therapists provided tx
B	avg of 14 wkly individual sessions (duration of session not provided); 2 therapists provided tx
C	avg of 19 wkly individual sessions (duration of session not provided); 2 therapists provided tx
D	wait list control group
Q	"trained and experienced" (>10 yrs) in the specific method conducted
T/M	-
AT	-
TI	supervisory sessions by senior advisors
IE	-

Measurqe

C	Name	Mode, Author (year)	R	V
NMH	Dutch Symptom Checklist-90 (SCL-90) (social inadequacy, somatization, agoraphobia, hostility, psychoneuroticism)	SR, Arrindell & Ettema (1981)	alpha b/t .74 & .96	
	State-Trait Anxiety Inventory (STAI)	SR, Van der Poeg et al. (1981)	rel coeffs b/t .85 and .91	
	State-Trait Anger Inventory (STAI)	SR, Van der Poeg et al. (1981)	" "	
	Dutch Personality Questionnaire (DPQ) (inadequacy, social inadequacy, rigidity, discontentment, conceit, dommance, self-esteem)	SR, Luteijn et al. (1975)	alpha b/t .80 & .89	
TS	Impact of Event Scale (IES)	SR, Horowitz et al. (1979)		
	1. intrusion		72	
	2. avoidance		.66	

Assessment Time

T1	before tx
T2	after tx
T3	3 months after T2

Design: True Experimental (pretest-posttest control group, ROXOO)

Results

WITHIN AND BETWEEN GROUPS

Key:

- a = p<.05 on t-test differences WITHIN groups
- b = p<.05 on GroupXTime BETWEEN groups analyses (A, B or C vs. D)
- c = p<.05 on t-test on residual gain scores (RSG) of GroupXTime BETWEEN groups analyses (A, B or C vs. D; RGS=based on actual difference between T1 & T2 on a mean group improvement; i.e., based on actual diffs between pre- and post-testing and on mean group improvement without being related to scores at pre-test)

MEAN AND SD'S FOR ALL MEASURES AND SIGNIFICANT RESULTS ("a," "b," and "c")

	Dutch SCL									
	Social Inadequacy		Somatization		Agoraphobia		Hostility		Psychoneuroticism	
Grp/T	M	SD	M	SD	M	SD	M	SD	M	SD
A/T1	19.2	8.0	38.1	12.2	14.7	7.3	7.6	2.9	218.3	66.7
A/T2	15.8a	7.1	30.2a	13.1	11.4a	6.0	7.0	3.1	172.2a	65.0
A/T3	16.4a	9.1	31.7a	13.0	11.3	6.7	7.3	3.2	171.9ab	73.3
									A less psychoneuroticism than D at T3	
B/T1	20.0	7.1	41.4	14.0	16.8	7.4	10.	5.1	241.6	54.3
B/T2	17.2	9.0	33.3a	18.8	13.3a	6.5	8.3ab	5.0	194.4a	84.4
							B less hostility than D at T2			
B/T3	15.9a	7.7	30.8	17.2	13.0	7.1	7.1ab	2.6	177.2ab	76.4
							B less hostility than D at T3		B less psychoneuroticism than D at T3	
C/T1	20.2	7.1	41.6	12.7	16.9	8.5	10.	4.9	234.0	58.9
C/T2	15.0ab	6.2	29.7a	12.4	11.7a	6.5	7.4ab	2.6	169.6abc	57.9
	C less feeling of social inadequacy than D at T2						C less hostility than D at T2		C less psychoneuroticism than D at T2	

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C/T3	13.4a	6.3	26.6a	13.2	10.4ab C less agoraphobia than D at T3	5.6	6.1ab C less hostility than D at T3	1.5	152.1ab C less psychoneuroticism than D at T3	57.1
D/T1	17.1	8.1	38.4	11.0	13.6	5.6	8.0	4.3	205.4	52.6
D/T2	16.8	8.1	33.8	11.5	11.6	5.5	8.0	3.9	193.3	67.7

	Dutch SCL		State-Trait: General Symptoms				Dutch Personality			
	Trauma Symptoms		Anxiety		Anger		Inadequacy		Social Isolation	
Grp/T	M	SD	M	SD	M	SD	M	SD	M	SD
A/T1	79.2	21.8	55.7	12.4	14.2	6.8	22.7	10.1	14.6	8.8
A/T2	56.2ab A less trauma sx's than D at T2	24.1	45.1ab A less anxiety than D at T2	13.2	12.3	6.0	18.2ab A less inadequacy than D at T2	9.7	13.5b A less isolating than D at T2	8.6
A/T3	55.7ab A less trauma sx's than D at T3	26.9	41.4ab A less anxiety than D at T3	14.8	12.7	6.0	18.2ab A less inadequacy than D at T3	12.0	13.5ab A less isolating than D at T3	8.5
B/T1	85.0	16.9	58.2	10.3	12.3	3.2	23.9	8.1	13.8	6.7
B/T2	65.4a	29.4	45.0ab B less anxiety than D at T2	15.7	10.9	1.9	19.3ab A less inadequacy than D at T2	11.1	13.6	7.2
B/T3	62.0a	28.2	43.4ab B less anx than D at T3	13.7	11.8	4.8	16.3ab B less inadequacy than D at T3	10.6	11.8b B less isolating than D at T3	6.5
C/T1	81.6	25.2	51.7	10.7	11.7	3.7	25.0	8.5	13.5	8.1
C/T2	57.0ab C less trauma sx's than D at T2	21.1	40.1abc C less anxiety than D at T2	13.2	10.8	2.5	18.4abc C less inadequacy than D at T2	9.8	12.2b C less isolating than D at T2	7.6
C/T3	52.2ab C less trauma sx's than D at T3	24.3	38.3ab C less anxiety than D at T3	14.0	10.9	1.9	17.5ab C less inadequacy than D at T3	9.8	11.2	7.3
D/T1	73.2	18.2	49.2	12.8	12.8	5.2	17.2	9.4	11.3	7.1
D/T2	66.4	24.3	48.2	13.0	14.1	6.1	18.1	10.9	12.9	8.1

	Dutch Personality									
	Rigidity		Discontentment		Conceit		Dominance		Self-Esteem	
Grp/T	M	SD	M	SD	M	SD	M	SD	M	SD
A/T1	27.7	8.3	20.1	7.6	10.6	5.1	13.1	5.7	21.1	7.9
A/T2	26.3	8.5	18.9	7.9	12.4a	5.7	12.8	5.5	22.7a	7.8
A/T3	29.2	8.6	18.9b A less discontent than D at T3	7.9	10.8	5.5	12.8	5.3	24.0a	8.4
B/T1	28.6	8.7	21.6	6.1	11.2	5.1	12.5	6.5	22.9	7.1
B/T2	28.7	10.4	23.0	6.8	12.4	5.8	13.5	7.1	23.5	8.2
B/T3	28.4	9.1	23.2	7.4	11.3	5.8	13.2	7.2	25.0	9.3
C/T1	25.6	8.5	20.6	7.3	11.0	5.7	12.5	6.8	22.0	6.7
C/T2	24.0	8.6	22.2	13.5	11.8	6.4	16.0bc D less dominating than D at T2	7.2	25.3	7.3
C/T3	22.6	8.8	18.3	9.3	12.8	6.3	12.4	7.8	26.9ab C greater self-esteem than D at T3	7.0
D/T1	27.3	7.0	20.7	8.1	10.9	4.0	14.1	4.7	24.7	4.6
D/T2	30.1	9.8	21.7	8.7	10.6	4.2	13.2	5.8	24.1	6.4

	Dutch Personality				State-Trait: Personality			
	Locus of Control		Intro/Extraversion		Anxiety		Anger	
Grp/T	M	SD	M	SD	M	SD	M	SD
A/T1	19.6	5.9	39.0	17.3	53.8	13.8	17.7	5.7
A/T2	18.8	5.6	41.7	17.0	47.2b A less anxiety than D at T2	12.7	17.2	4.6
A/T3	19.0	7.3	41.9	18.5	47.4ab A less anxiety than D at T3	15.7	17.3	5.1
B/T1	22.9	4.6	44.8	15.6	57.3	10.4	21.1	5.4
B/T2	22.3	5.5	42.7	16.1	45.1abc B less anxiety than D at T2	16.1	20.0	6.8
B/T3	21.4	5.0	44.6	21.2	45.9ab B less anxiety than D at T3	13.7	18.3	5.9
C/T1	19.8	6.0	47.0	7.8	57.5	10.2	20.4	4.4

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C/T2	18.5	6.8	50.3	18.7	45.2abc C less anxiety than D at T2	10.9	18.1a	4.5
C/T3	18.6	7.2	51.1	17.2	41.9ab C less anxiety than D at T3	11.6	16.9a	4.0
D/T1	17.2	6.5	46.5	16.0	50.4	10.8	18.6	7.8
D/T2	17.4	6.8	45.0	15.2	51.4	11.3	19.9	7.3

IMPACT OF EVENT SCALE

	Intrusion		Avoidance		Total	
Grp/T	M	SD	M	SD	M	SD
A/T1	24.1	5.3	18.9	9.0	47.4	12.0
A/T2	14.7abc A less intrusion than D at T2	9.8	10.7abc A less avoidant than D at T2	8.9	28.0abc A less impacted by event than D at T2	19.5
A/T3	16.0ab A less intrusion than D at T3	9.5	12.3a	10.4	31.3ab A less impacted by event than D at T3	21.1
B/T1	25.7	4.6	20.5	8.0	50.8	11.7
B/T2	17.1abc B less intrusion than D at T2	10.5	12.9ac	10.7	33.7ac	22.9
B/T3	15.7ab B less intrusion than D at T3	10.9	12.5a	10.4	31.7ab B less impacted by event than D at T3	22.0
C/T1	23.8	7.1	18.0	10.2	46.3	13.5
C/T2	18.4a	8.3	12.0ac	8.6	32.7ac	16.5
C/T3	15.0a	8.8	9.7ab C less avoidant than D at T3	7.6	27.0ab C less impacted by event than D at T3	17.0
D/T1	24.2	5.8	22.3	6.9	51.1	14.1
D/T2	22.3	6.4	20.5	8.7	46.5	15.2

Summary

Between*

General Symptoms

T1 to T2, 8 significant results:

- On a measure of negative mental health, the hypnotherapy group (B) and psychodynamic group (C) decreased hostility; C decreased psychoneuroticism; the trauma desensitization group (A) and C decreased trauma symptoms; and A, B and C decreased level of anxiety compared to the control group (D).

T2 to T3, 11 significant results:

- On a measure of negative mental health, A, B and C decreased hostility; C decreased agoraphobia; A, B and C decreased psychoneuroticism; A and C decreased trauma symptoms; and A, B and C decreased anxiety.

Personality

T1 to T2, 9 significant results:

- On a measure of negative mental health, A, B and C felt less inadequate than D; A and C isolated less; C was less dominating; and A, B and C had less anxiety than D.

T2 to T3, 10 significant results:

- On a measure of negative mental health, A felt less discontent; A, B and C felt less inadequate; A and B isolated less; C had greater self-esteem; and A, B and C felt less anxious than D.

Coping

T1 to T2, 4 significant results:

- Beneficial. On a measure of trauma symptoms, A and B decreased on level of intrusion, A decreased on level of avoidance, and A on total intrusion/avoidance compared to D.

T2 to T3, 6 significant results:

- Beneficial. On a measure of trauma symptoms, A and B decreased on level of intrusion, C on level of avoidance, and A, B, and C on total intrusion/avoidance compared to D.

Within

T1 to T2, 33 significant results:

- Beneficial. On measures of mental health, A experienced 11 changes; B, 10; and C, 12.

T2 to T3, 32 significant results:

- Beneficial. On measures of mental health, A experienced 10 changes; B, 9; and C, 13.

Sub

All Ss high-risk.

*Significant residual gain scores ("c") not included in summary because between group results ("b") indicate same significant difference except b takes into consideration the groups' pre-treatment scores.

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Article: Raphael (1977, 1978)

Abstract: 4, two hour individual support sessions with one experimental condition (high risk treatment) and one control group (high-risk non-treatment) demonstrated one significant beneficial between group difference post-treatment.

Sample

Group	Name	TH	n	N	Assignment
A	high risk tx	dyn	27		
B	high risk control	dyn	29		
TOTAL				56	random

Matched Char: yes; did not state what factors Ss were matched on
spousal loss; avg length of bereavement=7 wks; Ss aged less than 60; non-patients; all Ss predicted to go onto "bad outcome;" considered "high-risk" if met any of the 4 index criteria: 1) high level of perceived nonsupportiveness in bereaved's social network (10+ of 53 ares of crisis interaction explored were perceived as being unhelpfully dealt with); 2) moderate level of perceived nonsupportiveness in social network response to the bereavement crisis (6+ areas of of interaction perceived as unhelpful) occurring together with particularly "traumatic" circumstances of death, i.e., untimely, unexpected, anger-provoking or guilt-provoking; 3) previously highly ambivalent marital relationship with the deceased, traumatic circumstances of death, and any unmet needs; and 4) presence of concurrent life crisis as rated by 3 clinician raters

Att: 8 of 64 original Ss did not complete the study

Pre-tx: no

Method

A: avg of 4, 2 hr, "crisis" sessions in widow's home; all tx terminated by 3 mos after husb's death

B: no tx

Q: dynamically trained psychiatrist (author)

T/M: -

AT: assessor training information not provided; "an interview schedule extensively tested in previous retrospective and prospective studies (Maddison & Walker, 1957) was used to evaluate women's perception of their social network" [a risk factor] (p. 1451)

TI: -

IE: yes

Measure

C	Name (abr.)	Mode, Author (year)	R	V
NMH	General Health Questionnaire (GHQ) (health variables, as well as mental health factors such as depr, alcohol intake, work capacity, etc.)	SR, Madison & Viola (1968)	-	-

Assessment Time

T1: pre-treatment

T2: 13 mos post-death

Design: True Experimental (posttest only control group, RXO)

Results

BETWEEN SUBJECTS COMPARISON OF OUTCOME BASED ON GENERAL HEALTH QUESTIONNAIRE AT T2 (CONTROL GROUP RESULTS NOT REPORTED)

Outcome	A (n=27)	B (n=29)	Total (N=56)	Results
"good"	21	12	33	$\chi^2 = 6.22$, $p<.02$*, more tx Ss (A) went
"bad"	6	17	23	onto good outcome than did control Ss (B)

*Significantly greater frequencies of some sx's in group B compared to Group A between T1 and T2: more swollen or painful joints and general aching (both $p<.05$); more feelings of panic and excessive sweating ($p<.02$); excessive tiredness ($p<.01$); and more doctor's visits ($p<.001$)

Sub: **BETWEEN SUBJECTS COMPARISON OF PARTICIPANTS FOR EACH HIGH RISK INDEX CRITERION BASED ON GENERAL HEALTH QUESTIONNAIRE AT T2**

Index	Outcome	A	B	Result
1	good	14	2	$\chi^2 = 13.27$, $p<.001$, high risk controls (B) worse outcome
	bad	2	12	than high-risk treatment goup (A)
2	good	-	-	NS
	bad	-	-	
3	good	11	4	Fisher test, $p<.05$, B worse outcome than A
	bad	1	6	
4	good	-	-	NS
	bad	-	-	

Summary

Between

T1 to T2, 1 significant result:

- Beneficial. On a measure of general health, 21 treatment group Ss (A) proceeded to good outcome, six to bad; 12 control group Ss (B) proceeded to good outcome, 17 to bad ($p<.02$). Further analyses showed that group B reported significantly greater physical health problems, increased panic, increased fatigue, and increased healthcare utilization.

Within

No analyses.

Sub

All Ss high-risk.

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Article

Horowitz, Weiss, Kaltreider, Krupnick, Marmar, Wilner & DeWitt (1984); follow up by Horowitz, Marmar, Weiss, Kaltreider & Wilner (1986)

Abstract

12-weekly individual sessions with one experimental condition (stress response syndromes) and one control group demonstrated two significant beneficial between group differences post-treatment.

Sample

Group	Name	TH	n	N	Assignment
A	patients	SRS	31		patients seeking tx
B	volunteers	no	32		volunteers selected from death records
TOTAL				63	

Matched Char: adult loss of parent; A: bereaved avg 6 mos, 2 men, 33 women; mean age=31. B: avg length of bereavement not provided; 18 men, 19 women; mean age=38; 87% Caucasian; A=patients; B=volunteers; no risk assessment

Att: not clearly reports; # of Ss at different assessment times varied from 29 to 35

Pre-tx: A had significantly higher levels of symptomatic distress than did B; A had significantly greater number of unexpected deaths than B ($p<.02$)

Method

A	12 wkly individual dynamic sessions (duration of session not provided)
B	control group; no tx
Q	-
T/M	-
AT	-
TI	-
IE	no

Measure

C	Name	Mode, Author (year)	R	V
TS	Impact of Event Scale (IES) 1. intrusion 2. avoidance	SR, Horowitz et al. (1979)	-	-
	Stress Response Rating Scale (SRRS) (intrusion subscale only)	CR, Weiss et al. (1984)	-	-
NMH	Symptom Checklist-90 (SCL-90) 1. anxiety 2. depression 3. total	SR, Derogatis et al. (1976)	-	-
	Experience of Stress Scale (ESS)	SR, *	-	-
	Brief Psychiatric Rating Scale (BPRS)	SR, Overall (1962)	-	-
PMH	Self-Concept Rating Scale (SCRS)	CR, Gedo &Goldberg (1973)	.74	-
SA	Help Inventory: Perceived Social Support	SR, Horowitz et al. (1981)	-	-
Over	Global Assessment Scale (GAS)	CR, Endicott (1976)	-	-
	Life Events Questionnaire (LES)	CR, Horowitz et al. (1974)	-	-

Assessment Time

(A and B assessed at different times.)

	A	B
T1	wk 1	within first 2 mos of start of program
T2	4th session	no
T3	8th session	no
T4	12th session	no
T5	7 mos post T1	7 mos post T1
T6	13 mos post T1	13 mos post T1

Design

Quasi-experimental (non-equivalent control group, OXO)

Results

WITHIN GROUPS COMPARISON OF THE 7 MAIN DISTRESS VARIABLES AT T1 AND T6 FOR A & B

A (n=31 to 29)		@T1		@T6			
C	Name	Mean	SD	Mean	SD	t	p
TS	intrusion (IES)	20.07	7.77	8.37	6.22	8.16	.0001, T6<T1
	avoidance (IES)	20.80	10.61	6.23	8.23	6.59	.0001, T6<T1
	intrusion (SRRS)	17.59	10.66	7.14	5.92	5.19	.0001, T6<T1
NMH	anxiety (SCL-90)	1.64	.98	.75	.77	4.80	.0001, T6<T1
	depression (SCL-90)	1.21	.87	.56	.60	4.36	.0001, T6<T1
	total (SCL-90)	1.06	.65	.50	.53	4.97	.0001, T6<T1
	BPRS	16.49	4.41	10.13	5.62	5.50	.0001, T6<T1

B (n=32 to 30)		@T1		@T6			
C	Name	Mean	SD	Mean	SD	t	p
TS	intrusion (IES)	13.47	9.45	6.94	7.90	4.23	.0001, T6<T1
	avoidance (IES)	9.31	9.64	5.84	8.19	2.38	.02, T6<T1
	intrusion (SRRS)	7.50	10.75	3.30	5.06	2.13	.04, T6<T1
NMH	anxiety (SCL-90)	.78	.81	.50	.48	2.22	.03, T6<T1
	depression (SCL-90)	.66	.79	.31	.47	2.91	.007, T6<T1
	total (SCL-90)	.55	.60	.34	.32	2.36	.03, T6<T1
	BPRS	8.13	6.74	7.50	4.78	.51	NS

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OUTCOME OF BRIEF PSYCHOTHERAPY FOR 35 BEREAVED PATIENTS FROM THE PERSPECTIVES OF THE PATIENTS, THERAPISTS AND EVALUATING CLINICIANS

	Mean Scores				Effects sizes (SD units) of change between times		
Measure	@T1	@T3	@T5	@T6	@T1-T3	@T1-T4	@T1-T6
Patient							
1. intrusion (IES)	21	11	9	7	1.5, p<.01	1.7, p<.01	1.9, p<.01
2. avoidance (IES)	21	7	7	4	1.8, p<.01	1.6, p<.01	1.9, p<.01
SCL-90							
1. anxiety	1.2	.6	.6	.4	.9, p<.01	.9, p<.01	1.6, p<.05
2. depression	1.7	.6	.7	.5	1.5, p<.01	1.1, p<.01	1.6, p<.05
3. total	1.1	.5	.5	.3	1.3, p<.01	1.1, p<.01	2.0, p<.05
GAS	42	69	73	78	1.4, p<.01	1.4, p<.01	1.7, p<.05
Evaluating Clinician							
SRRS - intrusion	18	-	5	5	-		1.7, p<.05
BPRS	16	-	9	9	-		1.6, p<.05
GAS	59	-	72	72	-		1.2, p<.05
Therapist (eval made during first therapy hr)							
SRRS - intrusion	21	9	-	-	1.5, p<.01	-	-
BPRS	17	11	-	-	1.1, p<.01	-	-
GAS	56	69	-	-	1.5, p<.01	-	-

BETWEEN GROUP SCOMPARISON BETWEEN GROUPS A AND B FOR THE 7 MAIN DISTRESS VARIABLES AT T6 FOLLOWING THE DEATH OF A PARENT

		A@T6		B@T6			
C	Name	Mean	SD	Mean	SD	t	p
TS	intrusion (IES)	8.37	6.22	6.94	7.90	.79	NS
	avoidance (IES)	6.23	8.23	5.84	8.19	.19	NS
	intrusion (SRRS)	7.57*	6.27	3.30	5.06	2.90	005, A>B
NMH	anxiety (SCL-90)	.75	.77	.50	.48	1.56	NS
	depression (SCL-90)	.56	.60	.31	.47	1.83	NS
	total (SCL-90)	.50	.53	.34	.32	1.43	NS
	BPRS	10.13	5.62	7.50	4.78	1.96	.005, A>B

*Data differs from earlier table due to addition of one case with T6 data only

MEANS & SD'S FOR A & B ON SLOPE VALUES (*change* scores)

		A@T5		B@T5		Difference in means significant?	
C	Name	Mean	SD	Mean	SD	Raw mean	Initial values partialled out
TS	intrusion (IES)	-.3482	.416	-.1251	.141	yes, A>decrease	no
	avoidance (IES)	-.3620	.382	-.0769	.146	yes, A>decrease	yes, A>decrease
	intrusion (SRRS)	-.2691	.288	-.0912	.182	yes, A>decrease	no
NMH	anxiety (SCL-90)	-.0209	.027	-.0057	.012	yes, A>decrease	no
	depression (SCL-90)	-.0132	.023	-.0076	.012	no	no
	total (SCL-90)	-.0120	.015	-.0041	.008	yes, A>decrease	no
	BPRS	-.1118	.228	-.0251	.131	yes, A>decrease	no

PERCENTAGES OF PERSONS AT THREE LEVELS OF DISTRESS AT T6

		A			B				
C	Name	Low	Medium	High	Low	Medium	High	x^2	p
TS	intrusion (IES)	57	33	10	69	19	12	1.72	NS
	avoidance (IES)	73	17	10	75	19	6	.31	NS
	intrusion (SRRS)	53	37	10	90	7	3	10.04	.007
NMH	anxiety (SCL-90)	55	26	19	66	22	12	.87	NS
	depression (SCL-90)	68	19	13	85	6	9	2.88	NS
	total (SCL-90)	77	13	10	81	13	6	.26	NS
	BPRS	43	47	10	47	53	0	3.17	NS

Results not reported for the following clinician rated measures: ESS, PMH, SCRS, HIPSS, LEQ

Summary

Between*

T1 to T6, 2 significant results:

- Beneficial. On a measure of negative mental health, the treatment group (A) improved psychiatric ratings. On a measure of trauma symptoms, A improved on intrusion compared to the control group (B).

Within

T1 to T6, 7 significant results:

- Beneficial. On measures of negative mental health, A and B decreased on level of anxiety, depression, total anxiety/depression, and a psychiatric rating scale. On measures of trauma, A decreased on 2 scales of intrusion; B on 1 scale of intrusion; and both A and B on 1 scale of avoidance.

Sub

No risk assessment.

*Slope values notdescribed because it is another way of calculating the results reported for "Between" except that slope values are calculated for each participant individually rather than on the basis of the group means.

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Article: Schut, Stroebe, van den Bout, & de Keijser (1997)

Abstract: 7 individual sessions with two experimental conditions (problem focused, emotion focused) and one control group demonstrated one significant beneficial between group difference post-treatment and one at follow-up.

Sample

Group	Name	TH	n	N	Assignment
A	problem focused	no	23		random
B	emotion focused	no	23		random
C	control	no	59		systematically selected from parallel group
TOTAL				105	

Matched Char: grp C Ss selected to match A and B Ss at T1 on distress, gender and cause of death; spousal loss; 46% died of cancer; bereaved 11 mos; mean age=54; 76% widows; non-patients; medium to high levels of distress as determined by the General Health Questionnaire (scores=5+)

Att: 27 of original Ss did not complete the study

Pre-tx: A had a significantly higher level of income than B and C ($F(2,126)=3.41$, $p<.01$)

Method

A: 7 (4 wkly, 3 bi-wkly) counselling sessions between 14 and 17 mos after bereavement
B: 7 (4 wkly, 3 bi-wkly) counselling sessions between 14 and 17 mos after bereavement
C: no tx
Q: 26 experienced social workers
T/M: trained in either the emotion-focused or problem-focused treatment
AT: -
TI: audiotapes of sessions were reviewed for adherence to treatment modality
IE: -

Measure

C	Name	Mode, Author (year)	R	V
NMH	General Health Questionnaire (GHQ) (depression, somatic complaints, anxiety, sleep disorders, problems with daily functioning)	SR, Goldberg & Hillier (1979)	alpha=.91 to .93	-

Assessment Time

T1: baseline
T2: 18 mos post-loss (post-tx)
T3: 25 mos post-loss (follow up)

Design: Quasi-Experimental (non-equivalent control group, OXOO)

Results

MEAN GHQ SCORES BY CONDITION AT T1, T2, AND T3

		@T1		@T2		@T3	
Group	N	Mean	SD	Mean	SD	Mean	SD
A	23	14.9	4.9	10.9	5.2	8.8	4.0
B	23	14.7	4.8	12.5	6.4	10.4	5.3
C	59	15.0	5.1	12.7	5.6	12.3	5.8

- ANOVA: significantly smaller decrease in distress in C ($t_{sm}=2.29$, $p<.05$)
- Cross-sectional ANOVA: significant group difference in GHQ scores during T3 ($F(2,102)=3.57$, $p<.05$). Scheffe test indicated that this was due to differences between C and A

Sub: COHEN'S *d* FOR THE GHQ SCORES BY CONDITION AND GENDER

	@T2			@T3		
Group	Men	Women	Total	Men	Women	Total
A	.02	1.17	.79	.20	1.84	1.24
B	.32	.39	.39	1.16	.76	.85
C	-.19	.42	.43	.24	.56	.49

Note: *d* =.2=small; .5=medium; .8=large

"A is more effective in women and B leads to better results in men" (p. 69).

Summary

Between

T1 to T2, 1 significant result:

- Beneficial. On a measure of general health, the control group (C) decreased less than the problem focused group (A) or the emotion focused group (B).

T1 to T3, 1 significant result:

- Beneficial. On a measure of general health, groups A, B and C differed on symptom level; post-hoc Scheffe test indicated that A decreased level of health symptoms more so than C.

Within

No analyses.

Sub

All Ss high-risk.

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Article: Marmar, Horowitz, Weiss, Wilner & Kaltreider (1988)

Abstract: 12-weekly sessions with one experimental condition (individual, stress response syndromes) and one control group (group, mutual support) demonstrated one significant beneficial between group difference at follow-up.

Sample

Group	Name	TH	n@T3	n@T4	N	Assignment
A	tx	SRS	29	21		
B	self-help	no	26 (5-8 Ss per group)	7		
TOTAL					61	random

Matched Char: spousal loss; avg length of bereavement=54 wks; mean age=58; exclusion criteria: past/present psychotic disorder, prior psychiatric hospitalization, hx alcohol/drug abuse, concurrent psychological tx, pending litigation; or widowed less than 4 mos/more than 3 yrs; patients; pathologically grieved based on DSM-III: 29 adjustment disorder, 17 PTSD, 10 MDEpisode, 5 PTSD/MDEpisode

Att: 33 of 61 original Ss did not complete all four assessment times; 21 of 31 group A members completed the study versus 7 of 30 group B members ($p<.001$)

Pre-tx: no

Method

A: 12 wkly individual dynamic sessions (duration of session not provided)

B: 12 wkly, 1.5-hr mutual support group sessions

Q: A: avg 9.3 yrs of experience after completion of training (5 clinical psychologists, 4 psychiatrists, 2 psychiatric social workers); B: 4 female non-clinicians who had experienced the death of own husbands a mean of 8.5 yrs earlier; mean age = 53; screened for leadership suitability and mastery of their own losses

T/M: "manual for conducting mutual help-group treatments" (p. 204)

AT: -

TI: -

IE: yes

Measure

C	Name	Mode, Author (year)	R	V
TS	Impact of Event Scale (IES)	SR, Horowitz et al. (1979)	-	-
	1. intrusion			
	2. avoidance			
	Stress Response Rating Scale (SRRS)	CR, Weiss et al. (1984)	-	-
	1. intrusion			
	2. avoidance			
NMH	Symptom Checklist-90 (SCL-90)	SR, Derogatis et al. (1976)	-	-
	1. anxiety			
	2. depression			
	3. total			
	Beck Depression Inventory (BDI-short form)	SR, Beck et al. (1967)	-	-
	Brief Psychiatric Rating Scale (BPRS)	SR, Overall (1962)	-	-
SA	Social Adjustment Scale (SAS)	SR, Weissman & Bothwell (1976)	-	-
Over	Global Assessment Scale (GAS)	CR, Endicott (1976)	-	-

Assessment Time

T1: pre-tx

T2: 12 wks later, post-tx

T3: 4 mos

T4: 1 yr

Design: True Experimental (pretest-posttest control group, ROXOOO)

Results

SYMPTOMS OF WOMEN IN GROUPS A AND B: REPEATED MEASURES ANOVA FOR OUTCOME MEASURES BY GROUP, TIME, AND GROUP X TIME

			A			B		
C	Name	Time	N	Mean	SD	N	Mean	SD
TS	IES							
	1. intrusion	T1	31	23.90	8.87	30	22.73	5.88
		T2	31	20.58	8.70	30	20.73	6.46
		T3	31	20.08	8.00	30	16.37	8.75
		T4	31	15.42	9.55	30	14.33	9.71
	2. avoidnce	T1	31	16.32	8.96	30	17.53	9.57
		T2	31	14.39	8.24	30	17.77	10.26
		T3	31	13.48	7.96	30	12.90	10.62
		T4	31	10.84	8.12	30	11.47	10.18
	SRRS							
	1. intrusion	T1	31	11.77	5.50	29	15.38	11.07
		T3	31	10.26	8.83	29	9.90	8.17
		T4	31	7.03	7.87	29	8.69	8.00
	2. avoidance	T1	31	7.58	7.91	29	10.69	7.93
		T3	31	5.70	7.40	29	7.17	6.70
		T4	31	5.71	5.95	29	7.86	6.71

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	NMH	SCL-90							
		1. anxiety	T1	31	1.44	.73	30	1.73	.98
			T2	31	1.15	.95	30	1.36	.97
			T3	31	0.87	.86	30	1.20	.95
			T4	31	0.67	.59	30	1.08	.95
		2. depression	T1	31	1.93	.85	30	1.92	.89
			T2	31	1.51	.98	30	1.66	.86
			T3	31	1.27	.73	30	1.56	.91
			T4	31	1.04	.70	30	1.47	1.01
		3. total (a)	T1	31	1.25	.54	30	1.28	.62
		(a) GroupXTime	T2	31	0.93	.66	30	1.15	.64
		(F=2.78, df=3,	T3 (b)	31	0.77	.51	30	1.05	.59
		177, p<.05)	(b)*Significant difference between groups (t=2.00, df=59, p=.05)						
			T4 (c)	31	0.65	.42	30	0.98	.65
			(c)*Significant difference between groups (t=2.03, df=59, p<.05)						
		BDI (j)	T1	31	8.65	4.69	30	8.80	4.66
			T2	31	6.77	5.82	30	8.77	5.72
			T3	31	6.58	4.43	30	8.13	6.15
			T4	31	5.35	4.88	30	7.40	6.59
		BPRS	T1	29	21.00	8.27	30	21.53	9.67
			T3	29	19.16	9.11	30	19.45	11.38
			T4	29	17.45	10.01	30	20.52	13.31
	SA	SAS	T1	31	118.10	20.44	29	126.91	23.33
			T3	31	109.12	20.14	29	120.88	24.76
			T4	31	108.26	21.08	29	119.56	25.04
	Over	GAS	T1	31	61.42	9.43	29	65.27	9.36
			T3	31	63.16	12.54	29	61.90	12.45
			T4	31	63.81	17.54	29	60.34	13.84
	*t-tests to examine specific between group differences at each time point of evaluation as well as to determine the significance of within-group changes from one time point of evaluation to the next								
Summary	**Between** T1 to T4, 1 significant result: • Beneficial. On a measure of negative mental health, the treatment group (A) decreased in symptom level compared to the self-help group (B). Further analyses revealed that this difference was significant at T3 and T4. **Within** No analyses. **Sub** All Ss "pathologically bereaved."								

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Discussion

To explore the efficacy of treatment for bereaved adults, questions put forth in Chapter I are explored in this section. Information from Tables 2 and 3 are used to discuss the influence of treatment modality, i.e., group vs. individual, level of risk of participants, recency of loss, length of treatment, "patient" vs. "non-patient status," qualifications of clinicians, theory, Chambless and Hollon's (1998) concept of efficacy, methodological factors as introduced by Foa and Meadows (1997) and recommendations for future research. The specific concerns are listed below.

1. Discuss any relationship between individual versus group treatment and outcome.
2. Discuss any relationship between participants' level of risk and outcome.
3. Discuss any relationship between recency of loss and outcome.
4. Discuss any relationship between length of treatment and outcome.
5. Discuss any relationship between "patient" or "non-patient" status of participants and outcome.
6. Discuss any relationship between qualifications of clinicians and outcome.
7. Discuss any relationship between theory-based or non-theory based articles and outcome.
8. Discuss how the literature defines "self-help" and explore any relationship between self-help treatments and outcome.
9. Do any studies support the efficacy of a given treatment based on Chambless and Hollon's (1998) definition of efficacy: "for a treatment to be efficacious, it

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must demonstrate efficacy in at least two studies by independent research teams" (p. 7)?

10. Did any treatments demonstrate benefits on measures directly related to the theories (e.g., intrusion for Horowitz or exposure for CBT)?
11. How do these eighteen articles compare to the methodological "Gold Standards" of treatment outcome studies delineated by Foa and Meadows (1997)?
12. What areas can be improved upon in future studies?

Answers to the questions are discussed in the pages that follow. Each question is answered separately. For all answers, the term "beneficial" means that the treatment group experienced statistically significant *positive* between-groups change compared to the control group on a measure after treatment. "Non-beneficial" means either that (a) the treatment group did not change and the control group improved significantly, or (b) the treatment group had significant negative change compared to the control group after treatment.

1. Individual vs. group treatment and outcome.

Of the 18 articles reviewed, nine employed a group and nine an individual treatment. Seven of the group treatment studies reported significant between-groups differences while two did not. Of the seven that did, four demonstrated beneficial significant results (three quasi-experimental, one true experimental); two reported both beneficial and non-beneficial results (one quasi-experimental, one true experimental); and one reported only non-beneficial results (true experimental). All nine of the individual

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studies reported significant, beneficial between-groups differences (three quasi-experimental, six true experimental). Based on the eighteen articles, the results suggest that individual treatment is more beneficial than group treatment.

Further support that individual treatment is more beneficial than group treatment is revealed upon closer examination of the significant results. Of the seven significant group studies, four (Constantino, 1981; Lieberman & Videka-Sherman, 1986; Lieberman & Yalom, 1992; Schut et al., 1996) reported only one or two significant results favoring intervention in the areas of mental health, behavior and social adjustment while three (Barrett, 1978; Polak et al. , 1975; Walls & Meyer, 1985) reported beneficial (physical health, social adjustment) and non-beneficial[1] (grief intensity, social adjustment) significant differences. No significant results were reported by Sabatini (1988) and Tudiver et al. (1992).

However, the individual treatment articles reported beneficial results *only*, and had a greater number of significant findings favoring intervention per study than the group treatment articles in the areas of mental health, trauma symptoms, general physical and mental health, grief, attitudes and social adjustment. A total of 38 significant results were reported by Brom et al. (1989); two by Horowitz et al. (1984; 1986); one by Marmar et al. (1988); seven by Mawson et al. (1981); one by Parkes (1981); one by Raphael (1977; 1978); one by Schut et al. (1997); one by Sireling et al. (1988); and nine significant *items*

[1] In Barrett, the treatment group showed *greater* grief intensity than the control group at follow-up. In Walls & Meyer (1985), the treatment groups significantly *decreased* on a measure of potential for pleasurable activities compared to the self-help and control conditions at post-treatment. In Polak et al. (1975), the control group exhibited *less* socioeconomic concern and social well-being than did the treatment group at post-treatment.

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by, Vachon et al. (1980)[2]. In conclusion, individual treatments were found to be more efficacious than group treatments based on significant between group differences.

2. Risk level and outcome.

Different labels and methods were used to assess risk. "High-risk" and "low-risk" descriptors refer to patients who have features such as poor pre-morbid functioning, few social supports, or prior psychiatric hospitalizations that make them more inclined to develop a mood, anxiety, psychotic or other diagnosis following bereavement. The terms "complicated" and "pathological" refer to people who already meet the criteria of a significant mental health diagnosis. In the literature, the ten studies that examined risk employed such titles as "pathological," "morbid," "at-risk," and "high-risk" to distinguish either (a) low risk participants from those with increased likelihood of developing a morbid grief reaction (Parkes, 1981, participants bereaved for 20 months; Raphael, 1977; 1978, seven weeks) or (b) those participants already demonstrating one (Brom et al., 1989, up to five years; Lieberman & Yalom, 1992, between four and 10 months; Marmar et al., 1988, four months to three years; Mawson et al., 1981, length of time not provided; Schut et al., 1996, average of four years; Schut et al., 1997, 11 months; Sireling et al., 1988, more than one year; Vachon et al., 1980, length of time not provided).

Three articles used clinician ratings to determine risk. For example, Mawson et al. (1981) marked those at-risk who "complained of persistent distress of over one year's duration since the loss, plus two or more other indications: delayed or abnormal onset of grief after death, increased alcohol, drug or cigarette consumption; anniversary reactions;

[2] Vachon et al. (1980) compared treatment and control groups' responses on each *individual item* as opposed to the measure as a whole.

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excessive guilt toward the deceased; identification with the deceased; psychoneurotic reactions arising since death; or avoidance behavior concerning the deceased" (p. 186). Raphael (1977; 1978) delineated four index criteria; participants were considered high-risk if they met any of the following: (a) high level of perceived nonsupportiveness in bereaved's social network (10 of 53 areas of crisis interaction explored were perceived as being unhelpfully dealt with); (b) moderate level of perceived nonsupportiveness in social network response to the bereavement crisis (six or more areas of interaction perceived as unhelpful) occurring together with particularly "traumatic" circumstances of death, i.e., untimely, unexpected, anger-provoking or guilt-provoking; (c) previously highly ambivalent marital relationship with the deceased, traumatic circumstances of death, and any unmet needs; and (d) presence of concurrent life crisis. "Morbid" grief was described as "prominent symptoms relating to the time and content of the loss of a significant other, having started after the death, and persisted for longer than one year; avoidance of people, objects, places or conversations concerning the deceased, or of saying a final good-bye to the deceased" by Sireling et al. (1988, p. 123).

Articles described "high-risk" in a variety of ways. Three studies based risk on a patient's self-report on measures of mental and physical health; Parkes (1981) used a score of 18 or higher on the Harvard Health Questionnaire (measure of physical and mental health) and Vachon et al. (1980) and Schut et al. (1997), a score of five or higher on the General Health Questionnaire (measure of physical and mental health). Three studies based assessment on the DSM (edition different depending on year of article). Lieberman and Yalom (1992) defined "at-risk" patients as those with a psychiatric illness based on a

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diagnostic interview. Brom et al. (1989) stated that patients had "crisis-like symptoms" and suffered from "serious disorders" based on the diagnostic interview. The third article that assigned risk based on psychiatric diagnosis was Marmar et al. (1988) who considered patients "pathologically bereaved" if they met the criteria for adjustment disorder, PTSD, major depressive episode, or both PTSD and a major depressive episode based on a review of the pre-treatment records by two "experienced clinicians" (p. 204). Schut et al. (1996) was the only study that employed psychiatric inpatients; I placed this study in the high-risk category because patients that are admitted to a hospital are usually under greater distress than non-hospitalized patients.

In summary, a variety of methods were used to assess risk including the DSM, clinician ratings, and self-report measures. To assess risk-level, three articles used clinician ratings with subjective, study-specific criteria that are difficult to replicate (Mawson et al., 1981; Raphael, 1977; 1978; Sireling et al., 1988); one used an inpatient psychiatric population (Schut et al., 1996); three used self-report measures with actual cutoffs on scales (Parkes, 1981; Schut et al., 1997; Vachon et al., 1980); two used diagnostic interviews to make DSM diagnoses and one used a review of patient records to make DSM diagnoses. The variability in labeling and risk assessment is problematic and limits comparison of findings across articles.

Ten of the 18 studies reviewed employed either all high-risk participants (seven), a sub-group of high-risk participants (two), or a sample of psychiatric inpatients only (one). Of the eight studies that did not examine risk as a treatment factor, three reported significant beneficial results for treatment; three, both beneficial and non-beneficial results;

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and two, non-significant results. Compared to the articles that did not assess risk, the articles that did examine level of risk as a variable had significant between-groups differences in nine of the 10 studies (three quasi-experimental, seven true experimental including the one non-significant study). The concept of "regression to the mean" explains that people who begin with more extreme scores generally improve over time even without treatment. Thus, this reported benefit may be a product of people's natural regression to the mean upon repeat testing and may partially explain the greater number of statistically significant and beneficial differences among the studies with high-risk participants than those without. Therefore, these results *suggest* that high-risk participants may be more likely to benefit from treatment than low-risk participants.

Further analyses of the risk-assessing articles revealed the following distinctions. In the eight articles that employed all high-risk participants, treated high-risk patients did better at post-treatment on measures of mental health (Brom et al., 1989; Marmar et al., 1988; Mawson et al., 1981; Schut et al., 1996), grief (Mawson et al.; Sireling et al., 1988), behavior and attitudes (Mawson et al.), trauma symptoms (Brom et al.) and mental and physical health (Parkes, 1981; Raphael, 1977; 1978; Schut et al., 1997). Studies that compared a sub-group of high-risk participants who received treatment with a sub-group of high-risk participants who did not found non-significant differences in one study (Lieberman & Yalom, 1992) and one significant beneficial result in the other; Vachon et al. (1980) discerned that high-distress participants who received treatment were significantly more likely to have shifted to low distress than high-distress participants who had not received intervention based on a measure of general health.

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With its non-equivalent control groups and participants selected on extra values, quasi-experimental studies are more vulnerable to the influence of regression to the mean. Of the 10 high-risk articles, the seven true experimental studies are likely to be more accurate barometers of the impact of high-risk in treatment because participants are *truly* randomly assigned. In this category, one article (Lieberman & Yalom, 1992) had non-significant results while each of the other six articles reported beneficial, significant between-groups results. In summary, there are some suggestions, based on subgroup analyses, that high-risk participants benefit from treatment, but results are not consistent.

3. Recency of loss and outcome.

Fifteen of 18 studies reported the average length of time or range of time of participant bereavement before the commencement of treatment. Seven studies employed participants bereaved for one year or less (Constantino, 1981; Lieberman & Yalom, 1992; Polak et al., 1975; Raphael, 1977; 1978; Schut et al., 1997; Tudiver et al., 1992; Walls & Meyer, 1985); three studies employed participants bereaved for at least one year (Mawson et al., 1981; Parkes, 1981; Sireling et al., 1988); and five studies' participants were bereaved between two and five years (Barrett, 1978; Brom et al., 1989; Lieberman & Videka-Sherman, 1986; Marmar et al., 1988; Schut et al., 1996). Thus, most of the participants fall into one of two categories: those bereaved for an average of one year or less and those bereaved more than one year. Based on the above findings, participants bereaved for more than one year reap greater benefits than those bereaved a year or less.

Further analyses revealed the following distinctions. Of those seven studies with participants in the first category, i.e., bereaved for a year or less, four (two quasi-

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experimental, two true experimental) had significant, beneficial between group findings on measures of mental health and social adjustment (Constantino, 1981; Lieberman & Yalom, 1992) and general physical and mental health (Raphael, 1977; 1978; Schut et al., 1997). Walls and Meyer (1985, true experimental) reported both beneficial and non-beneficial findings on measures of social adjustment. One study reported only non-beneficial findings on a measure of social adjustment (Polak et al., 1975, true experimental) and one study had non-significant findings (Tudiver et al., 1992, true experimental).

Of those eight studies in the second category, i.e., bereaved for more than one year, seven (four quasi-experimental, three true experimental) had significant, beneficial between-groups results on measures of mental health (Brom et al., 1989; Lieberman & Videka-Sherman, 1986; Marmar et al., 1988; Mawson et al., 1981; Schut et al., 1996), behavior (Lieberman & Videka-Sherman), trauma symptoms (Brom et al.), grief (Mawson et al.; Sireling et al., 1988), general health (Parkes, 1981) and attitudes (Mawson et al.). Only Barrett (1978, quasi-experimental) had both beneficial (physical health) and non-beneficial (grief intensity) significant between-groups results; in addition, Barrett had one neutral finding on a measure of attitude. Based on the above studies, these results suggest that those studies with participants bereaved for more than one year are more likely to obtain significant treatment outcome results than those studies that employ participants bereaved for one year or less.

4. Length of treatment and outcome.

Fourteen of 18 studies reported the average length of treatment. In a study by Consumer Reports (1995), short-term treatment was defined as "treatment lasting less

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than six months" (p. 736). Each of the studies included in this review lasted six months or less. Thus, to discern a relationship between length of treatment and outcome, studies were divided into two categories, "*very short-term*" and "*short-term.*" Seven studies offered nine sessions or less on average and seven studies provided ten sessions or more. The findings suggest that both very short-term and short-term treatments are of equal benefit to participants.

Providing the least amount of treatment was Raphael (1977; 1978) with an average of four sessions of two hours each and Polak et al. (1975) giving two to six sessions (individual session length not provided). Four more studies provided six (Mawson et al., 1981), seven (Barrett, 1978; Schut et al., 1997), eight (Lieberman & Yalom, 1992), and nine (Tudiver et al., 1992) sessions of between one and two hours. Sireling et al. (1988) and Walls and Meyer (1985) each gave ten weekly, 90 minute sessions while Marmar et al. (1988) and Horowitz et al. (1984; 1986) provided twelve weekly, 50 minute sessions to the treatment condition of their studies. Three studies provided fourteen or more, one to two hour sessions (Brom et al., 1989; Sabatini, 1988; Schut et al., 1996).

Of the seven studies in the very short-term category, four (one quasi-experimental, three true experimental) had significant, beneficial between-groups differences on measures of general mental and physical health (Raphael, 1977; 1979; Schut et al., 1997), mental health (Lieberman & Yalom, 1992; Mawson et al., 1981), grief (Mawson et al.), attitudes (Mawson et al.) and social adjustment (Lieberman & Yalom). Barrett (1978, quasi-experimental) had significant, beneficial differences on measures of physical health, mental health and attitudes. The treatment groups combined however, reported greater

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levels of grief at follow-up compared to the control group. Polak et al. (1975, true experimental) had one non-beneficial result on a measure of social adjustment and Tudiver et al. (1992, true experimental) had non-significant results.

The short-term treatment category had a distribution of significant results similar to the very short-term group. Of the seven short-term category articles, five studies (two quasi-experimental, three true experimental) reported significant, beneficial results on measures of mental health (Brom et al., 1989; Horowitz et al., 1984; 1986; Marmar et al., 1988; Schut et al., 1996), trauma symptoms (Brom et al., Horowitz et al.) and grief (Sireling et al., 1988). Walls and Meyer (1985, true experimental) reported both beneficial and non-beneficial[3] significant between group differences on a measure of social adjustment. There were no significant results reported by Sabatini (1988, quasi-experimental).

In summary, the data suggest that treatment outcome findings that employ a very short-term treatment (up to ten weekly sessions) are similar in efficacy to those that employ a short-term treatment (between 11 and 19 sessions). It should be noted that Seligman (1995) stated that "long-term therapy [defined as lasting longer than six months] produced more improvement than short-term therapy" (p. 968) based on a study conducted by Consumer Reports (1995). Despite some methodological concerns documented by Kotkin et al. (1996), Hunt (1996) and Brock et al. (1996) on the same

[3] In Barrett, the treatment group showed *greater* grief intensity than the control group at follow-up. In Walls & Meyer (1985), the treatment groups significantly decreased on a measure of potential for pleasurable activities compared to the self-help and control conditions at post-treatment.

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study, the efficacy of long-term psychotherapy for general mental health problems has been demonstrated.

5. Patient or non-patient status and outcome.

For the purposes of this paper, a "patient-participant" was operationally defined as someone seeking treatment; "non-patient-participants" were those who responded to an advertisement or were recruited by an agency such as a coroner's office or hospital. Seven articles employed patients and eleven employed non-patients.

Of the seven patient-articles, six (two quasi-experimental, four true experimental) had beneficial, significant between-groups results on measures of mental health (Brom et al., 1989; Horowitz et al., 1984; 1986; Marmar et al., 1988; Mawson et al., 1981; Schut et al., 1996), grief (Mawson et al.; Sireling et al., 1988), attitudes (Mawson et al.) and trauma symptoms (Brom et al.). The article by Sabatini (1988, quasi-experimental) also employed patients but had non-significant results.

Seven (four quasi-experimental, three true experimental) of the eleven non-patient-articles reported beneficial, significant between-groups differences on measures of social adjustment (Constantino, 1981; Lieberman & Yalom, 1992; Vachon et al., 1980), general health (Parkes, 1981; Raphael, 1977; 1978; Schut et al., 1997), mental health (Lieberman & Videka-Sherman, 1986; Lieberman & Yalom), and behavior (Lieberman & Videka-Sherman). Three articles reported both beneficial (physical health, mental health, social adjustment) and non-beneficial[4] (grief, attitudes, social adjustment) significant findings

[4] In Barrett, the treatment group showed *greater* grief intensity than the control group at follow-up. In Walls & Meyer (1985), the treatment groups significantly *decreased* on a measure of potential for pleasurable activities compared to the self-help and control conditions at post-treatment. In Polak et al. (1975), the control group exhibited *less* socioeconomic concern and social well-being than did the treatment group at post-treatment.

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(Barrett, 1978; Polak et al., 1975; Walls & Meyer, 1985). The final non-patient article by Tudiver et al. (1992) had non-significant findings. In conclusion, treatment is no more likely to benefit patients than non-patients.

6. Qualifications of clinicians and outcome.

A wide variety of clinicians provided treatment in this body of literature, including masters social worker (MSW), licensed clinical social worker (LCSW), marriage and family therapist (MFT), psychiatric nurse, psychologist (PhD or PsyD), psychiatrist (MD), or students or interns of any of the previously listed disciplines. Non-clinician provided treatments were those offered by untrained volunteers or widow-to-widow support. Based on the results described below, clinician-treatments are more likely to have significant results than non-clinician treatments.

Four studies did not report clinician qualifications; four more used non-clinicians: Vachon et al. (1980), Sabatini (1988) and Tudiver et al. (1992) offered the services of a bereaved person, and Parkes (1981), a home care nurse or volunteer counselor (degree not provided). Two more studies by Schut et al. (1997) and Constantino (1981) offered masters level clinicians: a social worker and female psychiatric mental health nurses with masters degrees, respectively. Barrett (1978) and Walls and Meyer (1985) used doctoral level clinical psychology students. Six studies used a variety of clinicians including clinical psychologists, psychiatrists, psychiatric social workers, a psychiatric resident and/or an art therapist (Brom et al., 1989; Lieberman & Yalom, 1992; Marmar et al., 1988; Mawson et al., 1981; Raphael, 1977; 1978; Schut et al., 1996).

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Excluding the four articles that did not report on the qualifications of the providers, the remaining 14 articles can be divided into two groups: those that used a clinician and those that did not. Of the four non-clinician studies, Parkes (1981, quasi-experimental) reported one beneficial, significant between-groups difference on a measure of health and Vachon et al. (1980, true experimental) reported nine significant test item results on a measure of social adjustment. Tudiver et al. (1992, true experimental) and Sabatini (1988, quasi-experimental) had non-significant results.

For the ten clinician studies, eight (three quasi-experimental, five true experimental) reported beneficial, significant results on measures of mental health (Brom et al., 1989; Constantino, 1981; Lieberman & Yalom, 1992; Marmar et al., 1988; Mawson et al., 1981; Schut et al., 1996), social adjustment (Lieberman & Yalom), grief (Mawson et al.), attitudes (Mawson et al.), general health (Raphael, 1977; 1978; Schut et al., 1997) and trauma symptoms (Brom et al.). Two studies by Barrett (1978, quasi-experimental) and Walls and Meyer (1985, true experimental) reported both beneficial (physical health, social adjustment) and non-beneficial (social adjustment, grief) results.

In summary, only 14 articles reported the type of training or qualifications of the providing clinicians or counselors. Two of the four non-clinician and eight of the ten clinician studies had significant findings that favored treatment. Firm conclusions cannot be drawn because of the disparate number of articles between the two groups. However, the ratio of significant, beneficial clinician studies to total clinician studies (8:10) is greater than the ratio of significant, beneficial non-clinician studies to total non-clinician studies

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(2:4). Thus, this data *suggest* that the use of a trained clinician results in more significant, beneficial between-groups findings than those articles that do not employ a clinician.

7. Theory guided treatment and outcome.

Although seven articles did not base treatment on a theory, 11 did. Theories included feminist or gender-based, psychodynamic, Horowitz's stress response approach, interpersonal, cognitive, behavioral, or a combination of both cognitive and behavioral theories. Articles that employed a theory in a controlled, treatment outcome study are no more likely to report significant between group results than those that did not.

Of the seven non-theoretically-based treatment studies, four entailed self-help conditions and three a variety of treatments entitled "bereavement crisis intervention" and "socialization" (Constantino, 1981), American Red Cross' "First Step" (Sabatini, 1988) and "Problem-Focused" and "Emotion-Focused" (Schut et al., 1997). Five (four quasi-experimental, one true experimental) of the seven articles reported significant, beneficial between-groups differences in the areas of general health (Parkes, 1981; Schut et al.), mental health (Constantino; Lieberman & Videka-Sherman, 1986) and social adjustment (Vachon et al.). Two studies (one quasi-experimental, one true experimental), one by Sabatini and the second by Tudiver et al. (1992) reported non-significant findings.

Within the theory-based studies, eight (five true experimental, three quasi-experimental) reported significant, beneficial between-groups findings on measures of mental health (Brom et al., 1989; Horowitz et al., 1984; 1986; Lieberman & Yalom, 1992; Marmar et al., 1988; Mawson et al., 1981; Schut et al., 1996), trauma symptoms (Brom et al.; Horowitz et al.), general health (Raphael, 1977; 1978), grief (Mawson et al., Sireling

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et al.), attitudes (Mawson et al.) and social adjustment (Lieberman & Yalom). Three (quasi-experimental, one true experimental) reported both beneficial (social adjustment, physical health, mental health) and non-beneficial (social adjustment, grief intensity) significant results (Barrett, 1978; Polak et al., 1975; Walls & Meyer, 1985). Thus, based on this body of literature, the use of a theory-guided treatment does not lead to more significant results than a non-theory-based treatment.

8. Self-help vs. theoretically-driven treatments and outcome.

For this paper, self-help studies were operationally defined as those treatments without the involvement of a clinician. Clinicians were defined as professionals with some mental health training, such as a masters social worker (MSW), licensed clinical social worker (LCSW), marriage and family therapist (MFT), psychiatric nurse, psychologist (PhD or PsyD), psychiatrist (MD), or students or interns of any of the previously listed disciplines. A total of ten articles employed a self-help condition. Results suggest that self-help treatments are only mildly beneficial in the treatment of adult loss.

A closer examination of these ten self-help studies revealed the following distinctions. Two studies (Barrett, 1978, quasi-experimental; Walls & Meyer, 1985, true experimental) with "self-help" conditions were led by a clinician, i.e., clinical psychology doctoral students. Three non-self-help and non-theoretically-based studies (all quasi-experimental) involved social workers (Schut et al., 1997), a widowed person and mental health professional (Sabatini, 1988) and a female psychiatric mental health nurse with a masters degree (Constantino, 1981).

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The five final articles (one quasi-experimental, four true experimental) provided non-clinician self-help treatment: mutual support group led by a widow (Marmar et al., 1988), mutual support group led by a bereaved man or woman with counseling experience (Tudiver et al., 1992), individual support of a widowed female (Vachon et al., 1980) and individual support of a volunteer bereavement counselor (Parkes, 1981, further clarification of "counselor" not provided); Lieberman & Videka-Sherman (1986, true experimental) did not describe the leadership of its self-help group.

Of the five true self-help studies, three reported significant, beneficial between-groups differences on measures of mental health (Lieberman & Videka-Sherman, 1986), behavior (Lieberman & Videka-Sherman), social adjustment (Vachon et al., 1980) and general health (Parkes, 1981). Marmar et al. (1988) reported non-beneficial findings on a measure of mental health and Tudiver et al. (1992) reported non-significant findings. Based on the significant, beneficial results of three of the five non-clinician studies, self-help treatment is of mild benefit to adult bereaved populations.

9. Do any articles support the efficacy of a given treatment based on Chambless and Hollon's (1998) definition of efficacy: "for a treatment to be efficacious, it must demonstrate efficacy in at least two studies by independent research teams" (p. 7)?

Fifteen of the eighteen articles can be categorized into multiple theory- or approach-oriented groups: one used a systems theory; one, feminist; one, interpersonal; five, self-help (Marmar et al., 1988, had both a stress response syndromes condition and self-help condition); five, cognitive, behavioral, cognitive-behavioral (CBT), or behavioral-art; two, dynamic (Brom et al., 1989 had both a dynamic and CBT condition); and two,

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Horowitz's (1984; 1986; Marmar et al., 1988) stress response approach. Thus, the only approaches that have at least two articles in one category are self-help, cognitive-behavioral, psychodynamic, and stress response. Self-help, cognitive-behavioral and psychodynamic treatments demonstrated efficacy in at least two controlled studies and are thus considered "efficacious" according to Chambless and Hollon's (1998) definition.

As discussed in question eight on self-help and outcome, three of the five self-help articles had significant, beneficial between-groups differences: Lieberman and Videka-Sherman (1986, quasi-experimental), Vachon et al. (1980, true experimental) and Parkes (1981, quasi-experimental); Marmar et al. (1988, true experimental) and Tudiver et al. (1992, true experimental) did not report significant, beneficial between-groups differences.

Of the CBT-oriented studies, four (one quasi-experimental, three true experimental) had beneficial, significant findings on measures of mental health (Brom et al., 1989; Mawson et al., 1981; Schut et al., 1996), grief (Sireling et al., 1988) and trauma symptoms (Brom et al.); the final CBT article, Walls and Meyer (1985, true experimental), reported significant beneficial (social adjustment) and non-beneficial findings (social adjustment) in their use of cognitive and behavioral treatment conditions. The two studies (true experimental) that employed a psychodynamic orientation also reported beneficial results: Raphael (1977; 1978) had one significant finding on a measure of general physical and mental health, while Brom et al. (1989) reported 38 beneficial, significant between-groups differences on measures of trauma symptoms and mental health. There were two studies that employed a stress response treatment model (Horowitz et al., 1984; 1986, quasi-experimental; Marmar et al., 1988, true experimental). While both reported

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significant beneficial results, they were produced by the same research team -- a variable that precludes Chambless and Hollon's (1998) definition of an "efficacious" study.

To summarize, of the four categories with a minimum of two articles that demonstrated significant, beneficial between-groups differences, only the self-help, cognitive-behavioral, and psychodynamic studies were investigated by independent research teams. However, only CBT and psychodynamic articles included at least two, true experimental studies with unselected control groups. Thus, based on the significant results and the definition of efficacy, only these two approaches are considered efficacious.

10. Benefits on measures directly related to theory.

Eleven articles employed measures directly related to the theoretical constructs. Theories included interpersonal, systems, feminist, Horowitz's stress response syndromes, psychodynamic, cognitive-behavioral, exposure, and trauma desensitization. Brom et al. (1989), Lieberman and Yalom (1992), Horowitz et al. (1986), Mawson et al. (1981), and Sireling et al. (1998) demonstrated benefits on measures directly related to the theory.

Lieberman and Yalom's (1992, true experimental) interpersonal group therapy aimed at decreasing loneliness and isolation, facilitating role transition, and helping the bereaved to modify one's social network. Measures used to assess these areas were the Hopkins Symptom Checklist (Pearlin et al., 1981) depression subscale for isolation and loneliness; and a measure of single role strain (Pearlin et al., 1981) and stigma (Lieberman & Videka-Sherman, 1986) for role transition. No measure was noted that directly correlated with modifying one's social network. Although results from the Hopkins Symptom Checklist were not significant, there was a significant, beneficial between-

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groups difference on the measure of single role strain; the treatment group decreased in its level of strain compared to the control group post-treatment.

Polak et al. (1975, true experimental) approached treatment from a systemic perspective; treatment involved work with the entire family either through phone calls or home visits. Two measures of social adjustment, the Unrevealed Differences Technique (Ferriera & Winter, 1965) and Bodin Free Drawing Technique (Bodin, 1968) assessed family functioning. At post-test, there were non-significant results on these two measures. In fact, there was only one significant effect in this study; the treatment group performed worse than the control group on a measure of socioeconomic concern and social well-being. This suggests that this type of treatment was not effective in combating systemic family concerns.

One study employed a feminist theory in its treatment of widows. Barrett (1978, quasi-experimental) used three measures to evaluate women's changed awareness of how their experiences as widows relate to them as women. Attitudes toward remarriage and widowhood (Barrett, developed for the purposes of this study), self and other women (Gump, 1972), and radicalism vs. conservatism (Space & Helmrich, 1972) were assessed. At post-treatment, the treated groups showed less "other-orientation" (meaning not explained) than the control group, and at follow up, the treatment groups showed *greater negative attitudes* toward widowhood and remarriage, as well as less other-orientation. Although these significant between-groups results relate to the theory-based treatment, it is not clear whether decreased other-orientation is beneficial and the greater negative attitudes is not beneficial.

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Both Marmar et al. (1988, true experimental) and Horowitz et al. (1984; 1986, quasi-experimental) approached treatment from the perspective of Horowitz's theory of stress response syndromes. Both studies employed the same two measures of trauma symptoms: the Impact of Events Scale (Horowitz et al., 1979) and the Stress Response Rating Scale (Weiss et al., 1984). Only the study conducted by Horowitz et al. reported significant between-groups results on a measure directly related to the theory; the treatment group experienced significantly less intrusion than the control group at follow-up. Based on the significant, beneficial results of one study and the non-significant results of the second, conclusions about the efficacy of stress response syndromes at reducing trauma symptoms cannot be made.

Two studies used a psychodynamic theory in their treatments. Although Raphael (1977; 1978, true experimental) did not employ a measure that correlated with its treatment modality, the second psychodynamic study conducted by Brom et al. (1989, true experimental) did. The psychodynamic group was assessed on measures of personality variables including inadequacy, social isolation, rigidity, discontentment, conceit, dominance, self-esteem, locus of control, and introversion/extroversion (Dutch Personality Questionnaire, Luteijn et al., 1975) and anxiety and anger (State-Trait Personality Inventory, Van der Poeg et al., 1981). Although results were not reported for the psychodynamic group individually, all three treatment groups (trauma desensitization, hypnotherapy, psychodynamic) felt less inadequate, less isolated, less dominating and less anxious at post-test than the control group. At follow-up, the treatment groups reported feeling less discontent, less inadequacy, less isolation, higher self-esteem, less anxiety and

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more self-esteem than the control group. These results indicate that psychodynamic theory, hypnotherapy and trauma desensitization are effective at reducing problematic personality styles, suggesting a possible common mechanism of action between the treatments.

For the five cognitive-behavioral oriented studies, three studies demonstrated significance on measures directly related to the theory. Schut et al.'s (1996) behavioral-artistic treatment did not employ a measure associated with the theory. Walls & Meyer, however, used a measure of Irrational Beliefs (Jones, 1969) to assess the impact of its cognitive restructuring group; there were no significant results on this construct; however, participants did improve significantly on a measure of social adjustment. A measure of trauma symptoms was used to examine the influence of Brom et al.'s (1989) "trauma desensitization" group; the treatment group experienced less intrusion and avoidance compared to the control group post-treatment. Thus, behavioral desensitization demonstrated effects on theoretically-important measures whereas cognitive restructuring did not.

Two, true experimental studies by Mawson et al. (1981) and Sireling et al. (1988) employed a behavioral exposure-based treatment. To assess this treatment, measures of avoidance and distress related to bereavement-oriented tasks, grief anxiety and avoidance were employed. At post-test, the treatment groups in both Mawson et al.'s and Sireling et al.'s studies avoided the bereavement tasks significantly less than the control group. In addition, Mawson et al.'s control group became significantly worse on a measure of distress during bereavement-oriented tasks and the treatment group did not change.

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Mawson et al.'s treatment group also experienced significantly less difficulty thinking about the deceased than did the control group. This suggests that exposure and trauma desensitization treatments effectively reduced avoidance and intrusion in bereaved adults.

Based on the results, the theories associated with the final five articles reported significant, beneficial relationships between measures and theoretical constructs including: exposure (Mawson et al., 1981; Sireling et al., 1998); trauma desensitization (Brom et al., 1989); interpersonal (Lieberman & Yalom, 1992); stress response approach (Horowitz et al., 1986) and psychodynamic (Brom et al.). Four of these studies were true experimental designs and one, quasi-experimental.

11. Foa and Meadows' (1997) Methodological "Gold Standards."

Foa and Meadows (1997) offer seven "parameters of methodologically sound studies" (p. 453). The specific criteria are: (a) clearly defined target symptoms; (b) reliable and valid measures; (c) use of blind evaluators; (d) assessor training and experience; (e) manualized, replicable, and specific treatment programs; (f) unbiased assignment to treatment; and, (g) treatment adherence.

The first criterion is the use of a clearly defined target symptom. Foa and Meadows (1997) suggest that in addition to defining the target symptom so that appropriate measures can be used, the article should also specify "threshold of symptom severity" (p. 453) to reduce biases in determining treatment efficacy. For example, participants with mild levels of pathology at pre-treatment are less likely to demonstrate change than those with higher levels; concluding that a treatment is not efficacious based on such a sample would be potentially erroneous. Thus, the evaluation of

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psychopathology and the use of inclusion and exclusion criteria are the first gold standard recommendations made by Foa and Meadows.

Although eight articles did not report on level of pathology or inclusion/exclusion criteria, 10 articles did. Polak et al. (1975) and Constantino (1981) only excluded "families with another prior death within the past two years" and "individual history of psychiatric illness or current medication" respectively. One additional study used only those patients who were hospitalized (Schut et al., 1996).

Seven articles assessed both level of pathology and listed inclusion/exclusion criteria for participation in the study. Schut et al.'s (*1997*) participants had medium to high levels of distress as determined by a cutoff on a health questionnaire and excluded low distress applicants. Likewise, Vachon et al. (1980) also assessed pathology on a measure of general health and compared the subgroups of high- and low-distress participants who received treatment.

Two studies (Brom et al., 1989; Marmar et al., 1988) used the DSM-III for diagnosis (PTSD, adjustment disorder, major depressive episode) and exclusion criteria such as length of bereavement (no more than five years for Brom et al.; between four months and three years for Marmar et al.), history of alcohol/drug use, pending litigation, and present/past psychotic disorder. Sireling et al. (1988), Mawson et al. (1981) and Raphael (1977; 1978) used only those people who qualified as "high-risk" based on the study's specific operational definition (see question two for risk definitions). Thus, only these seven articles of the 18 reviewed in this paper met Foa and Meadows' (1997) first gold standard criterion.

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The second criterion put forth by Foa and Meadows (1997) is whether an article employs measures with "good psychometric properties" and the ability to assess symptom severity. Although twelve articles did not *report* reliability information, a majority of each article's measures have been validated. Six articles that actually included that information reported reliability (whether test-retest or internal consistency not stated in any of the articles except Constantino who reported both) coefficients ranging between 0.53 and 0.96 (mean=0.79) (Brom et al., 1989; Constantino, 1981; Lieberman & Videka-Sherman, 1986; Lieberman & Yalom, 1992; Sabatini, 1988; Schut et al., 1997). All articles included at least one reliable measure (reliability of 0.80 or higher). All articles employed measures to assess level of general health including symptoms of depression, grief, and anxiety, thus meeting a component of Foa and Meadows' second gold standard.

Another important factor relating to the use of measures is whether a study employs a variety of assessment methods, including self-report, clinician rated, and independent/masked evaluations at each assessment time. Use of disparate assessment tools reduces the influence of biases particular to one type, such as investigator bias for clinician rated and halo effects for self-report measures. In this review, 11 (Brom et al., 1989; Constantino, 1981; Lieberman & Yalom, 1992; Mawson et al., 1981; Polak et al., 1975; Raphael, 1977; 1978; Sabatini, 1988; Schut et al., 1996; 1997; Tudiver et al., 1992; Walls & Meyer, 1985) of the 18 articles used strictly self-report measures. Six more studies employed a combination of behavioral, self-report and clinician rated assessment tools (Barrett, 1978; Horowitz et al., 1984; Lieberman & Videka-Sherman; Marmar et al., 1988; Sireling et al., 1988; Vachon et al., 1980). Parkes (1981) used only one measure

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which was clinician rated. Overall, 88 (82%) measures were self-report, 11 (10%) were clinician rated, six (5%) were behavioral, and three (3%) were unknown.

Thus, 82% of the measures used by these 18 studies employed self-report inventories. The primary bias that operates with this type of measure is that participants are subject to the influences of social desirability. Participants may try to "place themselves in the best possible light" and "endorse condoned behaviors rather than the socially inappropriate behaviors" (Kazdin, 1992, p. 238). Without multiple perspectives of participant's pre-treatment, post-treatment and follow-up level of functioning, studies with findings based primarily on self-report inventories could be biased by participants wishing to look healthier than they actually are.

Criteria three and four relate to the use of clinicians who evaluate participants. The use of an independent evaluator is the third gold standard criterion. Five articles used a masked assessor who was unaware of the purpose of the study, to evaluate patients at pre-test and/or follow up (Horowitz et al., 1984; 1986; Marmar et al., 1988; Polak et al., 1975; Raphael, 1977; 1978; Sireling et al., 1988). The fourth criterion is met when assessors are trained to evaluate participants and, "at a minimum," use "interrater reliability and calibrate assessment procedures during the study to prevent evaluator drift" (Foa and Meadows, 1977, p. 454). No articles reported training of assessors. However, Lieberman and Yalom (1992) and Raphael (1977; 1978) made efforts to standardize assessments. Lieberman and Yalom used the Mellinger-Balter (1983) algorithm to classify participants. This algorithm has high validity; prior studies report a "significant relationship between classifications and subsequent visits to psychiatrists, psychiatric

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hospitalization, utilization of psychotropic medication" (p. 120). Raphael used "an interview schedule (Maddison & Walker, 1957) extensively tested in previous retrospective and prospective studies to evaluate women's perception of their social network" (p. 1451) which was a risk factor in the article. In summary, gold standards three and four were not adequately met by this body of bereavement literature.

Gold standard five calls for "manualized, replicable, specific treatment programs" designed to address the target problem (Foa & Meadows, 1997, p. 454). Only four of the 18 articles reviewed in this paper provided training or manuals to its treatment providers. Tudiver et al. (1992) offered eight hours of training on group process, orientation to the goals of the study, and manuals that described the self-help treatment. A three-day training course was provided by Schut et al. (1996), a training seminar that described the problems of bereavement, supportive counseling and community resources by Vachon et al. (1980), and a "training in either emotion-focused or problem-focused treatment" by Schut et al. (1997) to treating clinicians. The adult bereavement treatment outcome studies reviewed in this paper generally do not meet the recommendations of the fifth gold standard.

The majority of articles met Foa and Meadows' (1997) sixth gold standard, "unbiased assignment to treatment," which includes both random (Brom et al., 1989; Lieberman & Yalom, 1992; Marmar et al., 1988; Mawson et al., 1981; Parkes, 1981; Polak et al., 1975; Raphael, 1977; 1978; Schut et al., 1997; Sireling et al., 1988; Tudiver et al., 1992; Vachon et al., 1980) and stratified sampling procedures (Walls & Meyer, 1985). The remaining six articles employed a variety of methods. Sabatini (1988) and

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Constantino (1981) assigned the first half of callers to the treatment condition and the second half to the control. Barrett's (1978) participants were unable to be randomly assigned due to "limitation of availability of participants, geography, and timeliness of the start of the program" (p. 22). Using participants in a pre-existing self-help program, Lieberman and Videka-Sherman's (1986) participants were self-selected. Of the final two articles, the treatment and control group participants were assigned in different manners: Schut et al.'s (1996) treatment condition participants agreed to participate upon entry to the hospital and the control condition participants were members who had been in the regular treatment program one year earlier; Horowitz et al.'s (1984; 1986) treatment participants were patients seeking treatment and its control group participants were volunteers selected on the basis of death records.

The seventh and final gold standard entails efforts made by a study to ensure that clinicians are adhering to the treatment protocol put forth in the "manualized, replicable, specific treatment program." Only two articles employed measures to standardize treatment across providers: Brom et al. (1989) offered supervisory sessions by senior advisors; Schut et al. (1997) reviewed audiotapes of sessions to check for adherence to treatment modality. Neither of these attempts meet the expectations delineated in Foa and Meadows' (1997) seventh gold standard.

Most of Foa and Meadows' (1997) seven gold standards are not adequately met by this body of treatment outcome literature on adult bereavement. Seven studies met criterion one, "clearly defined target symptoms." Each of the articles employed at least one measure with a reliability coefficient of 0.80 or higher. Only five articles used

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UMI

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treatment. To further substantiate these findings, additional studies are needed that compare the same type of treatment (e.g., psychodynamic or cognitive-behavioral) within the study but that employ a group format for one condition and an individual treatment for the other. A further area of exploration are studies that compare the value of concurrent, individual and group treatment with therapy that employs only one type or the other.

To promote standardization across research on grief, the use of uniform measures may be the most effective way of assessing risk. To facilitate replication of research and assessment in the future, the use of a general health questionnaire or measures that pertain to pathological grief in particular, such as the Inventory of Complicated Grief (Prigerson et al., 1995) or the Texas Revised Inventory of Grief (Faschingbauer, 1981) may be most helpful and permit cross-study analysis of risk as a clinical indicator. In addition, diagnostic interviews such as the SCID could be used to assess whether participants meet specific DSM diagnoses (e.g., major depression or PTSD) at pre-test and follow up. Ideally, studies should assess both symptoms (via questionnaires and interviews) and diagnostic status as these are not identical.

The findings suggest that high-risk participants benefit more from treatment than low-risk participants. However, only two of the eight studies that assessed risk compared a sub-group of high risk participants who received treatment with a sub-group of participants who did not. To discern the benefits of treatment for high-risk patients versus low-risk patients, additional studies comparing sub-groups of at-risk participants are needed.

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Preliminary evidence suggests that exposure/trauma desensitization, psychodynamic, interpersonal and stress response syndromes approaches are effective in reducing symptomatology predicted by the theory. To further explore this issue, it is recommended that investigators employ mediator measures that directly assess the tenets of the theory when assessing the effects of a treatment approach.

Summary

In conclusion, this discussion explored the relationship between a variety of adult bereavement treatment outcome study variables and outcome. Variables explored included type of treatment, risk, recency of loss, length of treatment, patient status, clinician qualifications, theory, self-help treatments and methodology. Based on the data, the following twelve conclusions were made:

1. Individual treatment is more beneficial than group treatment.
2. Studies that select high-risk participants are more likely to discern significant, beneficial differences post-treatment than studies that do not.
3. Studies with participants bereaved for more than one year are more likely to discern significant, beneficial results than those with participants bereaved for one year or less.
4. Results from treatment outcome studies that employ a very short-term (3-10 sessions) treatment are similar to those that employ a short-term (11-19 sessions) treatment program.
5. Studies with patient-participants are no more likely to have significant, beneficial results than those with non-patient-participants.

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6. Data suggest that clinician-provided treatment studies are more likely to have significant, beneficial results than non-clinician-provided treatment studies.
7. Articles that employ a theory-based treatment are no more likely to report significant between-groups results than those that do not.
8. Based on the significant, beneficial results of three of the five non-clinician studies, self-help treatment is of mild benefit to the bereaved adult.
9. Only cognitive-behavioral and psychodynamic treatments are efficacious based on Chambless and Hollon's (1998) definition, i.e., "for a treatment to be efficacious, it must demonstrate efficacy in at least two studies by independent research teams" (p. 7).
10. Exposure, trauma desensitization, interpersonal, stress response and psychodynamic theory-based treatments had significant, beneficial findings on measures of constructs directly related to the theory.
11. The eighteen articles reviewed only weakly met Foa and Meadows' (1997) gold standards of treatment outcome literature: one study met no criteria; seven studies met one criteria; four studies met two criteria; four studies met three criteria; one study met four criteria; and one study met five criteria.
12. Recommendations were provided regarding group and individual treatments, risk assessment, treatment of high-risk participants, and the use of theoretically-consistent measures.

The purpose of this review was to determine the value of treatment for bereaved adult populations. Length of short-term (under 20 sessions) treatment, type of

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participants (patient vs. non-patient) and theory were not found to be critical variables in the treatment of grief. However, cognitive-behavioral or psychodynamic clinician-led, individual psychotherapy is clinically indicated for high-risk participants who have been bereaved for more than one year.

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CHAPTER III

THE APPLICATION OF THEORY TO TREATMENT

In this chapter, I explore how theory informs and is informed by clinical practice with three bereaved women. A brief sketch of each patient is given, as well as information on recruitment, methods of assessment, therapeutic procedure and supervision. In the discussion, tenets of Horowitz's theory and treatment model of stress response syndromes are compared and contrasted to therapy with the clinical sample. The components that are discussed in particular are: schemas, themes, phases of intrusion and avoidance, controls, therapeutic rapport and the clinical sample's results on the measures.

Recruitment

For one month, advertisements were placed in local papers. Flyers were distributed to funeral homes, chaplains, social workers and a psychologist who facilitates a grief support group.

Participants

In this section, each of the three women with whom therapy was conducted are described. Background information, behavior, physical presentation and diagnoses are discussed. The three women were experiencing difficulty adjusting to one significant loss by death, although two had additional losses of family members, friends and pets. Whereas one client reported extreme depression and lability for the past two years, two others expressed an inability to mourn the loss of a significant other for almost two years.

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All three women sought treatment because of physical, emotional and interpersonal distress. Identifying information has been altered to protect their identities.

Toby

Axis I	296.22	Major Depressive Disorder, chronic, moderate
	309.81	Post-Traumatic Stress Disorder, chronic
	305.10	Nicotine Dependence
	304.30	Cannabis Dependence
Axis II	V71.09	No diagnosis
Axis III		Migraines, hives, facial acne
Axis IV		Death of three-week-old baby; patient is victim of child neglect
Axis V		GAF = 55 (current)

Toby is a 29-year-old, single, unemployed, middle class, Caucasian woman who resides with her boyfriend of five years. She has a satisfying relationship with Kevin who is concerned about her and asks about her psychotherapeutic treatment. Although she is a spiritual woman, she does not identify herself with any specific religion. Toby learned of the bereavement therapy service through a close friend who noticed an advertisement in the paper. She sought therapy for depression over the death of her three-week-old baby boy. The child died of an infant disease two and one-half years earlier.

Toby has a slim build and long, straight brown hair; she wore no makeup to sessions and came casually dressed in sweat outfits or loose fitting jeans and a sweater. She was a bright, honest and personable woman. Deeply depressed and labile, she also was independent minded. She viewed her baby as the single most important person in her life; when the child died, Toby felt as if she no longer had a purpose or reason for existing.

Born and raised in a small, rural town of Minnesota, Toby was the only child of her Caucasian, lower class, non-religious, unmarried parents, her mother, a verbally

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abusive drug addict and her father, a domestically violent, alcoholic. Her mother "never held a real job" and she did not report her father's occupation. Toby recalled being beaten by her father before he abandoned the family when she was two years of age. She has not had any contact with him since then. Although she resided with her mother off and on, she considers herself to have been raised by her great-grandmother who lived nearby. Her mother married and had two more children, Toby's half-sister, younger by eight years and her half-brother, younger by fourteen; her step-father works in the computer industry. Although her mother divorced her step-father, Toby is closest to him and her step-family. Toby's father's whereabouts are unknown; her mother is still alive and resides in California. Toby has regular, monthly contact with her half-sister, half-brother, step-father, his second wife, and her extended step-family.

Toby did not have academic problems and reported to have been an average student achieving A's, B's and C's. She graduated from high school and rented an apartment with a friend while working at a retail store. Shortly after, her great-grandmother passed away (cause unknown), a loss that was very troubling for Toby since her great-grandmother was so supportive of her. When her friend moved away, she began dating her neighbor, Kevin, with whom she began to live. At 25, through family connections, she received a scholarship to attend college in Washington state; she always wanted to be a surgeon. Months before she was to begin classes, she learned she was pregnant with Kevin's child and decided to cancel her plans to attend college.

Not believing in abortion, she and Kevin decided to have the child. Although he asked her to marry him, she refused because "I didn't want to get married just because I

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was pregnant." Although she had been looking forward to college, she was happy to forego school to have the baby. She describes herself as naively entering into pregnant life and preparing for motherhood. She anticipated staying home for approximately two and one-half years to raise the baby before returning to school or work.

The baby was born healthy and Toby describes those first weeks as the most happy period of her life. She loved catering to the child's needs and remembers feeling deliriously happy. Shortly after the birth, the three-week-old would not eat and she noticed his skin seemed sallow. With Kevin away at work, she took the child to the emergency room. Hospital staff took the child straight into the intensive care unit and began to do blood work and a spinal tap. The doctor informed Toby that "the worst to expect is that he will be blind." The baby began to have seizures and died within hours. After this event, she entered into a severe depression in which she did not wish to leave the house or do anything at home but lay in bed. She attempted on two occasions to hold simple minimum wage jobs, but experienced a panic attack at one and "could not find the motivation" to return to the other.

Toby has never had any legal problems. She smokes cigarettes and marijuana daily. She does not drink. She reports being "relatively happy and well-balanced" before her son's death and she had not received prior psychological treatment. In the course of her current treatment, she became pregnant (unplanned according to Toby) and learned that the due date was the day following her first child's birthday. Toby was not pleased about the pregnancy and feared the repetition of events with her first baby. After extensive talks with her boyfriend, they chose to abort the pregnancy for fear of something

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"going wrong" and for practical reasons such as health insurance, finances and Toby's wish to return to school in the Fall. Toby suffers from migraines, chronic hives and facial acne. Although she reports having many friends and being active in sports growing up, she has pulled herself out of almost all activity in the past two years.

Toby attended all 12 sessions, and chose to continue in treatment after the six weeks follow-up. To help with Toby's treatment goal which was to "move on with life, get motivated," interventions based on Horowitz's treatment model were employed. Behavioral and cognitive techniques were also employed to address her vegetative symptoms; activities and interests were explored and practical issues discussed around pursuing them. Although Toby was ambivalent about medication and chose not to pursue it, she was referred to a psychiatrist for an evaluation. In session, cognitive elements were discussed that centered largely around the loss, such as guilt-laden ideas and catastrophizing about the future. The death also triggered a series of murderous fantasies toward her mother. The connection between her mother's neglect, Toby's dedication to her own child and her self-image that she is a "magnet for disaster" were examined. Due to Toby's proclivity to avoid painful material, she was encouraged to and did bring in baby pictures and Brian's funeral card announcement to help her to access feelings.

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JUDY

Axis I	309.81	Post-Traumatic Stress Disorder, chronic
	300.4	Dysthymic Disorder
Axis II	V71.09	No diagnosis, histrionic personality features (rapidly shifting and shallow expression of emotions, emphasis on physical appearance, speech lacked in detail, theatrical, seductive, easily influenced)
Axis III		Lupus, cholera, heart condition, fibromyalgia, arthritis
Axis IV		Loss of mother to cancer, victim of significant child sexual, emotional and physical abuse, resided in orphanage in her teenage years, teenage pregnancy
Axis V		GAF = 60 (current)

Judy is a 55-year-old married, Caucasian, spiritual woman who is a retired nurse (R.N.) and lives with her husband, 25 years her senior, who is beginning to show signs of senility. Judy was referred to treatment through a bereavement support group. She sought therapy due to the loss of her mother two years earlier; "I want to feel. I want to understand why my father abused me, and why my mom did not help me. I want to learn how to trust and understand why I feel differently than others." Because of the severity of the sexual, emotional and physical abuse Judy experienced as a child, the limitations of this therapy were discussed as well as the possibility that she might benefit from working with a therapist who would continue to be available; the researcher/therapist would complete her internship in seven months. Despite these restrictions, she chose to continue in treatment.

Judy came well-dressed and manicured to sessions. A very pretty, bright and charming woman, she made good eye-contact, laughed readily and talked spontaneously about her dreams. Moderately overweight, she wore brightly colored blouses, sweaters, loose-fitting slacks and decorative jewelry. Momentarily despondent in session, she spent

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most of her time in and out of therapy attempting to act happy in order to "keep from losing control." Rarely crying, she attempted to explore her relationship with her mother although she could only barely acknowledge the extreme ambivalence she felt. Judy did not report the occupations of her parents.

As a child, Judy was insulted, harassed and patronized by her father. If she made a "mistake," such as forgetting to empty his ash tray or was slow in bringing him a bottle of beer, he would beat her "to a pulp." Then, "as if to show how much he loved me, he would rape me." When asked when this treatment began, she stated "he treated me this way for as long as I can remember, until I finally ran away and never returned at 13." Judy suffered tremendously at the hands of her father with whom she has not spoken for 20 years. Inconsistently protected by her alcoholic mother, she remembers being taken by her mother to bars, presumably to avoid the wrath of her father. Judy believes her two brothers, older by two and four years, were also sexually abused. She described her home as a "dilapidated, leaky, vermin infected" abode. At 13 and tired of being her father's "slave," she ran away and refused to return when the police attempted to bring her home. Instead, she lived in foster homes with custodial parents with whom she no longer has contact. She did not explain why this is the case. She has regular bi-monthly contact with her brothers both of whom live and work (occupation unknown) in the same area as she.

At 11, she "fell in love" with a man who was to be her first husband. She had her only daughter with him when she was in High School. She reports having an IQ of 147 based on psychological testing in high school and claims to have skipped several grades; she graduated from high school at 16. She reports that after her husband returned from

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serving in Vietnam, he was a "changed man due to all the drugs" and they divorced. She married three more times after this and has had several affairs, some with powerful and wealthy men. She has been married to her current husband for the past ten years. Although she enjoyed the intelligence of her current husband, a retired physicist, she was never "in love" with him. Because of health problems, he is unable to have sex, and she reports missing terribly this aspect of life. She has befriended a physician who is "very interested" in her and with whom she flirts although this relationship is not sexual, yet.

Between the ages of 30 and 45, she abused alcohol but maintained a senior nurse position for over 25 years. She only retired recently when her mother passed away and when she was diagnosed with lupus, which she keeps under relative control through good healthcare. Her only daughter is married and works for a living (occupation unknown).

She has no history of legal problems. She sought insight-oriented therapy in the past for her molest issues but "wasn't ready to make use of it." She takes Prozac for depression, Premarin for hormone replacement therapy, Plaquenil for lupus and arthritis, Trazodone as a sleep aid, Claritin for allergies, and Compazine for side effects (nausea) to her other medications. (The name of her prescribing doctor is unknown.) She is diagnosed with arthritis, fibromyalgia, lupus, a heart condition and cholera. She has financial difficulties and is angry with her husband for mismanaging their savings. I believe Judy was a reliable historian of her background and experiences.

- Judy attended six sessions and then left for a planned vacation. Upon return and after a three week delay, she was contacted via phone and a seventh session was scheduled. During that phone call, Judy reported that her father had died and she had

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been "very busy." She failed to show for this seventh session. A message was left for her which she never returned. Because she never responded to this message, no efforts were made by the investigator to ask Judy to complete the measures for a second time.

The reasons for Judy's failure to keep her final session are unclear. She was diligent about scheduling and attending the first six sessions. She had explained ahead of time that she was to go on vacation and indicated she would call to reschedule when she returned. Perhaps Judy did not feel understood in therapy and that is why she chose not to continue; I struggled to empathize with her degree of trauma and she may have felt this. It is also possible that she was really terrified to talk about her feelings about the death of her mother and the abuse she received as a child, and that therapy was simply too overwhelming for her. Due to the death of her father, she may have needed to attend to the practical demands of funeral arrangements and other concerns. In addition, the death of her father may have triggered a barrage of feelings which she was unable or unready to deal with and so she chose to drop out of treatment, albeit suddenly and without allowing for discussion.

In treatment, sessions focused on the emotional working through of the loss of her mother, and occasionally, on the additional losses of three friends and one cat in the past decade. In line with Horowitz's focus on avoidant and intrusive phases of working through the loss, efforts were made to identify Judy's attempts to avoid thinking about painful subject matter. Because this so regularly happened during the course of a therapeutic session, resistance and defenses were identified by both patient and therapist. And, since her skills for controlling her affect inside and outside of treatment were so

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sophisticated, greater emphasis was placed on actual experiencing of the emotion elicited by the loss(es) during the therapy session. The patient was encouraged to bring in pictures of herself as a child and memorabilia of her mother. Although she once brought in childhood pictures, she chose not to view them and swiftly returned them to her purse.

DEBBIE

Axis I	300.4	Dysthymic Disorder
	300.6	Depersonalization Disorder
Axis II	V71.09	No diagnosis
Axis III		None
Axis IV		Death of mother; loss of two aunts; recent break-up with partner
Axis V		GAF = 70 (Current)

Debbie is a 39-year-old, middle-class, Christian (denomination unspecified), African-American, single woman with a high school degree who lives with a close friend and works as a front desk supervisor at a fitness club. She was referred to individual counseling by a psychologist who conducts a weekly grief support group which Debbie attended. She sought individual therapy because of the loss of her mother two years earlier to cancer. She stated that "it's very hard for me to get into my feelings and emotions. I would like to be able to express what I feel and think."

A petite, fit woman with short black hair, Debbie wore colorful outfits, sweatsuits or khaki pants with loose fitting, crisp cotton tee shirts to sessions. She is a pensive woman who presents in a polite, poised and controlled manner. Although she reported weeping outside of therapy, she teared-up only once in the course of our treatment. She described her mother as her best-friend and primary support. When her mother died,

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Debbie felt as if she "lost the one person on whom [she] could rely" for comfort, approval and companionship.

Debbie is the oldest of six half-siblings by four fathers who were born and raised by her never-married mother. She describes her mother as "gentle, kind, available, open-minded, solid and spiritual." She claims to have had a deep, almost mystical bond with her and recalls a time when her mother phoned and announced that "a taxi was on the way," when she and her partner were on the verge of being physically violent with one another; her mother's intervention prevented the violence. She remembers her father visiting on only one occasion and bringing a tike-bike to her as a small child. She has had no contact with him since.

After graduating from high school, Debbie attended a local college and received some school credits. During her late teen years and 20's she abused marijuana and separated from the family because "I didn't want to let my mother down." She stopped using marijuana in her late 20's and began to reconnect with the family. One day she noticed a woman where she worked and explained, "I suddenly knew, I just knew! She was so striking." From 25 to 30, she was in a committed, lesbian relationship with that same woman. Debbie did not explain why this relationship came to an end. In her early thirties and sobriety, Debbie became particularly close to her mother.

When her mother became ill with cancer (type unknown), she visited her regularly at the hospital and took a leadership role in caring for her. Ill for only several months before her death, her mother wished to spend her final days at the family home. It was during this time that Debbie chose to move a couple hours south of her hometown,

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believing that such a change would promote her adjustment after her mother's death. Her immediate and extended family gathered around her mother's death bed in the home. Debbie remembers being told by one of her half-siblings that she was expected to be the strong one, "not to cry."

After the loss of her mother, she continued working. She became involved in a second, significant lesbian relationship. Although her mother attended the commitment ceremony to her "first wife" (her words), she knew her mother wished something different for her. Approximately 18 months after the loss of her mother, Debbie began to hear her Lord wishing for her to pursue a position in the church and a straight lifestyle; she dreamed she had a husband and a baby and was very excited at this prospect. Over the course of the next six months, she communicated with her partner about her evolving needs and intentions. A couple months after therapy began, the same month as her 39th birthday and the second anniversary death of her mother, she separated from her partner and moved into the home of a close friend and reverend of the church which she attends.

Debbie has no history of legal problems or prior psychological treatment. She does not currently drink or abuse other drugs. She intends to return to bible school to become a minister and is highly involved in the activities at her church. She has a variety of friends and is beginning to attend Christian singles events "to meet people, not necessarily to find a partner." She laments that her mother is not here to witness her renewed faith, her decision to pursue a straight lifestyle, her pain through the break-up with her girlfriend, the loss of her cat, the death of two aunts, and the very recent death of a close church friend, William.

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Until the eleventh session, Debbie reported having a close-knit family; all her siblings still reside in their hometown and spend many weekends and holidays together. In the second to last session, Debbie reported that she had been "molested by her half-brother" at age nine, and "dissociated" often, for even an hour at a time. Informed consent was reviewed with her, and she refused to offer any identifying information. (I was advised by Child Protective Services that a report could not be filed under these conditions.) Other than her avoidant behavior, she did not report any other symptoms of traumatic stress. However, she stated she had a "very serious comfort zone" and the ability to "be aware of what was going on, and at the same time, totally absent."

In accordance with Horowitz's treatment model, Debbie was guided to identify feelings and express emotions relating to the loss of her mother. The patient struggled to "experience" her emotions but instead, presented in a controlled and rigid manner. Of Horowitz's two primary grief phases, intrusion and avoidance, Debbie experienced avoidance for the most part. The implications of the loss of her mother and how it related to her current life changes were explored. The therapist-patient relationship was also discussed, with special attention paid to expressing her true feelings even if they were of disappointment and frustration. Loss issues were further addressed through regular reminders of the number of remaining, available sessions. Although invitations were made to Debbie to bring in pictures of her mother, she chose not to do this.

Measures

Four validated instruments were used to assess all three clients on measures of grief, intrusion and avoidance, physical health and positive mental health. The measures

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were administered at time one (pre-treatment), time two (post-treatment, 12 weeks after time one) and time three (follow-up, six weeks after time two). Toby and Debbie completed the measures at all three assessment times. Judy only completed the measures at time one because she dropped out of treatment.

Inventory of Complicated Grief. The Inventory of Complicated Grief (ICG: Prigerson, Maciejewski, Feynolds, Bierhals, Newsom, Fasiczka, Frank, Doman, & Miller, 1995) is a 19-item questionnaire that discerns the presence of a complicated grief reaction based on symptoms such as survivor guilt, bitterness over the death, jealousy of others who have not experienced a similar loss, and distraction to the point of disruption in the performance of one's normal activities. Clients report the frequency (0=never; 1=rarely; 2=sometimes; 3=often; 4=always) with which they currently experience each of the emotional, cognitive, and behavioral states described in the ICG. Thus, the scale identifies "grief-related symptoms that could help to discriminate between uncomplicated and complicated grievers" (Prigerson et al., 1995, p. 67). Data for the scale were derived from 97 conjugally bereaved elders.[5] Respondents with ICG scores of greater than 25 were significantly more impaired in social, general, mental and physical health functioning and in bodily pain than those with ICG scores of less than or equal to 25. The internal consistency was high (Cronbach's alpha = 0.94).

Impact of Event Scale. This second scale entitled the Impact of Event Scale (IES: Horowitz, Wilner, & Alvarez, 1979) is a 15-item self-report instrument of subjective stress

[5] One of the limitations of using this measure for this dissertation's clinical sample is that the Inventory of Complicated Grief was validated on a sample of bereaved *elders*. Despite this obvious discrepancy with the age of the three women in this study, the ICG was chosen as a measure of grief because it is the only measure in the literature that distinguishes between "complicated" and "uncomplicated" grief.

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that asks clients to read sentences such as "I tried not to talk about it" and "I had dreams about it" and rate on a frequency scale (0, not at all; 1, rarely; 3, sometimes; 5, often) the degree to which the statement is true for them "in the past seven days" in relation to a particular event, in this case, bereavement. There are seven items relating to intrusion of thought and eight items on avoidance of their thought. In its development, the IES was administered to 16 men and 50 women between 20 and 75 years of age who had experienced bereavement (n=34) or a personal injury due to an accident, violence, illness or surgery. Despite disparate events among the participants, endorsement of items was relatively similar. Cronbach's alpha for intrusion was 0.78 and 0.82 for avoidance. A correlation of 0.42 between the intrusion and avoidance subscales scores indicates that these two scales are measuring related but different dimensions of stress. Test-retest reliability scores were strong as well (0.87 for total stress scores).

A second validation study on the IES was completed by Zilberg, Weiss and Horowitz (1982). Using a parentally bereaved population who sought therapy (n=35) and a parentally bereaved population who did not (n=28), the authors conducted a reliability check of the measure based on time of assessment (at entry into the study, four months after termination of treatment, and one year after therapy termination) and subject type (sought therapy, did not seek therapy). The coefficients of internal consistency ranged from 0.79 to 0.92 patient and non-patient groups across time.

Post-Traumatic Growth Inventory. The 21-item Post-Traumatic Growth Inventory (PTGI: Tedeschi & Calhoun, 1996) was developed to assess positive outcomes reported by persons who have experienced traumatic events. Items were scored from zero

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("I did not experience this change") to five ("I experienced this change to a very great degree"). The scale includes the following factors: new possibilities, relating to others, personal strength, spiritual change, and appreciation of life. Men (n=199) and women (n=405) who had experienced a significant negative life event (bereavement=36%; injury-producing accidents=16%; separation/divorce of parents=8%; relationship breakup=7%; criminal victimization=5%, academic problems=4%; unwanted pregnancy=2%; and a variety of other problems) in the past five years participated in the validation study. In the validation study, the internal consistency of the 21-item PTGI is 0.90 with subscale alphas ranging from 0.67 to 0.85. Test-retest reliability ranged from 0.65 to 0.74 for most factors except personal strength (r=0.37) and appreciation of life (r=0.47).

Wahler Physical Symptoms Inventory. This 42-item physical symptom measure (WPSI: Wahler, 1968) can be completed within five to 10 minutes. Designed to assess somatic complaining, items are scored from zero ("almost never") to five ("nearly every day). Based on tests with multiple subpopulations including students and people with chronic schizophrenia, the WPSI demonstrated internal consistency between 0.88 and 0.94 (p. 8). Test-retest coefficients ranged from 0.69 to 0.94 over one day to one week (p. 9). To evaluate validity, groups were "selected for comparison on the basis of differences in the extent to which members could be expected to report and emphasize somatic symptoms" (p. 9). College students, psychiatric patients, rehabilitation patients and disability claimants were used in four separate samples. Compared to the student group, the other three groups scored significantly higher on level of physical symptoms. The disability claimant group also scored significantly higher than the two patient groups.

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Procedures and Treatment

Treatment consisted of 12, weekly, 45-minute sessions based on Horowitz's theory and treatment model of stress response syndromes. After the completion of these 12 sessions, therapy sessions were suspended for six weeks; patients were informed that if they chose to continue after this time, they could do so[6]. As part of the hospital's policy on outpatient therapy provided by psychology interns, patients were asked to pay $10 per session; health insurance was not accepted. Audiotaping and informed consent[7] were reviewed at the start of treatment. Informed consent forms were signed by each patient. Audiotaping permission forms were signed by two of the patients; Debbie did not want to be audiotaped. For one woman with a significant incestuous sexual and physical child abuse history, informed consent included a discussion of the patient's probable need for further therapy and the limitations of the therapist's availability. This patient chose to continue despite these issues.

Treatment was based on Horowitz's theory of stress response syndromes (Horowitz, 1993) which postulates that successful working through of grief issues requires alternating between avoidant and intrusive phases of dealing with the loss. Toward this end, the therapist helped the patient to identify moments of avoidance and intrusion within the sessions and out, confront memories or triggers (e.g., visit the grave site, view the funeral card announcement or pictures of the lost person), and manage

[6] Treatment beyond the 12 weeks is not a component of Horowitz's program and was instituted to meet the concerns of the dissertation committee who suggested that 12 sessions might not be sufficient for some patients. One patient chose to continue treatment after the follow-up assessment time.

[7] To provide such limitations of therapist availability at the outset of psychotherapy constitutes an ethical obligation per the American Psychological Association's Ethics Code 4.01 (APA, 1992).

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intrusive experiences. Interpretations of avoidant behavior were offered and related to the client's perception of the meaning of the loss.

In keeping with Horowitz's treatment model, termination was discussed directly by the therapist in session six and for the remaining number of sessions. In the final twelfth session, the client and therapist acknowledged the ways in which the client had changed, as well as the areas in which the client could continue to develop. Throughout treatment, the client's self-definition and how it related to the deceased, and the impact of the loss on the client's worldview and relationships were clarified.

Supervision

Weekly individual supervision was provided by the Hospital's Director of Psychology Services, a licensed psychologist. In order to aid in her understanding of Horowitz's stress response syndromes approach, a presentation was made on the theory and treatment model before the commencement of therapy with the clinical sample. In addition to the discussion of treatment plans and specific interventions, audiotapes and transcripts of sessions were reviewed. Countertransference issues were explored. Additional consultation was sought by internship rotation supervisors and the author's dissertation chairperson, an associate professor of the school the author attended.

Discussion

The purpose of the clinical sample was to examine how theoretical work may guide real world experiences with clients. In this section, the application of Horowitz's research, theory and treatment model is discussed in relation to therapy with the three women briefly described above: Toby, Judy and Debbie.

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1. Schemas

Horowitz distinguishes among three types of schemas including: 1) worldviews, or one's perception of the world, 2) role-relationships, or one's perception of oneself in relation to others, and 3) self-image, or one's perception of oneself. Horowitz suggests that it is the discrepancy between one's pre-morbid and post-loss schemas that composes a major source of one's grief. Although all three clients explored these types of perceptions, they did so to different degrees. Proposed by the theory and evidenced by the three clients in the clinical sample, the loss of the significant other triggered the re-emergence of belief systems that were either dormant or partially resolved prior to the loss.

In the text to follow, I review each of the women's worldviews, role-relationships and self-images. In Tables 4, 5 and 6, I offer examples of each of the three women's schemas at pre- and post-treatment using quotes from the individual therapy sessions.

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Table 4

Toby: Schemas

	Pre-Treatment	Post-Treatment
Worldview	"I am a magnet for disaster." "I am fated for misery." "I am here to be tortured." "There is no telling what will happen [if I become pregnant again]."	"Maybe people agree with me that I'm a 'disaster magnet' because I'm so *insistent* about it." "I'm thinking of having a baby in one year. I really like kids."
Role-Relationships	"I hate needing people." "Everybody else [my friends' mothers] seemed to like me." "I feel responsible [for the baby's death]. Maybe if I had been able to breast feed, or if I had had better healthcare. I knew something wasn't right." "I must be a bad daughter, a bad person. My mother certainly seemed to hate me." "Kevin's only with me because he feels sorry for me. He probably thinks that if he left me, I'd *really* fall apart." "No one seems to like me. The phone doesn't ring." "I feel like I'm intruding if I were to ask my step-family to be included at the holidays." "I feel like my step-dad must not want to be with me if he doesn't make more time to spend together when he's in town." "My great-grandmother really loved me." "Why couldn't I protect my son?" "Everyone keeps telling me what to do, to get out of bed, to get out of the house." "My sister has done all these things, she's going to school. And I'm not working, and I couldn't even keep my baby safe."	"My mother seemed to project all her self-hatred onto me." "Kevin and I are thinking about marrying this summer." "My friends are calling me now. I'm doing things." "My step-family is calling me." "My step-dad said he was really glad I spoke to him and invited me up there to spend sometime together." "I've been doing things with my half-brother, the 14-year-old." "It's important for me to be able to do things on my own, like, to decide on my own what I'm going to do or not." "My girlfriend's little boy really likes me. He comes over to play." "I seem to have this connection with kids." "I still miss him [baby]."
Self-Images	"I can't hold a job. I can't do anything." "I'm worthless, nobody wants me around." "Why, after all my hell, do I deserve this?" "I'm pathetic, I should be done crying." "I just can't handle it [the death of the baby]." "I just feel like I'm taking up space." "I'm ugly. I hate these hives. I'm pale." "I don't like being vulnerable."	"I'm helping Kevin out with the business at home." "I'm registered for this dental assistant course in September." "I'm doing things." "Maybe I'm not so bad." "I'm not used to feeling like I can't handle things."

Toby: Worldviews. Toby's worldviews were so intimately tied to her negative self-images, the two were hard to differentiate (see Table 4). After the loss of her infant child, Toby experienced the emergence of maladaptive schemas that had been kept in

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check prior to the event by a fragile veneer of defenses, namely denial and suppression. According to Toby, the schemas that emerged after the death of her baby centered largely around her imagined fate in the world. Ideas such as "I am a magnet for disaster," "I am fated for misery" and "I am here to be tortured" pervaded her thoughts and fueled her depression. From these statements and others, it may be extrapolated that Toby viewed the world as unsafe and unpredictable. Her decision to abort a pregnancy during the course of treatment is evidence of her concern with her ability to control the environment. She admitted, "There is no telling what will happen."

Over the course of treatment, Toby modified her worldviews through her acknowledgment of the pain she incurred at her emotionally abusive mother's hand. Specifically, she began to recognize that perhaps she is not a "terrible person" or "disaster magnet," but rather, the unfortunate child of a mother with few coping skills and a significant mental health history, including Bipolar Disorder and Substance Dependence (reported by Toby). Her growing trust in herself appeared to enable her growing trust in the world.

Toby: Role-Relationships. As Toby moved through treatment, the connection between her feelings of her own childhood and her short-lived motherhood became more clear. Having been abused and neglected herself, she dreamt of giving all she could to her newborn. "I was going to do everything my mom couldn't do for me." She strove to reconcile her wishful role relationship, to be the best mother, with her reality as the mother of a dead child. She often explained, "my mother hated me. But the other mothers, my friends' mothers and people, like at softball, they really liked me."

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As a child, she had discerned that she must be a "horrible person," a message Toby fought to disprove to herself and to me. For example, she spontaneously reviewed the people who liked her as a child and adult during session. In the transcript (Appendix A), Toby finishes an emotionally demanding session with some comments about her friend's young child: "...her little boy calls me on the phone, wants to talk to me all the time...he's got [a button with my number programmed into it], and says, 'But [Toby], I just needed to talk to you again.'" Prior to the loss, she may have only superficially succeeded at disproving in her own mind that her mother's belief that she is a "horrible person," is false.

Toby expended much energy to maintain a facade of strength and "goodness," an image that quickly faded when she perceived herself as having "failed" as a mother. In a follow-up session after the third assessment time, Toby reported, "I really want to have children. I'm thinking, in a year." This positively altered perspective reflects her modified view of herself as a "good person" and a potentially "good mother," capable of bearing and protecting a child.

Toby: Self-Images. Early in treatment, much of Toby's self-images centered around self-criticism: "I can't hold a job," "I can't do anything," and "I'm worthless. Nobody wants to be around me." Prior to the loss, Toby had thought of herself as "strong and independent." During therapy, she recalled an incident when she was 10 years old and she protected herself and her baby sister from an intruder by shooting a rifle in the person's direction, compelling his departure. She recollected seeing herself as a quite capable child, raising herself and sister, maintaining good grades, and leaving a boyfriend that once hit her. These memories served to reinforce a pre-morbid self-image as an

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effective, self-possessed woman. Her child's death, however, triggered the emergence of suppressed self-schemas, such as being defective, worthless and earmarked for disaster; she reasoned, "bacterial meningitis is so rare. For my child to contract [this disease] means there must be a reason. Even the emergency room doctor said the worst thing that would happen would be Brian would be blind. But he died. I just want to know, why, after all my hell, do I deserve this?"

In the last sessions, Toby cried and began to allow herself to feel some of the intense hurt caused by her mother's neglect. Acknowledging this pain seemed to attenuate the pressure she felt to act infinitely strong. She stated, "I'm not used to feeling like I can't handle things." In the face of devastation, she pushed herself to maintain the image she had labored to project but only partially believed. The pressing reality was that she could *not* handle the loss of her baby. However, she began to consider that she could be worthy even though her mother mistreated her and even though her child died of a very rare and hard-to-prevent disease.

Although Judy also struggled with her self-image, role-relationship and worldview schemas (see Table 5), these perceptions were less modified through her six sessions possibly because of her intense avoidance or a potential incompatibility between the therapist and patient. Because she dropped out of treatment, some of the discussion about Judy is limited to therapeutic speculation.

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Table 5

Judy: Schemas

	Pre-Treatment	Post-Treatment
Worldview	"This is all part of a journey." "I believe we're all reincarnated and that God works on us in each life." "I think the world keeps striving for harmony." "I wish I could understand why I was so different, why I was treated the way I was." "The world is all interconnected, intertwined." "I'm afraid of losing control." "I feel powerless, uncontrolled sometimes."	Unchanged*
Role-Relationships	"I'm terrible for even thinking about having an affair on my husband." "I feel like a bad person for wanting to leave him now that he's so incapacitated [in bed]." "I never really loved him [husband]." "I'm really mad at him for becoming ill." "I feel like I should have taken better care of my mother when she was sick." "I think I was a bad daughter. I mean, I don't think I did anything wrong. But I think I was bad." "I always felt as if life should be like the TV show, 'Father Knows Best'." "Why did my father do those things to me?" "Why didn't my mom help me?" "The doctor finds me attractive."	(Not explicit, but implied, "You [therapist] are safe enough to begin to open up to.")
Self-Images	"I've been a wreck most of my life." "I've been good all along but felt bad." "I feel different than others." "I think I'm smart." "I gained a lot of weight, but have lost some of it now." "It's [her mother's death, her own abuse, her affairs?] my fault." "I couldn't do anything right."	Unchanged

* Judy only attended six sessions and then dropped out of treatment without warning or discussion.

Judy: Worldviews. Unlike Toby, Judy was better able to articulate her perceptions of the world. And despite her trauma history, she did not express *as much* distrust and skepticism as Toby. She did admit however, that she felt "powerless, uncontrolled" and was "afraid of losing control." I interpreted these statements as reflective of her sense of the world as potentially lacking in safety or unpredictable. On a positive note however, Judy believed her experiences were part of a journey and the life

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was preparing her to some degree for her next life. She believed that the world is all intertwined and interconnected and that there is an endless striving for harmony.

Judy: Role-Relationships. In relationships with others, she became lost. She had had numerous husbands and affairs. Her current husband was many years her senior; there was no physical intimacy with him and she was contemplating a sexual relationship with one of her medical doctors (according to her self-report). She admitted that her life seemed hectic and out of control, but in treatment, could not identify more explicitly her sources of dissatisfaction. Primarily, the death of her mother seemed to trigger the re-emergence of herself as a "defective and bad" daughter. As a child, she was abusively reminded of her deficits; as a bereaved adult, she only remembered her failures, but now in a much larger sense: a bright and retired nurse, she could not preserve her mother's life.

Complicating this apparent feeling of guilt was confusion around her mother's genuine love for her. Judy believed she was a good person with good intentions. She had been faithful to her mother: always trying to please her, including her in her child's life, and caring for her in the hospital. However, she considered it feasible that her mother "wished" Judy were dead, and Judy herself was ambivalent about her mother's life and death. She had a desperate need for approval, and thus maintained a type of "love" for her, and yet simultaneously, withstood her mother's verbal abuse and harbored memories of her mother's failure to protect her from her father's wrath. This obvious contradiction troubled her and exacerbated a sense of herself as defective. As long as her mother lived, she could hope to reconcile her mixed feelings. Her death, however, seemed to abandon Judy in a purgatory of hatred and love, of being both a "good" and "bad" daughter.

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Judy: Self-Images. In some ways, Judy was almost lacking in defined self-schemas. Her time in therapy seemed superficial, less focused, more tentative. Her self-images were broad and sweeping, lacking in detail; "I've been a wreck most of my life" and "I've been good all along but felt bad." She claimed she felt "different than others" but could not articulate in what way. Without prompting, she described dreams in detail, but could not or would not explore their meaning. When invited to bring in childhood pictures, she refused to view them and swiftly returned them to her purse: "I've seen them before. They're for you. I don't want to look at them. They're ugly [depressing]."

At 55, Judy still longed for a fabricated version of familyhood as modeled after a childhood drama series, "Father Knows Best" and strove to merge her own experience in the world with the televised version. "Why did my father do those things [physical and sexual abuse] to me?" and "Why did my mom not help me?" were her most pressing concerns. "Things are coming to me" she stated, but could not elaborate what she expected. It is also possible that she was seeking a fabricated "feel good-no pain" version of psychotherapy. It is this potential piece, "a feel good-no pain" therapy, that in retrospect, I believe I resisted or denied even recognizing. Upon the loss of her mother, Judy thought she may have wanted to understand her own experience as a child, adult, daughter, wife and caretaker. These role-relationships were diffuse outlines of a person who felt fundamentally broken and dilapidated. Although treatment did not help to modify these perceptions, it did bring them closer to her awareness and triggered intense, negative affective responses in the days following each session.

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In the next session, Debbie's schemas are discussed. Table 6 offers a brief synopsis of her pre- and post-treatment worldviews, role-relationships and self-images. Although change was noted in her perception of her relationships and self-representations, her reported worldviews remained the same over the course of treatment.

Table 6

Debbie: Schemas

	Pre-Treatment	**Post-Treatment**
Worldview	"Things happen for a reason." "God has a purpose for me." "This is all part of preparing me to be a better minister in the future." "I'm learning something."	"I have a stronger religious faith."
Role-Relationships	"People can't be trusted." "My mother was my best-friend." "God is telling me that a husband and a baby are in store for me in the future." "I was counting on having her [mother] around." "I need her [mother] to make decisions, to watch me, especially when I have children of my own." "I wanted her [mother] to see me ordained." "It feels like a part of me is missing." "My cat has been with me through so much stuff. She sleeps with me every night. She was there with me through my mother's death." "I always wanted an older sister." "My mother was really good at that [reading other people's minds]." "She died too early. I only have memories and memorabilia."	"I still miss her [mother], but there are other things to think about." "This relationship stuff is hard. If this is what it's all about, I'm not sure I want it." "She [friend] betrayed me." "He [someone she just began to date] betrayed me." "I'm the vice president of the board at church." "It was important for me to decide when the cat would go. I took time to find a home for her." "Rev. Kathleen is very important to me." "It's not, 'all I have left,' but rather, what she gave me. I *have* the memories and the relationship. It's different now, but I still have what she gave me." (Unsaid, but perhaps implied: "I can trust you [therapist].")
Self-Images	"I can't live on my own." "I'm afraid to be alone." "I know I need to go through this." "I have a very serious comfort zone." "I can't express my feelings." "I'm afraid to be in charge of the church board now that William [the president] passed away."	"I wasn't as controlled and rigid." "It was important for me to put up the camping tent by myself." "It's still hard, but getting easier to talk." "I'm pushing people away." "I couldn't believe I was at a 'church' party, and there was no drinking or smoking. I was glad, but I couldn't believe it. There was a time when that's all I would do is smoke and drink." "I applied for a new job, one more in line with what I want in the future."

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Debbie: Worldviews. Because Debbie's worldviews are so intimately connected with her spiritual ones, the two seem to blend. In nearly each session, Debbie expressed the view that "things happen for a reason" and that "this is God's way." "I must be patient and appreciate that there is a purpose here for me and what I need to learn for the future." Debbie kept this perspective throughout the treatment. I suspect that Debbie did not give voice to her other perceptions of the world -- a world that first denied her of her father, molested her by a half-brother, and than robbed her of her mother at a relatively early age. If I could extrapolate Debbie's worldviews from the 12 weeks in treatment, I would surmise that she harbored a significant degree of resentment towards an abandoning, betraying and untrusting world that disappointed, tricked and deserted her at many turns of her development in her 39 years, "shortened" further by 10 years of substance abuse.

Debbie: Role-Relationships. Debbie experienced the re-emergence of dormant role-relationships as a consequence of the death of her mother. Prior to the loss, she experienced the comfort of a loving and supportive relationship with her mother: "She was my best-friend. I always cried on mom's shoulder." Even though her mother was religious and did not "approve" of Debbie's lesbian lifestyle, she "supported" it by attending the wedding, including Debbie's partner in family functions and asking about the relationship. After the death however, Debbie reported an acute sense of "loneliness and emptiness" that made her feel isolated in the world. Never having had a relationship with her father, Debbie claimed that she felt abandoned and alone. In fact, Debbie measured time by her mother declaring that "every date is in relation to mom's death." Debbie

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longed for the support of her mother during her recent break-up. "I was counting on having her [mom] around. Here I am all by myself and I cannot call my mother." Debbie did not express disappointment with her mother as a parent despite inquiries to that end.

Debbie's relationship with her mother symbolized a self-validation of Debbie as a spiritual person. "I would have loved for her to see me ordained" she professed. Her mother's absence stole the reality of Debbie's life changes. "I wanted her to see all my accomplishments -- college, bible school. And I wish she could have seen her [future] grandkids" and later she stated, "It feels like a part of me is missing."

Toward the end of treatment, Debbie used less therapy time to discuss her mother's death. When asked about this, Debbie admitted that she felt less concerned with it, "there are other things to think about." She became less concerned with her loneliness, and more interested in building connections and support systems with new social circles. The pursuit of self-sufficiency *in* relationship may have been symbolic of Debbie's desire to reconcile her sense of neediness with her new "orphan" status; in the wake of her grief. Debbie strove to abandon her childhood and assume the perspective of a grown woman.

Debbie: Self-Images. Perhaps always mildly conscious of her fear of being on her own, Debbie tested her ability to be independent after the death of her mother. She moved out of her hometown and began a spiritual journey that resulted in the termination of her relationship with her partner the same week as the second year anniversary of her mother's death. When she chose a new living arrangement that disallowed pets, she was forced to give up the cat "which had been with me through my mom's illness." After this, she described having great difficulty sleeping in her bed alone. "I decided to put up my

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camping tent in the backyard and slept there the last two nights. It was a challenge to put it up by myself. It was hard to do and kept on falling down but I needed to do it by myself... When I brought the cat to the shelter, I felt like I was doing it by my will because I chose when to do it and where to take Claudia. But it was also not by my will because I knew she had to go." Debbie's decision to put up her tent after giving up her cat may have represented her decision to overcome a pre-morbid self-image as needy or incompetent with a desired self-image as strong and independent.

In summary, each of the women evidenced a conflict between how they would like to envision themselves, and qualities that were magnified as a result of the loss. Debbie and Toby struggled primarily with issues around independence and self-sufficiency, perhaps also a way to deny pain and hurt (i.e., "I don't need you"). Since Debbie was African-American, lesbian and Christian, she might have discussed the impact of these roles spontaneously, but did not. Even upon direct inquiry about recent changes in her spirituality and sexual orientation, Debbie only stated, "It's been hard" but did not elaborate. She may have benefitted from further exploration of the reasons for her decision to change her sexual orientation, and the emotional impact of this decision. It could be important to establish that this was indeed a personal choice, as opposed to just a response to negative societal attitudes and pressure from family, church and community. Other possible contributing factors to this decision could have been a wish to please her deceased mother, or feelings of guilt or shame for separating herself from her family in this way.

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Although less effectively accomplished, Judy's challenge was to work through a mixture of emotions directed toward her deceased mother. Because of child abuse issues, her feelings toward her mother were intimately tied to the assaultive, childhood messages she had internalized. Overall, Debbie and Toby were more successful than Judy at expressing and resolving some of the discrepancies between their pre- and post-treatment schemas.

2. Avoidance and Intrusion

Horowitz suggests that both normal and pathological grief involves switching between avoidant and intrusive phases. The intrusion state is described by unbidden ideas, "rushes" of feeling and compulsive actions; the avoidant state by refusal to face the trigger event, the forgetting of important issues, and emotional experiences described as "numbing, withdrawal and constriction" (Horowitz, 1986, p. 242). Per Horowitz's theory, alternating from one state to another is adaptive and helps clients modulate their grief. Abnormal denial is extreme avoidance that may be facilitated by substance abuse or thrill-seeking behavior. The intrusive phase may also reach pathological levels, resulting in hypervigilance, startle reactions, illusions and flooding. The content of these images varies and changes over time.

Each of the three women seen in therapy were highly skilled at avoidant behavior. In therapy, they used subtle and overt techniques to avoid painful subject matter, including smiling and laughter, switching the topic, answering different questions than the ones asked, and waiting until the last five minutes of session to bring up an important piece of information. Outside of treatment, the three patients reported employing a variety of

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methods to manage intense emotion; Toby described dissociative states and vegetative symptoms of over two years duration; Judy was beginning yet another marital affair; and Debbie began a very close friendship with an older and spiritual woman approximately the age of her deceased mother, a woman who had lost her own adult children several years earlier. In addition to avoidance, these three patients also reported moments of extreme intrusion, especially as therapy progressed. At first, methods of avoidance were promptly employed to manage these unbidden images; later in therapy, the patients allowed these distressful memories to remain in their thoughts for a slightly extended period of time, and discussed these experiences in treatment. The specific avoidant and intrusive phases of each of the three women is discussed below.

Toby reported overt symptoms of intrusion. She described her intrusive states as "Panic. Frozen. I'm stuck in thought. I'm tense in the face, eyes, lips, shaking and my eyes twitch." She also had nightmares about her baby, mother and boyfriend where she was trapped in the hospital where Brian died. During flashback episodes, Toby reported going to the child's bedroom and finding him missing. She replayed these events in her mind. During one session's review of Brian's baby pictures, Toby admitted she had images of going to the graveyard and "digging him up. I want to be close to him again. I expect to see him at the cemetery."

Toby's clinical picture seemed to best resemble Horowitz's description of pathological grief: "overwhelmed, panic, exhaustion, suicide, drugs, flooded states, frozen states, psychosomatic responses" (Horowitz & Kaltreider, 1980, p. 164), a list of symptoms that also resembles PTSD or Acute Stress Disorder. Her symptoms had

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continued even after two and a half years; she had kept herself house-bound for much of this time, rarely leaving except to buy groceries; and her description of warding off techniques exposed a severity of discomfort. Although her substance abuse lessened over time, she smoked pot almost daily as a sleep aid at bedtime. She avoided visits to the grave and thoughts about "it" by turning on the TV or doing "nothing at all, freezing my mind." She felt withdrawn, isolated, and tired much of the time. She claimed she would "gloss over it, hold my breath" and typically "keep things inside." She reported being embarrassed to cry, to "pour myself out." She developed some physical symptoms that she connected with the trauma including hives, acne, migraines and a "sick feeling." In addition, her responses to my invitations to discuss her abortion during treatment were superficial at best; she stated, "it's not like I can feel it kicking or anything. I feel good about the decision." Because of the symptoms of PTSD (nightmares, flashbacks, arousal), marijuana use and the length of time of her bereavement (2.5 years), Toby's intrusion and denial phases largely fit the pathological response to grief.

Judy was also skilled at avoiding conversation about her deceased mother. In dress, conversation style, and content, she hid her emotions. Colorful, matching, organized and bejeweled, her style of dress betrayed her true sadness. She laughed regularly and was rarely was able to match her affective presentation with the content of her talk, and even upon invitation, avoided exploring the implications of the death of an unprotective parent. She also failed to return some of the initial intake forms for the first three weeks of treatment. When asked about this, she stated, "Oh, it's the same old stuff, comprehensive. I've had to fill out so many of those forms, social security number, etc.

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It's an invasion of privacy." When asked if she knew where the papers were, she stated, "Not really. I'd have to think about it. I probably hid them somewhere. Out-of-sight, out-of-mind." As is the case in this example, Judy was unable to state her feelings toward me assertively for asking her to complete these forms. She could not or chose not to articulate the real reason for not wanting to fill out the papers. It is possible that she feared that they would cause her to think about her loss, or maybe she wanted to challenge my "control." This behavior reflects her basic deficits in insight and self-observation, and ultimately, her use of avoidance and passive-aggressive behaviors as primary defense mechanisms.

Judy only attended six sessions, and then missed her seventh session. Judy did not return the phone call about this missed session. Thus, one additional way in which she may have avoided thinking about her grief was through terminating treatment. She also avoided an honest and assertive discussion about the treatment, possible dissatisfactions, or other concerns, by not discussing her decision with the therapist. When the seventh session was scheduled, Judy reported that her father had died just recently; this loss and the feelings it triggered may also have contributed to her decision to discontinue treatment.

In the past and present, Judy escaped her feelings through numerous extramarital liaisons. In treatment, she smiled gleefully when she mentioned a current individual with whom she had a mutually, flirtatious relationship. Embarrassed by her long history of adultery, she admitted during one session, "I wasn't going to bring this up!" This policy of "not bringing this up" really guided much of Judy's work in treatment and obstructed

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any real progress. Judy gauged her presentation to a degree that restricted an honest exploration of meaningful topics. She declared, "I'm taking stock of how I was sounding [about relationship history]." In one session, she entered, sat down, and began to describe the emotional affairs of three of her friends. When asked what this has to do with the loss of her mother, she stated, "Nothing." When further inquired as to why she wanted to talk about it today, she said, "I don't know." Her unwillingness to examine these issues and her other behaviors in session were evidence of just how fearful she was of broaching her feelings.

Despite efforts of avoidance, Judy reported that after each session, she had multiple nightmares with morbid and gruesome imagery. Smiling and theatrical, she eagerly described these to me at the start of the following sessions. When asked what they might mean, she never offered an interpretation. She also reported having dissociative experiences during the course of a week in which she would claim to "forget" where she placed certain items, such as the intake forms, her mother's belongings or childhood pictures. Because of her limited time in treatment (six sessions), not much change was evidenced in her intrusive and avoidant phases.

Debbie exhibited the clearest picture of normal grief as defined by Horowitz to include "fear, sadness, rage, refusing to face the memory, unbidden thoughts, facing the reality of what has happened, and going on with life" (Horowitz, Field & Classen, 1993, p. 770). Her intrusive phase was mostly experienced through feelings of longing for the emotional support of her mother. During the course of treatment, she broke up with her partner, abandoned a gay lifestyle and considered living alone. As she and her partner

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discussed the relationship coming to an end, Debbie wished her mother could be there to help her discuss her feelings. In these moments, she remembered her mother supporting her through the break-up of an earlier relationship. Debbie also wished her mother could be there to support this significant change in lifestyle, giving up a gay relationship and committing to pursuing a heterosexual one, as well as pursuing work in the ministry. In fact, her decision to make these changes may have been an effort to ally with her mother, who was both very spiritual and heterosexual. Debbie recollected how her mother had witnessed and supported her when she gave up drugs and alcohol and also her graduation from high school. As she made further steps in her spirituality, career and relationship, Debbie longed for the friendship and validation that she felt only her mother could provide.

Debbie's avoidant techniques came in more subtle forms. On the intake form, she did not fill out the part, "Why are you seeking psychological services at this time?" When asked why this was the case, she stated, "Because I don't like 'psychological services.' I'd prefer it to say 'Grief support.' I don't like to think I need psychology services." She admitted that therapy was uncomfortable because of its one-on-one nature. "I'm not use to having all the focus on me." Also, despite invitations for Debbie to explore her revised sexual orientation and her mother's strengths *and weaknesses*, she resisted. Her idealized view of her mother could be another way in which she avoided thinking about her mother's less than perfect qualities. And her superficial, in-session examination of her sexual orientation, or the process of her decision to "modify" it, could be another way in which she avoided certain topics.

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In session, she became teary-eyed on only one occasion. Early in treatment, she often waited until the *very* end of session to raise significant issues, such as the recent death of a close friend from church, her fear of moving out of the home she had with her ex-partner that afternoon, and the need to give up her cat because her new apartment disallowed pets. This behavior may have allowed her to contain her affect. She also tended to describe minute details of less important topics, such as the demands of her job, a camping trip with some friends, and the activities of her church's administrative office. Even more subtly, Debbie focused almost exclusively upon how there was "something to be learned" from this loss and how she is being "prepared," a perspective that she believed was related to her Christian faith. What might be considered healthy, that is, her focus on how this loss strengthened her as a person and future minister, could also be considered avoidant because of the acute absence of admitting in a genuine, emotional manner the real disadvantages of the premature death of her mother. Forever trying to project as strong and capable, Debbie often denied herself an honest reckoning of how her mother's death had some significant, negative repercussions for her personal growth and development.

In conclusion, all three women manifested evidence of avoidance and intrusion. Judy and Toby experienced nightmares and other PTSD symptoms. Debbie's intrusive phase was marked by deep longing and sadness. Each of the women also reported using methods of denial, including distraction, over-involvement in unhealthy relationships and substance abuse and dependence. Prior to treatment, Toby, Debbie and Judy experienced involuntary shifts between intrusive and avoidant phases that limited their ability to work through their feelings about the losses. Over the course of treatment, Debbie and Toby

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became much more comfortable with admitting and exploring their feelings, and demonstrated an increased willingness to be vulnerable with the therapist, as well as with friends and lovers. Although Judy's degree of change was limited, she also evidenced a mildly increased comfort with expressing her feelings without needing to promptly cover them with laughter and feigned ignorance.

3. Controls

Horowitz suggests that it is the client's ability to mobilize "control processes" that facilitates recovery from trauma. Ideally, one "doses" oneself with memories of the event at a tolerable rate enabling the approximate although idiosyncratic succession through the phases of grief: dying, death and outcry, intrusion and denial, working through and completion (Horowitz, 1986, p. 242). For example, survivors may allow themselves to recall a particularly compelling memory that evokes tears or sadness. After a couple minutes and moving into the denial phase, they may "forget" that image, and focus on caring for a pet or returning to work activities. In this way, patients move back and forth between the denial and intrusive phases at a pace that is optimal to recovery and functioning.

Controls differ from avoidance in that controls are constructive and intentionally employed to modulate affect. Examples of controls include: (a) distracting oneself from the memories, (b) placing the loss in the context of a lifetime, (c) being aware of one's ability to successfully control the emotion and invoking those abilities, (d) learning or even benefiting from the trauma, and (e) taking "one step at a time" (Horowitz, 1997, p. 102). Toby, Debbie and Judy employed each of these techniques and others to aid them through

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the intense affect triggered by the loss and by therapy. Debbie and Judy experienced more difficulty employing controls to modulate affect than Toby. For all three women, the purpose of the process-oriented treatment was to help them observe, identify and more consciously choose to utilize controls instead of unwittingly succumbing to denial and intrusion.

Approaching the second year anniversary of her mother's death, Debbie anticipated that this would be a difficult time for her and thus specifically chose to pursue therapy at this time. The anticipation of her feelings was a positive indicator of her interest and ability to work through her sadness and longing. In the beginning of treatment, moments of avoidance were identified by the therapist. Over the course of therapy, Debbie began to identify these moments as well. If she changed the topic or waited until the close of session to mention a concern, she noted it. Later in treatment, she considered in advance what was important for her to talk about, and identified when she was waiting until late in the session to raise significant issues.

Judy had greater difficulty with voluntary employment of defenses than did Debbie. Having guarded against intrusive images for decades, Judy acknowledged that the purpose of this treatment was to allow herself *to feel*. With the commencement of treatment, she began to have semi-regular nightmares in the immediate days following a session. Without invitation, she described these in the next session, but resisted any discussion of their meaning. The presence of these nightmares, which seemed out of her control, may be evidence of her difficulty with modulating her affect. Her methods of avoidance were so

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ingrained, Judy could not purposefully allow herself to consider her emotions except in her dreamlife.

Possibly the one way in which Judy sought to modulate her affect was through her intermittent mentions of her faith. She described her belief in "life forces. I'm not afraid of death. I believe in reincarnation and that in each life, we have something to learn. I have something to learn." This spirituality organized her understanding of her mother's passing; "She's in a better place" she reasoned. This increased sense of commitment to her belief system helped her to reconcile her feelings about still needing her mother with the reality of her death.

Because Toby's methods of avoidance made her feel "numb" and "frozen," they were maladaptive and prevented a more balanced "dosing" of her feelings. In the beginning of treatment, moments of avoidance were identified by the therapist to the patient. When she answered a question different than the one asked, the therapist inquired if she were aware of "what just happened." When she discussed how her mother continued to disappoint and hurt her brother, this too was pointed out by the therapist, and later, a possible explanation, such as she was avoiding her own feelings of deep hurt, was offered. When she plotted murderous fantasies toward her mother, the reason for this was explored, and the therapist proposed that aggression helped her defend against other feelings about her mother, specifically sadness and pain. Her awareness of this "avoidant" behavior happened gradually over the course of treatment. When the therapist identified these moments for her, Toby, at first, laughed. She seemed to recognize that she was being clever and avoidant. It was towards the second half of treatment that her tendency

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to employ these avoidant maneuvers almost vanished. She consciously chose to explore painful topics and allowed herself to cry more openly.

During therapy, Toby began to acknowledge some of the ways in which she denied her emotions outside of treatment. She considered that she was irritable and moody with her boyfriend instead of admitting that she was afraid he would leave her. She reckoned that her incessant self-debasing for needing to cry was a way to avoid the chronic feelings of inadequacy and defectiveness. To help her with this issue, she was encouraged to cry when she felt the impetus to do so, and to journal about the feelings that arose during those episodes. She did do this and reported that it was hard sometimes to identify her thoughts and feelings. Toward the end of treatment, Toby found relief in time spent with her brother and best-friend, increased activity with her boyfriend, gardening, errands, and paperwork related to her boyfriend's business. She stated that she still thought about Brian, but only intermittently. By addressing some of the more subtle ways in which she avoided issues surrounding the death of the baby, she became more conscious of her behavior. The identification of these moments in therapy also seemed to validate her experience of this event as traumatic and deeply troubling. Thereafter, the pressure which she felt to avoid them subsided, and it became easier for her to think about painful materials, and then comfort herself with more pleasant, distracting activities.

In summary, it was the process of observing, identifying and choosing to employ defenses that facilitated an increased sense of power over the loss. Growth was effected by this gradual change in which each of the women recognized how they were subtly and overtly managing their feelings. Possibly because Debbie and Toby were more willing to

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acknowledge these behaviors than was Judy, they reaped a greater confidence in their capacity to dose themselves with the affect triggered by the loss.

4. Themes

Horowitz discusses nine themes that commonly emerge during the course of therapy. These include: fear of repetition, fear of merger with victims, shame and rage over vulnerability, rage at the source, rage at those exempted, fear of loss of control of aggressive impulses, guilt and shame over aggressive impulses, guilt and shame over surviving, and sadness over losses (Horowitz, 1997, p. 17). Probably because of the nature of the illnesses associated with the losses of the three patients -- cancer and bacterial meningitis -- some themes, such as "sadness over losses" and "rage at the source" were more prevalent than others, such as "fear of merger with victims." In the case of loss attributable to murder or suicide, perhaps this latter theme and others would have emerged more often. Themes that centered around feelings of anger and guilt were most common; other than Horowitz's nine themes, no others emerged. Compared to the two women who lost their elderly mothers to cancer over the course of months, Toby rushed her infant child to the emergency room, the baby seized, and died within hours; Toby's was a sudden and tragic loss. While each of the women struggled with issues of anger, guilt and sadness, it was Toby who evidenced the greatest number of themes and in a more intense fashion.

The first theme, fear of repetition, not only entails the fear of a second loss by death, but also a fear of repetition of emotion and thought associated with the loss. All three women were afraid of losing another person in their life or re-experiencing some of

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the intense affect associated with the death they had recently experienced. They expressed hostility toward the prospect of crying again. "I can't cry. It's a short, unfulfilling process. Primitive, wailing, in the fetal position," declared Judy. Both Toby and Debbie admitted to crying and often said they were "tired" of crying.

Toby experienced the most compelling fear of repetition when she discovered over the course of treatment that she was pregnant again. "I'm afraid it [death] will happen again. Aborting would be easier." She talked about how she felt "unlucky" and that the fetus is a "tiny, defenseless baby." The fetus' due date was the day after Brian's birthday and she "hated that time of year." She continued, "I'm just not ready. We're both [her boyfriend] really scared." She claimed, "If I have this child, it will die. I just want my baby back, I don't want a new one."

Another common theme is "shame and rage over vulnerability" in which the survivor is confronted with the reality that they are less in control of life than they wished. When her mother was in the hospital, Judy invited a elderly priest to the room to pray with her dying mother. During that visit, the elderly man slipped in the hospital room and broke his hip. This fall triggered a sudden, downward spiral; he became ill and died with two weeks. Shortly after, Judy's close friend was killed in a freak car accident in his own driveway, and her step-son died of an alcohol overdose. Perhaps if her loss had been limited to the death of her elderly mother to cancer, Judy may have preserved her sense of control or predictability in the world. But these collective, random deaths created an overwhelming sense of powerlessness and disorientation in her emotional life. She reported feeling "powerless, uncontrolled" and expressed deep "fear over losing control

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[of herself]." It is possible that all of these losses played some role in the way she approached therapy and in her dropping out of treatment.

After the loss of her baby, Toby as well expressed concerns about life being "so unpredictable. If you open yourself up for something like that [love], you'll open yourself up for a world full of hurt." She questioned life, "What else do I really have to go through?" Debbie, however, did not experience the same sense of unpredictability and disorientation reported by the other two women. Perhaps because of her deep faith, or because of her defensive focus on how loss is "necessary for my personal and professional growth," she did not admit to feelings of vulnerability or powerlessness.

"Rage at the source" involves conscious or unconscious resentment, anger or hurt directed at the person(s) who are perceived as contributing to the loss, even if intellectually the survivor realizes they are not to blame. Debbie experienced a diffuse sense of frustration at the loss of her mother. She did not express overt rage or hostility, but would state instead, "I wish she were here," "I need her now in my life," and "I feel like just when I was getting to know her, she left." Judy, as well, could not clearly articulate her anger but did reveal her sadness. Having returned from Disneyland one weekend with her grown daughter, she shared a time when she had gone there with her mother in a wheelchair, not long before her death. When they left the park to head towards the car, she recollected crying with her mother and hugging, as if "knowing she'd never do it again." On more than one occasion, she taunted herself, "I should have done better keeping mother alive." In recalling her contribution to her mother's healthcare, she expressed resentment and agitation with herself for "failing" to be a better caretaker.

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Toby, however, expressed overt rage at the people she perceived as contributing to the death of her baby, including the hospital staff, her obstetrician-gynecologist, Medicare, the emergency room physicians, the nurses at her labor and her baby's death and primarily, herself. Toby recalled hearing a radio announcement of the death of the person who invented the vaccine for bacterial meningitis. She stated resentfully that she did not know a vaccine existed. This news triggered a rush of feelings around who was responsible for what she perceived to be the wrongful death of her child. She was angry with the staff for letting her go to the bathroom unsupervised after her water had broken, hours before the birth; she resented the physician for his failure to protect her child from this disease; she feared the laboratory might have mixed up Brian's bloodwork with someone else's causing the infant's diagnosis to go undetected; she hated the facility where she gave birth, the Medicare office she visited for prenatal care, and herself, for her inability to nurse which "might have supplied Brian with the necessary antibodies against meningitis." Toby's rage as well, was directed at the manner in which she had handled the loss. For each day that she remained paralyzed in her home, not working, not living, not pursuing any activities, it triggered a downpour of self-ridicule. "I'm not going to get over this. He [Brian] made me happy and he was stripped away. I can't handle this. I use to think I was strong and could handle things, but I can't take this. I can't."

Although Debbie and Judy did not express anger at other's good fortune, Toby did manifest evidence of the fifth theme, "rage at those exempted." Upon the death of her baby, her dormant rage at her own mother emerged. "I just don't understand. That woman never cared about her children, and she had three healthy ones. And all I wanted

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was to love my baby, and I couldn't even do that." In session, Toby described elaborate, murderous and vengeful fantasies of how she was going to ruin her mother's life, either by "just killing her" or by going to her job and "getting her fired." "I hate that woman," she announced sternly.

Related to the themes of "rage at the source" and "rage at those exempt" are two corollary themes: "guilt or shame over aggressive impulses" and "fear of loss of control of aggressive impulses." Only Judy and Toby struggled with these two issues. Proud of how she had handled herself in the face of her mother's physical and verbal abuse and overtly inappropriate behaviors, including stealing money and belongings from her as an adult, Toby was not afraid of her aggressive fantasies toward her mother. She confidently admitted to the things she would *like* to do to her mother but always inserted, "but I would never." On the one occasion in which she did see her mother, she related having spoken only in an assertive and mature fashion in which she expressed her needs and expectations, and delivered her mother to a homeless shelter for her own protection.

Although Judy did not blame her mother for her death, she was angry and hurt by the manner in which her mother treated her, especially in the final days when Judy cared for her by her bedside. According to Judy, even on her deathbed, her mother snarled, "God dammit [Judy], can't you do anything right?" Judy's reaction to the loss of her mother can be largely described as numb; she admitted that she was not sure if she was sad that her mother died or if she felt rightfully vindicated! In therapy, Judy indicated that after a session, she could rely upon having fitful sleep and nightmares. Smiling, she declared, "In fact, I'm angry at you for having the dreams!" Her dreams could be

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described as morbid and aggressive and often included significant figures such as her mother, father and different ex-lovers. This material was often intertwined with memories of herself as a child when she was in danger or terribly frightened. Although Judy did not genuinely fear that she was at risk for hurting anyone, there was a chronic level of aggressive imagery in the sessions and in her dreamlife which, in my estimation, exposed her possible guilt and shame over her mixed hostile and loving feelings toward a mother who did not protect her as a child and sabotaged her efforts as an adult. Thus, she may have been embarrassed or afraid of her aggressive fantasies toward her mother.

The eighth theme is "guilt and shame over surviving." While Toby experienced a wish to be dead like her daughter, she did not report experiencing guilt for living. Rather, the pain of existence without her child was "torture" and at times she comforted herself with the fantasy that she might have been spared this agony. Punishing herself may have been a way of expressing guilt; rather than acknowledging the guilt; she could have been acting it out by rejecting overtures from all her friends and family and hibernating at home for two and a half years.

Although Judy and Debbie did not openly admit to feeling guilty for surviving, Judy did report a sense of burden or pressure that may have connected to her feelings of guilt and shame, either for surviving or for feeling ambivalently towards her mother. "The guilt. It waxes and wanes. Something in me, belongs to something, and I just want it out." Although this quote seems cryptic, I understand that she refers to feeling overwhelmed or "weighed down" by something "so heavy." She explained that her mother had given her a plant and that recently, it had been on the verge of dying. Judy

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described an urgent sense of needing to prolong or revive the flowers and so she buried it in new soil, and "it came back and blossomed!" "She [mother] is such a presence" she added, "it's weird to have her gone." In this monologue, it was almost as if the plant had become her mother, and Judy described an obligation to help the plant survive. In this session, she also explained how her mother used to insult her ability to garden and state that she "couldn't do anything right." This passage, where the plant becomes intermingled with the life of her mother reflects her sense of duty toward her deceased parent. It is this sense of obligation that may have fueled the aggressive imagery in and out of Judy's dreamlife.

The final theme, "sadness over losses" was experienced by each of the women. Although each came to therapy for a specific loss, each spontaneously listed all the other recent losses in their lives, and often discussed additional losses of people, careers, friendships, lovers and ideals through the course of treatment. For example, Debbie described a variety of losses in the first session: "My mom died. My two aunties died afterwards as well. I'm breaking up with my girlfriend of two years, and I have no one to talk to about it. I am making sense of the loss of the gay and lesbian lifestyle. I'm giving up a lot." Over the course of treatment, Debbie experienced additional losses. A gentleman at her church passed away, and she was forced to give up her pet when she moved into a new apartment. She discussed the loss of certain dreams; such as the dream for her mother to see her through her pursuit of a career in ministry and of a heterosexual relationship.

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Judy as well reviewed each past and present loss. She acknowledged material, financial, physical health, familial, friendship and relationship losses including a dramatic change in her financial stability, her diagnosis of lupus, her voluntary career retirement, her husband's inability to have an erection (due to his physical health problems) and thus the loss of sexual intimacy with him, the death of several friends, the death of her 15-year-old cat, and the loss of her childhood which she hinted at upon review of pictures of herself as a child. Toby's most significant loss related to the recognition that she had been denied a loving mother. Although she could not articulate this loss in a clear fashion, her affective presentation changed when the subject was broached.

In summary, the themes of fear of merger with the victim and fear of loss of control of aggressive impulses were not experienced by any of the women. Four more themes were expressed by only one woman, including rage at the source, rage at those exempt, guilt and shame over aggressive impulses and guilt and shame over surviving. Shame and rage over vulnerability was expressed by two women. Two themes, fear of repetition and sadness over losses, were prevalent in all three of the women's treatment.

5. Therapeutic Relationship and Measures

Horowitz highlights the importance of the therapeutic relationship and its influence on the course of therapy. With a good therapeutic alliance, patients can be expected to show improvement on three issues in particular: (a) the patient should retain a sense of competence and self-worth, and gradually accept the changed circumstances without a sense of hopelessness or deep assault on the view of the future; (b) the patient should continue to pursue life activities such as maintaining relationships, developing new ones,

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and continuing in other hobbies and work; and ideally, (c) the patient should experience the trauma as an opportunity to learn and strengthen oneself (Horowitz & Kaltreider, 1980) after a successful negotiation of the earlier phases of grief, including shock, rage, resistance and sadness.

I enjoyed working with each of these three bereaved women. Even though more progress was made with some than with others, I really looked forward to the sessions; I enjoyed sitting with patients, hearing about their concerns, exploring the meaning and implications of the loss; and, I often felt positive and hopeful after each session and about future treatment. In this section, I explore the connection I felt with each of the three women and counter-transference issues. I also examine the potential relationship between working alliance and recovery for each of the three women. Results from the quantitative measures are included to reflect change over time. All normative means and standard deviations are listed in the third column of Table 10.

Debbie. Debbie sought treatment to help her express her feelings about the loss of her mother. As reported in Table 7, from pre- to post-treatment, she moved from a decile rank of three to one (scale range: 0 to 10) on a measure of somatic complaints (Wahler Physical Symptoms Inventory, WPSI: Wahler, 1983). On a measure of complicated grief (Inventory of Complicated Grief, ICG: Prigerson et al., 1995), she achieved a score of 38 at pre-test and 18 at post-test. Her pre-treatment scores suggests "significant impairment in social, general, mental and physical health functioning" (any score over 25 is considered significant). On a measure of intrusion and avoidance (Impact of Events Scale, IES: Horowitz et al., 1979), Debbie was higher on the subscale of avoidance (20) than intrusion

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(13); at post-test, each of these subscales were zero! On a scale that measures "how successful individuals are at coping with the aftermath of a trauma and in reconstructing or strengthening their perceptions of self and other" (Post-Traumatic Growth Inventory, PTGI: Tedeschi & Calhoun, 1996, p. 455), Debbie achieved a score of 55 at pre-test and 79 at post-test (possible range is 0 to 105) suggesting a moderate pre-test and high post-test level of coping.

Debbie's results on three of the four measures at follow-up did not vary much from those at post-treatment. On a measure of grief, her score increased by only one point (19). She received a decile rank of one at both post-treatment and follow-up on a measure of psychosomatic symptoms. On a measure of perceived benefits, Debbie's score shifted four points, but was still within one standard deviation of the normative samples. It was only on a measure of trauma that Debbie's results changed in a relevant manner: her total score went from zero at post-test to 14, her intrusion subscale from zero to 6, and her avoidance subscale, zero to 8. (These results are within one standard deviation of the healthy normative sample mean.) This change might suggest that she felt worse after terminating treatment, or she was being more honest with reporting her trauma symptoms at follow-up compared to post-treatment. This measure, in particular, may have been particularly difficult for Debbie to admit to a level of distress upon because as a measure of intrusive and avoidant symptoms, it pertains to one's sense of control. I believe this increase reflects a healthy change in that Debbie was able to admit to a minimal level of discomfort. In summary, and with the exception of the measure of trauma, Debbie demonstrated largely the same level of progress at follow-up as she did post-treatment.

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Table 7

Debbie: Outcome Measure Results

Construct	Measure	Time 1	Time 2	Time 3
Trauma Symptoms	Impact of Event Scale (IES) 1. intrusion 2. avoidance	33 13 20	0 0 0	14 6 8
Grief	Inventory of Complicated Grief (ICG)	38	18	19
Psychosomatic Symptoms	Wahler Physical Symptoms Inventory (WPSI)	3	1	1
Perceived Benefits	Post-Traumatic Growth Inventory (PTGI)	55	79	75

A higher score on the IES, ICG and WPSI indicates greater distress.

Based on results from the measures, session notes, supervisory discussions and the therapist's perception of the treatment, some conclusions can be drawn about the relationship between Debbie's progress in treatment and the therapeutic alliance. When Debbie's mother died, her difficulties were compounded by the fact that her mother was also one of her closest friends; she felt isolated in the world. Complicating her ability to deal adaptively with her sense of loss was her lack of awareness that she had few social supports or close friends. In the course of treatment, this became more apparent to her which helped her to understand why she continued to long for her mother's friendship and support two years after her death.

While I enjoyed working with Debbie, I also felt disconnected from her. I believe that this resulted from her lack of expressiveness in treatment. Her persona, which I perceived as stoic, reserved, polite and methodical, distanced me. I felt as if a deeper bond eluded us. I think I am the kind of person who is willing to be vulnerable, and may have withdrawn myself from her in response to what I perceived to be her austere facade; I was concerned by this counter-transference reaction and took steps in supervision to discuss the potential impact of my thoughts and feelings on treatment. I believe my efforts

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to bring her into the here-and-now were at times successful, and at others, stymied by her reticence to share her inner feelings, which she struggled to identify, nonetheless admit.

In considering the multiple factors that may have contributed to our strained therapeutic relationship, cultural issues must be considered. Greene (1994) discusses the unique challenges particular to White, heterosexual therapists working with gay men and lesbians who are members of ethnic minority groups. In addition to delineating an array of potential assumptions and counter-transference issues around sexual orientation, Greene expresses concern for the tendency of therapists of the dominant culture to over-pathologize an ethnic minority gay man or lesbian. Dominant culture therapists risk dismissing or minimizing the "anxiety-provoking nature of the coming-out process [for ethnic minority gay men and lesbians] and the tendency for such anxiety levels to result in the expression of behaviors or feelings that may resemble symptoms of severe psychopathology" (p. 249). For Black people in particular, the "African-American family and community has functioned as a necessary protective barrier and survival tool against the racism of the dominant culture" (p. 245). As an African-American lesbian who had only recently decided to "become heterosexual," Debbie may have been experiencing some unique challenges which I either overlooked or misunderstood.

Other factors may also have contributed to my lack of connectedness with Debbie. It was not until five minutes before the close of the eleventh session, when she mentioned, in passing, that she was "molested by [her] brother." Not that a child history of sexual abuse explains what I experienced as her "detached" behavior, but it may have contributed to what Debbie identified herself, which is a general lack of trust in people. Also, she

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mentioned that she did not like that once I referred to her as a "patient" and resisted the language in the intake form that stated she was receiving "psychological services." She expressed concern about what other people might think about her, given that she was in therapy. Thus, part of her reserved nature in treatment may have been a product of her disliking her need for therapy.

Connected to her concern with being a "patient" may have been her concern with her perception of somehow being "less than." The power differential inherent in our roles, "patient" and "therapist," may have been disconcerting to her. Alternatively, her focus on the patient-therapist dynamic may have been a reflection of a much larger, racial issue. According to Westermeyer (1987), "Patients who have experienced racial, economic, political, or legal prejudice in the United States may have little reason to trust another representative of a native social institution" (p. 474). Thus, a contributing factor to the distance experienced in treatment may have resulted from our differing ethnicities. There has historically been a power differential between Blacks and Whites in America. This may lead some African-Americans to be more guarded around Caucasians or may increase their sensitivity to being stigmatized or put in a "one-down" position. Although I invited her to talk openly about this potential issue early on in treatment, she did not pursue the potential impact of the color of our skin. However, the history of African-American oppression may have played a role in our ability to connect with one another.

Furthermore, Debbie may have felt as if she were, in some sense, "betraying" her community by seeking mental health assistance with a Caucasian woman. Neal and Turner (1991) suggest that "at times of emotional distress, African-Americans are more likely to

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seek help from a general physician, minister or hospital emergency room... or the local community mental health center... than mental health professionals..." (p. 401). Debbie admitted that it was difficult enough for her to expose her deep emotional needs and sadnesses; it is possible that this "exposure" was made much more challenging as a consequence of my not being part of her African-American community. Neal and Turner continue, "African-Americans do seek help for mental health difficulties, but it is often sought from agencies and institutions located within the African-American community" (p. 408). A final thought that might have contributed to our difficulty connecting could have resulted from the peculiar and ironic nature of our therapist-patient dyad. Debbie "hired" me to help her and yet, it is historically uncommon for the African-American experience to include the hiring of Caucasians. Commonly, it is the reverse.

Despite my vague sense of therapeutic connection to her, I feel Debbie benefited from treatment. She reported feeling better as a result of treatment. She also met some of her goals; she followed through on her decision to end a relationship and began developing new friendships. She strove to challenge her ability to be independent and felt proud of her gestures toward this end, including moving out of the home she shared with her partner, giving up her cat, and joining some clubs that allowed her to meet new people. She emphasized that there was "something to be learned" from this loss. She believed that as a result of losing her mother, she would become a more compassionate minister, a more faithful person, and a more self-sufficient woman. Debbie retained her sense of self-worth, and also began the process of identifying, expressing and embracing some of her feelings which she had been in the habit of denying. Thus, Debbie evidenced

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improvement on all three features of progress including sense of self-worth, resumption of new and old activities, and the experience of positive outcomes as a result of the loss.

Judy. Of the three women, my rapport with Judy was possibly the least strong. She warded off affect in such a consistent manner that it prohibited a deeper exploration of the meaning of her loss, and also, a deeper therapeutic alliance. As was the case with Debbie, I had counter-transference feelings of frustration and disappointment with Judy's resistance or inability to discuss her feelings more openly. Judy attended only six sessions and dropped out of treatment without discussion or explanation. Table 8 denotes her results on the measures at pre-treatment. Although efforts were made to contact her after she dropped out, the patient was not asked to complete the forms for a second time because this was deemed to be inappropriate by the researcher/therapist.

At pre-treatment, Judy reported a high degree of physical symptoms scoring a decile of nine on the WPSI; these symptoms may have been elevated as a result of her lupus and fibromyalgia. On a measure of complicated grief, she scored on the cusp of significance at 25. She achieved a higher score on a subscale of avoidance (30) than on intrusion (19) on a measure of traumatic symptoms. And on a scale that assessed her ability to cope, grow and learn from the trauma, she achieved a moderately high and positive score of 75 (range 0 to 105). This results seems inappropriately elevated given her level of reported distress; her "highly" optimistic view as indicated by this score could be further evidence of her lack of insight or denial of her problems. Post-treatment and follow-up scores were not available because the patient did not complete treatment.

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Table 8

Judy: Outcome Measure Results

Construct	Measure	Time 1	Time 2	Time 3
Trauma Symptoms	Impact of Event Scale (IES) 1. intrusion 2. avoidance	49 19 30	-	-
Grief	Inventory of Complicated Grief (ICG)	25	-	
Psychosomatic Symptoms	Wahler Physical Symptoms Inventory (WPSI)	9	-	-
Perceived Benefits	Post-Traumatic Growth Inventory (PTGI)	75	-	-

"-" Time 2 and 3 data were not available because patient dropped out of treatment. A higher score on the IES, ICG and WPSI indicates greater distress.

Probably for many reasons, including our weak connection and the patient's histrionic features, lack of insight, and severe childhood abuse, Judy did not appear to experience a tremendous amount of change over the course of treatment. She could not meaningfully examine her feelings of ambivalence or hurt. She wavered between knowing that her parents were cruel and simultaneously feeling responsible for her mother's death. The only new activity she pursued over the course of treatment was a steadily growing closeness with a new man. She did not discuss how another affair might have prevented her from addressing the fact that she was in an unfulfilling marriage with a man she did not love. Because she did not explore how her mother's death bothered her, it was difficult for her to elaborate how she might have "benefited" or grown from the event. Overall, a lack of awareness obstructed Judy's ability to realize therapeutic change.

Toby. I experienced the closest alliance with Toby. In treatment, she seemed genuine in her struggle to reconcile her feelings of grief. She was deeply labile, and then suddenly withdrawn and angry. She laughed at herself when she felt too overwhelmed and described "freezing over" and "going away in my mind" when she felt sickened by the

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death of her baby. She was six months younger than I, and I felt as if I could understand what it was like for her to lose the single most important person in her life.

From pre- to post-treatment, Toby's WPSI score went from a decile of nine to a decile of eight. On a measure of complicated grief, her score decreased from 34 at pre-treatment to 31 post-treatment; both scores (above 25) indicate that she was "significantly more impaired in all areas of functioning." Clinically, I think I may have underrated her level of pre-treatment intrusion (29) which was higher than her avoidance (20) on a measure of trauma symptoms. Toby's intrusion decreased to 18 and avoidance increased to 24 at post-treatment. Although she did not verbalize this in treatment, Toby's ability to assess positive outcomes as a result of the traumatic event was reflected in her increased (positive or beneficial) scores on the PTGI, from 27 to 35.

At follow-up, Toby evidenced positive growth on all four measures. The most significant gains were made on a measure of trauma symptoms. On the intrusion subscale, her score decreased to 5 and avoidance subscale to 1. Although still significantly elevated at 28, her result on a measure of grief was three points below her post- and six points below her pre-treatment scores. With a decile rank of 7 on a measure of physical symptoms, Toby maintained her trend in the direction of fewer physical problems. And finally, on a measure of one's ability to "cope with the aftermath of trauma and reconstruct or strengthen their perceptions of self, others and the meaning of the events" (PTGI: Tedeschi & Calhoun, 1996, p. 455), Toby demonstrated a more healthy outlook at 49.

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In Table 9, Toby's results on the outcome measures are reported. Toby distinguished herself from Judy by attending all 12 sessions *and* from Debbie, by showing greater consistency in results across time. Overall, Toby improved on all four measures.

Table 9

Toby: Outcome Measure Results

Construct	Measure	Time 1	Time 2	Time 3
Trauma Symptoms	Impact of Event Scale (IES) 1. intrusion 2. avoidance	49 29 20	42 18 24	6 5 1
Grief	Inventory of Complicated Grief (ICG)	34	31	28
Psychosomatic Symptoms	Wahler Physical Symptoms Inventory (WPSI)	9	8	7
Perceived Benefits	Post-Traumatic Growth Inventory (PTGI)	27	35	49

A higher score on the IES, ICG and WPSI indicates greater distress.

Over the course of treatment, Toby may not have dramatically increased her sense of self-worth, but she was able to acknowledge how much she harbored hurt and self-rejection as a result of her mother's mistreatment of her. This was a significant challenge for her since she had steadfastly repressed and resisted such a possibility for so many years. Acknowledging this was particularly important since it was so intimately related to her grief over the baby.

On the second criteria of progress, resumption of activity, Toby made significant change. I was very encouraged by her increased level of activity; she reported gardening, running errands, going out with her partner, and spending time with more family members. She even admitted "sometimes I don't feel like it, but I make myself do it anyway." This was important progress since her exhaustion and states of intrusion had paralyzed her at home for the 28 months prior to treatment. It was also promising that she was helping her

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boyfriend with his business by performing some paperwork out of their home, and also, she had initiated plans to return to college in the fall.

On the third criteria of progress, an ability to grow and learn from the event, Toby reported at follow-up on the PTGI that she felt "less self-reliant" and less confident that "she could handle difficulties." Given Toby's pre-treatment insistence on being self-sufficient and berating herself for ever needing someone, her admittance that she *does* in fact need people *is* progress for her! She also reported on this self-report measure that she "felt closer to others," "had greater compassion for others," "put more effort into relationships," "felt she was more likely to try to change things which needed changing," "discovered she was stronger than she thought" and "learned a great deal about how wonderful people are." These results are indicators of the positive change Toby experienced over the 12 weeks of treatment. These results also strongly suggest that she probably would have continued to benefit, according to the measures, if I had administered them in our continued treatment.

Unlike Debbie and Judy, for whom I identified a negative counter-transference reaction, I experienced a positive counter-transference reaction with Toby. I felt frustrated with Debbie and Judy's lack of authenticity. I am aware that in my own family of origin, superficiality or "acting" upsets me. My personal history may have caused me to withdraw emotionally from these two clients in subtle ways, and therefore, contributed to what I perceived as their hesitance in treatment. In Toby's case, it was the interaction of her ability to *struggle* with her feelings and *my wish* for her to wrestle with them that attracted, challenged and rewarded me. Whereas I described Debbie as "stoic, polite and

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reserved" and Judy as "superficial" and "histrionic," I used words such as "struggled," "fought," and "wrestled" to describe my impression of Toby in therapy. Those active verbs enlivened me during the course of treatment and consequently, may have played a substantial role in our work together. In summary, my counter-transference feelings probably interacted with these women's experiences and influenced their decisions around therapy, including cooperation with prompt completion of the pre-treatment measures, in-session avoidance, and length of treatment.

6. Overall Sample Comparison

In order to facilitate a comparison of patients' relative improvement, Table 10 delineates patient scores and the normative mean and standard deviations (SD) for each measure. Since all three patients were female, means and SD's for female populations are listed if available. In the remainder of this section, these questions will be explored: (a) Which patient improved the most and least over time, and on what measures? (b) Did any patient return to normative levels for clinical or non-clinical samples? (c) Did quantitative scores match the clinical impressions, and what are possible reasons for the differences?

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Table 10

Sample and Normative Results

Construct	Measure/ Range	Norms/ Mean & SD	Debbie			Judy			Toby		
			T1	T2	T3	T1	T2	T3	T1	T2	T3
Trauma Symptoms	Impact of Event Scale (IES) {0, 75} intrusion {0, 35} avoidance {0, 40}	female students: intrusion=6.1 avoidance=12.7 female patients: intrusion=21.0 avoidance=42.1 (SD's not reported)	33 13 20	0 0 0	14 6 8	49 19 30	-	-	49 29 20	42 18 24	6 5 1
Grief	Inventory of Complicated Grief (ICG) {0, 76}	healthy participants =15.25, SD=8.50; bereaved=17.74, SD=12.42	38	18	19	25	-	-	34	31	28
Psycho-somatic Symptoms	Wahler Physical Symptom Inventory (WPSI) {decile range: 0, 9}	female college students=5; female psychiatric outpatients=5; (SD's not reported)	3	1	1	9	-	-	9	8	7
Perceived Benefits	Post-Traumatic Growth Inventory (PTGI) {0,105}	female college students=75.18, SD=21.24; trauma college students=83.16, SD=20.47	55	79	75	75	-	-	27	35	49

"-" Time 2 and 3 data were not available because patient dropped out of treatment. "T1" Time 1, "T2" Time 2, "T3" Time 3. A higher score on the IES, ICG and WPSI indicates greater distress.

(a) Patient-to-Patient Comparison. At pre-treatment, Toby presented as the least healthy compared to Debbie and Judy. Toby's scores demonstrated the fewest perceived benefits, a level of trauma symptoms and somatic complaints as high as Judy, and a degree of grief almost as high as Debbie. Although elevated on different scales, Debbie and Judy's pre-treatment level of functioning was similar. Debbie reported fewer somatic complaints, but Judy's level of perceived benefits was the highest of the three patients. Debbie's overall amount of trauma symptoms was lower than Judy's, but her level of grief surpassed both Judy and Toby. It is noteworthy that Judy reported the greatest level of

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avoidance and Toby, the greatest level of intrusion on the trauma symptom subscales at pre-test.

Although post-treatment results were not available for Judy, both Debbie and Toby demonstrated beneficial improvements at post-treatment across all measures. Given their different pre-treatment scores, Debbie and Toby improved similarly on measures of psychosomatic symptoms and coping over time. However, Debbie made more gains than Toby at follow-up on a measure of grief.

It is noteworthy that Debbie reported zeros at post-treatment on the measure of trauma symptoms. Compared to her pre-treatment results, this dramatic change is questionable and may be a product of Debbie's wish to be asymptomatic. Although follow-up results were not available for Judy, Toby made significant gains. In fact, Toby's symptoms of trauma lessened considerably. The large changes Debbie and Toby made on this measure of trauma over time are compelling, and may speak to the virtues of Horowitz's stress response syndromes approach. The treatment model aided these two women in the reduction of intrusive images, flashbacks and nightmares, and decreased their need to avoid cathected stimuli associated with the death.

(b) Normative Data. In Table 10, the normative data for clinical and non-clinical samples are listed. On the Impact of Event Scale, a measure of trauma symptoms, the normative data for female students and female patients are delineated for each of the intrusion and avoidance subscales. All three women's pre-test scores were above the normative mean. Although Debbie's avoidance and intrusion scores decreased below clinical and non-clinical normative means at post-test, Toby's remained elevated at levels

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comparable to patient levels. At follow-up, Debbie's trauma scores were similar to those attained by healthy students and Toby's were below. Although Toby's course of recovery from intrusive and avoidant phases required more time, both Debbie and Toby attained levels of trauma symptoms similar to a healthy, female student sample, over time.

On the Inventory of Complicated Grief (ICG), a measure of grief, normative means and SD's are listed in the third column of Table 10. Healthy and bereaved participants' mean scores differed by only two points, although the SD for the bereaved normative sample was greater than the healthy sample. At pre-test, Debbie and Judy's scores were above the normative means, while Judy's lied on the cusp of significance (25). Although Debbie's post-test ICG score was within one SD (+0.32) above the healthy normative mean score, Toby's post-test score was greater than one SD above the healthy normative sample and the bereaved normative sample means (+1.85 & +1.06 respectively). Debbie's follow-up score was within one SD above the mean; Toby's was greater than one SD (+1.50) above the healthy normative sample mean and less than one SD (-0.82) from the bereaved normative sample mean.

On the Wahler Physical Symptoms Inventory, a measure of psychosomatic complaints, raw scores are converted to decile ranks. According to Table 10, female psychiatric outpatients and female college students' decile means are identical at a decile rank of five. At pre-test, Judy and Toby's scores were above the normative mean (decile rank, 9 for both) and Debbie's (decile rank, 3), below. At post-treatment, Debbie's score dropped further (decile rank, 1) below the normative means and remained there at follow-

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up. Toby, however, achieved decile scores above the mean at post-test (decile, 8) and follow-up (decile, 7), indicating an elevated level of psychosomatic difficulties.

On the Post-Traumatic Growth Inventory (PTGI), a measure of perceived benefits, means and SD's are reported for two normative samples: female college students and college students who had experienced traumas. The PTGI means for the clinical and non-clinical normative samples were close and the SD's for the two normative groups nearly identical. At post-test and follow-up, Debbie's PTGI scores were within one SD above the means for normative clinical and non-clinical samples. Toby, however, was closer to two SD's (+1.89 & +2.35 respectively) above the mean of the non-clinical and clinical normative samples. At follow-up, Toby was greater than one SD (+1.23 & +1.66 respectively) from the mean of the two normative samples.

In summary, on the Impact of Event Scale, a measure of trauma symptoms, Debbie and Toby attained levels of trauma symptoms similar to a healthy, female student sample over time. On the ICG, a measure of complicated grief, Debbie reached a non-clinical normative level at post-treatment and follow-up, and Toby, a clinical normative level at follow-up. Although both Debbie and Toby's score decreased over time on a measure of physical symptoms, the WPSI, Debbie was below the mean for the normative groups and Toby remained several decile points above the mean even at follow-up. On the fourth measure, the PTGI, a measure of perceived benefits, Debbie attained normative levels by post-treatment and retained them at follow-up. Toby remained greater than one SD from the norm even at follow-up. Post-treatment and follow-up results were not available because the patient dropped out of treatment.

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(c) Quantitative vs. Qualitative Results. In comparing the treatment outcome measure results with the qualitative discussion, several conclusions can be drawn. The measures simultaneously support some of my clinical impressions, and refute others. For example, although I reported that all three women exhibited a high degree of avoidant behavior, they each attained pre-treatment avoidance means (20, 20, 30) on a measure of trauma symptoms below the clinical normative sample mean (42) (SD's were not reported). My overemphasis of their avoidant behaviors could be a result of my tendency to expect more of patients than they may be capable of at that time, or at all. I tend to be the kind of person who eagerly shares personal information, and sometimes may unfairly hope for this kind of communication from others.

Judy's pre-treatment intrusion subscale score (19) was only two points from the mean (21) for the female patient normative sample, and yet, I believe I may have underestimated this in planning her treatment. Perhaps it was the interaction of Judy's superficiality with my lack of awareness of her distress that contributed to her decision to discontinue treatment. Her history of physical, sexual and emotional trauma, lack of insight, fear of *feeling* and consistently avoidant behaviors in combination with my potential insensitivity to her experiences may have created a difficult environment for us to make authentic contact. However, the fact that she did diligently schedule and keep the first six sessions, may reflect some degree of connection. Ironically, it was during her short time in treatment that I *did* experience some very troublesome "intrusive images" of a movie I had watched years ago. I believe that my unconscious retrieval of those images was my mind's way of helping me to better empathize with Judy's experience in therapy.

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Results from the other three measures are mostly concordant with my clinical interpretations. For example, Toby and Judy reported being plagued by psychosomatic complaints through their measures and directly in treatment. Judy contributed her physical health problems to her fibromyalgia and lupus; Toby believed she reacted to emotional stress with outbreaks of hives, acne and migraine headaches. Their results on the WPSI, a measure of physical symptoms, reflect their reports and my understanding of them.

It is noteworthy that Toby had the lowest pre-treatment score (27) on a measure of perceived benefits, the PTGI, compared to Debbie (55) and Judy (75). This is concordant with my clinical impressions, which were that Toby was most aware of her depressed outlook. Both Judy and Debbie appeared to hide their true level of despondency, and thus may have made greater efforts to "act positive" on the PTGI at pre-test than did Toby. Toby and Debbie's improvements on this measure of perceived benefits are also commensurate with my clinical impressions, which were that they were both becoming stronger and more confidant as treatment progressed, and consequently, feeling more capable of handling their distress.

The results from the ICG, a measure of grief, are largely congruous with my view of the patients' level of grief. Over the course of treatment, I noted to Debbie that she spent less time in session talking about her mother. After some discussion, it was clear that this loss was less of a focus than it was earlier in treatment when she was anticipating the anniversary of her mother's death, mother's day, and her birthday (also the day before the anniversary of her mother's death). To reflect this diminished emphasis, Debbie's level

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of reported complicated grief decreased by 20 points from pre- to post-treatment, thus placing her within one SD above the non-clinical normative sample.

On the IES, a measure of trauma symptoms, I believe Debbie's self-report was purposefully misleading when the scores mysteriously dropped from 33 at pre-treatment to zero at post-treatment. Debbie continued to exhibit avoidant behaviors, although to a lesser degree, until the close of treatment. This clinical impression was *incongruent* with her post-treatment results. I think the reason for the discrepancy between my interpretation and the scores is demonstrative of my view of Debbie in therapy. I suggested that this woman is avoidant and detached; I experienced her as unavailable and talked about feeling as if "a bond eluded us" earlier in this paper. I believe Debbie's scoring of this 15-item measure with 15 zero's ("not at all") is testimony to her disconnection from her feelings and her tendency to minimize problems. It may also be a product of her desire to believe she is "in control" and not in need of "psychological services." A further explanation of this dramatic change of scores could be that she wanted to please me or spite me! Offering all "zeros" to this scale could be a form of rebellion against the measures, and my demands of her to talk about her feelings in general. Most likely, these low scores signify Debbie's lack of insight into her feelings and her overriding desire to be psychologically "healed."

The apparent "healthy" increase of Debbie's scores at follow-up on this same measure of trauma are interesting as well. Although I believe she underestimated her post-treatment functioning, it is possible that her score was an accurate depiction of her functioning, and thus, perhaps her follow-up results are also true. In this scenario, it is

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conceivable that Debbie's level of trauma symptoms increased during the six week period without treatment. More likely, her willingness to acknowledge the presence of her intrusive and avoidant symptoms at follow-up reflects her growing ability to admit to psychological pain. Furthermore, her ability to acknowledge a low level of pathology may have resulted from a positive therapeutic alliance and from her work in therapy in which she felt validated to have such feelings. Thus, treatment may in fact have aided her with her original treatment goal, which was to "identify and express feelings."

In conclusion, my qualitative interpretations did not align with the quantitative outcomes on the subscale of a measure of trauma symptoms at pre-test. I also underestimated Judy's degree of intrusion on the same measure at pre-test. I was surprised at the level of improvement of two patients on a measure of trauma at successive testings. My clinical impressions of the patients in session were more congruous with the results on the measures of grief, physical complaints and perceived benefits at all three assessment times. Interpretations were limited by the lack of post-treatment and follow-up data for one patient. Furthermore, results may have been subject to biases of social desirability, since patients returned measures to the therapist/investigator, and to halo effects, since patients may have wished to believe themselves improved.

Summary

In summary, the purpose of Chapter III was to discuss the applicability of theory and research to applied work. In particular, Horowitz's theory and treatment model of stress response syndromes was reviewed in relation to three bereaved women who were experiencing acute distress as a result of loss by death. The theoretical tenets of

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Horowitz's research, including the concepts of "controls," "intrusion and avoidance," and "themes" were evidenced by the psychotherapy patients over the course of Horowitz's 12-session treatment model. The discussion that composed Chapter III demonstrated the mutual applicability of applied work to theory and research, as well as theory and research to patients.

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Adult Bereavement:

A Critical Review of Theories and Treatment Outcome Studies

An Abstract of a Psy.D. Clinical Dissertation

Presented to the Faculty of the

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In Partial Fulfillment of

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1999

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Melanie A. Greenberg, Ph.D., Chairperson

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Appendix A. Abstract

ABSTRACT

Adult bereavement is a major negative life event with potentially serious physical and mental health consequences. The purpose of this paper was to review the value of psychotherapy for bereaved adult populations. In Chapter I, controlled and uncontrolled treatment outcome research on adult loss was reviewed. In Chapter II, the 18 controlled studies found in the literature up to April 1999 were put into table format. The tables included information on each article's sample, method, measures, assessment times, design and results. Discussion questions guided the analysis of the table data. The relationships between the following issues and outcomes were explored: (a) type of intervention, (b) risk level, (c) recency of loss, (d) length of treatment, (e) patient or non-patient status of participants, (f) clinician qualifications, (g) theory guiding treatment, (h) self-help vs. theoretically-driven studies, (i) treatment efficacy as defined by Chambless and Hollon (1998), (j) use of measures directly related to the theory employed, (k) adherence to Foa and Meadows' (1997) "gold standards," and (l) areas for improvement in future research. The findings suggest that length of treatment, type of participants and theoretical framework are not critical variables in the treatment of grief. However, clinician-led, cognitive-behavioral and psychodynamic, individual psychotherapy are clinically indicated for high-risk participants who have been bereaved for more than one year.

Chapter III contains a discussion of a 12-session treatment based on Horowitz's stress response syndromes approach (Horowitz, 1997) conducted with three bereaved

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women. A brief sketch of each patient was offered as well as information on recruitment, assessment, procedures and supervision. Horowitz's approach was compared and contrasted with the course of psychotherapy with the clinical sample. Components of Horowitz's theory which were discussed included schemas, themes, phases of intrusion and avoidance, controls, and therapeutic rapport. Results from the four treatment outcome measures of grief, trauma, coping and psychosomatic complaints were reported. Chapter III explored how theory informed and was informed by clinical practice.

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Appendix B. Inventory of Complicated Grief

Please fill in the circle next to the answer which best describes how you feel right now:

1. I think about this person so much that it's hard for me to do the things that I normally do...
not at all rarely sometimes often always

2. Memories of the person who died upset me...
not at all rarely sometimes often always

3. I feel I cannot accept the death of the person who died...
not at all rarely sometimes often always

4. I feel myself longing for the person who died...
not at all rarely sometimes often always

5. I feel drawn to places and things associated with the person who died...
not at all rarely sometimes often always

6. I can't help feeling angry about her/his death...
not at all rarely sometimes often always

7. I feel disbelief over what happened...
not at all rarely sometimes often always

8. I feel stunned or dazed over what happened...
not at all rarely sometimes often always

9. Ever since she/he died, it is hard for me to trust people...
not at all rarely sometimes often always

10. Ever since she/he died, I feel as if I have lost the ability to care about other people or I feel distant from people I care about...
not at all rarely sometimes often always

11. I have pain in the same area of my body or have some of the same symptoms as the person who died...
not at all rarely sometimes often always

12. I go out of my way to avoid reminders of the person who died...
not at all rarely sometimes often always

13. I feel that life is empty without the person who died...
not at all rarely sometimes often always

14. I hear the voice of the person who died speak to me...
not at all rarely sometimes often always

15. I see the person who died stand before me...
not at all rarely sometimes often always

16. I feel that it is unfair that I should live when this person died...
not at all rarely sometimes often always

17. I feel bitter over this person's death...
not at all rarely sometimes often always

18. I feel envious of others who have not lost someone close...
not at all rarely sometimes often always

19. I feel lonely a great deal of the time ever since she/he died...
not at all rarely sometimes often always

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Appendix C. Impact of Event Scale

Below is a list of comments made by people after stressful life events. Please circle the answer which best describes how frequently these comments were true for you *DURING THE PAST SEVEN DAYS.* If they did not occur during that time, circle "not at all."

1. I thought about it when I didn't mean to.
   not at all rarely sometimes often

2. I avoided letting myself get upset when I thought about it or was reminded of it.
   not at all rarely sometimes often

3. I tried to remove it from memory.
   not at all rarely sometimes often

4. I had trouble falling asleep or staying asleep, because of pictures or thoughts about it that came into my mind.
   not at all rarely sometimes often

5. I had waves of strong feelings about it.
   not at all rarely sometimes often

6. I had dreams about it.
   not at all rarely sometimes often

7. I stayed away from reminders of it.
   not at all rarely sometimes often

8. I felt as if it hadn't happened or it wasn't real.
   not at all rarely sometimes often

9. I tried not to talk about it.
   not at all rarely sometimes often

10. Pictures about it popped into my mind.
    not at all rarely sometimes often

11. Other things kept making me think about it.
    not at all rarely sometimes often

12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.
    not at all rarely sometimes often

13. I tried not to think about it.
    not at all rarely sometimes often

14. Any reminder brought back feelings about it.
    not at all rarely sometimes often

15. My feelings about it were kind of numb.
    not at all rarely sometimes often

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Appendix D. Post-Traumatic Growth Inventory

Directions Indicate for each of the statements below the degree to which this change has occurred in your life as a result of your experience with bereavement.

0 = I did not experience this change
1 = I experienced this change to a very small degree
2 = I experienced this change to a small degree
3 = I experienced this change to a moderate degree
4 = I experienced this change to a great degree
5 = I experienced this change to a very great degree

_____ My priorities about what is important in life.

_____ An appreciation for the value of my own life.

_____ I developed new interests.

_____ A feeling of self-reliance.

_____ A better understanding of spiritual matters.

_____ Knowing that I can count on people in times of trouble.

_____ I established a new path for my life.

_____ A sense of closeness with others.

_____ A willingness to express my emotions.

_____ A knowing I can handle difficulties.

_____ I'm able to do better things with my life.

_____ Being able to accept the way things work out.

_____ Appreciating each day.

_____ New opportunities are available which wouldn't have been otherwise.

_____ Having compassion for others.

_____ Putting effort into my relationships.

_____ I'm more likely to try to change things which need changing.

_____ I have a stronger religious faith.

_____ I discovered that I'm stronger than I thought I was.

_____ I learned a great deal about how wonderful people are.

_____ I accept needing others.

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Appendix E. Informed Consent

INFORMED CONSENT FORM

You are being requested to participate in a research study. This study is part of a Clinical Psy.D. Dissertation being presented to the faculty at the California School of Professional Psychology - San Diego (CSPP-SD). Before you consent to participate, please read the following and ask as many questions as necessary to ensure your understanding. Your signature at the end of this document is your agreement to participate and notes your understanding of the information contained in this document.

Investigator	Sharon Durland, M.A., Psy.D. candidate
Dissertation Chairperson	Melanie Greenberg, Ph.D., Associate Professor of the Health Ph.D. program, Core Faculty at CSPP
Purpose of Treatment	To offer short- or long-term outpatient psychotherapy to clients who are experiencing emotional distress as a result of bereavement. Clients will be encouraged to talk in depth about the specifics of the loss, the meaning of this event in their lives, and feelings related to the death. Treatment may involve additional, optional exercises such as visiting the site of the grave or talking with friends or relatives.
Duration of Treatment	One 45 minute session per week for a minimum of twelve weeks, but no longer than one year.
Procedures to be Followed	Each participant will complete an intake form and four measures including the Inventory of Complicated Grief (1995), Physical Symptoms Inventory (1968), Post-Traumatic Growth Inventory (1996), and the Impact of Event Scale (1979). These measures will be completed at the close of therapy, and six weeks after termination.
Risks Involved	Commonly, people who enter therapy experience an initial increased level of distress before they begin to feel better. This is to be expected, and is part of the process of discussing painful memories.
Benefits Involved	Short- and long-term therapy may be helpful in reducing the anxiety, depression and other problems (e.g., substance abuse) that people experience as a result of a traumatic life event. In order to reap these potential benefits, a commitment of at least 12 sessions is encouraged, although a client may terminate whenever they choose.

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Confidentiality

All information discussed in therapy will be kept confidential with several exceptions. The investigator is supervised by a licensed clinical psychologist. Thus, material from the therapy session will be reviewed with the supervisor on a weekly basis. Sessions will also be reviewed periodically in the Psy.D. clinical dissertation group and with chairperson of the investigator's dissertation.

In addition, if the participant informs the therapist that they have any intention to hurt themselves, hurt someone else, or if the client reports any child, elder, or dependent adult abuse, the therapist is required to report this to the appropriate agency (e.g., police, psychiatric emergency team, or Child Services Bureau, etc.).

Some content from the therapy sessions may be used in the investigator's final document. The participant's real name and identifying information will be altered.

Withdrawal

The participant is under no obligation to continue with this therapy, and may choose to drop out at any time. Sometimes, the client may experience emotions that are quite difficult or uncomfortable, and consequently, he or she may wish to terminate treatment. The client is encouraged to discuss any wish to discontinue therapy with the therapist during the session, as talking about fears, anxieties or discontents are integral to the therapeutic process. Honesty about these feelings may improve treatment. However, if the client wishes to discontinue treatment, he or she maintains that privilege.

Acknowledgment My signature below indicates that I have read the above information and have the opportunity to ask questions about my participation.

Signature of Participant _____ **Date** _____

Signature of Witness _____ **Date** _____

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Appendix F. Audio/Video Tape Permission

CALIFORNIA SCHOOL OF PROFESSIONAL PSYCHOLOGY - SAN DIEGO IN CONJUNCTION WITH SHARP MESA VISTA HOSPITAL

CONSENT TO PARTICIPATE IN AUDIO/VIDEO TAPE PROGRAMS

It has been explained to me that as part of the psychotherapeutic program, audio/video taping is frequently used for the purposes of enhancing psychotherapy and for educational purposes through discussions and written materials. I have been advised that the tapes will be seen/heard only by other doctoral students and supervising faculty members who are associated with the hospital and with the clinical psychology training program at CSPP-San Diego.

I hereby consent to participate in such programs, and to be audio/video-taped for such purposes. I understand that such audio/video tapes and associated case notes will be held in strict confidence and will be used only for purposes of supervision and training. I further understand that such audio/video tapes and any written transcripts from the tapes will be destroyed when they are no longer of value for my psychotherapy and/or for staff educational purposes. Other written documents might not be destroyed. My name and identifying information will be altered to protect my identity.

My signature indicates that I have read and agreed to the above:

Signature of Participant _____ **Date** _____

Signature of Witness _____ **Date** _____

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Appendix G. Outpatient Intake Questionnaire

INTAKE QUESTIONNAIRE

Name _____ Home phone _____ Work phone _____

Address _____ [ ] Male [ ] Female

Date of Birth _____ Age _____ Today's Date _____

Ethnic Origin [ ] European-American [ ] African-American [ ] Asian-American [ ] Native American

[ ] Latino [ ] Other _____

Relationship Status (circle all that apply)

Single, not dating Separated from partner/spouse Living with partner

Single, dating Divorced Widowed Married

Who lives in your home with you? List names, ages, and relation to you.

_____

_____

_____

_____

Do you have children who don't live with you? If so, list names, ages, where and with whom they live:

_____

_____

_____

_____

When is the last time you had a general medical check-up? _____

Are you currently being treated for any health problem or recovering from any injury, surgery, etc.? If so, briefly describe here:

_____

_____

_____

_____

Are you currently taking any prescription drugs? If so, list below:

_____

_____

_____

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Have you ever experienced a head injury, concussion, or been "knocked out" or unconscious? Y N

Have you ever experienced an extremely high fever (over 103 degrees)? Y N Don't know

Were there any complications before, during or just after your birth? Y N Don't know

List any major illnesses or surgeries you have had:

_____

_____

_____

_____

Are you presently seeing any other professional counselors or therapists for psychological services? Y N

Briefly describe why you are seeking psychological services:

_____

_____

_____

_____

_____

How long have you had these concerns? _____

_____

Have you seen a psychiatrist, psychologist or mental health counselor in the past and if so, describe:

_____

_____

_____

Circle the highest grade completed in school? 4 5 6 7 8 9 10 11 12 Associates BA MA

Other _____

_____

Circle the number most true for you:

"Getting my schoolwork done has often been a problem."
(Not at all true of me) 0 1 2 3 4 5 (Definitely True of Me)

"I've had a lot of good times in school."
(Not at all true of me) 0 1 2 3 4 5 (Definitely True of Me)

"I've been in trouble a lot at school."
(Not at all true of me) 0 1 2 3 4 5 (Definitely True of Me)

"When I was younger, I was unhappy a lot of the time."
(Not at all true of me) 0 1 2 3 4 5 (Definitely True of Me)

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How satisfied are you now with your relationship with your mother?
(Not at all satisfied) 0 1 2 3 4 5 (Very Satisfied)

How satisfied are you now with your relationship with your father?
(Not at all satisfied) 0 1 2 3 4 5 (Very Satisfied)

How satisfied are you now with your relationship with your stepmother/stepfather?
(Not at all satisfied) 0 1 2 3 4 5 (Very Satisfied)

How satisfied are you now with your love life, partnership or marriage?
(Not at all satisfied) 0 1 2 3 4 5 (Very Satisfied)

How satisfied are you now with your friendships and social contact?
(Not at all satisfied) 0 1 2 3 4 5 (Very Satisfied)

How many hours per week are you working now? 0 1-25 26-40 41+

How satisfied are you now with your work situation?
(Not at all satisfied) 0 1 2 3 4 5 (Very Satisfied)

List the kinds of work you have done & how long, working from the present back through the last 3 jobs:

_____

_____

_____

_____

List any over-the-counter medications that you take on a frequent or regular basis:

_____

_____

How many cigarettes do you smoke <u>each day</u>?	0	1-10	11-20	20-?
How many cups of coffee/soda do you drink <u>each day</u>?	0	1-10	11-20	20-?
How much alcohol did you drink this <u>past week</u>? (One drink = one beer = a glass of wine = a mixed drink with one ounce of liquor)	0	1-10	11-20	20-?
How many days in the <u>past month</u> did you smoke marijuana?	0	1-10	11-20	20-?
How many days in the <u>past month</u> have you taken any form of cocaine, crystal or speed?	0	1-10	11-20	20-?
How many days in the <u>past month</u> have you taken any pain-killing or sedative drugs, such as valium, quaaludes, heroin, morphine, opium, etc. that were not prescribed by a doctor?	0	1-10	11-20	20-?
How many times in the <u>last year</u> have you taken hallucinogenic drugs such as LSD, mescaline, mushrooms, ecstasy, etc.?	0	1-10	11-20	20-?

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