AN EXPLORATORY STUDY OF CONJUGAL BEREAVEMENT WITH OLDER WOMEN

by Dianne M. Mowdy

University of Manitoba

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A practicum
submitted to
the Faculty of Graduate Studies
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CHAPTER I

INTRODUCTION

> Working through our endings allows us to redefine our relationships, to surrender what is dead and to accept what is alive, and to be in the world more fully to face the new situation. (Keleman, 1974, p. 53)

This is a practicum about endings . . . and loss . . . and grief.

Having worked with elderly people largely in a medical setting for over eight years, I became very intrigued with issues of loss. I often pondered why it was that one 87 year old woman who required hip surgery might zestfully throw herself into her rehabilitation and quest for independent functioning, while another in objectively similar circumstances, would languish abed and become physically and psychologically incapacitated. How was it that some elderly individuals seem to have successfully weathered a lifetime of significant hardships and losses, while others seemed to have fallen apart under circumstances of seemingly far lesser strain? I observed that it was not the objective magnitude of the loss per se, but the individual's processing of it that would portend either a healthy resolution or a despairing maladjustment to the loss. How best could one

respond in the face of change and loss? What attitudes and behaviours predispose one to a positive resolution to loss? What could I as a professional do to facilitate another person's moving along an adaptive course in the resolution of their losses? These were burning questions of great relevance to me both professionally, as a social worker in a medical context, as well as personally, in terms of my own everyday "surviving". This practicum was born out of my need to further explore these questions about endings . . . and loss . . . and grief. The loss that I chose to focus upon in this practicum was that of the ending of a marriage through conjugal bereavement. The death of a spouse is an obviously identifiable and significant loss, and one that I believed held tremendous potentiality in terms of what I could learn from it about grief.

As widows outnumber widowers by nearly five to one in Canada (Statistics Canada, 1982), I decided to direct my practicum to working with elderly widows. This was also a population that I, as a hospital-based social worker, often came to be concerned and care about during their husbands' hospitalization, yet with whom I usually had quite limited contact upon their partners' death. For this reason, my practicum was all the more special to me, for it allowed me to explore this "missing piece" of my experience, and to

discover from the experts, the elderly widows themselves, that which I had so often wondered about--what becomes of these older women once their husbands have died?

The Holmes Social Readjustment Rating Scale of stressors rates the death of a spouse as by far the most stressful of life events. (Holmes, 1967) Studies indicate that individuals experience significant increases in physical and psychological complaints following bereavement. (Lindemann, 1944; Maddison & Walker, 1967; Glick, Weiss & Parkes, 1974; Clayton, 1979; Bowlby, 1980)

Epstein, Weitz, Roback and McKee (1975) concluded that conjugal loss was associated with increased risk of dying at all ages, and in England and the United States, the risk for the widowed during the first six months of bereavement was twice as great as that for married individuals.

It has been suggested that elderly individuals who experience conjugal loss are a particularly vulnerable group. (Skelskie, 1975; Kozma & Stones, 1980)

The percentage and absolute numbers of people over 65 years of age is rising. In 1981 the elderly comprised 9.5%

of the population of Canada, but it is projected that they will comprise 20% by the year 2031. (Naus, 1979)

As it has been the norm in North America for women to marry men older than themselves, and being that men do not generally live as long as women, the majority of bereaved elderly individuals are women. As the elderly population is increasing, so are the numbers of elderly widows having to deal with bereavement. In North America these elderly widows face bereavement in a largely male-defined, youth-oriented, death-denying society. It is a society that provides little normative support or cultural guidelines to help the widows deal with the bereavement tasks they face. (Gorer, 1965; Parkes, 1972; Vachon, 1976; Kavanaugh, 1977) This renders the elderly widow in a more vulnerable position as she negotiates her transition to widowhood.

In consideration of the growing numbers, and vulnerability of this sector of the population, this exploratory practicum study focused upon conjugal bereavement with elderly widows. In this practicum the situation of elderly widows within our North American social context will be considered from a feminist perspective.

The objectives of this exploratory study were:

1. To explore and to learn about the bereavement experiences of elderly widows within our North American social context.

2. To provide a bereavement follow-up service to some elderly widows to support and facilitate their grieving process through the sharing of their bereavement experiences.

3. To gain greater expertise in facilitating the grieving process.

The bereavement follow-up was based upon the bereavement objectives, principles and procedures outlined by J.W. Worden in Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner (1982).

Reference was also made to Raphael's (1980) "therapeutic assessment interview" (p. 155) format appended.

In this study the target population were local widows of elderly men who had died within the Department of Geriatric Medicine at the St. Boniface General Hospital, in the 18 month period preceding the start of this practicum in July of 1984. Initially, introductory letters were sent to the widows inviting their participation in the study. A telephone call follow-up to these letters established those women who were willing to become involved. A total of 12 widows were visited in their homes. Three more widows partook in some limited contact by telephone. The widows

ranged in age from 50 - 78 years. Contacts ranged between one and seven sessions, from three and one-half hours to 20 hours in total. Widows were nearly equally distributed between those who were more recently bereaved (i.e. within the previous five months), and those whose bereavements had occurred within the preceding 12 - 18 months. While the practicum was primarily conducted between July and December of 1984, some continuing contact was maintained with one woman over 22 months.

The widows were engaged at the point where they were at in their bereavement process. For some the interventions focused upon the "grief work"; for others it was looking more outwardly to the reconstruction of their lives as single women.

In the end, this practicum specifically:

1. provided me with an enriched learning experience about the bereavement experiences of older widows within our social context;
2. provided for bereavement follow-up of a supportive nature to facilitate the elderly widows' movement through their bereavement process;
3. provided me with a holistic and integrative learning experience through which I learned how I could best use myself in the facilitation of the grieving process.

More generally, however, this practicum provided me with some of my much sought after answers about endings, and loss, and grief. This learning is of great significance to me both professionally and personally.

Professionally, I believe that dealing with endings, loss, and grief is one of the cornerstone issues of social work in general, and medical social work in particular. Thus the knowledge and skills that I have acquired through this practicum experience have great professional relevance to me whether I am providing bereavement follow-up to an elderly widow, working with the mother of a stillborn child, an individual who surgically has lost a part of their body, a stroke patient and his or her family who have lost a former life style, or an elderly person who is facing nursing home placement due to increasing dependency needs.

Personally, I believe that learning more about endings, loss and grieving has helped me to perceive my own life's losses in a more constructive and healing way, and has enhanced my own personal growth and re-investment in living.

Today, and today and today are our tomorrows. Learning to live our todays more fully allows us to face our tomorrows without regrets. My practicum has been a truly

enriching and personally integrative learning experience that has fostered both my professional and personal growth, and has helped me to live more fully today . . . and today . . . and today . . .

It is with pleasure that I share it with you.

CHAPTER II

LITERATURE REVIEW

2:1 INTRODUCTION

This review of the literature focuses upon three specific subject areas related to the bereavement experience.

The first subject area to be explored is that of the emotional impact of bereavement: grief. In this section the contributions made by some of the foremost theorists on the subject through time, will be presented. This includes the works of Sigmund Freud, Erich Lindemann, Beverley Raphael, Mary Vachon, Helena Lopata and John Bowlby. Attention will also be given to providing some perspectives upon (1) the phases of grieving, (2) morbid or pathological grief reactions, (3) hallucinations and grief, (4) determinants of grieving outcomes, (5) the length of the grieving process, as well as upon (6) the research on the particular experience of bereavement in the later years of life.

The second subject area to be reviewed will focus upon some of the various clinical interventions with grief. A behavioural approach, re-grief therapy, feminist counsel-

ling, and a number of right-brain oriented adjunctive therapies such as gestalt, psychodrama, intensive journal process, hypnosis, and phototherapy, will be examined. Social interventions such as those of self-help groups, widow-to-widow programs, and feminist consciousness-raising, will also be addressed.

The final section of this literature review will examine the situation of the elderly widow in the North American social context, from a feminist perspective. This will include an examination of the social stereotypes of elderly women and how these social attitudes impact upon the self-perceptions and social realities within the lives of these elderly women.

2:2 PERSPECTIVES ON GRIEF

2:2:1 Sigmund Freud

Sigmund Freud was one of the earliest theorists to expound a psychodynamic explanation of the grieving process in his work, "Mourning and Melancholia" (1917).

In Freud's view, mourning is the natural response to the loss of a loved object. He writes, "although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition" (S.E., Vol. 14, p. 243). Thus Freud viewed mourning as a natural grief reaction and not an illness or a disease entity.

In Freud's precepts, the function of mourning is "to detach the survivor's memories and hopes from the dead" (S.E., Vol. 13, p. 65). This was to be accomplished through "a withdrawal of the libido from this object and a displacement of it onto a new one" (S.E., Vol. 14, p. 249). This withdrawal was to be achieved through a process that Freud termed hypercathexis; a process wherein the mourner withdraws from the real world to invest all her or his available energy in the struggle to decathect the loved object.

(Glick, Weiss & Parkes, 1974) By focusing their attention on the lost person and by consciously reviewing all relevant memories of the deceased, the mourner thus gradually sets free the libidinal attachment to the deceased.

In comparing normal mourning with melancholia, a type of pathological grief or depression, Freud describes:

> the same painful frame of mind, the same loss of interest in the outside world . . . the same loss of capacity to adopt any new object of love . . . and the same turning away from any activity that is not connected with thoughts of him [or her]. (S.E., Vol. 14, p. 244)

In "Mourning and Melancholia" (1917), however, Freud denotes features which distinguish mourning from what he terms melancholia. These include the presence in melancholia of: a disturbance of self-regard, ambivalence in the love relationship and identification with the lost object.

In his later works, however, Freud revised his thinking about identification being only an aspect of pathological mourning or melancholia. He concluded that libidinal withdrawal is commonly accomplished by means of the ego identifying with the lost object in the normal mourning process.

Freud's view that identification with the lost object is normal was later shared by other theorists such as Abraham (1927), Hinton (1967) and Pincus (1974). They concur that not only does identification with the lost object normally occur, but that it is essential that it does occur for mourning to proceed to its natural completion.

Thus Freud was one of the first to describe and theorize a conceptualization of the grieving or mourning process. His work stood as a primary authority on the topic for many years, until the work of another psychiatrist, Erich Lindemann, gained prominence in this field.

2:2:2 Erich Lindemann

A classic work in the area of grief is Erich Lindemann's "Symptomatology and Management of Acute Grief" (1944).

Lindemann primarily derived his data from his observations of 101 recently bereaved patients who had lost loved ones in a tragic fire in the Coconut Grove Night Club in Boston in 1942, where nearly 500 people lost their lives.

Despite some criticism of the limitations of Lindemann's recording procedures (Parkes, 1972), Lindemann's study remains a much quoted, important work in the area of grief. Lindemann rendered a very accurate description of acute grief as a distinct syndrome which deserved attention.

Lindemann (1944) described five characteristic symptoms of normal grief. These were:

1. Somatic distress occurring in waves lasting from twenty minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing, an empty feeling in the abdomen, lack of muscular power and an intense subjective distress described as tension or mental pain. (Lindemann, 1944, p. 61)

2. An intense preoccupation with the image of the deceased, . . . a slight sense of unreality and a feeling of increased emotional distance from other people. (Lindemann, 1944, p. 62)

3. Feelings of guilt - the bereaved individual continually reviews the circumstances prior to the death for evidence that she/he did not do enough for the deceased.

4. Hostile reactions, which often take the bereaved individual by surprise and lead them to fear the loss of their emotional stability.

5. Loss of normal patterns of conduct, wherein activities of daily routine are carried on only with great effort.

In Lindemann's conceptualization, these five symptoms - somatic distress, an intense pre-occupation with the image of the deceased, guilt, hostile reactions and the loss of normal patterns of conduct were all indicative of a normal grief reaction.

Lindemann termed delays or distortions of the normal grief reaction as morbid grief reactions. Lindemann believed that skillful psychiatric intervention could transform a morbid grief reaction into a normal grief reaction, which could then be successfully resolved in eight to ten interviews in four to six weeks. (Lindemann, 1944)

Another manifestation of grief that Lindemann identified is termed "anticipatory grief" (Lindemann, 1944, p. 76). This occurs when an individual, in anticipation of a threatened loss, undergoes the full grieving process prior to the loss. Lindemann suggests that while this process may help prepare the individual for the actual bereavement, difficulty arises when the loss does not materialize as anticipated, yet the relationship has been psychologically terminated. Lindemann documents the effects of "anticipatory grief" in the return of wartime servicemen to deadened marital relationships.

Lindemann termed this process of working through a grief reaction, "grief work" (Lindemann, 1944, p. 64). Lindemann states the goal of grief work to be:

> the emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formulation of new relationships. (Lindemann, 1944, p. 64)

A first consideration in facilitating grief work is "giving the person permission to feel suffering and to express it" (Lindemann, 1944, p. 73). Once this is achieved the bereaved individuals are encouraged to verbalize their feelings about their relationship to the deceased. They review formerly shared activities and consider future possibilities for meeting some of these role-loss needs precipitated by the death through new relationships.

"The replacement of specific roles is the peculiar problem of grieving" (Lindemann, 1961, p. 173), according to Lindemann. As such, grieving is viewed as a role transition that necessitates the need "to redesign role function on a major scale" (Lindemann, 1961, p. 174). Lindemann regarded this role transition precipitated by bereavement as a potential situational crisis for the bereaved individual.

This situational crisis is viewed as a social event that puts great demands upon the individual's coping capabilities, and may result in the healthy physiological and psycho-social reorganization of the individual, or in a maladaptive state in which the crisis fails to be resolved.

Lindemann's strongly focused emphasis upon the need for preventive intervention in such situational crisis, to facilitate the normal grieving process, and to thwart the development of maladaptive defence mechanisms is a most positive and significant thrust of his work.

2:2:3 Beverley Raphael

Beverley Raphael is an Australian psychiatrist who, like Lindemann, conceives of the bereavement experience as a situational crisis. While Raphael in no way minimizes the intrapsychic process precipitated by the bereavement crisis, she states that a major purpose of her work is:

> to emphasize the unique importance of the interaction between psychological processes and social networks, and to indicate the extent to which the individual's mourning and its outcome can be modified by social process. (Maddison and Raphael, 1975, p. 27)

The vital importance of the preventive aspects of crisis intervention in bereavement is a central theme in Raphael's work. (Maddison & Raphael, 1975; Raphael, 1977; Raphael, 1980; Raphael, 1983) To this end, Raphael (1977) has done research to demonstrate the preventive value of bereavement counselling when a high-risk group is defined.

Raphael has also developed a therapeutic assessment format through which she explores risk variables in a supportive, nondirective interview conducted in the weeks following the death. This format has been termed a "therapeutic assessment interview" (Raphael, 1980, p. 155), since the process of gleaning information is in itself therapeutic, facilitating the normal grieving process.

It is Raphael's contention that the bereaved individual's response pattern to the bereavement is established early in the crisis. (Raphael, 1980) She suggests that the optimal time for preventive intervention is between two to eight weeks, and even up to three months after the death. (Raphael, 1983) Failure to receive appropriate help at this time of crisis may result in the development of a pathological or morbid grief response. (Lindemann, 1944; Gorer, 1965; Parkes, 1972; Vachon, 1976; Raphael, 1983) Through the use of the "therapeutic assessment interview" early in

the bereavement crisis, Raphael screens the bereaved individuals so that more specific crisis intervention can be directed to those in need, thus averting them from a maladaptive course of adjustment. In this way the "therapeutic assessment interview" has been used as a tool of preventive intervention in the bereavement crisis.

Raphael (Maddison & Raphael, 1975) also stresses the need for a variety of social network interventions provided by helpers of varying degrees of sophistication and training. Such interventions could include: the mobilization of social networks by social support programs, the empathic linkage of widows with other widows, educational programs to promote an enhanced understanding of the grieving process in the greater community, as well as the essential need for preventive measures to identify and intervene with high-risk bereaved individuals before maladaptive defence mechanisms develop.

Through such timely preventive interventions within the broader social network, Raphael looks to facilitating the normal grieving process and to preventing the development of pathological or morbid grief reactions in the bereavement crisis.

2:2:4 Mary Vachon

The relevance of social network support through the bereavement crisis is also a research interest of Mary Vachon and her colleagues at the Clarke Institute of Psychiatry in Toronto, Ontario.

Walker, MacBride and Vachon (1977), having studied different models of support network structure, suggest "that there is often a lack of fit between the social and psychological needs of the individual in crisis and the individual's social support network" (p. 40). Social networks vary in their capacity to provide for their members' social and psychological needs as these needs vary over time, and especially at times of crisis. For example, a small close-knit social network that proved to be very supportive and comforting to the newly bereaved widow may become a closed, limiting and somewhat stifling experience to that same widow as she endeavors to recreate her life anew, seeking new friends, perhaps employment and a new life style. Walker, MacBride and Vachon (1977) suggest that mental health professionals might be most effective by directing their efforts to adjust this fit between the individual's social and psychological needs and the network support structure.

To this end, Vachon, Lyall, Rogers, Freedman-Letofsky and Freeman (1980) undertook a study of a social network intervention with the creation of a widow-to-widow program for newly bereaved women. This program was much akin to that originated by Phyllis Silverman (1974) with trained widow contacts who extended themselves to the new widows to provide emotional support and practical assistance for as long as they were needed. Vachon's Canadian study, however, was a two-year controlled study with an evaluation component.

The data from this study confirmed Vachon's hypothesis that widows move through a "pathway of adaptation" (Vachon et al., 1980, p. 1380) in the bereavement process. Vachon found that widows initially proceed down a pathway related to concerns of intra-personal adaptation, where inner turmoil, withdrawal and preoccupation with the loss and the past are paramount. This is much like the "grief work" previously described. Once the widow comes to terms with these concerns, she then moves along a pathway of interpersonal adaptation, where the widow starts to look outward again at new roles, activities and relationships; the reconstruction of her identity as a single woman. According to Vachon, it is only by progressing through these stages of inward and then outward directed pathways of adaptation that

a widow can significantly reduce her overall level of distress. In Vachon's study (1980), the attainment of these stages of adaptation was shown to be accelerated with participation in the widow-to-widow program. "This good outcome reiterates the appropriateness of the social support system as a focus for intervention." (Vachon, Rogers, Lyall, Lancee, Sheldon and Freeman, 1982, p. 1001) Surprisingly however, it was not until two years after bereavement that a difference in overall disturbance between intervention and control groups became apparent (Vachon et al., 1980) indicating the long-standing impact of the bereavement experience.

2:2:5 Helena Lopata

A sociological perspective of conjugal bereavement is provided by Helena Lopata's study (Lopata, 1973a) of 301 metropolitan Chicago widows aged 50 years and over. In her study, Lopata found that in conjugal bereavement:

> The degree of disorganization depends upon the pervasiveness of the role of wife, the psychological and social dependency of a woman upon being the wife of that particular man, the extent to which the couple operated in the home and externally as a team, the circumstances of the death, and the resources the widow can marshall in the grief work process. (Lopata, 1973b, p. 14)

Lopata (1973a) categorized three distinct types of widows in her study. Firstly, Lopata describes the self-initiating woman who flexibly is able "to enter and to exist from social roles as she reaches the different stages of life or redefines her situation" (Lopata, 1973a, p. 265). This woman engages in self-initiated action rather than by only reacting to external events going on around her.

Women who are a part of a closely-knit, sexually-segmented ethnic community comprise Lopata's second genre of widow. Being solidly engaged in a closely-knit network of family, peer and neighborhood relationships, these women's involvements continue with little modification after the death of their spouse.

The third type of widow that Lopata identifies is the social isolate. These women were often marginally involved in the broader society and lacked the ability to re-engage in new social roles and relationships upon the loss of their significant attachments. Lopata's findings indicate that these socially isolated widows were "not happy with the world" (Lopata, 1973a, p. 266) as they experienced it. Factors other than choice frequently had a bearing upon these widows' isolation.

> Basically those who are isolated or lonely are those who lack the skills, money, health and transportation for engaging or re-engaging in society. (Lopata, 1973a, p. 277)

While it may be heartening to think that the provision of such resources could alleviate the suffering of these isolated widows, the problem is far more complex than that. Lopata relates that it took many years for these isolated women to develop this marginal life style in relation to society at large and no haphazard, one-shot out-reach involvement is likely to produce change. It would take much time, trust and relationship-building to help these women regain the courage (from the French, corage, for "heart") and personal competency to be willing to venture out again into what has been to them, an inhospitable world.

From her study, Lopata concludes that:

> the way in which different types of women re-engage in society following the death of the husband reflects their location in the modern social system. (Lopata, 1973a, p. 263)

2:2:6 John Bowlby

John Bowlby is a psychoanalyst who theorizes a biological basis for understanding the grieving process. Like

Klein (1940), Engel (1961) and Marris (1974), Bowlby regards grief as an illness. In Bowlby's view, grief is "a state of biological disequilibrium brought about by a sudden change in the environment" (Bowlby, 1961, p. 322). Like other illnesses, Bowlby views grief as having a recognized cause, a predictable symptomatology, and an identifiable course.

In Bowlby's conceptualization, grief is intimately related to separation anxiety, except that in grief the loss is permanent, while in separation anxiety it is potentially retrievable. Bowlby based his theory upon observations of grief manifested in research upon animals (Darwin, 1872; Yerkes, 1925; and Lorenz, 1952), as well as upon his own studies of separation anxiety in human infants (Bowlby, 1960). Bowlby noted that when animal and human infants were separated from their mothers, they wailed, wept and raged to bring about a reunion. Bowlby viewed this to be biologically functional behaviour to effect a reunion and to prevent further separations. Bowlby came to regard grieving as a manifestation of this same biological response to effect the return of a lost object, even though the loss through death is permanent. Bowlby notes that:

> In the course of our evolution, it appears our instinctual equipment has come to be so fashioned that all losses have been assumed to be retriev-

able and are responded to accordingly. (Bowlby, 1961, p. 333)

Through his observations of this grieving process, Bowlby conceptualized "three phases of mourning" (Bowlby, 1961, p. 331) which in collaboration with Colin Murray Parkes (1970a) were later revised to four. An outline of these phases of grieving follow in section 2:2:7.

2:2:7 Phases of Grieving

Many authors have similarly identified that grief proceeds through distinct phases. (Bowlby, 1961; Kubler-Ross, 1969; Parkes, 1970b; Pincus, 1974; Vachon, 1976; Kavanaugh, 1977)

John Bowlby (1961) was one of the first to publish the concept that mourning had phases, and it is basically the findings of this work that have been replicated or expanded upon by other theorists, including Colin Murray Parkes.

Colin Murray Parkes (1970b) studied the psychological reactions to conjugal bereavement of 22 London widows under the age of 65 years in a prospective, longitudinal study over 13 months after the deaths of their spouses. Parkes

found that: (1) Bereavement typically begins with a phase of shock or numbness often accompanied by denial of the loss. (2) Bereaved individuals then pass through a phase of intense grief and frustrated searching for the lost spouse. Crying for and dreaming about the deceased are typical of this searching phase, as is a preoccupation with thoughts of the deceased, and a tendency for bereaved individuals to direct their attention to objects and places in the environment associated with the lost person. (3) Depression and apathy are characteristic of the third phase of grief, wherein bereaved individuals become resigned to the reality of the loss. In Bowlby's view this phase of disorganization and despair is, while painful,

> an indispensable preliminary to new adaptation . . . one must accept the destruction of a part of his [or her] personality before he [or she] can organize it afresh towards a new object or goal. (Bowlby, 1961, p. 335)

(4) The final phase of grieving is one of reorganization, founded upon a reality-based acceptance of the loss and its permanence. The bereaved person then gradually resumes a normal but often radically changed life style.

There is, however, a tendency for bereaved individuals to deny or abort the expression of the pain of their grief,

fearing its intensity and their own loss of control. Pathological or morbid grief reactions occur when the normal grief response becomes distorted. (Lindemann, 1944; Gorer, 1965; Parkes, 1972; Vachon, 1976; Raphael, 1983; Worden, 1982)

2:2:8 Pathological or Morbid Grief Reactions

The phenomena of pathological or morbid grief has been described in the works of Freud (1917); Lindemann (1944), Parkes (1972) and Raphael (1983). Raphael's categorization, which is quite representative of the literature generally, follows herein.

Raphael (1983) identifies five pathological patterns of conjugal bereavement.

First, there is absent grief where the bereaved individual shows no response to the death of the partner, acting as if nothing has happened.

Delayed grief is another pathological pattern which is related to the avoidance of the pain of the loss or a fear of a loss of emotional control.

Inhibited grief shows itself when the grief response is minimized or short-lived in comparison to the intensity of the lost relationship. This partial grief response keeps a partial denial of the loss alive, maintaining an unwillingness to relinquish the former relationship through the grieving process.

The distorted grief response is characterized by a preponderance of one prominent aspect of grief such as ongoing and extreme anger or guilt to the exclusion of sadness and all other normal grief responses.

The final pathological pattern described by Raphael is that of chronic grief. The bereaved person continues to be as severely grief-stricken, as one would expect of a newly bereaved individual, for months and years beyond the death. In chronic grief, Raphael suggests the widow or widower seems to maintain their relationship to their spouse by keeping their grief alive and a part of their own life. (Raphael, 1983)

All the available literature reviewed suggests that such pathological responses result from the bereaved's inhibition to engage in or proceed through the normal grief response. As such, grief may never resolve. Schneiderman

(1979) suggests that "hidden grief never goes away, it just changes form" (p. 79).

Interestingly, Parkes (1972) notes that while pathological grief responses

> differ in intensity and duration from the more usual reactions to bereavement, certain aspects of which may be exaggerated or distorted, they do not differ in kind. (p. 117)

2:2:9 Hallucinations and Grieving

The normality of hallucinations in a normal grief reaction has been demonstrated in studies by Marris (1958) and Rees (1973).

Rees (1973) defined "hallucinations" to include "a sense of the presence of the dead person" in addition to visual, auditory and tactile hallucinations. Rees' study of 293 bereaved individuals found hallucinations to be a common experience after widowhood affecting 50% of the men and 45.8% of the women. The hallucinations occur irrespective of sex, creed or domicile. They do not affect overt behaviour and they tend to disappear with time. There is no evidence of associated illness or abnormality to suggest

that the hallucinations are abnormal features. They are more common in people whose marriages were happy and who had children, as well as in people able to integrate the experience and to keep it secret. Most people reported that they felt they were helped by their hallucinations. Those least likely to perceive hallucinations are those widowed below the age of 40.

Such hallucinations, compounded with an elderly widow's acceptance of social stereotypes associating aging with senility, could do much to undermine an elderly widow's confidence in her own mental competence. Normalizing such grief experiences is vastly reassuring to bereaved individuals. (Fleming, 1985; Freese, 1977; Gramlich, 1974; Glick, Weiss & Parkes, 1974, in the forward by Gerald Caplan)

2:2:10 Determinants of Grief

Factors affecting the outcome of conjugal bereavement have been a concern of research.

Studies (Maddison & Raphael, 1975; Raphael, 1977) have found one significant determinant to be the nature and quality of the lost relationship. High levels of ambiva-

lence or dependence in the pre-existing relationship create greater problems in the grieving process.

The presence of concurrent life crisis, at or around the time of death, also adds to the stress experienced by bereaved persons and heightens the risk of morbidity. (Maddison & Walker, 1967; Parkes, 1972; Maddison, 1974a, 1974b; Maddison & Raphael 1975; Vachon et al., 1982)

Circumstances of the death--be it sudden and unanticipated, or long and drawn out--are another consideration in the outcome of conjugal bereavement. Parkes (1972) in his study of younger bereaved individuals found that sudden, unexpected deaths that are perceived as being untimely are more likely to be associated with pathological outcomes. In contrast, Clayton, Halikas, Maurice and Robins (1973) found no difference in outcome at one year between elderly bereaved individuals who had experienced anticipatory grieving (i.e. having time to psychologically prepare for the death) and those who had not. Further, Gerber, Rusalem, Hannon, Battin and Arkin (1975) found that a spouse's chronic fatal illness of more than six months' duration, predisposed the elderly bereaved to poorer medical adjustment. It was hypothesized that many widows had neglected their own health during the time of their spouse's illness, resulting in

their own deteriorated condition following the death. These divergent findings about the relevance of anticipatory grief indicate that this area of enquiry requires further study.

Other circumstances around the death that complicate the grieving process include suicide (Raphael, 1980; Worden, 1982) and situations where the body is not found or recovered (Raphael, 1980).

The pervasiveness of the wife role and the extent to which the marital couple operated as a team is another factor identified by Lopata (1973a) as relevant to the bereavement outcome. Women over 50 years of age whose identity was largely vested in the wife role and who shared most activities with their husbands, experienced a greater degree of disorganization upon bereavement.

Social network support was the most significant factor related to bereavement outcome in studies by Maddison and Walker (1967), Maddison (1974a, 1974b), Maddison and Raphael (1975) and Vachon et al. (1980, 1982). In the Maddison and Walker (1967) study, those widows who perceived their social network as nonsupportive during the bereavement crisis were the ones who proved to have poor bereavement outcomes. These widows reported disappointment with the lack of

practical assistance and encouragement that was forthcoming from their social network, which they viewed as actively unhelpful. The relevance of a supportive social network is further borne out in the success of Vachon's et al. (1980) widow-to-widow intervention. This two-year controlled study demonstrated that participation in the widow-to-widow intervention accelerates the widow's progress through "the pathway of adaptation". (Vachon, 1980, p. 1380)

2:2:11 Length of Grieving

Theories about the length of time one grieves following a bereavement have altered radically over time. Initially, Lindemann, operating on a "crisis model" of intervention, suggested that a normal grief reaction could ordinarily be resolved with eight to ten interviews over a four to six week period. (Lindemann, 1944)

Studies of conjugal bereavement by Glick, Weiss and Parkes (1974)suggest that although the most severe pangs of grief occur within the first two to five weeks following the death, "even a year after a major bereavement grief is still prominent" (Glick, Weiss & Parkes, 1974, p. 10). Parkes (1972) suggests that the bereaved individual must pass through at least one year of birthdays, holidays and anni-

versaries without their spouse before grief can resolve. Grief may even be evoked years later by the chance finding of a photo or possession of the deceased or on the occasion of an anniversary date.

Gerald Caplan, in the forward to Glick, Weiss and Parkes (1974) book, The First Year of Bereavement, relates that while he initially held the belief that grief could be resolved within six weeks (the crisis model), he now believed more realistic estimates would be in terms of years. "We now realize that most widows continue the psychological work of mourning for their dead husbands for the rest of their lives." (Glick et al. 1974, p. viii)

Stephen Goldston, director of the Office of Prevention at the U.S. National Institute of Mental Health, concludes that "it is becoming clear that there is no strict timetable for grieving" (Joyce, 1984, p. 42).

2:2:12 Bereavement in Later Life

While greater attention has been focused upon the subject of grief and bereavement over the past 25 years, "grief in elderly people has been studied scientifically

only on a few occasions" (Gramlich, 1974, p. 65) with inconsistencies in these findings.

An issue most considered in the literature is whether younger or older bereaved persons are more prone to manifest their grief through emotional or psychiatric disorders, or through the somatization of their grief.

Bowlby (1980) and Clayton (1979) suggest that although all widows and widowers suffer from significant depressive symptoms in the first year of bereavement, young widows and widowers have more physical distress than the elderly bereaved.

In contrast, studies by Stern, Williams and Pardos (1951), Parkes (1964), Maddison (1974a), Gramlich (1974) and Wiener, Gerber, Battin and Arkin (1975) all reveal the opposite finding; that the elderly are more apt to channel their grief experiences into somatic complaints.

A third differing viewpoint results from a longitudinal study by Heyman and Gianturco (1973). This study suggests that the elderly adapt to the death of a spouse in a manner characterized by: (1) emotional stability, (2) stable social

network, (3) few life changes, and (4) only time-related health deterioration.

Such divergent findings suggest a demonstrated need for further scientific enquiry into the area of grief and the elderly. While the need for further research is indicated, concerns about the type of research to be done represents a second issue apparent in the more recent gerontological literature.

Researchers with a feminist perspective express grave concerns over the lack of research focus on elderly women in the gerontological literature. (Block, Davidson & Grambs, 1981; Burwell, 1982; Conrad, 1982; Nett, 1982b) Research related to elderly bereaved women is even more scant.

Eichler (1984) suggests that the most current research is not "good" research because it has a sexist bias and "it distorts what it claims to observe and explain" (p. 35).

For example, sexism creeps into gerontological research when elderly males and females are treated from an androcentric perspective (Eichler, 1984) and are grouped together in research as "the elderly" or "senior citizens" without regard of their sex.

Activist Tish Sommers (1976) suggests that such research practices mask the "tremendous differences between the sexes and above all obscure how much aging is a woman's issue" (p. 15).

A dramatic Canadian example of this sort of sexist research is put forth by Louise Dulude in Women and Aging: A Report on the Rest of Our Lives (1978). Dulude relates in this 1978 report that neither Statistics Canada's data on low income families and individuals nor the Federal Health and Welfare Department, which has been administering the Old Age Security and Guaranteed Income Supplement for more than 25 and 10 years respectively, are capable of providing information on their clients or recipients by sex. As a result, government was ignorant of the dire financial plight of elderly women, mostly widows.

These social realities have come to light with the advent of the feminist perspective in the research process engendered by the Women's Movement, and conducted by female researchers cognizant of women's issues and women's realities.

The facts spoke for themselves. There were three times more women than men who were over 60, single, widowed, or

divorced living in poverty. (Canadian Advisory Council on the Status of Women, Fact Sheet #2, 1977) "Seventy percent of widows and single women aged 75 and over live in poverty." (C.A.C.S.W., Women and Pensions: Women in Poverty, 1983).

This clearly demonstrates how poverty is a women's issue, and how the feminist perspective in research brought these significant findings to bear so that these social realities could no longer be ignored.

Margaret Conrad suggests that:

> The failure to examine systematically gender differences over time has resulted in a "half-history" of aging and the substitution of half-baked generalizations for concrete evidence when questions relating to elderly women are raised. (Conrad, 1982, p. 216)

The need for the feminist perspective in gerontological research to more accurately reflect the particular needs and issues of elderly women is apparent. (Beeson, 1975; Payne & Whittington, 1976; Posner, 1980; Block, Davidson & Grambs, 1981; Conrad, 1982; Nett, 1982a; Burwell, 1982, 1984; Eichler, 1984)

> Sexist research serves to maintain sexist social structures (Eichler, 1984, p. 36) . . . Freeing research from sexism, then, is an integral aspect of the fight for equality for women. (Eichler, 1984, p. 38)

In conclusion, researchers with a feminist perspective have demonstrated that not until a comprehensive body of feminist research exists, can we truly identify the distinct needs of elderly women (mostly widows) as compared to those of elderly men; and only then can we hope to best address each of their respective needs and issues. This then is the challenge to future gerontological research.

2:3 CLINICAL INTERVENTIONS WITH GRIEF

This second section of the literature review will briefly describe a variety of therapeutic interventions, specifically highlighting their relevance and applicability in working with issues of grief.

Clinical interventions to be reviewed will include: a behavioural therapy, re-grief therapy, feminist counselling, an array of right brain oriented adjunctive therapies, as well as social interventions directed at enhancing the social support available to bereaved individuals.

2:3:1 Behavioural Therapy

Behavioural approaches to pathological grief have been suggested by Ramsay and Happee (1977); Gauthier and Marshall (1977), Gauthier and Pye (1979); and Mawson, Marks, Ramm and Stern (1981).

One powerful and dramatic behavioural approach to pathological grief is that of Guided Confrontation Therapy, G.C.T., (Ramsey & Noorbergen, 1981). This therapy regards the unresolved grief reaction as a phobic avoidance reaction that needs to be extinguished. The therapy sessions are

frequent, three 50 minute sessions per week, and are very intensive. The patient cannot escape from the sessions having contracted these terms of therapy at the outset. G.C.T. does not regard insight as a prerequisite to behavioural change. Instead, it is a forced confrontation with the patient of all the painful facts of the loss and what this loss means to the patient. "Denial in whatever form has to be extinguished." (Ramsey & Noorbergen, 1981, p. 130) The aim of G.C.T. is to force the breakdown of the patient's denial and to elicit the depression, guilt, anger, anxiety and full gamut of powerful emotions associated with normal grief until these affects of grief are extinguished and there are no further reactions to the loss.

> Every negative emotion that is connected with the loss is carefully brought to the surface, and the emotional outbursts that invariably follow are prolonged as long as needed--drowning the patient in tears--until the emotions are totally extinguished and there are no more tears left. (Ramsey & Noorbergen, 1981, p. 15)

Given the intensity and power of the emotions elicited, this therapy should only be conducted by highly skilled practitioners with access to hospital admission if the patient's condition or need for safety warrants.

The hardest task in the final phase of G.C.T. is that of "letting go" of the deceased. This task, according to Ramsey and Noorbergen, must be an absolute, active, verbal, "good-bye" response if the grief process is to be resolved, freeing the griever to once again re-invest in living.

Ramsey and Noorbergen thus claim success in using Guided Confrontation Therapy in treating patients with pathological grief that has had strong phobic avoidance aspects.

2:3:2 Re-Grief Therapy

Re-grief therapy was developed by Volkan and Showalter (1968) to treat patients with pathological grief reactions.

Volkan (1975) delineates two consistent features of the pathological grief response. One feature is an intellectual acknowledgement of the loss, coupled with an emotional denial of it, demonstrating an operative splitting mechanism. The second feature is unconscious or unacknowledged ambivalence in the bereaved's relationship with the deceased. Through re-grief therapy, patients are helped to accept responsibility for the negative aspects of their

ambivalence. According to Volkan (1975), the goal of re-grief therapy:

> is to help the patient bring into consciousness . . . his [or her] memories and the experiences he [or she] had with [the deceased], in order to test them against reality, to accept with affect--especially appropriate anger--what has happened, and to free himself [or herself] from excessive bondage to the dead. (Volkan, 1975, p. 334)

Re-grief therapy is an intensive, short-term intervention, with the patient being seen four times a week over two to three months. Feelings of transference are discouraged and "are quickly interpreted in order to prevent their ripening" (Volkan, 1975, p. 339).

The initial phase of re-grief therapy is the "demarcation" phase. (Volkan & Showalter, 1968) Through the examination of a photo of the deceased and a nondirective history taking, the therapist initiates the building of "boundaries" between the patient and the deceased. Circumstances of the death are also explored.

The therapist then focuses on the patient's "linking objects". "Linking objects" are objects that the bereaved invests "with magical and symbolic powers that permit a link with the dead" (Volkan, 1975, p. 336). Linking objects

might include an item of the deceased's personal jewelry or clothing, a photograph of the deceased, or an object like a camera, associated with a favoured hobby of the deceased. The therapist uses discussion about and the handling of "linking objects" to stimulate memories and the emotional reliving of experiences. The patient's dreams and fantasies are also examined for this purpose.

When the therapist feels the timing is right, the patient's splitting mechanism is challenged and they are asked how they became aware that the dead person was no longer alive. This question often stimulates a re-evaluation of reality and a "disorganization phase" (Volkan, 1975, p. 339) ensues. Patients may require hospitalization at this time.

The final phase of treatment is reached when patients come to see why they could not permit the deceased to die. Commonly, they either wanted or needed something from them or the deceased represented a part of themselves.

Having moved through the re-grief process, wherein the bereaved comes to an intellectual as well as emotional/affective acceptance of his loss, the therapist often

accompanies the patient on a graveside visit to concretize this reality.

The therapist "then helps the patient direct his [or her] energies to new objects" (Volkan, 1975, p. 339) as the "re-grief" therapy process is completed. It is advised that re-grief therapy should only be conducted by highly skilled practitioners who can ensure their patients' safety with hospital admission should the situation warrant.

2:3:3 Feminist Counselling

Feminist counselling is not an intervention specific to grief, but is rather an approach with certain premises, attitudes and values that can be used to sensitively broach any life concern, including that of grief. An explanation of the feminist counselling approach, as offered by Helen Levine (1983), follows.

Feminist counselling "is an approach geared to releasing the energies and abilities of women to change their lives individually and collectively" (Levine, 1983, p. 81). Unlike more traditional models that are pathology focused, the feminist counselling approach focuses upon a growth orientation. The presenting problem is not defined in terms

of individual pathology, but is rather seen as a product of women's oppressed position in the social, political, and economic spheres of society. "Consciousness-raising is at the heart of feminist counselling." (Levine, 1983, p. 80) This is a process of helping heighten the individual woman's awareness that her personal conditions and problems are representative of the conditions and problems of women generally in society, and that the solution to these concerns lies with individual and collective social political action for change. In addition to helping the woman make this connection between the personal and the political realms of experience, consciousness-raising also plays an important role in reinforcing the validity of the individual woman's personal experiences within our largely male-defined society.

Feminist counselling thus stresses helping the individual to reclaim their personal strengths and change their circumstances, rather than helping them to "adjust" to harmful pre-existent situations that motivated them to seek support in the first place. The feminist counselling emphasis upon "change" rather than "adjustment", is another divergence from the traditional therapeutic model.

Another point of departure from the more traditional model is the nature of the helping relationship within the feminist counselling approach. The helping relationship is regarded as a relationship of equals wherein reciprocity and mutuality are shared. This concept is again diametrically opposed to the power imbalance inherent in the more traditional type of expert/therapist - sick/patient relationship. The helping relationship within the feminist counselling approach provides for "conscious reciprocal learning between the counsellor and the consumer" (Levine, 1983, p. 82), through which authentic, mutual trust and respect grow. In such a relationship the counsellor manifests openness, and uses personal self-disclosure if it has relevance to the client's circumstance. Since the client is deemed to be the expert about their own experiences, the client controls their own process in this relationship. This too is contrary to the more traditional therapeutic models where the "expert" therapist actively directs the therapeutic process on the presumption that he or she best knows what the client needs. From this it is evident that Guided Confrontation Therapy and Re-grief Therapy, previously described, are of this more traditional vein, and as such are antithetical to the values and attitudes of feminist counselling.

Finally, feminist counselling also focuses upon helping women reassess the importance and value of developing relationships with other women. Through such relationships women can cultivate opportunities to grow and change, through a network of mutual support and a locus for collective action.

It should be noted however, that the primary underlying basis of feminist counselling is that of respect. Levine (1983) cautions that:

> if a feminist analysis of women in society is not connected to a fundamental respect for the consumer in relation to where she is, what she wants, how she works best at coping, moving on, making changes, then there can be no worthwhile process or product. (p. 80)

It is this fundamental and deep respect for the client and the client's own process, coupled with the reciprocal nature of the helping relationship and its growth orientation, that make the feminist counselling approach a sensitive, helpful and healing one when working with issues of grief.

2:3:4 Right Brain Adjunctive Therapies

Brain research of the past 15 years has discovered that we humans are really "of two minds". Ornstein (1972), Fagan (1977), Bolen (1979), Ferguson (1980) and Buzan (1983) relate the significance of this finding in the fields of human psychology and learning.

In essence, this research relates that the human brain is divided into two hemispheres, termed the "left brain" and the "right brain". Each hemisphere has a different role in our functioning. According to Bolen (1979), the "left brain",

> contains our speech centres, and uses the logic and reasoning of linear thinking . . . . It focuses on what is tangible and measurable . . . . The left hemisphere sees the "bits" or "parts" and the cause-and-effect relationships between them, rather than the whole interacting picture.
>
> The right cerebral hemisphere is quite different: Images rather than words are its tools. It knows through intuition what the totality of a picture is. The "right brain" can contain ambiguities and opposites. It takes in the whole of an event at once, rather than focusing on a detail or part. The right hemisphere compares through metaphor rather than measurement. (p. 7-8)

The right brain is also associated with emotional experiencing and expression, rhythm, music, images, dream-

ing, imagination, day dreaming, colour, and dimension, (Fagan, 1977; Buzan, 1983). Ferguson (1980) notes that "the right brain completes the gestalt. It is whole-making, holistic." (p. 78)

It is these right brain functions of affective expression, imaging, intuitive knowing and holistic closure that make interventions geared toward the right brain particularly useful with grief; especially when one considers the great importance in grief work of completing the gestalt of "unfinished business".

This section will briefly highlight five adjunctive therapies that elicit right brain functions and that have relevance as interventions with grief. These will include gestalt therapy, psychodrama, Progoff's Intensive Journal Process, hypnosis and phototherapy.

A. Gestalt Therapy

According to Frederick Perls (1980), its founder, the technique of Gestalt Therapy:

> is to establish a continuum of awareness. This continuum of awareness is required so that the organism can work on the healthy Gestalt prin-

> ciple: that the most important unfinished situation will always emerge and can be dealt with. (p. 51)

In grief interventions, the most important unfinished situation is often the "unfinished business" or unresolved issues that exist between the deceased and bereaved individual. (Kubler-Ross, 1969; Yablonsky, 1976)

A Gestalt technique useful in facilitating the completion of "unfinished business" is that of role-playing within the context of what is commonly termed "the empty chair technique" (Zinker, 1977, p. 150). In this technique the client is asked to express what he needs to say to the deceased who is visualized in an empty chair facing the client. Once the client has said what needs to be said, the client is then asked to move to the empty chair and to respond as the deceased. A dialogue evolves with the switching back and forth between the chairs. This technique provides the vehicle for the unfolding of the Gestalt premise that there is a natural "tendency of unfinished situations to complete themselves" (Perls, 1980, p. 280). It is important that unfinished situations in grieving, and in living generally be completed, for "if you resent, you can neither let go nor have it out" (Perls, 1969, p. 49). You become stuck in your pain.

Thus, this Gestalt technique allows the bereaved individual the opportunity to complete their "unfinished business" with the deceased, enabling them to achieve holistic closure in this relationship in the here and now. With such a completion of their unfinished Gestalten, the bereaved individual can then withdraw their emotional attachment from their relationship with the deceased, complete their natural grieving process and be freed to re-invest in living. This is a possibility that a more rational, logical, linear, left brain oriented intervention could not offer the bereaved.

It is important to note however that the essence of Gestalt is the continuum of awareness in the here and now, and not the Gestalt techniques. (Perls, 1977) The "empty chair" technique in and of itself is no more "Gestalt therapy" than "Gestalt therapy" is an empty chair. Gestalt techniques are a means to an end (awareness) and are not an end in themselves. Such techniques applied without regard to the specific situation and the individual's need of the moment are simplistic, superficial, mechanical and unauthentic.

> A Gestalt therapist does not use techniques; he [or she] applies himself [or herself] in and to a situation with whatever professional skill and

> life experience he [or she] has accumulated and integrated. There are as many styles as there are therapists and clients who discover themselves and each other and together invent their relationship. (Perls, 1977, p. 223)

Through this relationship and the continuum of awareness that is fostered, clients are provided an opportunity to complete their "unfinished business" in the here and now.

B. Psychodrama

Psychodrama is an action-oriented, adjunctive, group therapy process developed by Jacob L. Moreno in 1922. A psychodrama consists of three phases: (1) the warm up, (2) the action, and (3) the sharing session. (McLean, 1968)

In psychodrama the Protagonist (who is the focus of the psychodrama) is guided by the Director (who is responsible for the completion of the therapeutic enactment) through significant life situations of his or her past, present or future. Auxiliary egos from the group play the roles of those who are not present. (McLean, 1968) The structure and direction of the psychodrama emerge from an attunement with the specific needs of the individual in a particular situation at a given moment in time. (Siroka & Schloss, 1968)

Elements of psychodrama usually include the use of auxiliary egos, role playing, role reversals and doubling. Yablonsky (1976) notes that similar elements are found in Gestalt therapy with one important difference. In Gestalt therapy the roles are never played by other persons as they are viewed as projections of the patient. Psychodrama, however, regularly uses auxiliary egos to play the roles of those not present, with one exception. Psychodrama dealing with issues of grieving is very similar to Gestalt therapy in that they commonly use "the empty chair technique" (Mclean, 1968; Starr, 1977) or an interaction with a symbolic representation of the deceased (Abraham, 1973; Kaminski, 1981) rather than using an actual person (auxiliary ego).

The action orientation of psychodrama involves the participants both in mind and body, exerting an influence on their emotional, cognitive and behavioural aspects. Through this holistic involvement

> the "make-believe process" disappears as the patient becomes involved and begins to think, feel and act the way he [or she] does in actual life situations. (Starr, 1977, p. 5)

Thus psychodrama affords its participants the opportunity to re-create the past, or to rehearse present or future situations as they wish them in the here and now. (Yablonsky, 1976; Starr, 1977)

Abraham (1973) suggests that psychodrama has rarely been used to help humankind in their ability to face death due to social attitudes that render death a taboo subject. The usefulness of psychodramatic techniques in dealing with the subject of grief and death, however, have been supported by McLean (1968), Moreno (1973), Abraham (1973), Yablonsky (1976) and Kaminski (1981).

One psychodramatic intervention to facilitate the emotional withdrawal from the deceased and to free the bereaved individual for relations with the living, is the "good-bye technique", described by Robert C. Kaminski (1981) to resolve family grief. Kaminski utilized this technique during the enactment phase of a family psychodrama.

This "good-bye technique":

1) has the bereaved individual address the deceased person with a remembrance she/he has about him/her, be it positive or negative,

2) then has the Director instruct the bereaved individual to tell the deceased whether he/she will be missed, and

3) finally, the Director instructs the bereaved individual to make a clear "good-bye" statement to the deceased.

This "good-bye technique" was designed:

1) "to heighten the emotional impact and work toward facilitating a catharsis" (Kaminski, 1981, p. 110), and

2) to structure a final "good-bye" so that the emotional termination of a significant part of their relationship as they knew it could occur.

A second psychodramatic intervention related to grief and these same goals is described by Ada Abraham (1973). Her intervention is a variation of the "magic shop technique" (Starr, 1977, p. 133). Abraham, as director of the psychodrama, worked with a bereaved woman whose wish it was to have her brother alive. He had disappeared during World War II and was presumed to have died at Auschwitz. The woman could never reconcile herself to his likely death. The Director asked her questions, in the present tense, about her brother and what he is now doing, thereby inviting the woman to create her wish of having her brother alive. Having let her relish this fantasy in which she shared all about the family, children and life she imagined for her

brother now, the magic-shopkeeper (the Director) then collected the price for this wish. "Come on, lay some flowers on his grave, this is the price." (Abraham, 1973, p. 88) With the support of the Director and the group, the woman was then able to "find" her brother's grave, and to lay him to rest; something that she had not been able to do, emotionally, in over 30 years.

The above interventions demonstrate the value of action-oriented, holistic, psychodramatic techniques with issues of grieving; especially where the emotional component of grief has been stuck, due to "unfinished business" or has been frozen through denial.

C. Intensive Journal Process

The Intensive Journal Process was developed by Ira Progoff in 1966 with the basic text for its use, At a Journal Workshop, first published in 1975.

The Intensive Journal Process can be conducted within the contexts of a leadered workshop with a room full of people, under the individual guidance of a person trained in this skill, or by oneself, once one has learned the technique. In every instance, the Intensive Journal Process can

be an entirely private undertaking. It fosters holistic personal growth with potential benefits for:

(1) self-balancing, especially at times of crisis and transition, and

(2) life-integration, if one engages it continuously over time. (Progoff, 1975)

Through a process of meditation, contemplation (termed Twilight Imaging) and free-flowing, unconscious Journal recording and feedback, one leaves their everyday consciousness behind and travels "down into the well of our lives to work in the deep places of the underground stream" (Progoff, 1975, p. 285). Tapping this well allows one to access all people, of all places, through all time. It is this feature of the Intensive Journal Process that has particular relevance to interventions with grief. As such, the Intensive Journal Process allows an individual to dialogue, through their Journal, with anyone with whom they have "unfinished business" in the here and now, regardless of whether that person is living or dead. This permits the bereaved individual an opportunity to complete their "unfinished business" with the deceased so that they then can withdraw their emotional attachment from that relationship and be freed to re-invest in living.

As Progoff notes in quoting from the motion picture, I Never Sang for My Father, "Death ends a life, but it does not end a relationship" (Progoff, 1975, p. 164). Relationships between people have a life of their own, irrespective of the dimensions of time and space. The Intensive Journal Process allows us to explore those relationships of inner significance to us until their natural demise, when our Gestalten is complete and we have no further need for engagement.

D. Hypnosis

Success using hypnosis as an adjunctive therapy in interventions with grief was reported by Dr. Stephen Fleming, a psychologist, at The First Canadian National Conference on Palliative Care, in Winnipeg, Manitoba, on October 7, 1985.

Dr. Fleming uses hypnosis on clients with grief-related problems, wherein they have disassociated from the affective component of their grief and are feeling stuck in a state of inhibited grief. Fleming hypnotizes these clients to achieve an altered state of consciousness in which the emotional affect of their grief response becomes accessible, and abreaction is forthcoming. Their grief work is address-

ed in this altered state with Fleming's direct, verbal suggestion that the clients will remember all that has transpired within the session when they return to their normal state of consciousness. In this way, people who have inhibited their emotional response to their grief for fear of losing personal control, fear of losing their attachment to the deceased, or whatever reason, are freed to grieve fully in the safety and confines of the therapy session. They are thus able to work through and resolve their grief through the therapeutic use of hypnosis. These positive results have then carried over into these clients' everyday lives, demonstrating the effectivness of hypnosis as an adjunctive therapy in interventions with grief.

E. Phototherapy

> Phototherapy is not a therapy onto itself, but rather a methodology applicable to any theory or approach . . . it is an open-ended collection of methods that allow therapists and clients access to previously blocked areas of feelings, thoughts, attitudes, memories, expectations, etc., that had otherwise been unavailable through ordinary verbal means of counselling. (Weiser, 1985, p. 12)

Phototherapy usually involves the client in an exploration of one or more of the following: historical/biographical albums, photo-taking assignments by the client, photos

of the client by others, self-portraits, photos selected by the client, videotapes and darkroom work. (Weiser, 1985; Krauss, 1983A; Krauss & Fryrear, 1983)

Phototherapy's orientation toward the visual, non-verbal, metaphorical/symbolic, right brain type of accessing of information, stimulates clients to respond in less guarded, more intuitive and emotional ways. (Weiser, 1985; Krauss, 1983B)

The efficacy of using photos and phototherapy in working with issues of loss, endings and grief has been espoused by Lewis and Butler (1974), Volkan (1975), Wikler (1977), Ramsey and Noorbergen (1981), Krauss and Woldt (1983) and Reid (1985).

Specific functions of phototherapy, related to issues of loss and grief, include:

1) Evoking, in the present, the memories, emotions, and the feeling/state experienced at the time of the photo, in the past. (Volkan, 1975; Krauss, (1983A); and Weiser, 1985)

This function is very important in facilitating a client's acceptance of the emotional component of their

grief, as evidenced in Volkan's Re-grief Therapy (1975), previously described in Section 2:3:2.

2) Eliciting perceptions, insights and attitudes that were previously inaccessible, through the therapists sharing of the client's symbolic world, the visual metaphor that is the photograph. (Krauss, 1983A; Krauss, 1983B; Weiser, 1985)

3) Serving as a transitional vehicle in helping people move through discussions of "there and then", to discussions of concerns and issues facing them in the "here and now". (Lewis and Butler, 1974; Krauss and Fryrear, 1983)

Life Review Therapy (Lewis and Butler, 1974) uses photographs as such a transitional vehicle in helping elderly individuals come to terms with, and grieve for their past, their losses and their own mortality.

4) Stimulating the exploration of issues of "unfinished business", using the photograph as a symbolic representation of the deceased. (Volkan, 1975; Wikler, 1977; Ramsey and Noorbergen, 1981; Reid, 1985)

As evidenced above, phototherapy is a right brain oriented, adjunctive therapy that can be very useful when working with issues of loss and grief.

One must be cautioned, however, that photography techniques alone do not a therapist make. Such techniques are empty and superficial without due consideration of the nature of the client-therapist relationship, and the vital issues of trust and timing. (Krauss and Woldt, 1983). Expanding on this, Judy Weiser (1985, p. 15) concludes:

> Phototherapy is more a way of thinking than a set of fixed techniques, a state of readiness to fully comprehend the entirety of what passes by as comments are made, an ability to really hear what one is listening to, for what it may reveal about the person speaking, if only you are open to receiving it!!

2:3:5 Social Interventions

The final part of this section, Clinical Interventions with Grief, deals with Social Interventions. By this I mean interventions, primarily of a self-help nature, that are directed toward helping bereaved individuals by enhancing the social support available to them. Self-help groups, widow-to-widow peer counselling programs, and feminist consciousness-raising groups will be examined as social interventions intended to enhance the social support available to bereaved individuals.

A. Self-Help Groups

The impetus for the creation of self-help groups often grows out of the need of individuals who have experienced a bereavement to help others moving through a similar loss. These groups are generally run by and for bereaved individuals; some do maintain professional linkages for purposes of consultation. Through their group meetings, members share mutual support and friendship, the special empathy that can come from someone who has shared a similar loss, as well as practical resource information. (Raphael, 1983) Research by Bankoff, Bond and Videka (1980) suggests that people also join such groups seeking new social connections who could give them support not available from family or friends after the death of a spouse.

Two self-help organizations dedicated to the needs of bereaved individuals are:

1) The Society of Compassionate Friends, an international organization for bereaved parents, and

2) THEOS, Inc., a nation-wide American organization for the widowed.

Research by Borman and Leiberman (1981) that sent questionnaires to 721 members of a nation-wide self-help organization for the widowed, THEOS, with follow-up one year later, illustrated the value of such involvements to some of its members. Borman and Leiberman (1981) found that former members who had been actively involved with the organization and currently felt no further need for participation, as well as those who actively attended meetings and extended their social networks through relationships with other members, reported less depression, increased self-esteem, and a lower use of psychotropic medication than did those members who discontinued contact after one or two meetings, or who actively attended meetings but did not extend their social network through their membership. This study helps to demonstrate the importance of social network support in bereavement, and how self-help groups can provide for this need.

B. Widow-to-Widow Programs

Widow-to-widow programs are described in the works of Phyllis Silverman (1974; 1977; 1982), Mary Vachon et al. (1980) and her colleague, Joy Rogers et al. (1980). Such programs are viewed as a means of providing "a transitional support system" (Rogers, 1980, p. 846) to newly bereaved

women faced with the role transition from that of "wife" to "widow".

The widow-to-widow programs utilize the life experience of "widow contacts" (Vachon, 1980, p. 1381) who are widows who have resolved their own bereavements and have participated in training sessions on bereavement, supportive counselling, and community resources for widows. As such, the widow contacts bring empathy, emotional support, and practical assistance to the newly bereaved women whom they visit. Silverman notes that the widow contacts not only provide emotional support but also serve as positive role models and a bridge to the real world for the newly widowed. (Silverman, 1982)

In a Canadian controlled study of a widow-to-widow type of self-help intervention, Mary Vachon et al. (1980) found that those receiving the widow-to-widow intervention followed the same general course of adaptation as did the control group but that their rate of achieving landmark stages was accelerated by participation in the widow-to-widow program.

The extensive growth of other such programs (Rogers, 1980) and the results of this controlled study both demon-

strate the value of the widow-to-widow type of program as a social intervention that provides a significant transitional support system to newly widowed women.

C. Feminist Consciousness-Raising Groups

> . . . a process of realization, of making real inside the self an event that has already occurred in reality outside. (Glick, 1974, p. 8)

This is a definition of "grief" offered by Colin Murray Parkes. In many ways this definition also describes "consciousness-raising", a tool of feminism, wherein women get together in mutual support groups,

> to search out the commonalities in women's apparently personal, individual experiences and to trace their political roots in the social organization of women's lives in a male-dominated society. (Greenspan, 1983, p. 232)

Women in consciousness-raising groups, like widows, are undergoing "a process of realization, of making real inside [the personal sphere] an event that has already occurred in reality outside" [the political sphere]. The "event" is the "realization" that women are indeed collective victims of oppression in our male-dominated society. (Mander, 1974; Havens, 1980; Posner, 1980, Richards, 1980; Conrad, 1982;

Jagger, 1983) Like widows (Lopata, 1979) these women are faced with the loss of their former assumptive worlds and the task of reconstructing their self-identities in light of this new realization. Given that widows and women in consciousness-raising groups both face these same challenges, the consciousness-raising process could potentially be a healing, growth experience for women undergoing either a bereavement crisis and/or seeking personal development, as "therapy is a consciousness-raising process" (Mander, 1974, p. 37).

Research into the efficacy of consciousness-raising as a social intervention in the crisis of bereavement is lacking. One pioneering study, however, by Carol Barrett (1978) compared the effectiveness of a bereavement self-help group, a "confidant" group, and a women's consciousness-raising group, in facilitating change in widows of all ages, in all stages of widowhood, regardless of duration. Barrett found that:

> life changes were significantly more positive in the women's conscious-raising groups and post-test evaluations of the program by these subjects were significantly higher. (Barrett, 1974, p. 20)

Such empirical findings, as well as the positive personal experiences shared by the women in the post-test evaluation, demonstrate the significant value of consciousness-raising groups as a social intervention with widows.

2:4 THE ELDERLY WIDOW WITHIN THE NORTH AMERICAN SOCIAL CONTEXT: IN TRIPLE JEOPARDY

To be bereaved in a death-denying society, old in a youth-oriented society, and female in a male-dominated society is to be in a position of triple jeopardy. This is the lot of the elderly widow in the North American social context.

This section will provide an analysis of the status of elderly widows within the North American social context from a feminist perspective; feminism being broadly defined "as a movement for the elimination of sex-based injustice" (Richards, 1980, p. 4). This analysis will include an examination of societal attitudes, beliefs and the stigmas projected upon older women (most of whom are widows), as well as how these societal attitudes and beliefs manifest themselves in the self-perceptions and social realities within the lives of older women.

The first stigmatized status to be explored here is that of being bereaved in a death-denying society. Gorer (1965) describes "the modern pornography of death" (p. 175), wherein like sex in the Victorian era, death has become the unspeakable, taboo subject of our time. "Giving way to

grief is stigmatized as morbid, unhealthy [and] demoralizing." (Gorer, 1965, p. 113) Pine (1980) attributes this social attitude to modern society's institutionalization of dying. No more do people commonly die at home with their loved ones, but at nursing homes and hospital institutions. As such, society encounters death first-hand much less closely and this lack of familiarity with this part of the life cycle engenders fear, uncomfortableness and an ignorance of how to best cope with the death experience. Being as the majority of deaths occur amongst the elderly, the old become associated with the stigma of death and hence are devalued and avoided in our death-denying society. (Curtin, 1972; Freese, 1977; Levin and Levin, 1980; Posner, 1980) Widows, outnumbering widowers by nearly five to one in Canada (Statistics Canada, 1982), bear the largest brunt of this stigma.

Modern society's lack of normative guidelines and social support during bereavement have contributed to leaving bereaved individuals in an insecure and vulnerable state. (Gorer, 1965; Parkes, 1972; Kavanaugh, 1977; De Spelder & Strickland, 1983) Gorer (1965) and Parkes (1972) indeed suggest that society's attitudes to death and grieving contribute to the formation of morbid grief reactions.

Increased public education and awareness about death and the natural grieving process are essential to create healthier social attitudes and greater social sensitivity and support for bereaved individuals. (Kubler-Ross, 1969; Raphael, 1983; Fleming, 1985) Elisabeth Kubler-Ross is a foremost leader in this work of heightening public awareness about issues of death, dying, and grieving through her many books and lecture presentations. Her workshops also create healing opportunities to deal with issues of loss within a group context, for professionals and lay people alike.

Being "old" and being "female" are two further stigmatized statuses that jeopardize elderly widows. (Cohen, 1984; Dulude, 1978; Faulkner, 1980; Havens, 1980; Lesnoff-Caravaglia, 1984; Nett, 1982b; Payne & Whittington, 1976; Posner, 1980, 1984; Preston, 1975) Each of these stigmatized positions is powerful enough to bear, yet the social consequences of being old and being female are so intertwined and compounded in effect that they shall be dealt with together.

The power basis of this double stigma lies within our traditional socialization process. (Bardwick & Douvan, 1971; Komisar, 1971; Sontag, 1972; Faulkner, 1980; Posner, 1984)

In this process female children are taught that they are valued for "being" good girls, good students, good wives and mothers; in effect "being" in relation to the needs of others. (Bardwick & Douvan, 1971; Sontag, 1972; Posner, 1980, 1984) Female children are also socialized to believe that women are valued for their physical attractiveness and their young, beautiful bodies and that their roles in life are to be:

1) sex objects, to secure a male partner who will provide for them;

2) nurturers, to provide for the physical and emotional needs of their male partner, as well as for the bearing and raising of his children. (Komisar, 1971; Sontag, 1972; de Beauvoir, 1974; Faulkner, 1980; Posner, 1980, Levine, 1983)

The socialization process for male children is different, however, in that their physical attributes are not the focus of attention. "Women are their bodies, men are their accomplishments." (Posner, 1984, p. 70) Male children are socialized to believe that they are valued for "doing" and they are encouraged to actively pursue objective accomplishments in the world. (Bardwick & Douvan, 1971; Sontag, 1972; Posner, 1980) As such, males go through life developing skills, competence, and a personal sense of identity in the

world through their work and vocational roles, while females are socialized to adopt a derived status and a borrowed sense of identity through the man to whom they are attached through marriage. (Posner, 1980)

While this type of homemaker/breadwinner marriage was highly socially sanctioned and mutually acceptable to the marriage partners at the time, such arrangements held adverse consequences for both men and women given the complementary nature of the narrowly-defined sex roles that delimited both sexes from a more whole knowledge of their total potentiality and being. As the focus of this practicum is upon elderly widows, however, this paper shall only examine the psychosocial consequences of the traditional socialization process upon women.

The majority of older women of today were a part of such homemaker/breadwinner unions. It is this generation of women who are now most acutely experiencing the "double whammy" (Posner, 1980) consequences of being old and of being female in our male-defined youth-oriented society.

These consequences result from the traditional differences in the socialization process of males and females. As the male ages, his experience in the world and his accom-

plishments establish his self-identity and accrue to him social and economic power, as he increasingly becomes more socially valued and desirable with age.

The female, however, having been socialized to stake her being on her physical attractiveness, becomes increasingly less socially desirable and valued in our youth-oriented society as her youthful looks fade with age.

Years pass, children grow up and move out on their own, and the young wife and mother becomes "an older woman" who, through the death of her spouse, often finds herself alone for the first time in her life. Having derived her sense of identity from being the wife of a particular man, and viewing her role in life as that of nurturer of her husband and their family, the older woman is left both roleless and without a sense of personal identity upon the loss of her husband. (Lopata, 1973a)

Kuypers and Bengtson (1973) suggest that at such times of vulnerability, elderly individuals look outside themselves to the external world for cues regarding appropriate behaviour. In our male-defined, youth-oriented society, the cues that elderly women then encounter are powerfully negative sexist and ageist stereotypes of older women. (Payne &

Whittington, 1976; Nuessel, 1982; Butler, 1982) Their identifying with and integrating of these negative stereotypes as a part of their identity, results in a greatly devalued sense of self, and the development of an internalized sense of incompetence termed the Social Breakdown Syndrome. (Kuypers & Bengtson, 1973) It is thus hypothesized that negative societal attitudes and stereotypes of elderly people generally, and elderly women in particular, can dangerously impact upon the well-being and self-perceptions of these individuals.

While the death of her partner and her ensuing loss of self-identity and role is most stressful, the elderly widow is often faced with two other painful social realities resulting from being a bereaved, older woman in our North American social context. These are loneliness and poverty.

Loneliness is a major problem of elderly widows. Almost half of the widows in Lopata's study (1973a) listed loneliness as their most serious difficulty and another third name it as the second area of greatest concern. According to Lopata (1973a):

> They are lonely for the husband as: (1) a total individual, a unique person, (2) an object of love, (3) the person making them an object of

> love, (4) a partner or companion in activities, (5) an escort in couple-companionate interaction, (6) "someone" with whom to talk, (7) a partner within a division of labour within the home or tying her to the economic or social world, (8) "someone" around whom work and time are organized, and (9) "someone" around the house. (p. 178)

This is a very significant loss and one that is not easily replaced in the world of elderly widows. Many circumstances contribute to their plight.

In her study of elderly widows, Lopata (1973a) found that those who were lonely or isolated lacked "the skills, money, health and transportation, for engaging or re-engaging in society" (p. 277).

Lopata's study (1973a) also found that widows, feeling like a "fifth wheel" in their former couple-oriented relationships, often abandoned these former friendships.

The social world of the elderly widow is a shrinking one in which the widow may have lost contact with old friends through the life of her marriage or lost friends through death. In "The Meaning of Friendship in Widowhood" (1977), Lopata writes that women were discouraged from keeping in touch with old friends or from making new ones during their marriage.

> Women must "hang loose" in their relationships so as not to interfere with their husband's career and their shared social life. (Lopata, 1977, p. 94)

This primary investment of women in the role of wife, and their consequent exclusion from the role of friends in the traditional socialization of women, results in their lack of alternate significant attachments and support when their spouse dies.

The chances of an elderly widow remarrying are relatively slim as there are few eligible older men and they tend to marry women younger than themselves. According to Statistics Canada (1982), 60.1% of all elderly women over 65 years are single (meaning never married, widowed or divorced), while only 24.4% of elderly men are in this same circumstance. This means that many elderly women will be without male partners.

Many elderly widows, however, prefer it this way. Raphael (1983) relates that while the young bereaved person has a long future to look forward to and to plan for without the deceased, the elderly widow views her life in terms of "time left". As such, the younger bereaved person is future-oriented while the older widow has little motivation

to relinquish her relationship with her former spouse, or to invest herself in resocialization.

Neither siblings nor extended kin can be counted on to assuage the older widow's loneliness. In her study of older widows, Lopata (1979) found "that assumptions of an extended family network, actively exchanging supports . . . are not borne out for any relatives, other than children" (p. 253).

Adult children, however, often try to mitigate the loneliness of their elderly mother with more frequent visits and telephone calls. Significantly, a study by Arling (1976) found that regardless of the intensity, "involvement with [adult] children does not seem to be an effective substitute or compensation for the lack of neighbors and friends" (p. 179) in the morale of elderly widows.

One significant variable that does make a difference in the lives of elderly widows is the presence of a confidant, someone with whom they can share that which is most significant to them. In their study of elderly persons, Lowenthal and Haven (1968) found that "an individual who has been widowed within seven years, and who has a confidant, has even higher morale than a person who remains married but lacks a confidant" (p. 27). This highlights what a critical

variable personal intimacy can be to adaptation in the later years.

Given the increasing demographic prominence of elderly women, mostly widows, and the painful and prominent features of loneliness in conjugal bereavement, further research into this aspect of the experience of elderly widows is warranted.

A second major concern of elderly widows is finances. In Lopata's study (1973a), "a third of the respondents did not know anything about the couple's finances when their husband died" (p. 91). This was the result of a division of labour that left finances in the male domain. As a consequence, many of these elderly widows faced fear and uncertainty about their financial security. They also were faced with having to learn new skills and to assume greater responsibilities at a time when they felt least prepared to do so.

Such fears about financial security are realistic ones in our patriarchal society, that underlines the devalued status of elderly widows by penalizing them with inadequate pensions for having fulfilled the primary nurturing role in

the home that they were socialized to assume. In Canada today:

> 60% of single elderly women, four out of five of them widows, are poor. Canada's public pension plans (C/QPP) pay 25% of preretirement earnings, so that women, with lower pay than men throughout their lives, continue to receive less in retirement. Most employed women have no private pension plans, and few widows receive any survivor benefits from their husband's pensions. Full time homemakers are entitled only to benefits under the Old Age Security/Guaranteed Income Supplement Program - which as the sole source of income ensures a life of poverty. (Canadian Advisory Council on the Status of women, 1984)

Such poverty obviously limits the adequacy of the elderly widow's housing, nutrition, health care and opportunities for re-socialization; all of which greatly impact upon the elderly widow's health and well-being. Atchley's (1975) study of widowhood in the later years, views income inadequacy as a powerful factor predisposing the widowed elderly to a lack of social participation, loneliness and anxiety. Atchley recommends further research investigation of the relationship between the importance of income adequacy and the adjustment to widowhood in the later years. Further research within our own Canadian context, examining sex differences in respect to income adequacy and the adjustment to widowhood in the later years, is also needed.

To conclude, this section has examined the social consequences of being bereaved, old and female within the North American social context. These social consequences--such as a devalued social status, rolelessness, a lack of a personal sense of identity, loneliness, and poverty--can be directly related back to the differential treatment of males and females within the traditional socialization process.

This traditional socialization process has:

1. excluded death from the fullness of the human life cycle, relegating it and those associated with it to the realms of the "untouchables", to be avoided whenever possible;

2. limited women from having the opportunity to develop an independent status or an identity in their own right, by socializing them to adopt a derived status and a borrowed sense of identity through the men to whom they are attached;

3. prevented women from exploring alternate roles in life outside the home sphere, thereby limiting their potentiality in the broader world and confining their role options to those of wives and mothers; and

4. prevented women from having the opportunity to establish an economic base in their own right within the wage/labour market, thereby keeping women in a financially dependent position in relation to their male partners.

As a consequence of this socialization the elderly woman of today, having devoted herself to the nurturance and

care of her husband and family, and having dutifully fulfilled the role in life that she was socialized to assume, finds herself a victim in triple jeopardy--being bereaved, old and female within the North American social context, through no fault of her own.

It is not the intent of this paper to deride the nurturing role of women or to in any way indicate that the elderly women of today made poor choices, but rather to show how very limited their choices were due to the power of the traditional socialization process. This process, however, is the product of society and society can change, albeit, often very slowly. Younger women of today would do well to learn from the experiences of these older women who went before them; and to exercise the greater options that the younger women of today have, of which the older generation of women could only dare to dream. Then perhaps we could actualize Gray Panther, Maggie Kuhn's suggestion that, "young and old can and should work together for social change. Their needs and their concerns are not mutually exclusive." (Seskin, 1980, p. 129)

This section will close with a poem from The Farmers' Advocate and Home Journal of June 10th, 1910. This poem both satirizes how our patriarchal government refuses to

acknowledge women's socially valuable work in the home, as well as pays tribute to the women of that time. It is titled,

No Occupation

She rose before daylight made crimson the east
For duties that never diminished
And never the sun when it sank in the west
Looked down upon work that was finished.
She cooked unending processions of meals,
Preserving and canning and baking,
She swept and she dusted
She washed and she scrubbed,
With never a rest for the taking.
A family of children she brought in the world
Raised them and trained them and taught them
She made all the clothes and patched, mended and darned
Till miracles seem to have wrought them.
She watched by the bedside of sickness and pain.
Her hand cooled the raging of fever.
Carpentered, painted, upholstered and scraped
And worked just as hard as a beaver.
And yet as a lady of leisure, it seems,
The government looks on her station
For now, by the rules of the census report
It enters her - "No Occupation".
(Light and Parr, 1983, p. 189)

This struggle for the social recognition of the value of women's work both in the home and in the wage/labour market continues . . .

This concludes the literature review. An overview of different perspectives on grief, of a variety of psycho-social interventions with grief, as well as an examination

of the lives of elderly widows in the North American social context, have been provided.

The practicum report, describing my experience of this exploratory study of the bereavement experiences of elderly widows, follows in the next section.

In this study, I have endeavoured to consider the situation of the elderly widows within our social context through a feminist awareness. As the feminist perspective strives for the validation of the personal experiences of all women, as well as for the equality of interpersonal relationships, I shall write of my experiences, and those of the older women who generously shared their bereavement experiences for my learning, from a personal perspective.

CHAPTER III

PRACTICUM REPORT

3:1 INTRODUCTION

Once upon a time, I chose to pursue a master's degree in Social Work to enhance my professional skills and effectiveness. As issues of loss and grief and their effect upon the human condition had intrigued me both personally and professionally through the years, I elected to conduct an exploratory practicum study of conjugal bereavement with older women.

I have had a most enriching practicum experience with respect to honing my professional expertise. More significantly to me, however, was my learning that I was most professionally skillful and effective when I was most personally myself.

Further I came to discover that professional and personal satisfaction and growth is readily available to those who are open to the "magic" of relationship. This "magic" is adroitly described by Kenneth W. Watson (1979) in "Social Work Stress and Personal Belief".

> The magic I mean is that which occurs when people truly touch each other and become a part of each other's existence--the magic of relationship, the magic of love, and the magic of knowing another being and through that person and that experience becoming more fully oneself.
>
> The magic in social work comes not because we are magicians and bring it about. It comes as a result of our genuine acceptance of the fact that each of us is unique and that in that uniqueness lies the potential for inexplicable experiences. The pursuit of magic lies in reaffirming our humanity. (p. 12)

I have introduced my practicum report above in terms of the "magic" of relationship because I accord great significance and primacy to the relationship within the helping context. I have come to believe that the helping relationship itself is the heart of any significant, healing, growth-stimulating intervention. In this practicum report I shall relate some of what I have learned from and through the older widows with whom I shared of the "magic".

In this chapter the study, findings and evaluating process will be described, and significant themes that emerged through this practicum will be illustrated. The personal expressions of some of the widows within this practicum study are quoted herein from the process recording, and have been included to add a sense of the flavour of the interactions. The participants in this study

will be termed "clients" when referred to within the context of the helping relationship for a lack of a more semantically accurate word.

3:2 THE STUDY

3:2:1 Initiation of Study

This practicum was on exploratory study of conjugal bereavement with older women. The target population was local widows of elderly men who had died within the Department of Geriatric Medicine at the St. Boniface General Hospital, in the 18 month period preceding the start of this practicum in July of 1984. Initially, introductory letters were mailed to these widows inviting their participation in the study. A copy of this letter is appended, (Appendix A). The letter requested one interview in which the widow and I would discuss her bereavement experiences, with the possibility of meeting again if that was mutually acceptable.

Telephone follow-up to the introductory letter established those women who were willing to participate in the study.

By the end of the initial visit, I offered to again visit those widows:

1) whom I felt could benefit by having further support in discussing or acting upon their bereavement-related issues, and

2) from whom I felt that I could learn more through the further sharing of their bereavement experiences.

3:2:2 The Participants

A total of 12 widows agreed to participate in the study. These women were visited in their own homes, with some subsequent telephone contact with a few. Three more widows, who chose not to participate in the study, partook of some limited telephone contact.

The participants ranged in age from 50-78 years. Two distinct age groups emerged. There were:

1) three women (25%) in the 50-56 year old range, all of whom had adult children and had worked in the wage labour market at some point in their lives, and

2) nine women (75%) in the 66-78 year old range.

All but one of these widows had exclusively invested their labour in their families and/or family businesses or farms.

Three of the widows (25%) spoke English secondary to their native French language. Initially, these widows expressed self-consciousness about their "broken English",

but as the comfort of our relationship was established, language ceased to be a concern and the dialogue flowed.

Contacts ranged between one and seven sessions, of three and one-half hours to 20 hours duration.

Widows were nearly equally distributed between those who were more recently bereaved (i.e. within the previous five months), and those whose bereavements had occurred within the preceding 12-18 months.

While the practicum was primarily conducted between July and December of 1984, some continuing contact was maintained with one woman over 22 months.

The widows were engaged at the point where they were at in their own bereavement process. For some the interventions focused upon the "grief work", for others it was looking more outwardly to the reconstruction of their lives as single women.

3:2:3 Practicum Objectives

The objectives of the practicum were:

1) to explore and to learn about the bereavement experiences of elderly widows within our North American social context, and

2) to provide bereavement follow-up to some elderly widows to support and facilitate their grieving process through the sharing of their experiences.

More specific objectives of this bereavement follow-up were:

A. to help normalize the grief experience,

B. to explore some of the feelings associated with grief, such as sadness, abandonment, anger, guilt and helplessness,

C. to provide emotional support, encouragement and hope,

D. to encourage the widows' growth toward greater personal competency and self-confidence,

E. to assist widows in the solution of immediate, practical problems, e.g. Canada Pension benefits,

F. to help the widows consider their future life options and opportunities in their new role as single women,

3) to gain greater expertise in facilitating the grieving process through my practicum experience.

3:2:4 Method

The practicum objectives were pursued through the use of supportive, nondirective interviews guided by and based upon:

1) Bereavement counselling objectives, principles, and procedures outlined by J.W. Worden in Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner (1982),

2) Beverley Raphael's (1980) "therapeutic assessment interview" (p. 155) format, (Appendix B), and

3) Questions of interest to me derived from my reading widely of the literature. A listing of the areas explored is found in Appendix C.

The practicum objectives were addressed through the use of bereavement interventions designed to be supportive and facilitative of the widows' grieving process.

3:2:5 Relevance of Study Design

The design of this study, with its emphasis upon its voluntary and exploratory nature, was an integral part of the process that unfolded. That is, the design structure complemented the function that it was meant to serve.

Being a fully voluntary study the widows, who were apt to have experienced the loss of a sense of control in the face of death, were encouraged to decide whether they wanted to participate, and if so, to control their own process. This emphasis, upon the fully voluntary nature of their participation, was both most ethical and useful in restoring some sense of control to the older widows. A number of the

women made comments to this effect. They indicated that they were talking to me because they wanted to; they knew that they did not have to.

The exploratory nature of this study design allowed me to avoid what I deemed to be the "pitfalls" of a more problem-focused approach.

The "pitfalls" avoided were:

1) having grieving generally identified as a "problem", when I view it to be a part of the natural healing process,

2) labelling the participants and undermining their personal competency by suggesting that they have a "problem",

3) a power imbalance in the helping relationship that is more inherent in a problem-focused approach.

The exploratory nature of the study design allowed for the development of an egalitarian, reciprocal relationship with the widows through which the practicum objectives were achieved. The widows respected my experience and expertise, and I respected theirs as experts in their own grief. The exploratory nature of this study allowed for the widows and me to learn and grow together through the sharing of our own unique experiences.

Thus the study design was an integral part of the enriching process that unfolded in this practicum experience.

In this study, it was my intent to proceed with an approach that was congruent with my own style, attitudes and values. In retrospect, I have come to realize that the attitudes, and values reflected in the design and implementation of this study are also compatible with those of the feminist counselling approach, previously described.

3:2:6 Considerations for a Practicum in the Area of Bereavement are:

1) That grieving is generally a lengthy process. Graduate students cannot realistically hope to experience the start to finish progression of any one individual's grief, given the limitations of time involved in a practicum study. Instead, a practicum provides a valuable "sampling" of bereavement experiences touching on various phases of bereavement in the lives of a number of different individuals over a given period of time.

2) That bereaved individuals have their own personal timetables for grieving. It is my belief that bereaved individuals should be their own "taskmasters" in grieving,

pursuing that which is most important to them when they are ready to do so. The graduate student's creating a trustworthy, empathic and supportive relationship, helps facilitate this process by creating a safe and nurturing environment in which this can occur. It can, however, be very frustrating to a student working under time limitations to proceed at the bereaved individual's pacing.

For example, I discovered that some older widows, who said that they wanted to see me again, could not commit themselves to even setting up an appointment time with me because they wanted to remain "available" just in case their children called to invite them out. I put the process in their hands, asking them to call me when they wanted to see me; and these women eventually did so. As a graduate student working under time constraints, this was both difficult and frustrating for me to do. I continually wondered whether perhaps these women really did not want to see me, or whether they would call when they were ready. The latter was true in the end, but I did not know this until they called, and the waiting was a necessary, yet frustrating experience for me. Through this encounter I came to see how one must be vigilantly aware of one's own feelings, needs, and motivations, so that these personal needs do not unconsciously interfere with one's being sensitively

respectful of the bereaved individual's own process and pacing.

3) That working with bereaved individuals can be an intensive, dynamic, powerfully creative and personally enriching experience for those who are willing to risk being real.

3:3 FINDINGS: CONJUGAL BEREAVEMENT AND OLDER WOMEN

The following findings are based upon my exploration of conjugal bereavement with 15 older widows. These findings are not meant to be generalized beyond this study sample. They are, however, truly representative of the life experiences and personal realities of the 15 unique, older women who contributed to this practicum study.

3:3:1 Social Network Support

A) Relevance in the Facilitation of the Grieving Process

The relevance of social support networks during the bereavement crisis has been noted in the literature by Silverman 1972, 1974; Lopata 1973a; Maddison and Raphael 1975; Walker et al. 1977 and Vachon 1982.

The influence of social network support quickly become evident in this exploratory study with elderly widows in terms of the women's willingness to participate. The women who had a social network that would sanction or permit the expression of grief, had been encouraged by their network to participate in this study. One woman said that she had

shown my introductory letter to five different friends to see what they thought of her participation. They unanimously had encouraged her to see me. This woman related that while she initially thought that she would like to see me, her friends provided the "extra push" needed to support her decision. It is my belief that the widows with social networks supportive of the grieving process, knew that they wanted to talk about their grief, and also had a feeling-sense that their social network would encourage such an activity, and so these widows checked it out with their network to garner further support for this venture. In a sense, they wisely put in place a sort of psychological "safety-net" for themselves.

Other women, whose social networks did not tolerate the expression of grief, also agreed to see me without bothering to discuss their decision with anyone. I believe that these elderly widows sensed that their need to talk about their grief ran counter to the ethos of their social network. Not wanting to alienate their supports, these widows chose to make an independent, personal decision to participate.

Also encountered were women who chose not to see me because they said it was too painful for them to talk about their grief. During these telephone follow-ups to my

introductory letter, I told these women that I fully respected their decision not to see me, and I reiterated, as the letter clearly stated, that their participation was fully voluntary. Three of these women then proceeded to talk unprompted for up to an hour and a half about their grief, and why it would be too painful to talk to me about it. "I'm crying about it now!" Each of these women shared that their friends and/or families had encouraged them not to grieve. "He's dead and gone. You have to pick up the pieces and forget the past." With such clearly foreboding messages against the expression of grief in their worlds, these women chose not to commit themselves to see me to discuss their bereavement experiences. I believe that these vulnerable women feared that doing so may have alienated them from their social support networks.

Their circumstances are most unfortunate in consideration of the literature that bespeaks, (1) of the psychological necessity of grieving, and (2) of the vital importance of having a social network that supports the grieving process.

The relevance of social network support in facilitating the grieving process was thus in evidence within this study.

B) Role of Adult Children

Adult children were reported to be an important part of the social support network of virtually every widow who had children. Although the widows generally viewed their offspring as providers of emotional and instrumental support, their grief was one subject that could not fully be shared with their adult children. Western society's death-denying attitudes and sanctions against the display of powerful emotions, coupled with static, socially prescribed family roles (eg. strong parent/vulnerable child) all contribute to the older families' inability to share their grief.

Widows related their own firm "rules" about not crying in front of their children, even though their "children" were now adults with children of their own.

A few widows, who had previously tried to share their grief with their children, described their adult children's great uncomfortableness and inability to tolerate their mothers' tears and pain. These widows told of either being jollied out of talking about their grief, or being instructed that what is passed is passed. The subject was closed. These widows soon learned what they could share with their adult children. Kuypers and Bengtson (1983) have suggested

that such reversals of their historical pattern of familial exchange are often difficult for the older family to negotiate.

Thus while adult children were reportedly the most significant support of elderly widows in every other way, the sharing of grief was either denied or relegated outside the bounds of the parent/adult child relationship. This is not to say that the elderly widows and their children did not talk about the deceased; some did. They could not, however, fully share the affective component of their grief together.

C) Importance of a Confidante

Lowenthal and Haven (1968) have reported on the positive significance of a confidante in the psychological well-being of elderly people.

In this study, most of the widows lacked a real confidante. Family were not cast in the role of a confidante, and only one widow claimed to have a friend with whom she could talk about "anything". Most widows reported that their husbands had been their confidants, and now they were gone.

Next to adult children, sisters were the most frequently named support of the elderly widows. Many widows, however, did not share their deepest concerns with their sisters because they either wanted to protect their sister's feelings, or to preserve their own personal privacy. Over half of the elderly widows who had sisters shared their disappointment in the lack of support that they have received from their sisters through their bereavements, particularly since a number of the widows had extended themselves to these sisters during their own bereavements previously. "That's why I called you!", one widow told me, half-joking, half-despairing.

Nearly every woman with whom I had had more than one contact, shared a "confidence" with me that they said they had not told another living being. These women needed a confidante to listen to them--they held no expectation of the confidante doing anything for them other than listen. "There", gasped one widow with relief, "now that I have shared this secret with another human soul, my heart is less burdened. I can just feel the weight taken off, (extending her hands from over her heart). I feel so much better." Other women reported similar feelings of relief with their sharing. Thus from my experience, the presence of a

confidante is of paramount importance to the well-being of elderly widows.

D) Loneliness

The loneliness of widowhood is accentuated for the elderly. (Abraham, 1972; Lopata, 1973a)

Loneliness was the foremost problem reported by the widows in this practicum study. This was not loneliness for the company of another person, but more specifically loneliness for their husbands.

In considering the loneliness of widowhood, Raphael (1983) suggests that older widows, because of their more limited "time-left" perspective, are unwilling to terminate their relationship to their former spouse, or to re-invest themselves in new relationships at that point in their lives.

While a few widows in this study strongly felt that they would never want to have any relationship with another man, more widows said that they would like male "companionship only", someone with whom to share time with socially.

None of the widows visited had any desire to remarry. Reasons for not wanting to remarry included:

1) their sense of loyalty to their former husbands,

2) not wanting the responsibility of caring for another husband should he fall ill,

3) concern about not offending their adult children with a remarriage, as well as

4) enjoying their freedom too much to give it up!

While adult children were the persons most regarded as primary supports by the widows, their relationships with their adult children did not alleviate the widows' pangs of loneliness. This was also reported in Arling's (1976) study where he reported no association between the morale of older widows and their contact with kin, especially with their adult children.

Half of the women in this practicum study of older widows did not have what could be termed "close friends". As one widow laughingly retorted, "all my friends are either gone or left!" In my seeking of clarification, she explained that they were all dead or had moved away. This too was a finding of Lopata (1977) in her study of older widows.

The prospect of establishing new relationships was not one relished by these elderly widows. Two widows, who had particular difficulty considering entering new relationships, had both been hard-working farm wives who had devoted themselves totally to their families. These women explained that they never did have time to socialize, and so were never social "mixers"; consequently they felt that this was not something that they could now do or want to try.

The widows who did have a supportive network of friends were the women who had previously been involved with church and women's clubs and remained so; as well as two childless widows who had cultured a solid circle of long-time friends of various ages through time. These elderly widows indicated that these friendships provided a revitalizing antidote to, but not a cure for, their loneliness for their husbands.

Thus loneliness presented as a painful and prominent feature of widowhood in the lives of these older women.

3:3:2 Grief Experiences of the Older Widows

A) Religion

In this study, organized religion provided spiritual comfort and a network of social support for four widows (33%). The majority of the widows, however, viewed religion as their personal relationship with God, usually in prayer, that provided them with comfort and the strength to go on.

B) Society's Lack of Normative Cultural Guidelines

Modern society's lack of normative cultural guidelines with respect to the bereavement experience renders bereaved individuals in a vulnerable position, like being dropped in a strange new land without a map (Gorer, 1965; Parkes, 1972; Kavanaugh, 1977; De Spelder & Strickland, 1983). This lack of a "map" raised questions in many of the widows visited. Questions like . . . How should I be feeling? How long does grief last? Am I going crazy? Will I every come through this? Normalizing their grief experiences was an important part of the grief work. (Gramlich, 1974; Freese, 1977; Worden, 1982)

The use of personal self-disclosure about my own bereavement experiences and allusions to the literature were used, when appropriate, to normalize the widows' grief experiences and to help them to talk about their grief. Given some orientation about normal grief, the widows were reassured, and expressed relief in knowing that they were not "off", but were experiencing some typical, albeit sometimes frightening, aspects of the normal grief response.

C) Hallucinations

Hallucinations of a deceased spouse are a relatively common feature of conjugal bereavement. (Marris, 1958; Rees, 1973) Normalizing such hallucinations can be very helpful to bereaved individuals by reassuring them that they are not going insane. This is especially true for elderly people who are beset by negative social stereotypes that equate aging with senility, and who already may be fearing the loss of their sanity in the vulnerability of their grief.

Half of the older widows visited acknowledged having heard, seen, or sensed the presence of their deceased husbands. This finding is quite compatible with that of Rees (1973) wherein 45.8% of bereaved women of all ages experienced such hallucinations.

D) Dreams

Over half of the widows in this study acknowledged dreaming about their deceased husbands. Gorer (1965), Parkes (1970b) and Pincus (1974) have also noted the incidence of such dreams in widowhood. These dreams were described by the widows in this study as of two kinds. "Bad" dreams were characterized by frantic, frustrated seeking of their husbands. In one such dream one widow described herself running through the hospital corridor in a panic, checking in every room to find her husband. She never did. The dreams characterized as "good" were those in which a momentary reunion of the spouses occurred. In these dreams both partners are well, healthy and usually young. These dreams were regarded by the widows as a source of comfort. In one such "good" dream that a widow shared, her husband squeezed her hand and assured her that she will never again be alone. This dream had such a real quality that the woman reported that she could still feel the hand squeeze upon awakening. Such dreams diminished in frequency and intensity over time, with the husbands being described at a distance in the latter dreams.

E) Preoccupation with Thoughts of the Deceased

Widows preoccupation with thoughts of their deceased husbands are a normal feature of the grief response. (Freud, S.E. Vol. 14, 1957; Lindemann, 1944; Parkes, 1972) One, however, that is thwarted in our death-denying society. While it is natural and normal for widows to need to repeatedly review their relationship with their former husbands as a part of their grieving process, society puts these women in a double-bind by blocking their efforts to talk about their grief. I was struck by the great regularity with which different widows prefaced their comments with, "Tell me if I have told you this before." When I queried why these widows had said this, most indicated that friends and family had often lost patience with them and cut them off curtly when they started to talk about their deceased husbands, telling the widows that they had already told that story in the past. The widows now asked me, rather apologetically, to tell them if they had shared a given story before. This lack of respect and sensitivity for the widows' grieving process is a sorry reflection of our death-denying society.

F) Life-Review

The positive value of Life Review with the elderly has been extolled by Butler (1974) and Kaminsky (1978). In this practicum experience I found life review to be an essential part of the healing, grieving process. Life review provided the widows with an opportunity to secure a healthy, balanced perspective of their relationships with their husbands. It also provided an integrating function by allowing the widows to review their own past in relation to their present and future potentials. As such, old coping strategies and strengths become apparent, and were re-enforced to help enhance the widows' current feelings of personal competency and confidence. The widows naturally and enthusiastically engaged in the life review, thus demonstrating their need for such an integrating activity.

G) Feelings Other Than Sadness Associated with Grief

The older widows in this study described an amalgam of feelings in their grief experiences.

Loneliness for their deceased husbands was the most prominent feeling expressed.

Numbness or feeling "like a robot", mechanically going through the motions of living, was another grief-related feeling shared.

Anger was also an aspect of the widows' grief. In one instance this anger was directed at the husband for not having sought medical attention, as his wife and family had encouraged. In other situations the anger was primarily directed at life's unfairness. These women were angry because they felt that after a lifetime of hard work, and of being devoted husbands and fathers, their husbands had deserved to enjoy their golden years. Instead, chronic illness, incapacitation and pain left their husbands looking forward only to death.

Relief was another feeling that these widows particularly experienced, in that their husbands were only spared further suffering through death.

A third of the women shared feelings of regrets related to their inability to talk to their husbands about their dying. Four widows related how their husbands had tried to initiate such discussions in the days preceding their deaths, and how the women had closed the conversation by

telling them not to talk so silly. These women related that they could not believe that their husbands were dying.

Another third of the women expressed feeling a sense of comfort in having no regrets with respect to their husband's deaths. These women, having dedicated themselves wholly to their husbands' care, often in the hospital as well as on a 24 hour basis in their homes, felt sure that they had done all that was humanly possible for their husbands. They could have done no more.

Residual guilt mixed with anger and helplessness was also described by a few of the elderly widows. These feelings resulted from a quandary that these women had found themselves in before their husbands' deaths. One woman aptly described this predicament metaphorically as being "caught between the Devil and the deep blue sea". This circumstance arose when these women found themselves caught between the competing demands of the hospital rehabilitation staff to let their husbands "do for themselves", and their husbands begging them for help. These widows claimed that they usually assisted their husbands when they perceived that the staff held unrealistic expectations of their husbands' capabilities, yet they encouraged their husbands to do all that they could for themselves. These women

constantly felt pulled in opposite directions, and felt guilty no matter what they did in this double-bind situation. They felt that they had secured the wrath of both the hospital staff and their husbands. This also resulted in great stress upon their marital relationship during their husbands' prolonged hospitalizations, as well as survivor guilt for not having done enough, upon their bereavement. Anger at being caught in this position was also apparent.

One widow related that a hospital worker had said, "Don't you realize he has you wrapped around his little finger?"

The older woman had replied that, "If he does, it is only because I am allowing it, and that is my choice."

This predicament highlights the powerfully stressful relationship concerns and the significant long-term consequences of this issue upon bereavement. This example also underlines the vital importance of exploring such management concerns with couples during hospitalization:

1) to at best remove the woman from this double-bind position, or

2) at least help her to be more aware of the dynamics

> so that she can make an informed decision about her actions given her priorities.

It must, however, be understood that the avoidance of further conflict and stress in their long-time marital relationship, and the alleviation of guilt upon her husband's demise, may well be the woman's justification for doing her all to the point of risking her husband's more independent functioning and/or her own health. Should the woman come to this decision, it is her choice, and this should be respected as her way of doing what she must do for their marital relationship now, and her own peace of mind, without guilt, upon her husband's death.

Such double-bind situations need to be addressed with the older couple as they can be most counter-productive and harmful to the individuals involved during both the hospitalization and the bereavement experience.

Finally, to my surprise, happiness was also mentioned as a feeling associated with one woman's grief.

On my initial visits with this woman she had kept her home darkened, her blinds shutting out the light of day. She only wore dark clothing. She claimed that she had

little appetite, had lost interest in caring for her plants, and was not going out socially. She also admitted to feelings of guilt over having lost all interest in what was going on in the lives of her children and grandchildren.

I had started visiting this widow during the week of the first anniversary of her husband's death. Initially this widow related that she could only think of her husband as he was in his sickness, and that pained her greatly. With time, she had come to remember some of the happier occasions that they had shared, and that too was emotionally painful because those times were gone forever. Having explored her bereavement experiences over seven sessions, this widow shared that happiness was now a part of her grief too, because she could now enjoy remembering the happier times that she had shared with her husband as cherished memories, without the pain.

This widow also related that she was happy about feeling better. "Before I had a pain here (in her chest), now it is gone." She expressed further happiness over her renewed interest in life, and her family and friends. This woman shared that her concentration had improved, and that she felt "that something has clicked inside of me, and I feel that I have snapped out of my grief".

By the conclusion of our visits, this widow was wearing lively coloured clothing, was paying greater attention to her hairstyle, was leaving her blinds open during the day, reported having an improved appetite, and was cooking full meals and baking cookies too! She also was venturing out socially with some long-time friends, and visited a senior centre with me to explore new possibilities. Looking to the future, this woman was planning to invite her family to her home for a traditional Christmas dinner, something that she said she had not done in years!

Thus happiness too, is a part of the wholeness of the natural grief response. This is an important perspective that I too had experienced while moving through a grief reaction. It is a perspective however that I have never seen mentioned in the literature. I do not believe that this "happiness" experienced by this older widow, or as I prefer, this "quickening" of the life within, is an atypical reaction. I view it as the unfolding of the completion of the natural grief response. It is unfortunate that the literature stops short and does not reflect the wholeness of the grief response. Perhaps if it did, "grief" would not bear the strongly negative cultural connotation that it now has, but would be warmly accepted (not just tolerated), as

the healthy, healing, natural response to a significant loss, that it is.

H) What Bereaved People Most Need from Others

The following are those things that the older widows in this study felt that bereaved individuals most need:

One widow offered that a bereaved individual's greatest need is "to be left alone at first to grieve". This woman related how very hard she worked at being strong in front of her family, and how her greatest need had been to get away by herself "to cry herself out".

Significantly, every woman visited reported that she had been "good" at her husband's funeral. When asked what "good" meant, they all said that they never broke down and cried. This is our cultural expectation of the bereaved.

This expectation was fulfilled by every widow in this study, despite her need to cry following the painful severance of this most important, life-long relationship to her spouse. What these women truly needed was to be socially "bad". They needed support and permission to grieve. Unfortunately, the widows generally found that they

could only find this permission when alone. This illustrates the strongly death-denying ethos of society today, where there is no place for grief.

Another widow offered that having a close friend or confidante is most important to bereaved individuals. This widow had such a friend with whom she could share "anything". These women enjoyed a mutually supportive relationship that imparted purpose to both their lives.

Friendship, generally, was also deemed an important need of bereaved people. This included friends demonstrating their caring by sending cards, phoning, and visiting to let the widows know that they have not been forgotten. Invitations to dinner, and help with practical tasks around the home were also appreciated by a number of the widows.

The majority of the widows, however, when asked what a bereaved person most needs, replied someone to talk to about their grief. This was then qualified with "not just anyone, but someone they can talk to openly, and share their feelings with, like I have done with you".

Grieving is a social event, one that is not readily sanctioned in our death-denying society. This study provided some older widows with a much appreciated vehicle for the expression of their grief through their sharing of their bereavement experiences.

3:3:3 Economic Conditions of the Older Widows

Two distinct groups of older widows emerged in this study. There was a small, younger group of three widows ranging in age from 50-56 years, all of whom had adult children and had worked in the wage labour market at some point in their lives. There was also a larger group of nine older widows, between 66 and 78 years of age. All but one of these women had invested their labour exclusively in their families and/or family farms or businesses, and as such they felt that they had never really "worked" since they were not a part of the paid labour market. What these widows, as a group of older women shared, was the prospect of poverty. How they differed was in their reactions to this possibility.

Generally, the older cohort group (between 66 and 78 years of age) were quite satisfied with their financial lot in life. This, despite the fact that 1980 statistics

indicate that 70% of widows and single women aged 70 and over live in poverty (Canadian Advisory Council on the Status of Women Fact Sheet #7, 1983). These older widows had been socialized to accept the standard patriarchal view that only labour in the paid labour market constituted "real work" deserving of compensation. As these women had invested their labour in their homemaking and not in the paid labour market, they expected nothing, and were indeed very happy to be receiving the Old Age Security which they seemed to feel that they had not really earned.

While exploring financial resources with one older widow, I found her to be veritably amazed that she might qualify for a shelter allowance subsidy (S.A.F.E.R.). She was later thrilled to receive the maximum subsidy of $140 per month when she applied with my assistance. This money made an observable difference in this woman. She related that it had inspired her to cook and to invite her family "home" for a traditional Christmas for the first time in years. As she put it, she now felt that she had something to offer them. This example corroborates the research of Harvey and Bahr (1974) and Atchley (1975), that suggests that income inadequacy is a significant factor contributing to the lower social participation and higher loneliness and anxiety associated with widowhood.

Generally, however, this particular sampling of older widows did not complain about their financial circumstances. Some, indeed, expressed thankfulness for what they were receiving. As many of these older widows were in receipt of the Guaranteed Income Supplement and/or were living in subsidized accommodation, indicators that they were indeed of limited means, I believe that this contentment with their financial situations was more a reflection of their low expectations than a measure of their affluence. Socialized to be self-sacrificing wives and mothers, asking little for themselves, these elderly widows had carried these expectations and attitudes into their later years. Unfortunately, statistics as above, indicate that society provides older women with their expectations--of little--for their lifetime of labour in the home.

The younger cohort of widows, aged 50-56 years, responded to their changed financial circumstances in a markedly different way. Two of these widows faced a sudden 75% reduction in their income with understandable shock, anger and disgust.

One widow, who had spent the previous year providing 24 hour care to her ill husband while he was home on oxygen,

shared how she wanted to slap the face of the young pension worker who suggested to her that "there is always welfare".

Another widow related her disappointment with the Women's Employment Counselling Centre that was theoretically in existence to help women re-enter the work force. This widow had in the past held an administrative position where she had to work very independently. She now lacked the self-confidence to return to the job market and to compete against younger women without upgrading to give her a marketable edge. The Women's Employment Counselling Centre deemed this woman marketable as she was, and they would not fund her desired upgrading since she only needed one course. Had she wanted to enter a new field, however, they would have paid her entire educational and living expenses.

I was astounded that a Women's Employment Counselling Centre, which was supposedly geared to enhancing the opportunities of women in the labour force, would have such inflexible policies. By denying this minimal support, such policies relegate capable women to low paying jobs when the individual woman is capable and aspires to something more.

This widow expressed great relief that I understood her position, as she felt that the Women's Employment Counsel-

ling Centre really had not. I told this woman that she really does present herself well, and I could well understand why the Women's Employment Counselling Centre would deem her marketable. I could also understand however, her feeling the need for upgrading at her age:

1) to give her a competitive edge in the young labour market;

2) to bolster her feelings of self-confidence to face the labour market at this point in her life.

I asked this widow if I could contact the Women's Employment Counselling Centre on her behalf, and for my own learning about the realities of this resource. With her permission, I tried to represent her position to them. While they conceded that they fully understood both the widow's and my positions, they regrettably informed me of their policy not to fund single courses. This widow went on to take this course at her own expense, as it was so important to her in terms of her confidence-building.

In my subsequent contact with her, this widow informed me that she had been invited to speak to a committee from Ottawa, reviewing the Women's Employment Counselling Centre's functioning, and that as a consequence, the Centre now funded single courses! This woman shared that while she

did not benefit directly from this change in policy, she was happy that her actions contributed to effecting change for other women in her same position. The woman related her accomplishment with understandable pride and self-confidence.

In this study the great economic vulnerability of the younger cohort of older widows (50-56 years of age) became shockingly apparent. These widows were thrust from a position of economic comfort to one of poverty upon the deaths of their husbands. Not yet being of pensionable age, and without jobs, these women suddenly found themselves with no source of income in their own right. Having become accustomed to a given standard of living, these widows now found that standard threatened upon their husband's demise. In addition to having to deal with the painful realities of their grief and their new-found poverty, these widows were also beset by the fact that they now had to make their own way in a world that is not particularly sensitive to their needs, being as they are old in a youth-oriented society, widowed in a death-denying society, and female in a male-defined world. As such, these older widows truly are in a position of triple jeopardy.

Thus, from the sample in this study, I found that the younger (50-56 years), and the older (66-78 years) cohort of older widows differed both in their economic expectations and in their reactions to their circumstances.

Gray Panther, Maggie Kuhn, relates that her generation of older women, that is "older" older women, were:

> programmed to keep quiet, to accept things the way they were, to comply. (Seskin, 1980, p. 130)

This aptly describes the general attitude of the older cohort of older widows in this study.

The younger cohort group of widows was distinctly different. Despite the vulnerability of their grief, they were not content to acquiesce to their fate.

I hypothesize that the social and economic consequences of women's greater participation in the paid labour market were significant factors contributing to the differences in attitudes, expectations, and reactions between the two groups of older widows. According to Eichler (1983), in Canada in 1931 only 3.5% of wives participated in the labour force. By 1979, 47.4% of all Canadian wives were in the

paid labour market. This trend for women's greater participation in the paid labour market has only increased through time. During this time, many women who had became attached to the wage labour market, came to question and indeed challenge their traditional female socialization, attitudes, and values. As a consequence, I speculate that the widow of today, who is in her fifties and who has participated in the wage labour market, is generally quite different in expectations, attitudes and values from her counterpart who may be but twenty years older, yet who has not had this experience in the wider world beyond the home sphere. Such a difference was in evidence in this study.

Gloria Steinem has suggested that:

> the male pattern is to become more conservative with age, while the experience of societal injustices causes women to become more political. (Oberster, 1986, p. 7)

I believe that this is especially true of women whose life experiences have extended beyond the home with participation in the wage labour market, as has been the recent trend.

Governments should increasingly anticipate encountering a demographically powerful political lobby of higher edu-

cated, more articulate and worldly-wise older women, given the social inequities of the current economic system.

This is an economic system wherein:

1) Women's full time wages amount to approximately 64% of those of men in the wage labour market (Canadian Advisory Council on the Status of Women, Women and Poverty, 1985);

2) Pension income is tied to inequitable income-earning power. Thus a life-time of receiving an inequitable salary is rewarded with a proportionately inequitable pension;

3) No financial recognition is paid to homemakers, primarily women, who do "socially valuable work" (Dulude, 1981, p. 62) in the home, as providing for the care of young children or disabled relatives;

4) Our current pension plans, being the product of a male-defined patriarchal society, are designed to perpetuate women's dependent status.

As a consequence of our current economic system, most elderly women today face poverty. This will not change and no real equality of the sexes will exist until there are fundamental ideological and structural changes which recognize the equal value to society of work done by women in the wage labour market and the home. Collectively women, young and old alike, can work together to help effect political change for all our better tomorrows.

3:4 THE EVALUATING PROCESS

Components of the evaluating process included:

1) process recording with review and supervision with my primary adviser,
2) a participant feedback session, and
3) a self-monitoring process.

3:4:1 Process Recording, Review and Supervision

Regular meetings were held with my primary adviser through my practicum experience for the purpose of reviewing process recordings of sessions and of receiving ongoing supervision.

Examples from the process recordings have been incorporated within the context of this paper to illustrate significant themes.

3:4:2 Participant Feedback

Participant feedback was sought from the nine widows with whom I had had more than one contact. Feedback was gleaned through an informal, concluding interview in which the widows and I explored their experience of the time that

we had shared together. Appendix "D" contains a list of questions used as a guideline to elicit the participants' open-ended responses.

Full evaluating sessions were not completed with three of the women as:

1) one could not be reached, and

2) significant changes in the life circumstances of two of the women were such that the most immediate and appropriate focus of the follow-up sessions was their present situations.

Two central themes emerged from the feedback sessions:

A. the widows' experience of the time that we shared together, and

B. the significance of the personal characteristics that I brought to our relationship.

This second theme that emerged both surprised and gratified me. I was surprised that the widows themselves primarily focused their feedback upon the positive significance of the personal characteristics that I brought to our relationship. This especially surprised me since I had neglected to ask any feedback questions in this respect. Their feedback was most gratifying.

We live in a world where most people do not share their most significant thoughts and feelings with others when the time presents. All too often, perhaps as these widows had learned, the opportunity passes and we are left with regrets about the things that we have left unsaid.

The widows in this study did not by-pass this opportunity to share their feelings in the feedback sessions. Indeed, many outrightly told me that they wanted me to know that they had been open, honest, and sincere in their sharing with me.

The development of the two central themes that emerged from the participant feedback sessions follows.

A. The Widows' Experience of the Time That We Shared Together

From their experience, all but one of the widows indicated that if they had a good friend who was recently bereaved, they would recommend to her that she participate in the sharing of her bereavement experiences, as we had done.

One widow however indicated that while she personally found it very helpful to talk about her grief, not everyone

is the same. This woman related that she would take her cues from her bereaved friend, and that she would only offer her friend what she indicated that she needed at any given time. This was very sensitive and insightful advice, respectful of the bereaved friend's own process.

None of the widows could relate to anything that disappointed them, nor could they suggest anything that we could have done differently in the time that we shared together.

The widows generally expressed appreciation for the opportunity to talk about their bereavement experiences. Most related that they had nobody else with whom they felt comfortable with in the sharing of the feelings of their grief. As one widow told me, "You can let people cry; some people are uncomfortable with people who are crying. I don't cry with just anyone."

All of the widows indicated that it had been helpful and beneficial to them to talk about their bereavement experiences. Positive aspects of the sharing of their bereavement experiences included:

1) <u>The normalization of their grief reactions within the context of our talks</u>:

   (a) brought them comfort in knowing that they were not alone in their feelings,

(b) reassured them, as one widow expressed it, "That I'm not off!" (i.e. crazy),

(c) created a sense of hope and positive expectation that their grief will end.

2) The sharing of resource information.

This was another positive aspect identified by the widows as resulting from their sharing of their bereavement experiences. One woman expressed appreciation for my telling her about and accompanying her to a senior centre to help her re-engage in social life. Another appreciated information about vocational resources. Alternate housing options were discussed with a number of the widows, as was the Shelter Allowance for Elderly Renters (S.A.F.E.R.). One widow, upon applying for S.A.F.E.R. with my assistance, received the maximum rebate available of $140.00 per month, about which she was most pleased.

3) Gaining an opportunity to rehearse an important future event.

One widow, after having shared something of great importance to her, exclaimed, "There! Now that I have been able to explain this clearly to you without crying, I know that I can now tell my children!" Follow-up with this widow indicated that she had indeed done so successfully.

4) Receiving encouragement and emotional support.

This was a benefit verbalized by a great number of the women. "You give me encouragement . . . is that a word in English? You give me support."

5) The widows "feeling better".

Virtually every widow expressed that the sharing of her bereavement experiences helped her to "feel better". Some of the widows' responses as to how they came to feel are:

> "That sure was a load off my chest!"
>
> "When I talk about it I feel better. Then I don't think so much about it--I don't forget--I just think about it and let it go--but I don't forget it."
>
> "I feel better after we talk. I feel that you feel with me and share my grief."
>
> "It feels better after getting it out of my system."
>
> "I can't explain it but talking with you makes me feel lighter all over. I feel like something has gone out of me, (extending her hands off of her chest), and that feels so good."
>
> "Talking helped me to let go. Before I had a pain here, (placing her hands on her chest), now it is gone."

The many allusions above to the physical manifestations of grief, (e.g. a load off my chest, a pain), attest to the holistic nature of the grief experience. It is an exper-

ience that encompasses our physical, intellectual, emotional and spiritual being.

These feelings of enhanced well-being reportedly experienced by these widows through the sharing of their grief, highlights the vital importance of the task of grieving.

B. The Significance of the Personal Characteristics that the Social Worker brings to the Relationship.

The significance and nature of a positively perceived helping relationship became most apparent to me through the widows' feedback sessions. This feedback primarily came from the widows' response to the question: Is there anything that particularly pleased you about the time that we spent together?

Generally, the women responded that they were pleased to have had the opportunity to talk about their bereavement experiences. I then asked if the women could be more specific about what pleased them in the time we spent sharing their bereavement experiences. The great degree of commonality in their responses surprised me. The women essentially elaborated upon the positive significance to them of the personal characteristics that I brought to our interac-

tions. Those characteristics most appreciated by the widows were my:

1) "openness",
2) ability to "really" listen,
3) caring for the women,
4) understanding.

"Openness" was the word used by some of the widows to describe what others termed my "being easy to talk to". The widows described this "openness" and "being easy to talk to", in terms of their experience of acceptance by me and of trust and mutuality with me. As one woman phrased it, "With some people I worry about what I say, and what they will think of me. With you, I feel that I can talk freely. You understand."

The widows consistently related that they felt that they could tell me "anything", even those things that they could not share with their best friends and family. The women also expressed that they wanted me to know that they had been open and honest in their sharings with me. I had sensed this throughout my practicum, and I sincerely thanked the women for their "openness" in sharing.

Many widows expressed that they were pleased with how I "really listened" to them. They claimed my attentiveness to their sharing:

1) helped them "to get a lot out of their system",

2) demonstrated to them that I "really" understood what they were experiencing, because I always knew just what to say, and

3) showed that I really cared about them.

These feelings of being truly understood and cared about were widely mentioned by the widows as positive aspects in their sharing of their bereavement experiences with me.

Significantly, these concepts of "openness", "understanding" and "caring", as experienced, appreciated and described by the women in this study, are semantically akin to Carl Rogers' (1957) concepts of "genuineness" (p. 97), "empathic understanding" (p. 99) and "unconditional positive regard" (p. 98). Rogers (1957) hypothesized that these qualities are "the necessary and sufficient conditions" (p. 95) for therapeutic change toward "greater integration, less internal conflict, [and] more energy utilizable for effective living" (p. 95).

From the widows' emphasis upon the nature and the significance of the relationship, their reports of a positively enhanced sense of well-being, and my own observations of changes in the thoughts, feelings, and behaviours of some of the women in this study, I have come to believe that Rogers' hypothesis is true.

In this practicum the widows were given the freedom to determine their own process. Together, we explored that which was of most importance to them at the time. The interventions varied widely from psychodramatic techniques to those of resource acquisition. What was consistent however, across the interventions, was the primacy of establishing a close therapeutic relationship, one of openness, understanding and caring. From the widows' feedback, it was this relationship that the women most appreciated and through which they reportedly experienced significantly enhanced feelings of well-being.

It is my belief that a positively perceived helping relationship essentially creates a more enriched and nurturing milieu for the client. By creating this supportive relationship, the social worker helps the client to trust and to explore his or her own natural propensity toward self-healing and growth. Engaging the client's own natural healing process, the client and social worker

venture forth together as companions, towards health (from the Old English "haelth" for whole[ness]), and personal growth.

To conclude, the participant feedback sessions demonstrated to me, through the widows' shared thoughts, feelings, and behaviours that:

1) the widows felt that they had indeed benefited from the time that we shared together,

2) the widows had learned of the immediacy of life, and the importance of living and sharing in "the now",

3) the openness, sincerity and caring that I brought to our interactions, generated a reciprocal response in the women visited. Together we created the "magic" of relationship, previously described by Watson. That "magic" is real!

4) a positively experienced helping relationship is the heart of any significant, healing, growth-stimulating intervention. In this study such a relationship was characterized by openness, understanding and caring.

3:4:3 Self-Monitoring Process

Throughout my practicum experience I engaged in a self-monitoring process by focusing my awareness upon my engagement with the widows, and by considering the dynamics of our interactions. I pondered how what I said impacted

upon the women, how they reacted, how I reacted to their responses, and the meaning of what all transpired.

Through this self-monitoring process I arrived at some significant insights, two of which I would like to share herein:

A. the first insight is about trust, and

B. the second is the realization that I can not truly know the pain of your grief.

These insights struck me like "Ah ha!" experiences, wherein an apparent self-evident concept suddenly gains depth, clarity and a significant integrative meaning. A part of me feels that insofar as these insights can appear to be so self-evident, my growth and excitement over them is strictly personal; one of those experiences that you have to be there to appreciate. Yet, another part of me believes that these are enriched and meaningful insights meant to be shared. While I previously had had an intellectual knowledge of these self-evident truths, I now experienced a whole and integrated "knowing". A gestalt was complete.

But can one share an integrative learning experience through words, or is it truly something that one has to be there and experience to appreciate? That is something that

only you can know, as I risk sharing the insights of my experience in mere words.

A. Thoughts on Trust

> "What does that mean - 'tame'?" [asked the little prince]
>
> "It is an act too often neglected", said the fox. "It means to establish ties." (p. 80) The fox gazed at the little prince, for a long time. "Please--tame me!" he said . . . "One only understands the things that one tames", said the fox. (p. 83)
>
> "What must I do, to tame you?" asked the little prince.
>
> "You must be very patient", replied the fox. (p. 84)
>
> (de Saint Exupery, 1943)

The Little Prince (1943) is a modern classic, existential love story told by Antoine de Saint Exupery about a little prince who visits Earth from another planet to learn about Life. In the above quotation, a fox that he meets invites the little prince to "tame" him. Through the experience of this relationship the little prince learns that "taming" is really what we humans would term developing a trusting, loving relationship.

The nature of taming/trusting was something that I had

reaffirmed for me through my self-monitoring process in my practicum experience.

This process was stimulated by a significant piece of information that one widow shared with me in our final feedback session. This woman shared that after we had met a few times, she really came to trust me. She said that she felt she could say anything to me without worrying what I would think of her, and that she had never felt that way with anyone before.

This comment held a two-fold surprise for me. Firstly, I was surprised that she felt that way "after we had met a few times", since I had felt very close to her by the end of our initial session. Secondly, I was surprised at my own naivety in this respect, for although I intellectually knew that trust is earned and takes time to develop, I had lost sight of this fact in my zealousness to get on with my practicum. I viewed myself as a very trustworthy person, so why should she not trust me from the start?

What I failed to take into account was the widow's individual life experience with trusting and the fact that she, not I, was risking the sharing of her story.

This retrospective realization that I felt that the widow trusted me sooner than she felt she did, had not affected the nature of our relationship. We had grown very close. It did, however, help me to explain an incongruity in our relationship that had me puzzled.

Through time I had come to notice that significant aspects of this woman's story had changed through her re-tellings. I did not believe that this woman was trying to be untruthful, but I was perplexed by the changes.

For example, in our initial session, she shared that another significant loss for her had been the death of her 16 month old sibling, when the widow was six years old. When I queried about the cause of death, she simply said that "many little children died young in those days". Sensing her reserve in talking about it further, I backed off at that time. I recall how I had created my own closure about this situation by hypothesizing from my own past experience. I remembered how as a child I had discovered the children's section of our local cemetery. My parents had told me that many young children had died in the early 1900's due to a serious diphtheria epidemic. I imaged that perhaps her sibling was one such victim. Catching myself in this made me aware of how much of ourselves and our own histories we bring to an interaction, and how, if we are not

careful communicators, we can operate on wrong assumptions or misinterpretations.

Through time this widow gradually shared more about the circumstances of this death, and finally she told me that the baby had died "an unnatural accidental death". Tears streamed down her face as she recounted the tragic circumstances of the death, and the pity that she felt for the relative in whose charge the baby had been left, as this person was devastated by the experience.

This loss was still significant to the widow despite its distance in time, and she still had the need to process some of the feelings that she had bottled up for over 70 years. The trust of our relationship deepened and as this trust evolved, this woman once again shared the painful circumstances of her sibling's death. This time, however, she voiced her hostility at "the stupid woman who left the bāby unattended, even if it was for only a few minutes!"

I thus came to understand why her story had indeed changed, as did the feelings that she related through time. I was right in that the woman was not being untruthful; she was relating what was true for her at that time and point in our relationship. As the trust of our relationship grew, so did the woman's freedom to share the full gamut of her feel-

ings of grief--even those feelings that women generally find difficult to express, those of anger.

Through this self-monitoring process, I came to realize that while I had lost sight of "the fact" that trust-building takes time and patience, this had not negatively impacted upon our relationship because I had behaved differently, by allowing the widows to control their own process, and by respecting their need to pursue that which was most important to them, when they were ready to do so.

My self-monitoring process, however, has reaffirmed for me that:

1) as the little prince learned, trust does take time and patience to develop,

2) as trust develops, so does the breadth and depth of the relationship and of what is shared,

3) trust is essential in a relationship to facilitate positive change and growth.

B. I Can't Know the Pain of Your Grief

The title of this section is reflective of a significant insight that I acquired through the life of my practicum experience. This was an insight that changed in meaning, and developed through time and experience.

Initially, I faced my practicum experience in the subject area of bereavement with a mixed measure of both excitement and trepidation. Considerable personal and professional experience with loss and bereavement had instilled within me a solid internal sense that this was an area through which I could both grow and contribute. Yet, in my wildest fantasies, a little niggling fear persisted that I would be seeing totally helpless, dependent, inconsolable older women, who would end up being my case-load for life!

Examining this fear, I came to the awareness that my anticipating working with bereaved women had forced me to re-encounter my own feelings and fears about helplessness, dependency and pain in the face of a circumstance that was beyond any human control, that of death. This was before my practicum was yet underway; my fears had yet to be reality-tested. At this point my, "I can't know the pain of your grief" meant "I fear that I am unable to tolerate the pain of your grief and my own and survive."

Through the course of my practicum experience with elderly widows, I came to meet a very wise and resourceful older woman who shared that:

No one can know the pain of my grief.

Words don't exist that speak to the depth of my feelings.

I experienced the power of her words with my whole being. Her words stimulated in me one of those rare and exciting ah ha! experiences that suddenly aligned my understanding, like the turn of a kaleidoscope, into a dynamic, harmonious, complete whole, in the moment. I came to a truly integrative "knowing" that "I can't know the pain of your grief", now meaning "I am unable to comprehend the pain of your grief because I am not you." I came to realize that I can know my own grief, and through our common humanity, I "may" know what the pain of your grief is like, but I can never truly "know" the pain of your grief. I can however, respect it as your own.

This experience also precipitated my re-discovering my own personal boundaries. Being female within a social context wherein females are socialized to anticipate and provide for the nurturant needs of others, I had developed a highly attuned sense of empathy; one which if left unbridled, could leave me very vulnerable in the face of shared pain. By re-experiencing both the integrity and value of my personal boundaries, I was able to fully "be there" with the bereaved women in their pain, feel with

them, and share their pain because of our common humanity, yet I was not consumed by their grief. Instead, I became a conduit through which the pain of their grief passes, but is not contained. Thus, rather than becoming enmeshed in a symbiotic union of pained humanity drowning in an abyss of futility, what developed was the intense and intimate sharing of powerful feelings between equal, yet unique individuals moving supportively together through time and space and grief.

Through this encounter I also came to discover even greater meaningfulness in my own grief experiences. I came to view them as a tool or instrument, like a tuning fork, that allowed me to resonate from the core of our common humanity with another human's suffering, thereby having the capacity to provide them with compassionate understanding and support.

In the end, my initial fears did not withstand reality-testing. My wildest fantasies of a case-load for life did not materialize. Instead, the meaning of my, "I can't know the pain of your grief" changed from, "I fear that I am unable to tolerate the pain of your grief and my own and survive", to "I respectfully acknowledge the uniqueness of your individuality and our common humanity through the 'sharing' of the pain of your grief. I will not usurp your

pain for my own, but I will, with your permission, synergistically journey with you toward healing and growth."

3:5 SIGNIFICANT THEMES

In this section I shall illustrate, through prose and poetry, some of the more significant themes that emerged from this practicum study.

The first piece (3:5:1) illustrates that which is requisite for the healing of grief to start. Unfortunately bereaved individuals, fearing the intensity of their loss, often expend a lifetime of personal energy warding off that which they most need, the opportunity to grieve. The psychial strength of the defense mechanisms in early and middle adulthood, coupled with the reality demands and contingencies of everyday living, create circumstances wherein grief can be either denied or contained and put "on hold", but not without great personal expenditure. The grief remains intact until the bereaved individuals can either marshal their personal strengths and resources, and/or secure a supportive environment in which they can trust risking an encounter with their grief.

A second piece (3:5:2), rebukes the common cliche that "time heals all".

This is followed by a poem (3:5:3) by Shirley Holzer Jeffrey (1975), entitled "Sorrow", that sensitively depicts

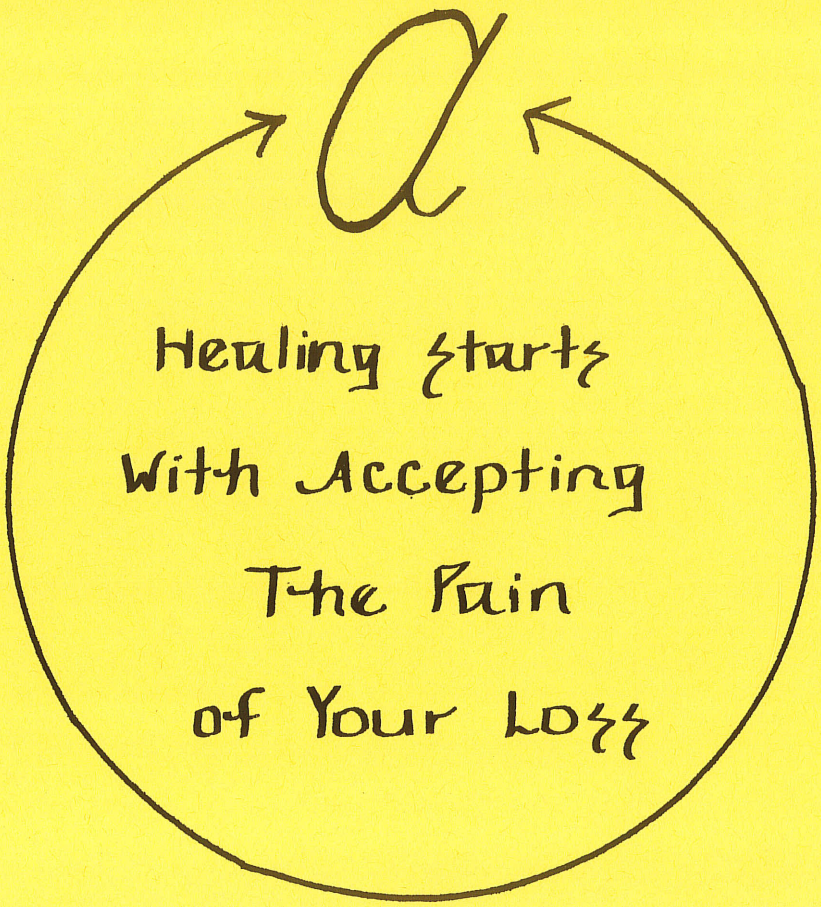
the intense intimacy and growth engendered through shared grief.

Other themes developed encompass, (3:5:4 A) my discovery of the value, relevance and applicability of right brain oriented adjunctive therapies in interventions with grief; (3:5:4 B) requisites to the effective use of right brain adjunctive therapies, as well as; (3:5:4 C) my exploration of how to best "sell" the concept of involvement in these more non-traditional right brain interventions to clients.

A short poem, (3:5:5) by Albert Camus (1954), follows and metaphorically illustrates how we humans are far more than any one of our parts. Yes, we are our vulnerabilities but we are this and more. Look again, deeper, and you shall see our strengths. Helping professionals would do well to help clients accept their vulnerabilities while looking to, calling on, and having faith in their clients' strengths and potentiality for growth. This holistic perspective can be too easily lost in a more problem-focused relationship.

Following this poem, the theme of "endings" (3:5:6) is explored.

This section of significant themes closes with my epitaph (3:5:7), a gem of wisdom about living, . . . and dying, uncovered on my practicum journey of discovery.


Healing starts
With Accepting
The Pain
of Your Loss

3:5:2 Time Heals All

A familiar cliche of our time holds that "time heals all". While the passage of time is essential for the healing process to occur, time alone does not heal the pain of loss.

This was starkly obvious in this study during our exploration of what proved to be a most vital question, that of other significant losses experienced by the women. Some of the widows who told of the untimely and accidental deaths of a sibling, their own child, and a parent, mourned these losses with the intensity one might expect of the newly bereaved, despite the passage of between 40 and 70 years!

I believe that these women, fearing the pain of their grief and/or their loss of self-control in their experience of it, had invested a lifetime of their psychial energy to contain and avoid the emotional pain of their loss. Rationalizations, intellectualizations, keeping very busy and actively avoiding thoughts about the loss, all worked toward keeping the denial of the pain of the loss intact. These defense mechanisms are intended to be self-protective, and I believe should be respected. Unfortunately, however, these defense mechanisms bind up much of the bereaved individual's personal energy in this containment of their grief.

Healing only starts with your accepting the pain of your loss as real, as painful, and as your own, on all levels of your being--intellectually, physically, emotionally and spiritually. It is most readily apparent intellectually and physically that a loss is fact. Daily living faces bereaved individuals with this hard truth. It is much more difficult to accept the reality, permanence and pain of our losses in our emotional and spiritual levels of being.

The journey toward healing in these emotional and spiritual areas requires:

A) A personal readiness to risk affronting the pain of loss, irrespective of the dimension of time. By this I mean that the time of readiness for an individual's grieving may have little relation to when a loss occurred in time. The time to grieve "happens" when the individual griever is ready to face her or his tasks of grieving, even if that time happens to be 40 years after "the fact".

In my experience, elderly people generally, and elderly women more specifically, are particularly adept and personally ready to risk engaging the healing, grieving process. Reasons for their great skill in this respect may be that:

1) Elderly people are in the later stages of their developmental life cycle. As such, they face a more limited "time-left" perspective and life's immediacy is impressed upon them. Hence the elderly are strongly motivated to work toward integrating and assimilating the meanings of their lives' experiences while time still permits.

2) Elderly people, having lived longer and having a potentially greater lifetime burden of hardships and grief to bear, are often "ripe" and ready for the opportunity to explore their issues of loss.

3) Elderly people often have a great deal of their psychial energy bound up in the pain of their grief. As such, they have less energy available to maintain rigid defense mechanisms. This, coupled with the motivations mentioned above, render the elderly very accessible and open to exploring their issues of grief, especially if they find themselves in a trusting social environment that nurtures and supports this activity.

B. A supportive social environment that condones and encourages the grieving process. Such an environment provides trust, caring, empathy, and acceptance of grieving individuals in their times of strength and in their times of vulnerability. There should be no external "task master" in the grieving process; only supportive companions who respectfully work "with", not "on", grieving individuals. The grief work then unfolds as a healing process that frees the bereaved individual to once again live, learn and love.

C. A commitment to one's grief work, the bereaved individual's creative investment of self in an endeavour of great inner significance. This is a striving

for wholeness. My experience suggests that grief work is a social event in that it requires the sharing of grief with at least one other human being. In my estimation grief work is something akin to the "work" of great artists, like Van Gogh, that similarly had suffering as their creative source. And like all human, creative endeavors, grief work is precious, unique in its manifestation and meant to be shared.

It is thus apparent that the passage of time, alone, does not heal all, . . . it only postpones the experience of the pain of grief. Paradoxical as it may seem, grieving itself is the pain that heals.

Sorrow:
It hurts deep down inside.
One feels diminished,
Less than he has been.
Empty,
Bereft-
forlorn and incomplete.
Sorrow is a painful word
But if someone is there
To share the feeling
It becomes endurable
And in the scheme of things
A time of being
That includes great emotion
And thus a time of closeness,
Growing and becoming someone mor
Than we have been before.

Jeffrey, 1975, p. 141

3:5:4 Right Brain Adjunctive Therapies and Grief

Right brain adjunctive therapies were previously described in section 2:3:4 of this paper. In this section I will report on:

A. my uses of right brain adjunctive therapies in interventions with grief;

B. requisites to the effective use of right brain adjunctive therapies;

C. how to "sell" the use of right brain adjunctive therapies to clients.

Reference will be made to examples of my use of photo-therapy, gestalt, and psychodramatic techniques within my practicum.

A) My Uses of Right Brain Adjunctive Therapies in Interventions with Grief.

In the western world our socialization and educational institutions tend to encourage and to place greater value on the use of our left brain hemispheric functions to the neglect of our right brain functions. (Bolen, 1979; Bry, 1979; Ferguson, 1980) We prize reason, logic and intellect, while placing a lesser emphasis and value upon creativity, holistic perceptions, and intuitive "knowing".

Grief, however, is a holistic process encompassing cognitive, emotional, physical and spiritual aspects. I believe that one cannot truly fathom the holistic experience of grief without providing for the balanced integration of the left and right brain functions. Society's difficulty in handling the grief experience is, in part, due to our reliance upon using our valued left brain functions alone, in the face of a process that requires a more holistic and integrated approach. Efforts to "explain" grief through the left brain alone provide empty rationalizations and cliches that bring little comfort to the bereaved. Right brain adjunctive therapies are an enriching addition to interventions with grief, as they round out our range of resources and call forth a more balanced response to the holistic process of grief.

Right brain oriented therapies are adjunctive in nature, and as such they may effectively be used in conjunction with most any other therapy modality. In my practicum experience I found the right brain adjunctive therapies particularly useful in:

1) creating a highly empathic helping relationship;

2) evoking in the present the memories, emotions, and feeling states experienced at the time of a loss in the past;

3) accessing material that was previously inaccessible through the normal verbal mode of communication;

4) completing issues of "unfinished business".

Right brain adjunctive therapies fulfill these functions through their common ability to allow a worker to access and to join a client's symbolic world in the here and now. Examples from my practicum of each of the above functions follow.

1) Creating a highly empathic helping relationship.

In my experience, right brain adjunctive therapies proved to be a valuable means of creating a highly empathic helping relationship. While an empathic relationship is vital to engaging a client in right brain oriented interventions, right brain adjunctive therapies further enhance an already strongly empathetic client/worker bond through the worker's actively joining the client's symbolic world.

For example, during our exploration of significant losses, one elderly woman shared that she had had to give up her only child to be raised by an elderly relative. She went on to recount, in a very matter-of-fact way, how this made every sense in terms of life's practicalities and that she did have regular contact with her child. The tone of

her voice, bodily posture and intellectualizations convinced me that this was a powerfully significant loss that she had just understated, perhaps because she felt that she had to be respectful of this elder as well. To establish contact with the other side of her ambivalence, I risked following my intuition and acting like a compassionate double, anticipating, voicing and validating that which I felt that she was unable to express, I responded--"And who did she think she was, to separate a baby from her mother?" The elderly widow then melted into tears and shared her feelings of hostility for this relative, the great pain of her loss, and how she felt that she had been cheated of the special closeness and love of the mother-child relationship. After awhile however, this elderly widow was again giving practical reasons why it was best for her child to have been with this relative. I accepted these, and then added that while these practical reasons made every sense here (pointing to my head), they did not change the loss and pain here (covering my heart). The woman again cried and said that that was indeed so. A very close, empathic and cherished relationship developed with this woman.

Thus through the use of a psychodramatic technique, the compassionate double, I joined the client's symbolic world and through the active sharing of this reality in the moment, forged a significant, strongly empathic relation-

ship. In such circumstances the client not only feels that you understand them, they know that you do through your actions. Other right brain adjunctive therapies used within this practicum that also proved effective in creating highly empathic bonds were gestalt and phototherapy techniques.

2) Evoking in the present the memories, emotions and feeling states experienced at the time of the loss in the past.

This function of right brain adjunctive therapies has particular significance in grief work since the client is not distanced from their grief by talking "about" it from the past. Instead, he or she becomes holistically involved in re-experiencing their unresolved grief and in working toward its resolution in the here and now.

The usefulness of phototherapy techniques in this respect was dramatically demonstrated when one elderly woman shared a photo of her child who had died 43 years ago. The woman, touching and intently gazing at the photo, had great streams of tears rolling down her face, and she mourned as if the loss had occurred yesterday. All the memories, emotions, feelings and circumstances of this death became re-accessible to working on in the present through this photograph from the past.

3) Accessing material that was previously inaccessible through the normal verbal mode of communication.

Within my practicum, phototherapy techniques became a most effective way of accessing previously inaccessible material. This is a vital function in grief work where unacknowledged ambivalence creates an unbalanced perspective of the lost relationship, and often portends unresolved grief due to unfinished business.

In one instance, a very reserved elderly widow spent a great portion of our time together sharing all the positive aspects about her husband. I had a strong sense that there was more, yet I was not yet sure how to broach this. We then examined some family photographs, at which point I said that her husband "looks to be quite the family man". In response to this, the woman then went on to relate another dimension of her husband's being, as if the truth had to be told.

In another situation, I was fascinated by a repeated pattern within the lay-out of a family photo album. I asked the woman if she had put the album together herself, and she indicated that she had. I told her that I found it very interesting that there was always a picture of an older woman, whom she identified as her mother-in-law, placed

between all individual photos of her and her husband. Tears came to the woman's eyes as she replied, "that was the way it was, she always came between me and my husband". She then went on to disclose the difficulties in her relationship with her mother-in-law, something she had previously only glossed over. It thus became apparent to me that right brain adjunctive therapies, as phototherapy techniques, access the symbolic, emotional and less consciously guarded aspects of a client's reality, and are thereby useful in accessing significant, previously inaccessible material.

4) Completing issues of "unfinished business".

A final significant function of right brain adjunctive therapies that I discovered within my practicum was their use in facilitating the completion of "unfinished business".

Unresolved issues between deceased and bereaved individuals often haunt the bereaved individual and inhibit their ability to engage in the normal grieving process.

Leo Buscaglia (1984) relates "that unexpressed love is the greatest cause of our sorrow and regrets" (p. 54). This was the painful source of regret shared by one of the elderly widows visited.

In our discussions about her husband, this woman quipped that when he was happy, you knew it, and when he was angry, you also knew it! When I suggested that her husband was a man who could express his feelings well, this elderly widow agreed and said that she deeply regretted not being able to do so herself. She shared that in the 59 years of their marriage she was never able to tell her husband that she loved him. She then went on to talk about her feelings of loss over her physical beauty, and how she was now old and wrinkled. I told her that I would bet that her husband loved her, wrinkles and all! At that point she started to cry and said that her husband had always told her that. Weeping, she again said that she regretted not having been able to express her feelings like he did to her. I placed my hand upon hers and said, "If you could talk to your husband once again, tell him what you need to tell him". The elderly woman, lovingly looking up and to the left, seemed to hold the image of her husband in her gaze. With rivers of tears pouring down the beautiful deep wrinkles in her face, she said "I love you". By then, I too had rivers of tears flowing down my face, and after a bit of quiet time, I told her that I was sure that her husband had heard her.

Through the use of this gestalt technique in the present tense, this woman was afforded the opportunity to

complete some of her unfinished business by verbally expressing her love to her husband. This was something this widow had deeply regretted not having been able to do in the 59 years of their marriage. Thus right brain adjunctive therapies, as gestalt techniques, can help facilitate the grieving process by providing healing opportunities for the completion of issues of "unfinished business" in the here and now. Thus, through my practicum experience, I came to appreciate the enriching value and efficacy of using right brain adjunctive therapies in interventions with grief.

B. Requisites to the Effective Use of Right Brain Adjunctive Therapies.

Worker characteristics and attitudes that are facilitative of any therapeutic relationship, but are especially requisite in right brain adjunctive therapies include:

1) The ability to develop a trusting relationship with the client with strong empathic bonds of compassionate understanding, through which the "worker/client unity" moves closely in synchronization.

2) The worker's openness, not only "about" but "to" right brain oriented interventions. This openness is based

upon a solid foundation of both intellectual knowledge and experientially-based "knowing". It is my belief that a worker can best engage in the use of right brain oriented interventions once they have integrated such experiences by being active participants themselves.

Their openness is actualized with the worker's willingness to risk chancing a right brain oriented intervention when they intuitively perceive the timing, person, relationship and circumstances are such that the right brain oriented intervention is the most appropriate one needed at that time.

Leo Buscaglia (1984), in sharing of what he learned from a Buddhist teacher, relates that "to know, and NOT TO DO, is not yet to know!" (p. 66) This openness to risking and to acting upon the intuitive knowing, gleaned through the trusting and empathic client/worker unity, is requisite to effectively engaging in right brain adjunctive therapies.

3) Responsibility is another worker characteristic requisite to the effective use of right brain oriented interventions. By responsibility I mean two things. Firstly, "responsibility", as defined by Webster's Dictionary (1986), means that the worker must be "trustworthy" (p. 345). Secondly, I mean that a responsible worker is one

with the ability to respond to the needs of the client, (i.e. respons-ibility). This does not mean that the worker assumes total responsibility for a client's living, and bears their burden like the proverbial albatross around her or his own neck, but rather that the worker has the capacity to be aware of, and be responsive to the client's needs of the moment. Being "respons-ible", the worker is able to be fully there and supportive of the client's growth. Thus the responsible worker does not assume responsibility for the client (in the sense of taking responsibility away from the client), but is "respons-ible" to the client, and hence is facilitative in helping the client grow in assuming responsibility for her or himself.

4) The worker's belief in the propensity of the self to heal itself (Kopp, 1972; Buscaglia, 1982; Levine, 1983), is a final worker attribute requisite to the effective use of right brain adjunctive therapies. As such, the client is allowed and encouraged to control their own process. This is especially appreciated by bereaved individuals who often have been feeling a great loss of personal control in the face of death. The worker then acts:

(a) to encourage and to build the client's confidence in their own ability to help and to heal themselves;

(b) as a supportive companion, within the context of a trusting, reciprocal relationship of equals, on a shared journey of personal growth and self-discovery.

Again, the client is thus positively supported in their controlling of their own process.

Thus are the worker characteristics and attributes that contribute to the effective use of right brain adjunctive therapies.

C. How to "Sell" the Use of Right Brain Adjunctive Therapies to Clients.

Prior to my practicum experience, this was a burning question of mine which the literature did not satisfactorily address. Having completed my practicum and having used right brain adjunctive therapies in it, I earnestly tried to conceptualize the answer to this question in words. While struggling with this, a sudden flash of insight struck me, and I came to realize that my difficulty was that I was asking a logical, left brain type of question about an illogical, non-linear right brain type of process. It occurred to me that I should try to translate this left brain question into the language of the right brain understanding through the use of a right brain tool. To help conceptualize the phenomena that I had experienced within my prac-

ticum, and yet was having such difficulty putting into words, I turned to the right brain "tool" of imagery.

The result was my being rather unexpectedly drawn to a line in a long-forgotten poem. I believe that the imagery in this line of the poem that follows, captures the essence of the movement of engagement in right brain adjunctive therapies.

> O body swayed to music,
> O brightening glance,
> How can we know the dancer
> from the dance?
>
> (Yeats, 1964, p. 123)

You cannot separate the dancer from the dance. They are one. Similarly, you cannot separate the worker/client unity from the process unfolding in their "dance".

Within the context of their trusting and empathic relationship, the worker comes to an intuitive knowing of the rightness for "the dance". Acting "respons-ibly" toward the client, the worker invites the client to dance when the worker hears "their song"; that is, the worker intuitively knows that the client, their relationship, the timing and circumstance are right. The dance begins and the client/ worker movements are complementary, forming a harmonious

movement through time. Like a graceful dance, this fluid, reciprocal, dynamic process naturally unfolds.

So, how do you "sell" the use of right brain adjunctive therapies to clients? Quite simply, you don't have to. Just get into "the music" and when you hear "your song", invite them "to dance"!

In the midst of winter,
I finally learned
that there was in me
an invincible summer.

Albert Camus, 1954

3:5:6 Endings

Endings are often associated with feelings of loss because they represent the end point in a relationship as we have known it. These feelings of loss can precipitate a grief reaction.

Dr. Stephen Fleming (1985) aptly described this grieving process as a movement "from losing what we had to having what we lost". This conceptualization of the movement of grieving is central to an understanding of endings.

I personally have often faced endings with discomfort. Having this awareness from the beginning, I made efforts to relate to the end point of my practicum with the widows from the start. I arrived at the end of my practicum faced with the task of concluding some close, enriching relationships with some very special women. I anticipated this task with discomfort.

A personal struggle ensued within me as I considered how and whether, indeed, I would "terminate". This issue grew not out of my discomfort with endings however, but out of my genuine concern for the women whom I had visited and their needs. As I considered the roller-coaster nature of

grief through time and the importance of the availability of ongoing support, I consciously decided that I would not formally "end" with the women, despite the literature that bespeaks of the necessity of termination. I believed that a formal letter of thanks to conclude our visits would in effect do just that, and would terminate all contact. As I wanted the women to feel that they could call on me again should they want to, I closed our visits by extending my sincere appreciation and thanks to them for their sharing, with an open invitation to them to call on me should they want to reconnect. Some did. I believe that such an "open-door" policy is essential in providing realistic bereavement support. I have also come to believe that the literature is inadequate in its representation of endings.

Through my experience of the Master's program, I have conceived of two broad categories of endings, of relevance to relationships whether the participants be living or dead. They are what I term:

A) terminations, and

B) closings.

A) Terminations.

I am defining "termination" as the outcome when an individual concludes their grieving for a departed relation-

ship by severing or walling-off any emotional attachment to the departed person. The relationship ends with the grieving individual disassociated from both the departed person, as well as from that part of him or herself that had integrated aspects of the departed person through the life of their relationship.

Terminations can occur in the context of positively or negatively perceived relationships. The sudden death of a beloved child can precipitate a parent's termination of this most positive relationship in avoidance of the great pain of their loss. More commonly, however, terminations are the products of painful relationships where differences are irreconcilable either because of the individuals' wills, or because of a circumstance, like death, that has foreclosed any possibility of working the issues of this relationship through within the dimensions of time and space.

In intimate relationships like those in families, terminations cannot occur without the terminating individuals losing a significant part of their own being as well. By "terminating" or walling-off their feelings about the departed and their experience of him or her, terminating individuals remain in a holding pattern of unresolved grief.

Terminations are characterized by:

1) an emotional severance or a walling-off of feelings from the departed person;

2) a lack of closure in the lost relationship;

3) a disassociation from both the departed person, as well as from that part of the self that had integrated aspects of the departed person;

4) little possibility of reconstructing the lost relationship in any form on this temporal plane;

5) an inhibition of personal growth:

   (a) through the denial of that part of the self that has integrated aspects of the other;

   (b) through the denial or blocking of the experience of this relationship, therein losing that which one could have learned through it.

B. Closings

Closings, like terminations, can occur within the context of a positively or a negatively experienced relationship. In my view, however, "closings" are antithetical to "terminations".

Closings are characterized by:

1) an acceptance of the pain of the loss;

2) a sense of closure in the lost relationship;

3) an acceptance of the integration of a part of the other within the self;

4) a closing of the relationship as you know it, with the possibility of re-opening the relationship on a new basis and in a different form;

5) The expansion of personal growth through:

(a) the acceptance of the positive, cherished aspects of the other as an integral part of yourself. A part that is yours forever;

(b) a "letting go" of those aspects of the relationship that you deem negative, through an engagement of the normal grieving process;

(c) an awareness of the possibility that negative aspects of the other might have also become integrated into your being, and that personal growth comes with such whole self-knowledge;

(d) an acceptance of the experience of the relationship as an opportunity for learning and growth.

It is my contention that "closings" are a more healthy response to endings than are "terminations". It has also been my experience that the use of right brain adjunctive therapies provide a means of converting terminations into growth-stimulating, life-affirming closings, irrespective of the dimensions of time and space.

- Endings are also a natural, inevitable, and difficult part of the helping relationship. In the professional literature however, the terms "ending" and "termination" are used synonymously. I believe that these two terms lack the specificity that is important to a more comprehensive understanding of "endingness".

In my conceptualization, it is important that social workers strive to appropriately "close", and not "terminate", the helping relationship.

A cherished "closing" of a relationship from my practicum study follows in the next section.

C. My Closing of a Positively Experienced Relationship.

People can be enriched and learn from all relationships; those deemed "good" and "bad". A positively experienced reciprocal relationship based upon genuine concern and authenticity, however, closes with an ongoing sense of connection.

Accepting the pain of their loss, the participants in such a relationship can openly acknowledge their significance to each other, as well as that of their loss.

Closure occurs when both individuals feel that they have shared all that they needed to with the significant other.

Through the life of their relationship the individuals

become an enriched and an integral part of each other because of what they have shared.

It is my belief that this integration of the "other" is of a literal, holistic, and metaphysical nature.

Literally speaking, the participants of such relationships are a part of each other in memory.

Holistically, I believe that we incorporate (from the Latin--in body) all that we live, learn and experience. In this sense, we embody aspects of all our relationships, physically, intellectually, emotionally, as well as spiritually. Positively experienced relationships become a cherished part of our self. A part that is ours forever.

Metaphysically speaking, it is my belief that psychial or spiritual connections exist between individuals who have shared significant experiences.

In the scientific realm of quantum mechanics, the study that embraces nearly all of physics, it has been reported "that once two particles have been near each other, they continue to instantaneously affect each other no matter how widely they may be separated" (Rucker, 1985, p. 17), to a

degree that defies probability. No scientific explanation for this phenomena exists in our world.

If such occurrences happen at the simplest cellular level, it is not unthinkable to expect that they can also occur in the world of the much more sophisticated human atom.

My practicum experience has convinced me of this. During my practicum, I experienced three incidents wherein I strongly felt that I should call three different women, at three different times. One of these women I had not had contact with in over six months. Each of the women expressed shock and dismay at my calling her, as each reported that she had been thinking about me and had been considering calling me. One woman described the experience as "eerie", while another shared her amazement at having had my phone number by her telephone in readiness to call me. All three women were at points of personal turmoil.

These personally experienced synchronistic events have convinced me that we humans share some type of psychial or spiritual attachment with those of whom we have shared positive, significant relationships. These remarkable occurrences have also affirmed for me the classical wisdom of

Tennyson's "Ulysses"; "I am [indeed] a part of all that I have met" (Brown and Bailey, 1962, p. 27).

I shall now conclude by sharing one such positive "closing" from my practicum that I shall forever cherish.

I had cultivated a very warm, caring, reciprocal relationship with this particular woman. I did not look forward to this ending. We had talked about the end of my visiting upon each of my previous three visits and now our time for parting had come.

I sincerely thanked this woman for her willingness and openness in sharing of her experiences for my learning. I told her that because of what we had shared together, she would forever be special to me, and that indeed a part of her had become a part of me through our shared experiences. I then related some of my all-time favorite story, The Little Prince (de Saint-Exupery, 1943) to her as it simply illustrates how relationships transcend the dimensions of time and space. The older woman responded to the story by saying that she thought that she understood what I meant.

I then asked the woman if she still had my telephone number. She said she thought that she did, but that she would take it again "just in case". I wrote out my tele-

phone number and handed her the piece of paper. The older woman excused herself, and as she left the room she said that she was going to put the telephone number "in a safe place".

Returning to the room, she stood before me, and looking me straight in the eyes she said, "You know, I probably will never call you." Her frank honesty touched me with its unaffected genuineness, and I replied, "but know that you can". I was gratified that this woman and I shared such an authentic relationship that she could feel comfortable enough to have shared her reality. All too often hollow, well-intentioned promises to "keep in touch" are made in partings to belie the reality of the moment.

The older woman then shifted her weight from foot to foot, as if to establish her equilibrium. Then, determinately clenching her fists at her sides and pulling her body up straight to its full four foot eight inch stature, she looked directly up into my eyes and said, "I love you".

This from a woman who had been unable to verbally share her loving feelings for her beloved husband in near to 60 years of married life!

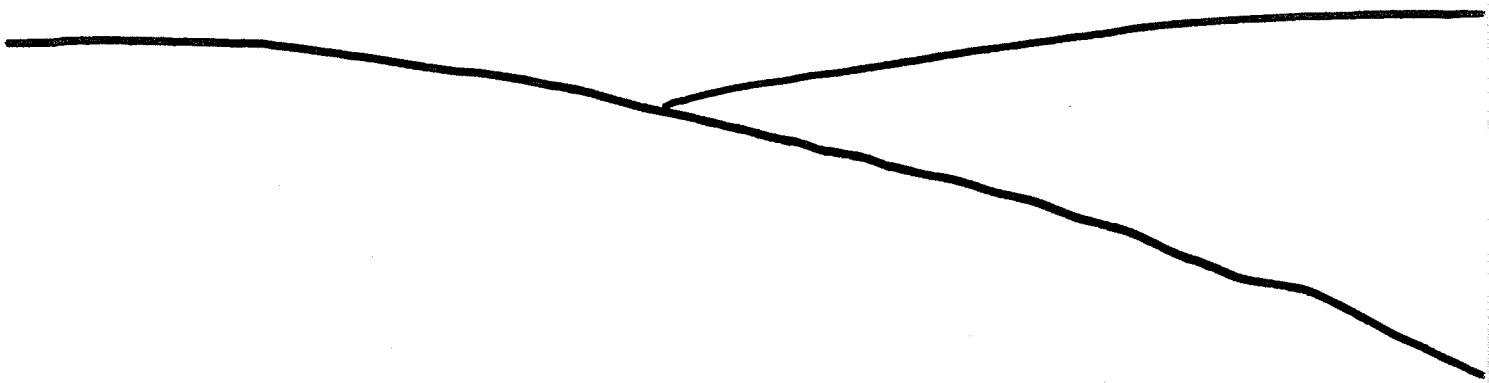
Her declaration was a parting gift that I shall always cherish. Her love is very special to me. I also cherish the moment because it demonstrated to me that she had personally grown in her ability to express her important feelings through our relationship.

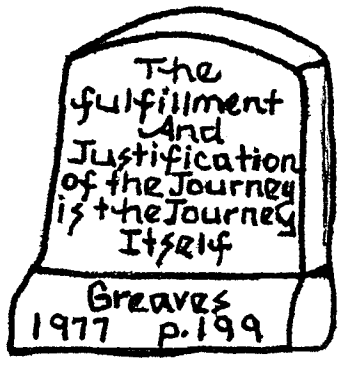
I had anticipated ending this encounter feeling sad and empty. Instead, I left feeling exuberant and full in the knowledge that I had both enriched and been enriched by a very special woman; a woman who taught me much about grieving, and living and loving through our shared experiences.

And yes Virginia, there are "good"-byes. So:

> Don't be
> dismayed at good-byes.
> A farewell is necessary before
> you can meet
> again.
>
> And meeting
> again, after moments or
> lifetimes, is certain for
> those who are
> friends.
>
> (Bach, 1977, p. 132)

3:5:7




The fulfillment And Justification of the Journey is the Journey Itself
Greaves 1977 p.199

3:5:8 Postscript

To my mind, and heart, this practicum report ended on the preceding page. In deference to the needs of our more left-brain dominant culture, I shall provide some delineated conclusions from my exploratory study of conjugal bereavement with fifteen older women herein. It should be noted that given the small sample size, these conclusions are not intended to be extrapolated beyond this study. I do believe, and the literature demonstrates, however, that these conclusions do have relevance within the broader context.

From my study, I have concluded that:

1) To be bereaved in a death-denying society, old in a youth-oriented society and female in a male-defined society is to be in a position of triple jeopardy. This is the lot of the older widow in the North American social context.

2) Many older widows, and especially those under the 65 year old pensionable age, are often left in drastically changed, dire financial straits with no source of income in their own right upon their partners' deaths.

3) Many older widows of today are of a personally resourceful, adaptable and resilient group of older women with the courage to risk pursuing their continuing growth. Ironically, I believe that many of their strengths came into being as a necessary adaptation to survival in our patriarchal society.

4) Grieving is a social act that is too readily thwarted by our largely death-denying society. This happens to the detriment of bereaved individuals.

5) A social support network that can accept and condone a widows' need to grieve is vital in facilitating her grieving process. Conversely, a social network that thwarts a widow's need to grieve is very detrimental to and inhibiting of her natural grieving process.

6) Right brain oriented therapies are most valuable and useful as adjunctive therapies in interventions with grief. They provide for a more balanced, well-rounded, experiential approach to the holistic process that is grief.

7) Education about the normal grief response is an important role in grief counselling to normalize the grief experience and to alleviate the bereaved individuals' fears about insanity.

8) Despite the common clinical features of the normal grief response, grief is complex, and it uniquely manifests itself in each individual. As such, an individual's grief should be respected in its uniqueness with the full knowledge that nobody can truly know the pain of another's grief.

9) As trust develops, so does the breadth and depth of a relationship and of what is shared. Trust is essential in a helping relationship to facilitate positive change and growth.

10) A positively experienced helping relationship is the heart of any significant, healing, growth-stimulating intervention. In this study such a relationship was characterized by openness, understanding and caring.

11) Time, alone, does not heal the pain of loss.

12) Healing starts with accepting the pain of your loss. The journey toward healing in the emotional and spiritual areas requires the bereaved individual's personal readiness to risk affronting the pain of their loss, a social environment supportive of the tasks of grieving, and a commitment to one's grief work, the bereaved individual's creative investment of self in an endeavour of great inner significance.

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DEPARTMENT OF SOCIAL WORK

July, 1984

Dear

My name is Dianne Mowdy. For the past seven years, I have worked for the Social Work Department at St. Boniface General Hospital. Presently, I am on a leave-of-absence from my job, and I am pursuing a Masters Degree in Social Work from the University of Manitoba, with my placement being out of the St. Boniface General Hospital.

My area of specialization is that of "bereavement".

After the death of a partner, I have often wondered about the woman who has been left behind; the woman that I, as a hospital worker, have come to be concerned and care about, yet with whom I usually lose contact.

I am now contacting many women like yourself, whose partners have died, with the hope that you would be willing to talk with me about your experiences. You may find that talking about your experience is helpful; or you may prefer not to bring up these memories at this time. I will certainly support your choice. You are under no obligation to participate or to share your experiences with me.

I will be telephoning you within the week to answer any questions that you may have, and to see if you would be willing to meet with me. If you are willing, I would hope to spend an hour or so with you, at a time and place that is most convenient to you; and perhaps meet again if that is mutually desirable.

I would be most appreciative if you would consider the sharing of your bereavement experiences with me.

Most sincerely,

APPENDIX B

Raphael's Therapeutic Assessment Interview Format

Dr. Beverley Raphael (1980), a psychiatrist, developed a format of questions for use with bereaved individuals to help assess their need for further bereavement counselling. Although the areas of query in the therapeutic assessment interview will be outlined in question form herein, they are meant to be incorporated within the context of a supportive, nondirective interview. In this way the therapeutic assessment interview itself:

1) provides the practitioner with the opportunity to assess the bereaved individual's need for further counselling, as well as

2) becomes a therapeutic tool, in that the process through which the information is elicited is itself therapeutic, and facilitative of the normal grieving response.

Examples of specific questions and the topics generally explored within Raphael's (1980) therapeutic assessment interview follow:

A) The Death Itself

> Can you tell me a little about the death? What happened on that day and during the time around it? (Raphael, 1980, p. 155)

Information gleaned in this area of query will:

1) start to give some indication of the presence or absence of grief as appropriate for this particular person at this particular point in time,

2) provides information about the bereaved individuals' perception of support or lack of support for grieving in their social network, as well as

3) identify special aspects about the death itself that may inhibit or complicate the resolution of the grief.

B) The Relationship

> Can you tell me a little about X and your relationship with him [or her]? (Raphael, 1980, p. 156)

This area of query will provide information about the nature and quality of the pre-existent relationship between

the bereaved and deceased individuals. It, in effect, explores the history of the relationship from its beginnings to its loss. Raphael recommends that it is especially important to assess and note high levels of ambivalence and dependency in the relationship. She suggests that areas of ambivalence may be gently opened with a simple question like:

> You've told me a lot about the happy times you've shared; could you tell me a little about the times that were not so happy. (Raphael, 1980, p. 157)

This comment gives the bereaved individual a clear message about the inevitability and acceptability of ambivalence in all human relationships, thereby opening the way for a discussion of some of the bereaved individual's ambivalent feelings.

Thus this exploration of the nature of their relationship provides information about:

1) the progress of the grief response,

2) any distortions, such as idealization or avoidance of grieving altogether,

3) special aspects of ambivalence or dependency that need to be addressed,

4) the bereaved individual's perception of the social network support available to him or her in grieving.

C) The Response to the Loss

> Can you tell me a little about what you've felt since the death, what's been happening in your life? (Raphael, 1980, p. 158)

This question garners information about:

1) the response of the bereaved individual, their family, and support network to the death,

2) other reality stressors, such as financial insecurity, the loss of a home, or other concurrent crisis that may be additionally taxing the bereaved individuals' coping abilities.

D) Other Issues

Other circumstances that Raphael (1980) suggests require further evaluation involve:

1) deaths by suicide,

2) deaths in major accidents,

3) deaths of children,

4) the elderly single person living with and looking after an aging parent who dies,

5) multiple bereavements occurring simultaneously,

6) situations in which the bereaved person experienced a major bereavement in childhood, such as the death of a parent.

APPENDIX C

Areas of interest to me that were explored in my interviews were:

1) The older widows' perceptions of the amount and quality of social support that was extended to them following their bereavements.

This is an important area of questioning in that social network support was the most significant factor related to bereavement outcome in a number of studies, as those of Maddison and Walker (1967), Maddison (1974a, 1974b), Maddison and Raphael (1975), and Vachon et al. (1980, 1982).

2) Other significant losses sustained by the older women.

This proved to be a most significant and productive area of exploration since a current loss seems to reaccess previous significant losses. This area of exploration provided valuable insights into the women's previous coping styles, as well as provided the opportunity to re-examine some previously unresolved issues.

3) What the widows perceived to be their biggest problem at this time.

4) Questions related to:

(a) changes in the widows' uses of medication since the bereavement,

(b) the widows' sleeping patterns and whether they had experienced any dreams about their deceased husbands,

(c) the widows' appetites and their eating habits.

5) The financial circumstances of the older widows.

I believe that this is important to broach once some degree of comfort and trust is established in the relationship. It is my experience that older women are not "complainers" and indeed expect very little. As a result, older women may understate their circumstances and loose out on benefits to which they are rightfully entitled. Providing resource information about financial resources and their qualifying criteria allows the older women the option of applying for those that they deem appropriate, without the

social worker necessarily having to delve into a lot of personal financial information.

6) Whether religion played a significant role in the lives of the older widows.

7) The widows' thoughts and feelings about their own deaths; as well as whether they have had thoughts of hurting themselves.

8) Whether the widows were left with any regrets with respect to their husbands' deaths.

9) What the women missed most about their husbands.

10) Whether the widows had ever considered the importance of nurturing and giving to themselves.

Women are socialized to be nurturers of others. Older widows have a life time career behind them of providing for the nutrient needs of others. Now they are alone. It is worthwhile to explore the importance of the widows' learning to nurture and to give to themselves, without feeling guilty.

11) An exploration of the widows' needs for social relations and how the older women thought that they would meet these needs.

The above questions were not addressed in any particular order. They were casually introduced at appropriate points within the context of a supportive, nondirective interview. The appropriateness and relevance of these questions became most apparent to me as the interviews unfolded, and I discovered that we had already touched upon most of these areas with me only occasionally having to plant the seed of a question.

APPENDIX D

Guideline questions used in the concluding, evaluating interview:

1. Through our time together, did you learn anything about grief or the bereavement experience that surprised you, or that you did not know before?

2. Do you feel that your feelings of grief, and the things that you have gone through, are much different from what others might experience in a similar situation?

3. Has it been beneficial to you to have an opportunity to share your bereavement experiences and your feelings about your grief with me? How so?

4. Can you identify any feelings other than sadness which you have experienced in your grief?

5. What do you feel a bereaved person most needs from others?

6. Do you feel better about anything particular as a result of our sharing your bereavement experiences?

7. Are you feeling more able to manage on your own, than you were say two months ago?

8. Has there been anything that I have been able to do with or for you that you have found to be particularly helpful?

9. Can you identify your most immediate problems related to your being widowed?

10. Have you given any thought to what you are going to do in the future?

11. Is there anything that disappointed you about the time that we have spent together? . . . Sharing this will be very helpful to my learning.

12. Could you suggest anything that we could have done differently in the time we shared together to have made the time more meaningful for you?

13. Is there anything that particularly pleased you about the time that we spent together?

14. If you had a good friend who found herself recently widowed, would you recommend to her that she partici-

pate in the sharing of her bereavement experiences as we have done?

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