Therapeutic intervention in the treatment of substance abuser's unresolved grief reactions in an inpatient hospital setting: A study of two group approaches

Alan Wayne Forrest

College of William & Mary - School of Education

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Therapeutic intervention in the treatment of substance abuser's unresolved grief reactions in an inpatient hospital setting: A study of two group approaches

Forrest, Alan Wayne, Ed.D.
The College of William and Mary, 1990
THERAPEUTIC INTERVENTION IN THE TREATMENT OF
SUBSTANCE ABUSER'S UNRESOLVED GRIEF REACTIONS
IN AN INPATIENT HOSPITAL SETTING:
A STUDY OF TWO GROUP APPROACHES

A Dissertation
Presented to
the Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
Alan Wayne Forrest
February, 1990
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by

Alan Wayne Forrest

Approved on February 1990 by

Kevin E. Geoffroy, Ed.D.
Chairman of Doctoral Committee

Fred L. Adair, Ph.D.

Charles O. Matthews, Ph.D.
DEDICATION

To the many alcoholics and drug addicted individuals who have suffered and known anguish, but discovered a new meaning in recovery;

To the many grieving and bereaved who have opened up their hearts and worked through the numbing pain and found a light still shining;

To the patients at St. John's Hospital who graciously agreed to participate in this study;

You have all so selflessly given to me and have contributed in my growth and my becoming - may you all find serenity, love, and acceptance in your sojourn down the path of life.
If I have discovered anything about the recovery from addiction and the recovery from the loss of a loved one, it is that it is a process that requires not only time, but also what you do with the time and that it is ongoing throughout one's life. And not unlike the recovery from addiction and grief, a dissertation is a process that unfolds over a period of time.

The individuals mentioned below have all been influential, over time, in the process of my growth and have made countless contributions to this project.

My parents - who have shown me the joy of living life to its fullest and for having provided me with a solid foundation from which to build.

My wife, JoAnn - who in addition to being a source of love and support was also willing to make numerous sacrifices to provide me the time necessary to complete this project.

My children, Andrew and Jamie - who provided constant sunshine and who helped keep me focused on what truly is important in my life.

My dissertation committee, Kevin Geoffroy, Fred Adair, and Chuck Matthews - who have each challenged me to extend myself and achieve when I had questions and uncertainties.

Dr. Ronald D. Suiter - my first psychology professor, mentor and friend, who instilled in me the importance of striving for the highest of academic standards.

Dr. P. Christopher Mohring - who was like a breath of fresh air and left the path of conventional wisdom to provide me with support and balance in examining addiction as more than an unidimensional process.

Elizabeth L. Hill - my group counselor who agreed to contribute her knowledge, talents and insights in a difficult and demanding task; my deepest gratitude and appreciation for the richness you added to this project.

Brad Ellison - who translated the language of computers and guided me through the world of statistics thereby giving my data meaning and giving me understanding.

Deborah Bird, Robin Barton, and Mary Moyer - each of whom provided the gifts of understanding, patience,
friendship, and love to help me maintain perspective in what I was doing.

Melinda and Kevin Smyth - for their word processing, editing, support and friendship over the years.

And lastly, Eisenhower College and the E.C. faculty - who provided a world view that has forever opened the window of opportunity for me.
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CHAPTER I

INTRODUCTION

Justification for Study

The death of a loved one is one of the most intense of all sorrows. The grief that is associated with a death is a profound experience that no individual can avoid. It is a shattering event that touches the center of our being. It presents a crisis that is difficult to accept, experience, and endure. It has been estimated that 10 to 15 percent of all the individuals who seek counseling at mental health centers have, underneath their particular psychological condition, an unresolved grief reaction (Lazare, 1979). This has been confirmed by Bowlby (1980) when he says:

Clinical experience and a reading of the evidence leave little doubt of the truth of the main proposition — that much psychiatric illness is an expression of pathological mourning — or that such illness includes many cases of anxiety state, depressive illness, and hysteria, and also more than one kind of character disorder (p. 23).

Grief has been compared to physical illness (Engel, 1961). The thesis presented is that the loss of a loved one is psychologically traumatic to the same extent as being severely wounded or burned is physically traumatic. Grief represents a departure from a state of well being and just as in the physiological realm, it requires a period of time to restore a state of equilibrium to the mourner. Therefore, Engel sees the
grief process similar to the process of healing. He sees mourning as a process that takes time until restoration of function can take place.

Losses are common in all individual's lives - divorce, amputation, job loss, losses experienced by victims of violence, and friends who come and go; all of these situations contain the ingredients in which the individual is confronted with the need to let go of one way of life and accept another. It is the lack of knowledge about grief that increases the feelings of despair, helplessness, and hopelessness that most mourners experience.

In recent years the study of grief and bereavement has focused on a wide range of population groups; primarily on the effect that parental death occurring in childhood has on the child (Birtchnell, 1969), and on the effect that childhood death has on parents (Poznanski, 1972). Other researchers have focused their attention on the grief following the death of a spouse (Parkes, 1968; Clayton, 1979); on the death of a parent (Donnelly, 1987); and on the death of comrades in a shared war experience (Horowitz, 1986). There has even been research conducted on the grief reactions of pet owners on the loss of their pets (Quackenbush, 1984). All of these studies examine the physical and psychological consequences that are experienced by the survivor.

A review of the literature reveals that little attention has been devoted to the presence of grief as a component in the dynamics and psychosocial treatment of alcoholism (Goldberg, 1980). Loss/grief reactions have been conceptualized and described by some
researchers as playing a central role in the disease of alcoholism (Belwood, 1975; Kellerman, 1977; Blankenfield, 1982; Friedman, 1984; Ward, 1988). The variety of losses which accompany the addiction process have been identified and categorized in a tentative fashion (Goldberg, 1985). Loss is intrinsic to the recovery process of substance abuse when the substance, in addition to old maladaptive psychosocial mechanisms, must be given up and replaced by healthier responses to life circumstances.

Few systematic studies have been designed to evaluate the efficacy of a group therapeutic intervention with such a population. The purpose of this study was to investigate the effect that two different group counseling approaches had on adult patients being treated in an inpatient hospital setting in relation to the addicted individual's loss of significant persons, unresolved grief, and substance abuse. The focus of this study was to determine what theoretical approaches and treatment interventions were most therapeutically beneficial to the identified population.

Statement of the Problem

There has been very little research and scarce data in regard to the relationship between unresolved grief and substance abuse. One reason for this may be that the grief process is highly personal and that the norms of American society do not support systematic gathering of information from bereaved persons. Until recent times the tendency has been for people, including
professionals, to avoid discussions of death. Counselors, however, need to be aware of the potential for unresolved grief reactions and various pathological development (Volkan, 1970).

A number of psychotherapeutic methods have been described in the literature for facilitating the work of mourning (Volkan, 1970; Parkes, 1975; Gottsegan, 1977; Worden, 1982; Horowitz et. al., 1984). The data reported from these studies suggest the importance of the individual's use of a variety of coping resources. The involvement of a solid support system is of particular importance; the lack of such a support system may result in emotional and behavioral difficulties.

The loss of a loved one is a universal experience that is repeatedly encountered. The nature, intensity, and length of the grief process is influenced by a large number of variables (Rando, 1984). It is the confrontation with death and aloneness and the lack of knowledge about grief that may institute a period of soul-searching and existential crises to a person (Becker, 1973). Therapy may be of great value here by helping people work through the loss and reach a point whereby growth can be achieved. If this does not occur due to a disturbance of the grief process, then an unresolved grief reaction may occur preventing successful progress toward acceptance/resolution of the loss. It was hypothesized that for the substance abuser, identification and treatment of the person's unresolved loss may contribute to his/her decision to become drug free. Rosenblatt, Walsh, and Jackson (1976) have noted that losses perceived by substance abusers are compounded by their
lack of ability to work through the grief process.

Therefore, the focus of this study was to determine the following:

What are the effects of a higher level inpatient therapy group as compared with a structured didactic group on adult substance abuser's unresolved grief reactions in an inpatient hospital setting?

Theoretical Rationale

It was Freud (1917), in the classic study "Mourning and Melancholia", who initially observed that mourning, although a severe disruption in an individual's routine pattern of living, is such an universal response that it is difficult to examine as being abnormal. Although Freud believed the reaction to grief was normal, he did note that it had distinguishing characteristics similar to the pathological condition of melancholia - profoundly painful dejection, loss of interest in the outside world, loss of capacity to love, and inhibition of activity.

The significance of Freud's contribution rests in the fact that for the first time the matter of grief was given some structure. With his theory of melancholia he developed the thesis of similar processes in mourning, but was unable to fully articulate the impact of ambivalence in "normal" grief.

As a refinement to Freud's theory of grief, Bowlby (1961, 1969, 1973, 1980) reported that there seems to be no difference between separation and loss from the mother on the part of the child and the separation and loss by the death of an emotionally significant person on the part of the adult. The anger that a
grieving person feels is comparable to the protest expressed by the infant. Bowlby's theory of healthy mourning emphasizes the cognitive biases of the individual that are learned through interaction with early attachment figures during childhood development. He sees separation anxiety, grief, and mourning as phases of a single process.

Despite the fact that "grief work" was discussed as early as 1917 by Freud, the study of grief as a psychological process is relatively new. Parkes (1968, 1972, 1981), the British psychiatrist, complained that grief as an area of study has undergone few systematic examinations that provide accurate insight as to the psychodynamics associated with grief and bereavement. Until the late 1970's most investigations consisted of subjective clinical impressions, opinions, and interesting theorizing based on unsubstantiated factual data.

Comprehensive and systematic investigations were conducted by C. Murray Parkes in the early 1970's. According to Dunlap (1978):

Parkes tells us grief is not a fixed state, but rather it is a process; it is not a set of symptoms which start with bereavement and then gradually fade away, but a succession of clinical pictures which blend into one another, replace one another, and recur from time to time in overlapping patterns.

Parkes postulated the following stages in the grieving process:

1) Numbness is the immediate reaction that follows death; it is the response to a stressful situation of loss. The numbness is frequently accompanied by denial and is
the result of a disruption in an individual's homeostasis.

2) Pining, yearning, and searching are present in the grieving process. There may by an overpowering urge to cry which can be translated as an expression of the helplessness and is necessary in an effort to gain needed sympathy and support.

3) Upon full realization of the loss (the separation anxiety) a depressive withdrawal follows. Pessimism, withdrawal, sadness, loss of interest, and guilt are characteristics of the individual's overall mood.

4) The recovery stage is a point in which the individual accepts that the event happened and that it is time to continue living.

Various dimensions of unresolved patterns of grief have been researched by Averill (1968), Parkes and Weiss (1983), and Raphael (1983). Many of their observations and findings overlap. In each there are components of denial or repression of aspects of the loss or of the feelings generated, as well as an attempt to hold on to the lost relationship.

Specified symptoms and behaviors indicative of unresolved grief have been systematically identified, examined, and enumerated by many researchers (Lindemann, 1944; Lazare, 1979; Worden, 1982). Individual symptoms may be unremarkable during the acute stage of grief, however they may serve to form the core of the primary signs of incomplete grief work when they are manifested beyond the
expected time for grief resolution. The more symptoms the mourner exhibits, the stronger the diagnosis of unresolved grief.

Two conditions which may stimulate difficulties in accomplishing grief work and thereby predispose the mourner to unresolved grief were identified by Jackson (1957). In the first condition the mourner is unable to tolerate the emotional stress of grief and is resistant to addressing the necessary tasks and feelings of grief. The second condition occurs when the mourner has an excessive need to continue interaction with the deceased; the mourner is in denial of the loss and fails to appropriately and emotionally withdraw from the deceased, thereby failing in the required tasks of grief work.

Parkes identified grief as a process of realization, of making real inside the self an event that has already occurred in reality on the outside. Although a loved person may have died, the modification of the internal world takes time. He goes on to state that the continued awareness of the conflict between the outside world and internal representation of it accounts for many of the feelings of frustration that frequently is a feature of grief. In the end, Parkes believes the intensity of pining and searching can be expected to diminish as other priorities begin to predominate.

Dunlop (1978) summarized Parkes' theory of grief by stating:

the grief syndrome is not so much a matter of letting psychological events take place in a known and predetermined order as it is of expecting their appearance in a predictable sequence but anticipating too that parts of the pattern may occur nonsequentially. The grief syndrome is full of remissions and relapses, but as a general rule it can be expected that persons will cope with bereavement with the same psychological
mechanisms they have employed previously with other life stresses.

When a death occurs, the normal routine of life is interrupted. It may be that humans find security in stability and any deviation in their environment will affect that stability. Once the stability is affected, an individual's security is threatened thereby resulting in tension, anxiety, and grief. How a person responds in a time of grief and whether or not it becomes transformed in an unresolved grief pattern, depends on a great extent on how the various predisposing factors are organized and how they function together.

**Definition of Terms**

**Adult patient/subject.** An adult patient/subject was an individual who is 18 years of age or older.

**Depression.** A disturbance of mood or emotional response which includes sadness, loneliness, apathy; a negative self-esteem; desires to escape, hide or die; and a change in activity level.

**Extremity of grief reaction.** The specific nature of an individual's grief reaction to a loss, e.g. delayed grief, prolonged grief, or acute unresolved grief.

**Grief.** The process of psychological, social, and somatic reactions to the personal experience of a loss. It consists of a deep and poignant distress.

**Higher level inpatient therapy group.** A type of therapeutic intervention in which a counselor assists a group of patients in
an effort to enable group members to understand and resolve their own problems in the here-and-now.

**Intraception.** The ability to engage in attempts to understand one's own behavior or the behaviors of others.

**Personal adjustment.** Possessing a positive attitude toward life, enjoys the company of others, and feels capable of initiating activities and carrying them through to conclusion.

**Structured didactic group.** A type of therapeutic intervention organized in such a way that individuals participate as learners; it is designed to convey instructions and information.

**Substance abuser.** An individual who has experienced negative consequences in his/her life as a result of excessive use of alcohol and/or drugs. Negative consequences includes effects in such areas as legal, medical, financial, social, and occupational.

**Succorance.** To solicit sympathy, affection, or emotional support from others.

**Therapeutic intervention.** A strategy or set of strategies implemented by a counselor so as to assist clients in resolving personal problems.

**Unresolved grief.** An interruption of the grieving process in which one or more of the phases of grief is absent, delayed, intensified, or prolonged.

**Research Hypotheses**

This study attempted to assess the results of a higher level impatient therapy group, a structured didactic control group, and
control group on substance abuser's unresolved grief reactions by pre and posttest measure. Data was obtained for treatment 1 group (higher level inpatient therapy group), treatment 2 group (structured didactic group), and control group on posttest extremity of grief reaction, depression, intraception, succorance, and personal adjustment. The following hypotheses were provided:

1. Subjects participating in the two treatment groups will experience a significant degree of grief resolution as to the extremity of grief reaction compared to the control group as measured by the Texas Revised Inventory of Grief (TRIG).

2. Subjects participating in the two treatment groups will experience decreased depression compared to the control group as measured by the Beck Depression Inventory (BDI).

3. Subjects participating in the two treatment groups will experience significantly greater changes on the Intraception Scale of the Adjective Check List (ACL) compared to the control group.

4. Subjects participating in the two treatment groups will experience significantly greater changes on the Succorance Scale of the Adjective Check List compared to the control group.

5. Subjects participating in the higher level inpatient therapy group will experience significantly greater changes on the Personal Adjustment Scale of the Adjective Check List compared to the structured didactic group and
Sample Description and Data Gathering Procedures

Subjects for this study were adult individuals, 18 years of age or older, who had been admitted into an inpatient hospital setting for substance abuse and identified as having an unresolved grief reaction to a prior loss or losses. The sample consisted of both male and female subjects who were randomly assigned to one of three groups, a higher level inpatient therapy group, structured didactic group, or control group.

Characteristics of subjects were obtained through a combination of demographic data collected by the hospital and demographic data collected specifically for the purpose of this investigation. Characteristics of particular interest that are known to affect the response of loss are the age of the subject at the time of the loss, type of loss and type of attachments, number of losses, existing relationship, and sudden versus anticipated loss; this information was necessary to obtain. In addition to the collected demographic data, there was a composite inventory instrument composed of the Texas Revised Inventory of Grief, the Beck Depression Inventory, and the Adjective Check List.

Treatment interventions were administered to the two experimental groups - the higher level inpatient therapy group and structured didactic group, and withheld from the control group. Data consists of pre and posttest scores of the instruments previously mentioned. The two treatment groups met for three
sessions each week for a time period of 75 minutes.

Each treatment session was audio-taped and reviewed. This served as a measure that the group facilitator conducted the groups with the prescribed treatment interventions. This functioned to insure that what was planned to happen in each treatment condition actually occurred.

**Limitations**

A number of limitations to the quality and generalizability of potential findings resulted from the procedures of the research. The most salient limitations are discussed below.

The subject population limited the applicability of obtainable results. The population consisted of substance abusing adults who had unresolved grief reactions which may vary from one year to five years to twenty years or longer. Although this data was obtained from the demographic data, no treatment distinctions were made based upon the length of time of the patient's loss and the therapeutic intervention. Additionally, participants in this investigation were volunteers drawn from the patient population at St. John's Hospital; they participated in the study because of numerous possible reasons. There may have been some individuals who required counseling, but never sought such treatment as used in this study.

The study included 41 adult inpatient individuals (18 years of age or older) drawn from the metropolitan Richmond area. The subjects had either chosen or been referred to St. John's Hospital for substance abuse treatment; some may have been reluctant to be
admitted into the hospital due to their denial. Denial, however, being a salient dimension of the addiction process, must be considered as a possible variable resulting in some subjects being resistant to participating in the inpatient treatment program; this study did not analyze the variable of denial.

This investigation did not control for prior therapeutic interventions concerning the patients substance abuse or unresolved grief. The therapeutic interventions were intensive and the groups met for 75 minute sessions three times a week until each subject had a total of 8 group sessions. Because the group was open-ended and on-going, subjects were introduced and exited from the group at different points in time; while this approach has positive effects it also may have had the limiting effect of somewhat disrupting the group process.

The facilitator's personality and effect it may have had on the group was not controlled for in this study. This investigation did not control for the effect that age, sex, race, socioeconomic class, religious preference, and number of years abusing substances has had on the group participants.

St. John's Hospital is a privately owned hospital in which health insurance coverage is required in order to be admitted. This certainly served as a gatekeeping device insofar as those individuals who were admitted, in most cases, were employed and earning average to above average wages; this may have served to skew the sample and thereby somewhat restrict the generalizability of the results.
Lastly, it may be that the mere presentation of the pretest composite instrument was viewed as a therapeutic intervention. Because of the content of the TRIG, BDI and ACL, it may have stimulated thought and/or discussion on the part of the individuals that composed the control group. Also, it was not possible to prevent individuals in the treatment intervention groups from interacting and communicating outside the context of the groups.

**Ethical Considerations**

The ethical guidelines established by the American Psychological Association for protecting the rights of human subjects were strictly adhered to in this study. A "Proposal for Research with Human Subjects" was submitted to the College of William and Mary Human Subjects Research Committee.

Confidentiality and necessary therapeutic follow-up was the responsibility of the investigator. All discussions, interviews, audio-tapes, and written data obtained in this study was treated in a strict confidential manner so as to protect the anonymity of each participant. Patients were informed that they could terminate their participation in the group at any time and could choose not to respond to specific questions or participate in certain activities.

In an effort to have provided for the safeguards of each subject the following procedures were used to counter potential risks: if the pretest results of any subject indicated that counseling was immediately necessary or counseling became necessary
beyond the scope of this study at any point between the pre and posttesting, then that individual was referred to their admitting psychiatrist/physician and/or appropriate staff Licensed Clinical Social Worker or Licensed Professional Counselor. Subjects in the control group that did not receive either treatment intervention as a part of this study were offered grief counseling at the completion of the investigation.

One counselor licensed by the Commonwealth of Virginia through the Health Regulatory Board (Licensed Professional Counselor), with twenty years of successful clinical substance abuse experience and training/experience in grief work facilitated the treatment groups. This served to assure that a qualified professional was present to conduct the groups and assist any patient who experienced severe emotional distress.

Prior to the beginning of this study, approval was obtained from the investigator's three-member doctoral committee, the College of William and Mary Human Subjects Research Committee, and St. John's Hospital's Chief Executive Officer, Medical Director, and the program's Clinical Coordinator.
CHAPTER II

REVIEW OF THE LITERATURE

Summary of Rationale and Relationship to Problem

Losses are common in all individual's lives; friends come and go; one job is lost, another is started; new skills are learned, old ones abandoned - in all these situations the person is faced with the letting go of one way of life and the acceptance of another. Grieving is something that requires notice, observation, and time in order to allow emotional healing to occur. According to Worden (1982), the grieving process creates tasks that need to be accomplished in order to offer hope that something can be done and that the grieving will end. It is the lack of knowledge about grief that increases the feelings of despair, helplessness, and hopelessness that most mourners experience.

The most recognized loss is that of death, however during a person's growth and development, one experiences numerous other losses which are of a more subtle nature (Viorst, 1987). Four distinct forms of loss have been identified and elaborated upon (Peretz, 1970): loss of a significant loved or valued person; loss of some aspect of self which may include loss of health, body function, social role, or self definition; loss of external objects - possessions or home; and developmental loss which occurs as a result of the growth process. Since it is the individual which defines a loss with both personal and symbolic meaning, it is only the individual who can differentiate between minor and major losses.
and their impact. Something perceived as a loss by one person may not be seen as a loss by another. One concept is clear, since all losses merge in the unconscious, the impact of loss, if unresolved can be cumulative.

Grief is a complex process; it is the normal emotional response to a recognized loss. The initial issue may not be the loss itself, but the manner in which it is or is not resolved. In recent years there has been an increase in attention given to the possible relationship between an addicted individual's loss of significant persons, unresolved grief, and substance abuse. In a study with recovering heroin addicts it was found that if the bereaved individuals are to successfully return to a normal, productive life, they need to "work through" their losses (Coleman, 1980). According to one researcher (Skolnick, 1979), substance abusers resort to the use of chemicals as an attempt to resolve emotional losses. Also examined, earlier losses of significant persons in the life of the substance abuser are never resolved. Belwood (1975) cites evidence that indicates a minimum of 20% of all patients admitted for alcoholism began drinking at the time of a major loss or separation. Denny and Lee (1984) substantiate the notion that unresolved grief can be a major problem to the addicted person who seeks to numb his feelings through the use of substances; and that involvement in a therapeutic intervention can assist such persons.

Loss is a dominant theme in the dynamics and psychosocial treatment of substance abuse. The comprehensive approach to
treatment has suggested to some researchers that there is a relationship between losses, unresolved grief, and substance abuse. From an examination of the literature it becomes apparent that there is a scarcity of systematic and comprehensive research that adequately explores this relationship. The purpose of this study is to investigate the differential effects of a higher level inpatient therapy group with a structured didactic group approach on adult substance abuser's unresolved grief reactions to prior losses.

The literature review which follows will focus on three major areas of consideration. The first area is a review of the research on the historical and theoretical overview of grief and unresolved grief. This section is followed by a general review of the research and intervention strategies of a Yalom (1983) approach to group counseling and research on structured didactic groups. The final section addresses the notable differences of comparable populations of this study.

**Historical and Theoretical Overview of Grief and Unresolved Grief**

A primitive psychological presentation of grief can be traced to Borquist (1906) where he linked the subjective state of despair, the desire not to live, "the feeling of being helpless, hopeless, and forsaken" with the physiological response. His observations brought him to a point where he related the death of a significant other with the subjective sense of one's own mortality and the fear a person feels in the realization of his inability to cope with the
threatening situation. It was suggested by Borquist that the evolutionary behavior of the grieving person allows for another person who can enter the situation of crisis and protect him from life threatening harm.

It was Freud (1917) who initially observed that mourning, although a severe disruption in an individual's routine pattern of living, is such a universal response that it is difficult to examine as being abnormal, especially since it usually dissipates over a period of time. Although Freud believed the reaction of grief is normal, he did note that it had distinguishing characteristics similar to the pathological condition of melancholia; e.g. painful frame of mind and a loss of interest in the outside world.

One of the first researchers who attempted to develop a specific in-depth description of bereavement and a theory that would provide some structure to the study of grief was Thomas Eliot (1930, 1933), a sociologist. In an attempt at a definition of grief, he states:

Psychologically, bereavement is a major type in the general class of traumatic frustration situations. Arrested impulse or thwarted habit is at the root of all sorrow. Bereavement is one's own blocked wish for response following the death of a loved object. The loved one is gone, but the associated memories and habits and needs remain alive as a real complex in the mind of the bereaved.

Eliot suggested that bereavement was essential and necessary for individuals and families. He noted that among the early impacts of bereavement is a sense of abandonment, shock, and denial, with varying degrees of guilt, anger, and intense or persistent longing.
for the deceased. Additionally, he discussed the disruption of normal patterns that bereavement produced.

Lindemann (1944) examined survivors symptomatology of grief reactions to a restaurant fire disaster. Specific descriptions were distinguished regarding normal and pathological grieving reactions. He postulated that there were a number of possible responses to the death of a loved one that are all part of the normal grieving process. One set of symptoms common to all people that Lindemann interviewed included:

sensations of somatic distress occurring in waves lasting from twenty minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing, and an empty feeling in the abdomen, lack of muscular power and an intense subjective distress described as tension and mental pain.

For the most part, the grieving period allows the bereaved individual to deal with the intense feelings that follow the death of a loved one.

Lindemann goes on to point out that:

1) acute grief is a syndrome with definite psychological and somatic symptomatology;

2) this syndrome may develop immediately after a crisis, be delayed, exaggerated, or apparently absent;

3) in lieu of the typical syndrome, there may be distorted pictures which represent one unique aspect of the grief syndrome;

4) through appropriate techniques these distorted pictures can be successfully changed into a normal grief reaction with resolution.
Jackson (1957) has continued to examine the theories originally proposed by Freud, that of distinguishing the differences of the grief reaction and emotional states that are similar to it. The importance of Jackson's theory is the four dynamic factors which he believes influence the grief reaction. These are: the personality structure of the bereaved, indicating that where an unhealthy interpersonal relationship has led to a weak ego there is danger of an unresolved grief reaction; social factors of crisis, support, and expectations affect the intensity of grief; the role which the deceased has played in the life system of an individual; and the value structure of the individual.

Jackson points out that grief is the "feeling of acute pain" accompanying the loss of an object of value to an individual, thus an object that is related to one's own selfhood. The center of the grief experience is anxiety. Jackson refers to the relation to one's own selfhood of the loss object and experience of a death of a significant person by stating, "in your death something in me also dies".

In examining the interpersonal nature of grief, Volkart and Michael (1957) stress the social and cultural aspects of the event as directly affecting the psychological. Different patterns of family life produce variable emotional levels of self-involvement with other persons, and this is a major factor in the behavioral responses of grief. In our culture with the nuclear family, much emotional investment in members of the family occur. There can be an overidentification, overdependency, and cultural definitions
that certain persons (mother or father) are irreplaceable. Thus, the death of a person is a loss to the other members of the family and this is reinforced by society at large. According to Volkart and Michael there is the need at the time of death for the bereaved person to replace the loss and to deal with his feelings of hostility and guilt.

William Rogers (1963) contributed to the understanding of grief by utilizing the concept of development of the self. He focused on the interaction of the organism within the context of its environment. Whenever a person loses an emotionally significant person (or object), it results in a response of perceived threat to the self which they had incorporated; it is this threat that is experienced as emotional pain, or what is commonly referred to as grief. The most painful loss is that of the death of a person with whom one is emotionally identified. Rogers states:

> the important point to remember is that grief is not the result of what happens to the loved one. It is rather the result of what happens to the bereaved. Something of great importance to the individual, something that is a part of his psychic life, has been torn out, leaving a great pain, the emotion which we call grief.

The boundaries between normal or uncomplicated grief and pathological or unresolved grief are not always clear. The distinction, however, is clinically significant. "Normal" grief is considered self-limited, relatively benign, and therapeutic intervention is not seen as necessary; however unresolved grief is associated with much social, psychological, and medical morbidity (Klareman and Izen, 1977).
Some degree of physiological disturbance is a common component of the normal grief process. Nevertheless, it may develop into a health risk for the bereaved. When comparing bereaved widows and widowers to a non-bereaved control group 13 months after the loss of their spouses, Parkes and Brown (1972) reported that bereaved subjects exceeded the control group in physical symptoms. They found that widows reported 50% greater autonomic symptoms than women in the control group and widowers exhibited four times as many symptoms as married men in the control group. The emotional distress of the bereaved sample was greater than the control group. Insomnia, changes in appetite, and changes in weight were also more frequent. Of the bereaved group 28% reported an increase in alcohol consumption and 26% had either begun taking tranquilizers or increased their use. It must be noted that physiological symptomatology does not automatically signify unresolved grief in and of itself; however normal physiological disturbances accompanying grief can themselves become pathological to the mourner.

Schneider (1980) described clinically observable differences between normal grief and pathological grief. He cites evidence indicating that if grief work is not actively pursued, the process may not achieve a healthy resolution, with the patient feeling that he may have escaped it. However, almost certainly an unresolved pattern of grief will appear sometime in the future.

Specific distinctions between normal and unresolved grief consist of six primary factors, according to Schneider. The first
factor is time of loss. Six months appears to be a minimum time necessary to determine if the bereaved will be able to mourn and resolve the loss and continue with their life. With unresolved grief intense reactions last longer than six months with only minimal signs of resolution or relief. Those in normal grief, however, will generally be able to carry on a preloss style of living by making the necessary adaptations to acknowledge the reality of the loss within the first year (Clayton, 1968).

A second distinction Schneider identified relates to reality testing of the loss. Characteristics of unresolved grief is an avoidance of reality testing where the bereaved continues to operate as if loss was still there. There is a chronic and continual hope for return of the lost person and a refusal to reality test. In normal grief there is a desire to believe the loss can be returned, however there is cognitive awareness that this cannot happen. Reality testing is intact.

Intense preoccupation with the loss is a clear sign of mourning. If this persists for more than six months and if there is an active seeking to reunite with the lost person and/or clear ongoing disruption and dysfunction in daily routine, then the grief has reached pathological proportions. Part of the preoccupation in unresolved grief is focused on reliving the events surrounding the loss repetitively and without emotional relief. Normal grievers experience an acute awareness of what occurred at the time of the loss on emotional, physical, and cognitive levels.

The fourth difference Schneider discusses relates to dream
content. In unresolved grief the manifest content is focused on attempts to save what was lost. Associated with these dreams are feelings of anxiety, guilt, and no sense of relief. In normal bereavement, the manifest content is more likely to acknowledge the loss.

Most grieving persons are ambivalent about discussing their losses and feelings because of the emotional pain and hurt it brings them; however in normal grief individuals are willing to do so (approach-avoidance behavior). The individual experiencing an unresolved grief pattern avoids situations which remind him of the loss.

And lastly, Schneider points to the distinction of intellectual/emotional integration whereby he believes that normal grieving involves a reintegration process which brings intellectual awareness of a loss, its implications and emotions together so that healing can begin. The integration process is clearly absent in unresolved grief.

Worden (1982) has identified five major factors that are important to examine with people experiencing unresolved grief. The first is the relational factor which consists of the definition of the type of relationship the grieving person had with the deceased. Worden states that the most frequent type of relationship that complicates people from adequately grieving is the highly ambivalent one; this can result in excessive amounts of anger and guilt which cause the survivor emotional difficulty. Horowitz (1980) believes that highly dependent relationships are
also difficult to grieve and may predispose an individual to an unresolved grief reaction.

Circumstantial factors surrounding a loss are important to the determination of the strength and outcome of the grief reaction. Three specific circumstances that Worden identifies are: (1) when the loss is uncertain; (2) when the loss is inconclusive; and (3) multiple losses.

A third factor occurs if an individual has unresolved grief reactions in the past, then there is a higher probability of having unresolved grief with subsequent losses.

Past losses and separations have an impact on current losses and separations and all these factors bear on future loss and separations and capacity to make future attachments (Simos, 1979; p. 27)

Personality factors are related to an individual's character and how this affects his ability to cope with emotional distress. According to Worden, there are some people who are unable to tolerate extremes of emotional distress so they withdraw in an effort to defend themselves against such strong feelings. Problems result because they attempt to short-cut the grief process and often develop an unresolved grief reaction.

The final determinant of grief identified by Worden that may result in unresolved grief involves social factors. Grief is a social process and best confronted in a social setting in which people can support and reinforce each other in their reactions to their loss. Lazare (1979) describes three social conditions which may be a portent to an unresolved grief reaction: (1) when the loss is socially unspeakable (e.g. suicide); (2) when the loss is
socially negated; in other words, when the person and those around him act as if the loss never occurred (e.g. abortion); and (3) when there is an absence of a social support network.

Zisook and DeVaul (1983) have suggested a relationship between unresolved grief and depression. They discovered that individuals with evidence of unresolved grief were significantly more depressed as measured by total scores and numerous items on the Zung Depression Scale. Although no cause and effect relationship could be identified, it did appear that individuals who reported that they had grieved and adjusted to the loss, and were able to talk about the deceased without difficulty were less likely to be depressed than those who indicated that they had not totally grieved. They concluded that while symptoms of depression are a common aspect of "normal" bereavement, a full-blown depressive illness may be as much related to the nonresolution of grief as to the loss itself.

In a later article Zisook and DeVaul (1985) proposed their own staging of the grief process and specifically identified issues related to unresolved grief. They discussed three partially overlapping, but distinct stages: (a) an initial period of shock, disbelief, and denial; (b) an intermediate acute somatic and emotional discomfort with social withdrawal; and (c) a culminating period of resolution. Often, however, the grief process does not follow an orderly three stage process. When incompletely resolved, the grief process is associated with relatively specific clinical syndromes such as depression and what Zisook and DeVaul (1977)
refer to as "grief-related facsimile illness." The frequency of unresolved grief is unknown and depends on numerous factors, as previously mentioned, but reported estimates range from 10%-25% (DeVaul, Zisook, and Faschingbauer, 1979; Lazare, 1979; and Zisook and DeVaul, 1983).

New and preliminary scientific research findings have begun to challenge some of the more widely held clinical beliefs about loss and resulting grief reactions. In a study conducted by Wortman and Silver (1989) attention has been given to how individuals respond and cope following losses. The new findings suggest that counselors may be too quick to note pathology in reactions that are actually normal.

Wortman and Silver review numerous research findings that examine the emotional course of understanding and accepting devastating losses. The data suggest that what is needed is an expansion of the beliefs of what is a normal grief reaction to a loss. The study cites five different studies of widows and widowers where no pathological or unresolved grief has been found with 25-66% of the sample population. Contradictory findings have been found to indicate that people who lost a child or spouse in an unexpected manner were likely to experience more depression and anxiety years later.

The study conducted by Wortman and Silver has been supported by the earlier research of Kessler, Price and Wortman (1985) in which they found that there appears to be considerable variability in the length of time it may take to recover from a loss; and some
individuals do not seem to recover simply through the passage of
time. This has led to an increased interest in identifying factors
that may enhance or impede the psychosocial recovery process.

In an investigation by Wortman and Silver (1987), variables
were identified which may enhance the likelihood that individuals
will react to a loss with a prolonged grief reaction. These
variables include: the nature of the relationship with the
deceased, circumstances surrounding the loss, the presence of
concomitant psychosocial stresses, and the availability of a solid
social support network.

Overall, the Wortman and Silver (1989) study concluded that
historically there has been a complex composition of biased input
and interpretation of data. This had led to the perpetuation of
unrealistic and sometimes incorrect assumptions about what is the
normal process versus pathological process of coping with grief and
loss.

Unresolved grief may manifest itself in several forms and has
been given many different labels. It has sometimes been referred
to as atypical (Parkes, 1972), pathological (Volkan, 1972),
complicated (White and Gatham, 1973), abnormal (Hackett, 1974), or
delayed grief (Worden, 1982). In the recent volume of the
Psychiatric Association, unresolved grief reactions have been
referred to as "complicated bereavement." But however it is
labeled, it is:

the intensification of grief to the level where the
person is overwhelmed, resorts to maladaptive behavior,
or remains interminably in the state of grief without progression of the mourning process toward completion . . . . [It] leads to stereotyped repetitions or extensive interruptions of healing (Horowitz, 1980; p. 1157).

Comparable Populations

A key figure in the development of grief theory is the British psychiatrist John Bowlby (1962, 1969, 1973, 1980). He developed a theory of mourning based on his observations of attachment behavior in young children and primates. Data included in his theories come from ethology, cognitive psychology, neurophysiology, and developmental biology. Bowlby's thesis is that attachments come from a need for security and safety; it is his belief that they develop early in life, are usually directed toward a few specific individuals, and tend to continue throughout a large part of the life cycle. The formation of attachments with significant others is considered normal behavior for the adult as well as the child.

Bowlby's phase theory of healthy mourning emphasizes the cognitive biases of the individual that are learned through interaction with early attachment figures during childhood development. It is his belief that there are good biological reasons for every separation to be responded to in an automatic, instinctive manner. He also suggests that in the course of evolution, instinctual equipment developed around the fact that losses are retrievable and the behavioral responses that compose part of the grieving process are directed toward reestablishing a
relationship with the lost object (Bowlby, 1980).

Parkes (1968, 1972, 1981) conducted empirical studies on grief and bereavement and is one of the first researchers to engage in controlled studies. In his view, grief is a realization process whereby an event that has already occurred on the outside must be made real inside. Although a loved one has died, the appropriate modification of the internal world takes time. The sense of frustration that is frequently felt is a result of repeated discrepancies between the outside reality of the world and the initial internal representation of it. Parkes believes that it is the repeated frustration of this pattern of behavior that eventually leads to its extinction. Eventually the intensity of pining and searching will lessen and other priorities will once again predominate.

Parkes (1971) developed his theoretical basis in a study (the London Study) conducted in an attempt to discover how an unselected group of twenty-two London widows under the age of 65 would cope with the stress of bereavement. They were interviewed at the end of the first month of bereavement, and again at the third, sixth, ninth, and thirteenth months, a minimum of five interviews in all. A strength of this procedure was to carry out the final interview one month after the one-year anniversary so as not to be influenced by the anniversary reaction.

In the London Study people were asked about their bereavement and how they reacted to it. Questions were kept to a minimum, some brief assessments were made, and all responses were recorded on a
survey form. The assessments were based on a number of psychological measures (e.g. preoccupation, tearfulness, restlessness, tension, social withdrawal, etc.) and combined with direct observations. Each feature was rated on a five-point scale as "very marked", "marked", "moderate", "mild", or "absent". Mean year scores were intercorrelated and the significance of all scores were tested.

Parkes (1972) interviewed 68 people in Boston, with a mean age of 36 years, 14 months after the loss of a spouse by death. Matched controls were used and it was found that in one-fourth of all patients, use of alcohol and anxiolytics were significantly increased (p < .001) but there was no real difference in those who "sometimes drank more than was good for them."

The results indicated that there are two main types of variables that go together and create two general trends of reaction to bereavement (a. preoccupation with thoughts of the deceased, and b. irritability and anger. It is my belief that relevant data can be obtained from detailed studies of a few people and from statistical studies of larger samples. Ideally these two types of studies should complement each other because only through close scrutiny of large numbers can we obtain significant data and generalize to larger populations.

Ward (1988), in an article that examines grief as a part of the recovery process, conceptualizes the belief that when an individual becomes involved in substance abuse treatment little attention is given to the losses experienced by the abuser. Ward
also postulates that even the loss of the chemical relationship must be grieved, just like any other loss of an important relationship. He believes that the answer to the dilemma is to provide education to increase the awareness of predictable reactions of grief and measures must be considered to assist the abusing person to acknowledge these reactions and deal with losses in recovery.

Intellectually the emotions of grief (anger, guilt, shame, sadness, and others) experienced by the substance abuser can be dealt with, but emotionally they frequently persist. Initially help for a loss may be readily sought after and accepted, however after the initial shock and numbness subsides, the individual is left to deal with their own issues; and based on past experiences, he/she utilizes substances as a way to cope with the emotional pain.

Ward concludes that the reactions of grief with substance abusers is unavoidable and must be resolved for recovery to be meaningful and longlasting. Understanding the grief process may provide the necessary answers and make greater sense of the emotional turmoil that the struggle to overcome addiction can cause.

Skolnick (1979), in an article that examines addiction as a symptom of pathological mourning, reported that drug abuse is an attempt to resolve the psychic disequilibrium caused by intrapersonal losses through the use of chemicals. She examines the problem from a psychoanalytic perspective - an attempt at
restitution of early losses - and raises a number of salient points to be considered. The theoretical approach is based upon her preliminary research examining drug use and loss theory.

Skolnick's thesis is that in an effort to alleviate the continual painful awareness of loss, the individual utilizes chemicals in an effort to relieve him of emotional suffering. What occurs is a chemical balance which creates a false sense of inner tranquility and impedes or retards the grieving process. Breaking free of the addiction spiral (use chemicals to achieve relief, followed by re-emergence of pain when the effect of the drug wears off, resulting in increased usage) becomes a frantic, and in many cases, a doomed cycle. The feelings of loss create a psychic and emotional imbalance for which the addict seeks relief. The result is that drugs become the defense against the pain and resolution of the mourning process. The normal completion of grieving is interrupted due to the use of chemicals and both experiencing the pain and the surrender of the lost object is either not attempted or never satisfactorily completed.

The pathological mourning approach in relating to losses was examined by Skolnick in a women's treatment group at a methadone clinic. Examining methadone withdrawal clients, the control group lost 44% of their population during withdrawal. The experimental group using a pathological mourning approach had 100% of the population remain in treatment. Also, the experimental group requested an average of 5.0 additional counseling sessions over the eight week period of the study, whereas the control group requested
an average of only 3.5 sessions.

In a follow-up study, when the staff of a methadone clinic were taught a pathological mourning method to be used in a group format, it was found that with a population of 58 clients that the mean number of weeks in which illegal drugs were used in April, 1974 was 2.6. A year later following the staff training, the mean was 1.4. The decline was significant $\pm 4.9$, p<.01. The study is important in that it offers some evidence that there may be a causal relationship between the loss of a significant other and substance abuse.

The conclusion drawn from Skolnick's research is that where there is group treatment whereby there can be a ventilation and sharing of losses, the grief process is more likely to occur and conclude toward the final stage. Criticisms of this study include: it was inferred that subjects treated by staff trained in a loss theory method are more open in requesting additional treatment; no compelling evidence was presented to support this statement. Secondly, the generalizability of results is questioned because of examining at a women's treatment group without matching it to a men's treatment group. Lastly, there was no check, by contacting family members, to determine if the weeks of illegal drug use was accurately reported. Active substance abusers tend to minimize the amounts of their use and their ability to be open and truthful has long been suspect.

In an Australian study (Blankfield, 1982) conflicting results were found regarding alcoholism and pathological grief. A survey
of clinical histories found the presence of grief in 12 out of 50 consecutive admissions in an alcohol treatment program (8 additional cases were later added to the survey). Losses had occurred in 14 of the individuals who were diagnosed as already having alcoholism and initiated alcoholism in six others, five of whom described a family history of alcoholism.

The Blankfield study demonstrated the various ways in which grief effected patterns of alcohol consumption. It was found that chronic alcoholism could influence the expression of grief and the process of mourning. What is contradictory to other studies in the literature is the finding that resolution of mourning can occur concurrently with increased alcohol intake. She states that "pseudogrief" in the withdrawal phase of treatment could be transient.

Variants of unresolved grief were present in half (N=10) of whom five came from the initial survey group. Blankfield hypothesizes the form of expression of unresolved grief could be related to a premorbid personality profile. The completion of the withdrawal phase was found essential for a meaningful diagnostic assessment to take place. The resolution of pathological grief was not necessarily associated with total abstinence of alcohol after treatment.

The overall conclusion of this survey suggests that the apparent role of bereavement as a precipitating factor in the production of an alcohol dependence syndrome is unclear. It is not known what the full extent of unresolved grief is in the alcoholic
and first admission with this complication can occur several years after the event. The literature, according to Blankfield, does not clearly define the relationships between alcoholism, admission for treatment, and unresolved grief.

An interesting study was conducted by Denny and Lee (1984) which focused on the implementation and outcome of a grief group conducted with substance abusers. Group participants (subjects who had completed a minimum of three months of treatment) were chosen through a randomized stratified sampling from a residential drug and alcohol treatment facility. Each subject had a primary psychiatric diagnosis and secondary diagnosis of alcohol and drug dependency. Both control and experimental groups were utilized to test the usefulness of grief group therapy.

The study was designed to test the following two hypotheses: (1) following treatment the group members would feel less depressed than control subjects; and (2) treatment group members would demonstrate a greater degree of grief resolution than control subjects at posttest.

The experimental subjects met for five group treatment sessions (each session met for 3 hours/week). The group session provided an environment whereby patients received support, encouragement, and confrontation from peers. Each of the therapy sessions were structured to include specific tasks and activities predetermined by the facilitators.

Measurements used in the study were the Beck Depression Inventory, a good-bye letter, and a self-administered 20-item
questionnaire developed by the experimenter designed to measure the patient's degree of loss resolution. Results indicated that treatment group participants were significantly less depressed and better able to resolve painful feelings about their losses. Denny and Lee conclude that the feelings that addicted people attempt to numb are the same feelings that need to be expressed so that movement toward the acceptance stage in the grief process adequately happens. Not only can unresolved grief provide a reason for substance abuse, but it can also delay and/or block completion of the grieving process.

Weaknesses in the Denny and Lee study include: a) small sample size; b) the lack of reliability of the good-bye letter test instrument; c) the lack of reliability and validity of the 20-item questionnaire; and d) they reported that some subjects could have benefited from a longer period of grief work, but made no reference as to safeguard that they received the continued therapy that they needed. Overall, the findings of this study are consistent with similar studies reported in the literature.

Friedman (1984), in a review of grief reactions of alcoholics, urges counselors to examine the recovery process from alcoholism as containing numerous losses, many of which are unresolved. Grief reactions are most intense following the death of a loved one, but can also occur following any significant loss. The losses experienced by the alcoholic are multiple and varied, e.g. loss of control, loss of self-respect, loss of ability to behave within the boundaries of social norms, etc.
The alcoholic's relationship to alcohol (the attachment to alcohol) is comparable to the attachment of a family member or close friend. Over time drinking has become the primary means of coping. Alcoholism becomes a way of life in which drinking meets the needs of companionship, comfort, and escape. Friedman believes that the individual who enters treatment for alcoholism perceives the loss of alcohol as a loss of a part of themselves (e.g., amputation of a body part). The process of grief is activated by the loss of alcohol; this coupled with many other losses, both present and unresolved, may be emotionally devastating and overwhelming to the alcoholic.

Friedman concludes that it is essential to obtain information on factors affecting reaction to loss and the manner in which the client has dealt with the loss in the past. Examining the recovery process of alcoholism as a loss, will initiate resolution and acceptance of other losses experienced in one's life and add a tremendous quality to a person's sobriety. If Friedman's argument is accepted, then all substance abusing individuals who make a commitment to abstinence, experience a grief reaction.

Two separate studies (McGovern, 1986; McGovern and Peterson, 1986) are noteworthy in that they provided somewhat conflicting results. In the first study, which examines the effects of comprehensive inpatient alcoholism treatment on measures of loss and grief, McGovern assigned patients to two treatment groups. One group of subjects (N=25) underwent the traditional model of alcohol treatment; the other group (N=25) experienced an amplified model
Both groups received a core program of treatment which consisted of the individual and group experiences based on the Minnesota (Hazeldon) experience (Anderson, 1981). The participants in the amplified model of treatment underwent a loss/grief experience which consisted of three individual counseling sessions in weeks two, three, and four of treatment dealing with the nature of loss and grief. Therefore, the study examined the effects of the two models of treatment on measures of loss identification and grief awareness. Treatment, the two differing models, was the primary independent variable.

Results, based on comparisons of pretest and posttest mean scores of the Loss Identification Measure and Grief Awareness Measure, produced an increase in loss identification and slight decreases in grief awareness in both treatment models. No significant treatment differences resulted from the analysis of covariance. McGovern concluded that the addition of a loss/grief experience to a comprehensive and traditional treatment program did not enhance loss identification or grief awareness. The ability of traditional models of treatment to facilitate and maintain a significant loss/grief reaction was upheld.

The primary weakness of McGovern's first study was the use and reliance of the Loss Identification Measure and Grief Awareness Measure both of which were experimental instruments developed by the investigator from his clinical impressions of loss and grief. The measure likely requires refinement and validation, especially
through the development of specific subscales to determine the relative importance of different types of losses and the strengths of the various grief characteristics.

In a second study, McGovern and Peterson (1986) conducted a pilot study which attempted to distinguish between depression and grief in alcoholism. They report that current findings in the literature indicate that a depressive symptomatology experienced by alcoholics decreased significantly as a response to detoxification and treatment. The current study compared post-detox measures (pretest) of depression and loss/grief with the same measures on the completion of a 28 day treatment program (posttest). The Beck Depression Inventory, Loss Identification Measure, and Grief Awareness Measure were used to measure the change.

The outcome showed the depression score significantly decreased ($p < .0001$), the loss identification score significantly increased ($p < .01$), and a significant measure of grief present at the beginning of treatment declined somewhat ($p < .05$). McGovern and Peterson tentatively concluded that a distinction could be made between depression and a loss/grief reaction in an inpatient alcoholic population.

**REVIEW OF RESEARCH ON INPATIENT GROUP PSYCHOTHERAPY**

There are various approaches to inpatient group psychotherapy, the psychoanalytic (Battegay, 1974), the encounter (Elmore and Saunders, 1972), the educative (Maxmen, 1974), and the ego-
supportive (Kibel, 1978, 1981) among others. However, despite its prevalency as a treatment modality, inpatient group psychotherapy has received insufficient attention (Kibel, 1981). In comparison with the literature on outpatient group psychotherapy, theory is sketchy and techniques vary considerably. The emphasis of this section will be to describe and examine the theory and research on short-term group treatment within the inpatient hospital setting.

Numerous definitions of "group therapy" can be found in the literature, but it is Rogers (1970) who provides a concise definition of a group as being one that:

stresses personal growth through the development and improvement of interpersonal relationships via an experimental process.

Using some of Rogers' basic concepts, Thomas (1969) defines a group simply as a number of individuals committed to the task of becoming fully more human in their daily lives. In each definition an implicit importance of spontaneity and freeing of human potential is emphasized.

Experiencing is a central concept in the overall effectiveness of a group. According to Rogers (1959) it refers to the "unity of emotion and cognition as they are experienced inseparably in the moment." It is vital that an individual in a group who is experiencing an emotion be aware of that feeling and express it. Since part of an individual's problem may be associated with a lack of openness to experiencing, a primary goal of the group is to help a person become aware of what he/she is feeling in the here-and-now (Yalom, 1983).
The therapeutic or curative quality of the patient-group interaction has been a primary focus in group therapy research. The individual most associated and responsible with the study of therapeutic factors in group therapy is Yalom who in 1970 introduced a 12-factor construct of the curative (therapeutic) process in group psychotherapy (Yalom, 1985). The 12-curative factor constructs have since been reduced to the following eleven: interpersonal learning, universality, instillation of hope, imparting of information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, catharsis, existential factors, and cohesiveness.

Insofar as Yalom's (1983) general principles of inpatient group therapy and the use of therapeutic factors, it is his belief that interpersonal learning is particularly potent. Underlying interpersonal learning are three basic assumptions which must be understood. The first assumption is interpersonal theory which states that an individual's character structure is shaped by prior interpersonal relationships and that the patient's current symptoms are a manifestation of disordered interpersonal relationships. Yalom clearly indicates that each patient's complaint must be translated into interpersonal terms and treated accordingly in the context of the group.

Secondly, Yalom believes that the therapy group functions as a social microcosm. This concept states that the patient's maladaptive interpersonal patterns of relating to others is re-
enacted in the context of the therapy group and it is this maladaptive behavior that disrupts a patient's adjustment to his/her social milieu.

The final assumption Yalom makes is that the information necessary for the patient to understand his/her current situation is present in the therapy group, in the here-and-now group interaction. The assumption rests on the belief that patients who are able to understand and adjust maladaptive interpersonal patterns of behavior and risk new behavior in the here-and-now of the group will eventually transfer this learning to their outside lives. Therefore, the primary task of the therapy group is to assist each member to learn as much as possible about the way he relates to every other group member.

In a study that reviews the literature regarding curative factors in group therapy, Butler and Fuhriman (1983) examined studies in an effort to identify consistent findings as well as identifying some of the methodological problems that have limited the usefulness of the Yalom model of the group therapy process. Three types of groups were studied that utilized Yalom's model: outpatient psychotherapy groups, personal growth groups, and inpatient therapy groups.

Results of the study lends strong credence to two concepts regarding inpatient group psychotherapy: (1) hospitalized group therapy patients value the therapeutic process differently than outpatient group participants; and (2) the experience of belonging to a caring group (cohesiveness) appears to be a vital factor for
severely disturbed psychiatric patients. Overall, the studies reviewed demonstrate interesting consistency with regard to the highly ranked curative factors (self-understanding, catharsis, and interpersonal learning). Butler and Fuhriman also raise issues related to the interrelatedness of the factors and how they vary across different groups.

A second study conducted by Brabender, Albrecht, Stillitti, Cooper and Kramer (1983) was designed to gather additional information of patients' perceptions of curative factors in a short-term group. The researchers focused on 84 inpatients who participated in eight 90-minute group sessions held 4 times each week over a two-week period. The groups were process oriented and were conducted along the parameters described by the Yalom model (1975). The primary goal was for the patients to improve their ability to relate to others by receiving feedback on their group behavior from other group members. At the conclusion of each session patients in the group completed a critical-events questionnaire. Results indicated that the most frequently identified curative factor was vicarious learning. It ranked significantly above the other three most frequently mentioned factors - acceptance, learning from interpersonal actions, and universality. A comparison of this study's findings with those of Maxmen (1973) and Yalom (1970, 1975) is tenuous because this study used less structured techniques for measuring perceptions of curative events. Differences in the overall nature of the groups also make comparisons difficult.
Despite group therapy's prevalence many inpatient hospital programs question the effectiveness of inpatient group psychotherapy. Many other inpatient hospital programs utilize the group psychotherapy approach, but have no working conceptual knowledge or concern for the research evidence as to the efficacy of what they are doing. According to Yalom (1983), group therapy has been criticized as a viable form of treatment in the contemporary inpatient unit because of two basic factors: (1) the brief hospital stay; and (2) the wide range of psychopathology. In spite of all the arguments surrounding inpatient group psychotherapy, one issue that has been articulated by Yalom (1983) is certain; that is, the current inpatient hospital program presents significantly different clinical conditions that requires a radical departure from the traditional group psychotherapy approach.

A study by Froberg and Slife (1987) describes obstacles that constrain the complete implementation of Yalom's (1983) model of inpatient group psychotherapy. They address issues and make recommendations proven useful, in their experience, to overcome the following obstacles: (1) the situational constraint of the length of group therapy sessions being insufficient to accomplish interactional goals; (2) patient resistance and confusion to focus on the here-and-now because it does not appear to patients to address their "problems"; (3) tendencies toward therapist-centered interaction whereby patients appear more comfortable directing comments to and through the therapist as if he/she were the sole
agent of change in the group; this establishes the norm that group therapy is individual therapy with an audience; and (4) the difficulty inpatients have in processing interpersonal interactions within the group context.

Froberg and Slife conclude that although Yalom's model of inpatient group psychotherapy holds great promise, it is somewhat idealistic when considering the problems on many inpatient units. Patients typically experience significant confusion in interactional groups and each bring individual expectations of how a group operates. The authors believe it is an essential requirement for the therapist to model the interactional process desired.

The research evidence that has examined the efficacy of inpatient group psychotherapy has utilized two basic methodological strategies: (1) the relationship between outcome and the type of inpatient treatment program; and (2) patient's retrospective impressions about the value of group therapy.

In a study (Rosen, Katzoff, Carrilo, and Klein, 1976) that compared short-term hospitalization (86 days) versus long-term hospitalization (180 days), short-term patients showed significantly greater improvements when compared to the long-term patients. Improvement occurred with social competence, affective functioning, and cognitive functioning. The investigators discovered that the differences in improvements between the short-term and long-term patients was almost entirely attributed to the significantly greater use of group therapy on the short-term units.
Additionally, it was found that patients who received group therapy—either short- or long-term—demonstrated significant improvement (especially in social skills) than did patients who received no therapy. It should be noted that in 1989 86 days is no longer considered to be a short-term hospitalization stay, however scarce data is available that addresses an acute unit with an average hospital stay of 28 days or less.

Beutler, Frank, Scheiber, Calvert, and Gaines (1985) conducted a well-designed experiment which attempted to examine inpatient group therapy on a rapid-turnover inpatient unit. The study investigated 176 consecutively admitted psychiatric inpatients with diagnoses that included substance abuse, schizophrenia, bipolar effective disorder, and adjustment reactions. Upon admission patients were randomly assigned to one of four research groups.

The four types of groups were:

(1) a process/patient focused group—a supportive group in which the facilitator attempted to clarify interactions between patients;

(2) a behavioral task group—a behaviorally oriented therapy programs for each patient were designed by the facilitator;

(3) a psychodrama/gestalt group—each patient was asked to identify, share, and experience strong affect;

(4) a control group which received no group
therapy experience/intervention. Outcome measures included the Minnesota Multiphasic Personality Inventory (MMPI), the Shipley Institute of Living Scale, ward ratings completed by nurses, and impressions of improvement from each patient's primary therapist. Groups were offered twice weekly with the average number of sessions attended by patients being 3.2. The results indicated that the process-patient focused group had significantly better outcome than in the other 3 group settings.

Two major studies have been reported in which patients, upon the completion of their hospitalization, were asked to share their views about the group therapy they received. Maxmen (1973) conducted an investigation in which perceptions of patients who were hospitalized and who had participated in very short-term groups were examined. A questionnaire was administered to 100 hospitalized patients for the purpose of assessing which specific therapeutic factors (Yalom, 1970) were helpful in short-term group psychotherapy. Results indicated that from the patient's perspective instillation of hope, group cohesiveness, altruism, and universality were believed to be the most useful. Evaluation of this study suggests that these factors should be encouraged in short-term groups with hospitalized patients.

Another study examining the value of inpatient group psychotherapy from the patient's perspective was conducted by Leszcz, Yalom, and Norden (1985). This study addressed two primary questions: (1) how valuable and effective do psychiatric inpatients find their group psychotherapeutic experience, and (2)
which aspects of the inpatient group psychotherapy experience, as based upon therapeutic factors, seem to be most and least beneficial to the patients?

Fifty-one patients, hospitalized an average of 21 days, were studied. Subjects participated in a voluntary group attended only by higher functioning patients. The groups of 10 patients met for 75 minutes, four times each week. It was structured to promote patient interaction in the here-and-now with the specific focus of examining interpersonal relationships.

Statistical analysis of the patient's evaluation of the group experience and of their rankings of traditional group psychotherapy curative factors were performed. Three central findings were: (1) group psychotherapy is highly valued by inpatients; (2) inpatients may have very different expectations and needs to be explored in the group; and (3) the inpatient group should be a sufficiently successful and positive experience that the patient will desire to continue during post-hospitalization. It was concluded that group psychotherapy can be an essential component of the inpatient treatment process. It is most so when the therapy group is conducted in a manner that recognizes the heterogeneity of the inpatient population.

Kahn, Webster, and Storck (1986) state that it is difficult to conduct therapeutic groups in an inpatient setting; the researchers compared two groups: an Awareness Group designed to facilitate psychodynamic change; and a Focus Group designed to assist patients with chronic or severe problems, reduce isolation
from others and elicit support. The study explored group format, length of treatment, and benefit of treatment. Patients were assigned to groups based upon diagnosis, level of functioning, and goals in treatment. They met twice weekly, for 90 and 60 minutes, respectively. The mean number of group sessions was 6.4 and 7.9 respectively. Curative factors were ranked according to mean scores of an independent 4 point Lickert Scale.

Results indicate that the patients who benefited from the group treatment (either group) did not report any specific curative factor as being more or less helpful than those who did not. Universality, instillation of hope, altruism, and involvement seem relevant to the psychological experience of hospitalization. The study concludes that it may be the individual's presence in a group with an opportunity to reconnect socially and to share experiences is the most important factor to patients. Maintaining safety and providing structure within the group context may be more important than patients selected, group goals, or techniques used (Kahn, 1986).

Weaknesses evident in the Kahn et al. (1986) study consist of the absence of a comprehensive outcome measure and a lack of standardization of specific techniques used.

In an investigation that examined health care professionals and how they deal with issues related to death and bereavement, Barton and Crowder (1975) found role playing exercises in small groups to be extremely useful. Vignettes that simulated clinical situations illustrated psychodynamic principles and focused on
dimensions involving the grieving member of the family. The exercises allowed the group participants the experience to deal with their responses, attitudes, and feelings surrounding death and the grieving process.

In a study that focused on death awareness conducted by Whelan and Warren (1980) it was learned that an experiential group format was most effective in integrating both the emotional and cognitive aspects of death. Exercises were developed that paralleled the five stages of dying for terminally ill patients based upon Kübler-Ross' theory (1969). The results indicated that the Death Awareness Workshop developed by Whelan and Warren had a significant impact on the meanings attached to death by participants of the treatment group. The individual's ability to overcome denial and eventually gain acceptance seemed to elicit feelings and attitudes that did not follow the ordered, sequential movement through Kübler-Ross' stages.

Engel (1980) conducted an investigation that integrated both the didactic instruction of the classroom and an experiential group that focused on personal involvement. He demonstrated that an appreciation of the individuality of the grieving process experience must be incorporated into the broader understanding of grief as a loss process. The results of the study emphasize that presentation and discussion of the current knowledge bases of grief and the processes of mourning without the opportunity for the expression of feelings does not suffice. Engel states that, "students and teacher must be moved emotionally so that they can
sense and feel their essential humanity" as it relates to death and grief. He concludes that a complete understanding of grief must include both a didactic component and the group dynamics of group involvement.

Conner (1985) discusses how a supportive group counseling atmosphere may alleviate stress, validate group members experience, and enable members to accept themselves and others as grieving persons. He points out the following benefits to be derived from a supportive group experience: 1) the group provides "permission to grieve", and that grieving is a natural human response to the pain of loss; 2) myths and fears of death can be exposed; 3) support to examine emotions and problems in a non-threatening environment; and 4) link participants to their own support networks of family, close friends, pastor, counselors, etc.

In his article Conner does not specifically mention the Yalom model of group counseling. However, it is apparent that the dimensions he believes necessary for allowing grieving individuals to confront their grief, are encompassed in the Yalom approach.

Recent research as to which specific therapeutic factor or factors is most useful with inpatient individuals experiencing group psychotherapy appears to be at the extreme contradictory, and at the very least in need of further qualification. Butler and Fuhriman (1983) conclude that cohesiveness seems to be the central feature of the group process for hospitalized patients. Brabender et al. (1983) report that perceived vicarious learning is the most important factor in the group experience. Other studies have been
presented and conclude that "clearly" other of the factors or number of factors are central to the group process.

Behavioral evidence for the factors, relationship of the factors to treatment outcome, and increased specificity for methodological clarity are all important concerns that require additional research. What is important may not be which specific factors are most salient, but rather that the Yalom model is widely recognized as the preeminent approach to group psychotherapy and has received much research attention in the literature.

The Yalom model of group psychotherapy has made numerous contributions to group counseling. It provides a foundation and structure from which to understand the complexities of the group process. It is his description and use of a higher level inpatient therapy group that addresses the population used in this study.

Review of Research on the Structured Didactic Group Approach

In a retrospective study conducted by Fulton (1970), it was revealed that profound social ties are severed at the time of death and that a wide range of physical, psychological, and social reactions and responses are activated by the loss. This is not a particularly new insight as it was previously demonstrated by Lindemann (1944), however it is important enough to be restated here because most people are unaware of the subtle and profound changes that they go through upon the death of loved one.

Another finding that has been previously observed was by Wollman (1971) and also bears restating; that is, the quality of
the relationship that has been broken by death will have significant effect upon the nature of the grief experienced by the survivor.

Numerous researchers (Kübler-Ross, 1969; Kübler-Ross, 1975; and Becker, 1973) have reported that death education and grief education are instrumental in removing denial, thereby facilitating exploration or the intricate details and processes of death and grief in an effort to reach a state of acceptance and resolution over a loss.

Durlak (1978) conducted a systematic study in which he examined the effectiveness of experiential groups and didactic groups in assisting individuals' understanding of death and grief. The didactic group participated in an educational program that emphasized lecture presentations and small group discussions. In contrast, the experiential group confronted, examined, and shared their own feelings and reactions to death and grief. Role playing, death awareness, and grief exercises were used for this purpose. The results of the study suggest that a small group experience of either didactic or experiential in nature will increase an individual's awareness and understanding of death and the grieving process.

A study comparing the difference between a didactic and experiential death education curriculum models was conducted by Combs (1981). The didactic model consisted of formal lectures and audiovisual aids presented by a speaker to an audience. The experiential model consisted of student involvement in role-playing.
exercises designed to explore feelings and emotions related to death and dying. Each model consisted of eight weekly sessions, each lasting 1 1/2 hours.

Nursing subjects were randomly assigned to two treatment groups (didactic and experiential death education curriculum models) and one no treatment group. Education subjects were randomly assigned to comparable but separate treatment and one no treatment groups. Measures used were the Death Anxiety Scale, the Death Concern Scale, and the Death Acceptance Scale.

Results of the study indicate that death education was effective in increasing death anxiety for the nurse experiential group at mid-testing and did not significantly decrease death anxiety at posttesting for any group. It was believed that the experiential model was more effective in increasing death anxiety than the didactic or no treatment.

The Combs (1981) experiment obtained results which indicate that death education possibly only increases death fear and anxiety. Such results may be due to a poor curriculum model design. Also, death education may have been of insufficient length and/or quality to decrease death anxiety and increase death acceptance scores significantly. Accurate measurement of death anxiety and death acceptance change and may not have been appropriately captured in this study. Perhaps the instruments used in this study were not sensitive to changes in death anxiety and death acceptance feelings, therefore they were not valid measures of what they were attempting to measure.
Trent, Glass, and McGee (1981) conducted a study that examined the impact of a workshop on death and dying and on death anxiety, life satisfaction, and loss of control. The conceptual framework that served as a basis for the design of this study and for the development of the content of the workshops centered around the concepts of attitude formation and attitude change.

The major emphasis of the study was to determine whether middle-aged and older adults' attitudes of death anxiety could be significantly changed through participating in a 12 hour workshop on death and dying. The results demonstrated that death anxiety could be decreased a small but significant amount through participating in a workshop.

It was felt that perhaps the greatest value to be gained from an educational experience on death and dying is that such a learning experience brings people to the point of confronting their own mortality. A positive resolution of examining the existential aspects of one's life may help people move toward self-fulfillment and greater happiness in life.

It would appear that in studies that examine the effectiveness and impact of the didactic approach to understanding death, attitudes can be somewhat changed over a relatively short period of time six weeks. The findings of Trent, Glass, and McGee (1981) support this. Another result of this experiment suggests the need for further examination on didactic experience workshops and groups on the psychological well-being of adults. Factors that need to be more seriously examined are: a) group facilitator (leader)
attitude; b) learning climate; c) a design of learning experiences; d) learning style of participants; and e) how change over time may effect the individual.

Bertman, Greene, and Wyatt (1982) describe a didactic group based upon the humanistic concern of the grieving process of the dying individual and that of the family. The group was developed to explore intimate personal, cultural, and social expressions of death and the grieving process. It was found that the grieving process may consist of the following problems:

1) communication difficulty;
2) psychological responses such as feelings of loneliness, vulnerability, alienation, and mutilation, all of which may be kept within the person and result in a deep sense of suffering;
3) concern with dependency resulting in feelings of being ashamed, childlike, resentful, and helpless;
4) a sense of loss of control of events in one's environment leading to a diminished sense of personal dignity and self-esteem;
5) deep concern for the future of loved ones;
6) concern with certain existential issues such as the meaning and purpose of one's life and one's relationship with God.

Stillman (1983) examined the parallels between death education and group psychotherapy. She pointed to the fact that death education is highly affective as well as cognitive in much of its
content and most death educators believe in the beneficial effects of teaching and taking a course in death education. The primary purpose of her thesis was to examine the group process factors inherent in seminar-type death education courses. Stillman attempted to fit the identified curative factors in group psychotherapy (Yalom, 1975) and the objectives and content of a typical seminar course in death education.

Fitzgerald (1988) has designed and implemented a structured educational focused program which she refers to as the Seminar on Grief. It is theoretically based on the four tasks of mourning as described by Worden (1982). The Seminar on Grief consists of five sessions, each with a specified topic that is presented in a brief lecturette style, exercises related directly to the presentation, a discussion, and when appropriate handouts and/or homework activities are assigned.

The five sessions consist of the following topical areas: (1) a focusing on reducing denial and accepting the loss; (2) the process of grief (stages); (3) depression; (4) examining fears, physical symptoms, and anger; and (5) letting go and getting on with one's life. In a discussion meeting with Fitzgerald examining the five sessions and the application of them to a substance abusing population, it was suggested to include two additional sessions that jointly address the experiences of loss and maintaining a recovery from substances. The two additional areas were guilt and the need to understand its dynamics; and powerlessness which examines the loss of ability to control events.
Both guilt and powerlessness are central aspects of the substance abuse recovery process and both are areas that have been identified and discussed by Schiff (1986) as necessary components, to what she refers to as "the road to healing," in discovering comfort and hope after experiencing a loss.

It is my observation that much of the research and information conducted concerning the effects of death and grief education on individuals has been contradictory or disappointing.

Crase (1978) discussed the impact of death education by reviewing studies that reported to measure changes in attitudes and behavior. My belief is that much of the conflicting data can be explained by methodological problems that include such problems as small sample sizes and lack of precise measuring instruments.

Didactic lectures or documentary films directed to the grieving person are not likely to challenge one's perceptions or beliefs on more than an abstract, intellectual, and therefore superficial level. If discussions remain solely theoretical or passive, as such classroom exercises so often times are, then there will be no connection between feeling, thinking, and behavior. It is important to relate to others with similar feelings on a human level, then creating the space for a person to share his feelings must be incorporated into the teaching structure.

Summary

The literature contains a large body of research that has been reported on grief and unresolved grief. The primary focus of this
research has been on the effects and treatment of the grief experience with regard to the loss of a spouse, child, or parent. In recent years there has been somewhat of an increase in attention directed at the possible relationship between a substance abusing individual’s loss of significant persons, unresolved grief, and their addiction. It is apparent that there is a scarcity of systematic and comprehensive research that adequately explores this relationship.

Although alcoholism and drug addiction have presented, and continue to present, a multiplicity of problems to our society in the twentieth century, it has not been until the past ten years that the effects of losses and substance abuse have been examined; and even at that it has been in a tentative manner and with conflicting results. The grief that is associated with a loved one is multidimensional and effects an individual’s emotions and life in ways that may not be immediately apparent.

Currently, there are conflicting results found in the literature. Blankfield (1982) reports that grief resolution can occur concurrently with increased alcohol consumption; and McGovern (1986) found that the addition of a loss/grief experience to the traditional treatment program did not enhance loss identification or grief awareness. Others (Skolnick 1979; Denny and Lee, 1984) report that not only can unresolved grief provide a reason for substance abuse, but it can also delay and/or impede completion of the grieving process.

Individuals who experience loss pose a challenge to
counselors. Parkes (1972) and Bowlby (1980) both state that mourning is completed when an individual reaches the final phase of acceptance. The addition of an individual's substance abuse may serve as a complicating variable to achieve this goal. Treatment interventions that have been researched and proven successful with the dual factors of substance abuse and unresolved grief have been scare. The purpose of this study was to examine the effect that a Yalom model of higher level inpatient therapy group (1983) and a structured didactic group approach would have on adult patients being treated in a hospital setting in relation to loss of significant persons, unresolved grief, and their addiction.

Unresolved grief may in its most severe form result as a block to a substance abuser's recovery process or pose a concomitant emotional disorder; and in its lessor form may serve as a threat to the recovering individual's attempts at abstinence and a substance free life. To the individual both are potentially life threatening.

There is a sense in which grief and mourning can be completed and on the other hand there is a sense it can never be completed. The following quotation by Sigmund Freud (1961) captures this feeling:

We find a place for what we lose. Although we know that after such a loss the acute stage of mourning will subside, we also know that we shall remain inconsolable and will never find a substitute. No matter what may fill the gap again, even if it be completely filled, it nevertheless remains something else.
CHAPTER III

METHODOLOGY

The purpose of this study was to compare the differential effects that a higher level inpatient psychotherapy group and structured didactic group have on adult patients being treated in an inpatient alcohol/drug hospital setting in relation to their loss of significant persons, unresolved grief, and substance abuse. The individual inpatients interpersonal and emotional adjustment was measured by specific standardized techniques. This allowed the investigator to determine select changes in emotional adjustment and grief resolution of the participants in this study.

Subject Population and Selection of Sample

Subjects included in this study were adult individuals, 18 years of age or older, who had been admitted to St. John's Hospital in Richmond, Virginia and had been diagnosed as being either alcohol and/or drug dependent. Each patient who was admitted into the hospital inpatient treatment program received a composite inventory instrument of the Texas Revised Inventory of Grief (TRIG), Beck Depression Inventory (BDI), and Adjective Check List (ACL), (Appendix A). This was administered upon completion of the detoxification phase of treatment and within twenty-four hours of beginning the treatment phase of the program. A representation of referral sources from which the subjects of this study were drawn included but were not limited to the following: area businesses

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and health organizations, mental health centers, physicians, attorneys, etc.

Participation in the groups was on a voluntary basis. It was acknowledged that use of volunteer subjects was likely to result in a biased sample of the target population (Rosenthal and Rosnow, 1975). However, it must be remembered, that the accessible population of this study consisted of individuals whose substance abuse and resultant behavior necessitated their being hospitalized; therefore the generalizability and research results are applicable to them, not the substance abusing population at large.

The sample consisted of both males and females. These subjects were randomly assigned to one of three groups, the higher level inpatient therapy group, structured didactic group, or control group. Ideally each group would have consisted of between six and ten members, large enough to allow sufficient interaction and not so large as to prevent each member from having enough time to participate (Yalom, 1983). However, there were fluctuations in group size that ranged from four to twelve members.

A consensus of the literature (Meander, 1971; Bednar and Batterby, 1976; Melnick and Woods, 1976; and Hansen et al., 1980) suggests that the ideal size for a group is six to eight members, with a range from 6-12 persons. The lower limit is determined by the fact that when the group is significantly smaller, it tends not to operate as a group and the individuals find themselves involved in individual counseling within the group setting. Additionally, opportunities for utilizing the dynamics within the group are
reduced. The upper limit is determined by the fact that less time is available for working through individual problems when there are additional members. As the group size increases, it is more difficult for the less forceful members to express their ideas. Lastly, Hare (1962) found that an increase in the size of the group brings a corresponding tendency for subgroups to form and usually these subgroups are disruptive to the group process.

Due to the uncontrollable variable of the rise and fall of hospital census and the availability to continually have three groups operating concurrently, true randomization was somewhat compromised; this fact was acknowledged statistically through the use of covariance. Such procedures have significance not only because logistical shortcomings warranted it, but also because this occurrence can be viewed as reflecting the realities found in census variability in any inpatient treatment program. Should the intervention strategies yield the desired results under such conditions, then certainly the issue of replicability would have been somewhat neutralized.

Subject characteristics and demographics were obtained through data collected on each patient upon admission to the hospital. This data was obtained during a rigorous admission process that included a thorough intake interview with the patient and his/her family.

Factors which have been known to effect an individual's response to a loss were captured through use of the Texas Revised Inventory of Grief (TRIG). Such factors include: 1) type of loss
and type of attachments; Marris (1974) has indicated that the two factors which account for the principle variations in grieving are the nature of the attachment and the habitual patterns which are disrupted; 2) age of the individual at the time of the loss; 3) number of losses; depression is more likely to occur when the number of losses exceeds an individual's capacity to limit his/her experience of helplessness and hopelessness (Paykel, 1979); 4) relationship with the deceased; and 5) sudden versus anticipated loss; Parkes (1981) data based on longitudinal comparison of sudden versus anticipated loss suggests that those that experience sudden loss are more likely to have difficulties accepting their loss.

The total number of subjects used in this study was 41. The frequency was N=16 (39%) for the higher level inpatient therapy group; N=12 (29.3%) for the structured didactic group; and N=13 (31.7%) for the control group. In the random assignment of subjects to groups there was no control for age, sex, religion, time since the loss, the person who died, closeness of the relationship, and whether or not the death was expected or unexpected. However, this data was collected for the total subject population and is presented in the appendix (Appendix B).

Treatment and Data Gathering Procedures

Subjects (S's) were randomly assigned to the two experimental and one control groups. The composite inventory instrument consisting of the Texas Revised Inventory of Grief, Beck Depression Inventory, and Adjective Check List was administered to all S's.
All test materials were provided for each subject in individual folders numbered for coding purposes. Treatment was administered to the two experimental and withheld from the control group. The experimental data consisted of pre and posttest scores of the above mentioned instruments. The S's who received the two group interventions completed the pretest prior to the initial treatment group and the posttest after completion of the final group session.

All testing was administered by a St. John's Hospital staff member trained and briefed as to the proper assessment procedures. This included assurance that each subject read all test instructions, emphasized the necessity to make a sincere attempt to answer all test items without conferring with others, and that there were no test disruptions during the testing periods. This individual was not provided with test manuals and therefore was unaware of the parameters for scoring the results. The raw test data was collected and forwarded to the investigator for scoring, compilation, and analysis.

The collected test data was kept strictly confidential. Statistical comparisons were made among and within groups, but the identity of participants was not disclosed. After the test data was gathered and grouped, all answer sheets were destroyed.

The design of this study necessitated the use of two treatment groups and one control group. The groups were open-ended and continued until a minimum of twelve subjects had completed each group intervention. The two treatment groups met for 75 minute sessions three times a week for the testing period. The group
facilitator was a qualified individual with demonstrated knowledge of inpatient group psychotherapy and substance abuse experience. The clinician also received specific training in appropriate techniques and procedures for each respective group.

The first group received the higher level inpatient therapy group model (Yalom, 1983). The basic structure of the group consisted of the following five described phases.

At the start of each group the approach was to provide a basic orientation and preparation to the members, describe the purpose of the group, and lastly, clarify the procedure that the group followed. In the basic orientation statement, the group facilitator discussed the time of the meeting, its length, the reason for the session to be audiotaped, and reviewed basic ground rules (e.g. necessity of punctuality or rules about smoking, etc.). The basic procedure of the group was described briefly reviewing the five phases of the group. The duration of this phase was 3-5 minutes.

The second phase was the agenda go-round (20-30 minutes) whereby the group facilitator asked each member to formulate a brief personal agenda for the meeting. The agenda identified some area in which the patient desired to address and change regarding his loss and grief. The facilitator assisted each group participant to formulate their agenda and address some issue which was interpersonal in nature and worked in the here-and-now of the group.
The third phase (20-35 minutes) was where the group members worked on their agendas that they had identified. The group attempted to address as many agendas as possible within the time constraints of the session. It was the responsibility of the group facilitator to help the group members transform individual interpersonal agendas into a here-and-now agenda, address resistance to the agenda task, and put individual agendas to work.

The fourth and fifth phases of the group meeting consisted of an analysis or "wrap-up" of the first hour of the group. The final twenty minutes were divided into two equal segments, (1) discussion of the meeting by the counselor; and (2) group member's response to this discussion which included responding to the counselor's discussion, exploring issues suggested in the discussion, processing the meeting themselves, or working on unfinished business of the session.

The second group received intervention via a structured didactic group experience. Each of the eight sessions had a specific focus (Appendix C). In the first session the focus was on reducing denial and accepting the loss. To assist in the acceptance of each group member's loss, an exercise was presented in which each participant was instructed to write down what he/she misses most about the person who has died and what he/she misses least (Handout No. 1). Discussion included holidays - which ones are missed most and why; and how to get through them. Each group member was assigned to keep a journal throughout their 8 sessions.
of the group. This assignment was given to each new group member as they joined the group.

The process of grief was the topic of the second group. This included a presentation of how we live in a death denying society and a number of theories of the grief process were presented and discussed (Handout No. 2). The goal of this session was to have each group participant to recognize the stage process of grief and identify where they currently saw themselves in that process. It also served to normalize the grieving process.

The third session entailed a description of guilt, where it comes from, and how to deal with it. Exercises (Handout No. 3) encompassed dealing with regrets and guilt, things one was glad they had done, and what each person has learned from their regrets/guilts that made their life and the lives of significant others better.

A thorough discussion of depression and grief composed the presentation of the fourth session. Symptoms of depression were described. Also, suicidal thoughts and techniques of how one can help themselves was presented. Each group participant was asked to identify more memories (Handout No. 4) and discuss the relationship they had with the deceased.

In the fifth session, the areas of fears, physical symptoms, and anger was presented. With each there was a presentation of techniques to help oneself cope with these feelings. The primary emphasis of the group was on anger and a handout (Handout No. 5) was provided to help the group participants work through their
anger. Also, there was an article (Handout No. 6) given to each group member at the completion of the session that examined anger.

The purpose of the sixth session was to have each group member understand that the loss of ability to control events is universal following the loss of a loved one. Powerlessness was defined and discussed in the context of each person's loss. An article (Handout No. 7) and exercise to list some aspects of their lives that they are powerless over was provided.

The seventh session's topic was religion; the objective was for each group participant to develop a rational concept of the impact of death upon their spiritual/religious beliefs. A poem was provided to each group participant (Handout No. 8), read by the group facilitator, and discussed in the session. The primary emphasis was to examine a potential source of support and examine feelings (possible anger) toward each person's Higher Power.

Letting go and reinvolving one's life in other relationships was the focus of session eight. An emphasis was placed on additional issues of grief (e.g. dreams, self-identity, trips to the cemetery, etc.), unfinished business, and examination of the roles each person's loved one played in his/her life (Handout No. 9).

Ethical Safeguards and Considerations

Potential risks existed to the group participants with the use of instruments containing items of a personal nature and involving the area of grief and bereavement were utilized. The ethical
guidelines established by the American Psychological Association for protecting the rights of human subjects were strictly adhered to in this study.

Confidentiality and necessary therapeutic follow-up were the responsibility of the investigator. All discussions, therapy groups, interviews, audiotapes, and written data obtained in this study was treated in a strict confidential manner so as to protect the anonymity of each participant. Patients were informed that they could terminate their participation at any time and could have chosen not to respond to specific questions or participate in certain activities. All test interpretations were conducted by a qualified individual and subjects were given the opportunity to receive their personal test scores which were explained by the investigator.

In an effort to provide for the safeguards of each subject, the following procedures were used to counter potential risks: if the pretest results of any subject indicated that counseling was immediately necessary or counseling became necessary beyond the scope of this study at any point between the pre and posttesting, then that individual was referred to their admitting psychiatrist/physician and/or appropriate staff Licensed Clinical Social Worker or Licensed Professional Counselor. Subjects in the control group that did not receive either treatment intervention as a part of this study were offered grief counseling at the completion of the investigation.
One counselor licensed by the Commonwealth of Virginia through the Health Regulatory Board (Licensed Professional Counselor) with twenty years of successful clinical substance abuse experience and trained in grief work facilitated the groups. This served to assure that a qualified professional was present to conduct the groups and assist any patient who experienced severe emotional distress.

Prior to the beginning of this study, approval was obtained from the investigator's three-member doctoral committee, the College of William and Mary Human Subjects Research Committee, and St. John's Hospital's Chief Executive Officer, Medical Director, and the program's Clinical Coordinator.

**Instrumentation**

Very little attention has been given to examining unresolved grief issues with a substance abusing population. There appear to be very few controlled studies utilizing valid and reliable measures to assess an individual's intrapsychic processes and emotional distress to losses that have been experienced. As Brasted and Callahan (1984) have stated, the initial step in grief research is to determine a valid and reliable methodology to assess grief. Until the development of the *Texas Inventory of Grief* (TIG) (Faschingbauer, DeVaul, and Zisook, 1977), studies of grief tended to consist of retrospective analyses, individual anecdotes regarding reactions to grief, or statistical analyses of large
numbers of bereaved individuals without any effort to quantify their grief reactions (Klareman and Izen, 1977).

Middleton and Raphael (1987) cite the work of Zisook and his associates as an example of what bereavement researchers need to do in order to fully understand the discriminating differences of the grief process. They describe the development of the grief inventory as a method of better describing, operationalizing and measuring the process of grief.

The Texas Revised Inventory of Grief (TRIG) (Faschingbauer, 1981) is a two scale Lickert-type measure of grief following a loss that was expanded from the original TIG. It was designed specifically to assess grief as a present emotion of longing, as an adjustment to a past life event with several stages, and as a personal experience. The TRIG is composed of 21 items divided into two content areas: past behavior and present feelings.

Test-retest reliability coefficients for samples of individuals (N=260) from all areas of the United States who had lost a loved one to death for Part I (past behavior) was .77. Caverly (1980) had independently reported an alpha coefficient of .81 for Part I. Reliability coefficients for Part II (present feelings) as reported by Faschingbauer, Zisook, DeVaul, Moore, Parks, and Click (1980) was .86. Caverly (1980), again in an independent study, reported a reliability coefficient of .89 for a group of 72 widows.

Construct validity was assessed for Part I whereby it was hypothesized that the death of individuals who were emotionally
close and important in the everyday life affairs of the bereaved would produce increased levels of disruption in their lives than those less actively involved.

Faschingbauer (1981) reported an analysis of covariance which controlled for sex of the bereaved and his/her relationship to the deceased. Results indicated a significant difference in which individuals attending the funeral scored lower on Part I (past behavior) compared with those who did not attend the funeral \((p < .05)\). Therefore, Part I appears to be a reasonably valid measure of an individual's early adjustment to death of a loved one. Part II (present feelings) is also a valid measure of grief as suggested by normative data for 422 bereaved subjects (Faschingbauer, 1981) in which the emotion of grief worsened after the first year and did not begin to decline until after three years.

The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, and Erbaugh, 1961) is a clinically derived self-report inventory of depression originally designed for use with a psychiatric population. It was constructed to determine the present depth of depression and consists of 21 items which correspond to a specific category of depressive symptoms and/or attitude. Each category is purported to describe a specific behavioral manifestation of depression and consists of a graded series of four self-evaluative statements. Each statement is rank ordered, weighted to reflect the range of severity of the symptom, and numerical values are assigned each statement to indicate degree of severity (neutral to maximum).
Two validation studies were reported by Beck et al. (1961) assessing the depth of depression comprising the criterion measure with which the depression inventory was compared. Biserial correlation coefficients of .65 and .67 were obtained (N=226 and N=183, respectively). It is these validation studies which may be the primary reason for the rather widespread application of the BDI. As of ten years after the development of the instrument, it had been used in well over 100 published studies (Beck and Beck, 1972) and continues to be extensively used in research in general and in research examining grief and substance abuses.

An evaluation of internal consistency (Beck et al, 1961) was to determine the split-half reliability. Ninety-seven cases were chosen and analyzed whereby the score for each of the 21 categories was compared with the total score of the instrument for each individual. The Pearson r between the odd and even categories was computed and yielded a reliability coefficient of .86.

The BDI has been subjected to a variety of tests designed to determine its reliability and validity. It appears that most of the studies of BDI reliability have used psychiatric patients. Test-retest reliability was studied in the case of 38 patients who were given the BDI on two occasions (Beck, 1970). It was found that the changes in BDI scores were consistent with changes in the clinical assessment of the depth of depression; this indicated a clear relationship between BDI scores and the patient's emotional state. Reliability figures were above .90. Individual item analysis showed a positive correlation between each item of the BDI
and total score. The level of significance for these correlations was .001. Internal consistency studies (Beck and Beamesderfer, 1974; Mayer, 1977; and Reynolds and Gould, 1981) demonstrate a correlation coefficient of .86 for test items, and the Spearman-Brown correlation for the reliability of the BDI provided a coefficient of .93.

In assessing the validity of the BDI, the issue of face validity must be discussed. The BDI appears as though it is evaluating depression; although this has its advantages, it also may make it easy for a subject to distort the results of the test. Content validity appears to be quite high since the BDI seems to adequately evaluate a wide variety of symptoms and attitudes associated with depression. Concurrent validity was reported by Beck (1970) in which results of the BDI were compared with results of other measures of depression, such as the Depression Adjective Check List (DACL) and the MMPI. A correlation of .66 between the BDI and DACL was found and a correlation of .75 between the BDI and MMPI D Scale. Another study demonstrated a correlation of .77 between the BDI and psychiatric rating using university students (Bumberry, Oliver, and McClure, 1978).

In a more recent psychometric study (Reynolds and Gould, 1981) the standard and short form of the BDI was compared using a substance abusing population. It was reported that internal consistency (alpha coefficient) reliability was .85 with the standard form. It was also found to demonstrate adequate internal consistency reliability. It should be noted that the sample in
this study represented a moderately depressed group involved in a clinical program; the findings substantiate the validity of the BDI for the assessment of depression with a substance abuse population.

The **Adjective Check List (ACL)** (Gough, 1965) is an alphabetized listing of 300 adjectives commonly used to describe an individual's attributes. Although originally developed as an instrument to be used by observers in describing others, the ACL can, and has been extensively used, as a tool for self-description. The ACL has been primarily utilized as a research instrument because it represents item simplicity as an economical assessment of general adjustment (Vance, in Buros 1975). The adjectives presented on the ACL tend to describe normal dimensions of personality and incorporates autographic and normative techniques to provide a comprehensive description of personality (Teeter, 1985).

Gough and Heilbrun (1983) present alpha coefficients as calculated on large samples of both males and females and the stability of ACL scale scores is quite strong. Six-month test-retest correlations for the male sample produced a median value of .65. One-year test-retest correlations for the female sample produced a median value of .71. The reliability estimates based on single trial data are well within the commonly accepted range of correlations found for self-report inventories. As Gough and Heilbrun report, reliability over time seems to be a meaningful psychological variable and not solely a statistical property of the ACL.
Examining the three scales that have been selected for use in this proposed study, reliability coefficients (Gough and Heilbrun, 1983) are as follows: Intraception (Int) alpha coefficients are .79 and .77 for males and females respectively; test-retest coefficients are .62 and .59 for males and females respectively. Succorance (Sue) alpha coefficients for males are .56 and for females .64; test-retest coefficients were .57 and .64 for males and females, respectively. The Personal Adjustment (P-Adj) Scale produced alpha coefficients for males of .63, females .66; test-retest coefficients were .65 and .55 for males and females, respectively. A likely and justified explanation suggested by Gough and Heilbrun is that the relatively low test-retest coefficients on some scales is related as much to changes in the individual in addition to errors in the measurement instrument.

Validity information is provided in terms of correlations between ACL scales and scales of the California Psychological Inventory (CPI), the Minnesota Multiphasic Personality Inventory (MMPI) and several other instruments. The construct validity of the ACL scales appears to be modest, however validity coefficients were frequently found to be significant (Fekken, 1984). The ACL scales tend not to be confounded by vocabulary level or social desirability as evidenced by the small correlations presented in the manual. A weakness discussed by several individuals (Rorer, in Buros 1972; and Vance, in Buros 1975) who critically examined the ACL is that in general the ACL scales correlate more highly with each other than with other instruments.
Research Design

The model for the experimental design that was employed in the present study was provided by Campbell and Stanley (1963). It was the Pretest-Posttest Control Group Experimental Design with two treatment intervention conditions. The design is represented as follows:

R O₁ X O₂ (Yalom made for inpatient psychotherapy)
R O₃ X O₄ (structured didactic group)
R O₅ X O₆ (control group)

Key: The R indicates that subjects will be randomly assigned to treatments; "O" refers to the pretest and posttest which is designed to measure the effects of the independent variable; and "X" represents the treatment or exposure to the independent variable as manipulated by the researcher; all symbols in a given row apply to the same specific group.

The aforementioned experimental design was chosen because it effectively controlled for the eight threats to internal validity identified by Campbell and Stanley (1963): history, maturation, testing, instrumentation, regression, selection, mortality, and interaction effects.

Statistical Analysis

Statistical analysis of the data was accomplished by means of parametric tests of statistical significance. An analysis of covariance was employed to determine changes made by the three different groups during the time of the intervention strategies.
The dependent variables examined were posttest scores of the Texas Revised Inventory of Grief, the Beck Depression Inventory and Intraception, Succorance, and Personal-Adjustment of the Adjective Check List. The independent variables were the treatment interventions (the higher level inpatient psychotherapy group and structured didactic group) and the covariates were the pre-test scores. It was necessary to covary the pre-test scores due to non-random differences between groups that were unable to be controlled for by sampling procedures. All statistical treatments were established at a five percent level of significance ($p < .05$).

**Hypotheses**

The following null hypotheses provided the basis for testing whether or not there were significant differences ($\alpha = .05$) among the Yalom model higher level inpatient therapy group, structured didactic group, and control group. On posttest extremity of grief reaction, depression, intraception, succorance, and personal adjustment measures:

$H_0_1$: There will be no significant difference of grief resolution as to the extremity of grief reaction ($\alpha = .05$) among two groups and control group as measured by the Texas Revised Inventory of Grief.

$H_0_2$: There will be no significant difference ($\alpha = .05$) of depression among the two treatment groups and control group as measured by the Beck Depression Inventory.

$H_0_3$: There will be no significant difference ($\alpha = .05$) on the Intrception Scale of the Adjective Check List among the two treatment groups and control group.

$H_0_4$: There will be no significant difference ($\alpha = .05$) on the Succorance Scale of the Adjective Check List among the two treatment groups and control group.
Ho₂: There will be no significant difference (α = .05) on the Personal Adjustment Scale of the Adjective Check List among the two treatment groups and control group.

**Summary**

The purpose of this study was to evaluate the effectiveness of a Yalom model higher level inpatient therapy group as compared with a structured didactic group on adult substance abuser's unresolved grief reactions in an inpatient hospital setting. To achieve the objective of this study, the differential effects of the adult substance abusers who were experiencing an unresolved grief reaction were examined in the context of two experimental group conditions. Standardized measures of emotional and personal adjustment were obtained. The subjects were volunteers who were randomly assigned to one of two treatment groups or a control group. The groups were led by a qualified counselor with pre and posttesting based on the Pretest-Posttest Control Group Experimental Design. The statistical procedure of analysis of covariance was utilized to determine the efficacy of the two different group approaches. The variance between groups was evaluated for significant differences by an ANOVA procedure which included a one-way analysis. Five null hypotheses provided the basis for testing whether or not there were significant differences (α = .05) among the Yalom model higher level inpatient group, structured didactic group, and control group on posttest measures of grief resolution, depression, intraception, succorance, and personal adjustment.
CHAPTER IV
RESULTS

The purpose of this investigation was to determine the effects of a higher level inpatient therapy group and a structured didactic group as intervention strategies on adult substance abuser's unresolved grief reactions in an inpatient hospital setting. A total of 41 patients in a hospital-based substance abuse program participated in the study. Sample population attrition was a problem due to a number of reasons; 41 subjects were used in this investigation out of a total number of 56 for which partial data was collected. Reasons for excluding 15 potential subjects included: (1) individuals who left treatment against medical advice and therefore never completed the requisite number of groups to be included in this study; (2) individuals who, for clinical reasons, were removed from the group by the hospital staff; (3) individuals who completed all group sessions, but did not complete the posttest inventory or only partially completed it; (4) individuals who completed the necessary pre and posttests, but their responses appeared random and therefore results were invalid; and (5) one individual whose responses varied to such a significant degree from the pretest to the posttest that his scores were suspect and therefore deemed as an anomaly when compared with the other respondents.

A Pretest-Posttest Control Group Experimental Design with two treatment intervention conditions was selected for use in this
An analysis of covariance was utilized to determine differential changes among the three different groups. The 0.05 level of significance was established as the criterion point for acceptance or rejection of the hypotheses. The SPSS (Statistical Package for the Social Sciences) was chosen because of its appropriateness for the investigation. All statistical results of the study are presented by hypotheses.

**Hypothesis One**

It was hypothesized that there would be significant improvement in the grief resolution as to the extremity of grief reaction as measured by the Present Feeling scale of the Texas Revised Inventory of Grief (TRIG) which could be attributed to the group counseling intervention. To test the hypothesis, posttest data was subjected to analysis of covariance which adjusted for pretest differences among the Past Behavior and Present Feeling scores of the TRIG with the higher level inpatient therapy group, the structured didactic group, and the control group. Data pertaining to this hypothesis is presented in Table 4.1 and Table 4.2. The analysis indicated that pretest scores were significantly related to posttest scores with an F-ratio of 24.431 and p< .001; thus the pretest explains much of the variance in the posttest scores. The calculated F-ratio of the treatment effect was not significant at the 0.05 level (F= 2.11, p= .136). Therefore, the hypothesis was not supported.
TABLE 4.1

ANALYSIS OF VARIANCE FOR THE PAST BEHAVIOR SCALE OF
THE TEXAS REVISED INVENTORY OF GRIEF COVARYING FOR PRETEST SCORES

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
<th>SIG OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariate (Pretest)</td>
<td>1532.702</td>
<td>1</td>
<td>1532.702</td>
<td>215.650</td>
<td>0.000</td>
</tr>
<tr>
<td>Treatment</td>
<td>33.837</td>
<td>2</td>
<td>16.919</td>
<td>2.380</td>
<td>0.107</td>
</tr>
<tr>
<td>Explained</td>
<td>1566.539</td>
<td>3</td>
<td>522.180</td>
<td>73.470</td>
<td>0.000</td>
</tr>
<tr>
<td>Residual</td>
<td>262.973</td>
<td>37</td>
<td>7.107</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1829.512</td>
<td>40</td>
<td>45.738</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(N=41)
**TABLE 4.2**

**ANALYSIS OF VARIANCE FOR PRESENT FEELING SCALE OF**

**THE TEXAS REVISED INVENTORY OF GRIEF COVARYING FOR PRETEST SCORES**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
<th>SIG OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariate (Pretest)</td>
<td>1079.422</td>
<td>1</td>
<td>1079.422</td>
<td>24.431</td>
<td>0.000</td>
</tr>
<tr>
<td>Treatment</td>
<td>186.208</td>
<td>2</td>
<td>93.104</td>
<td>2.107</td>
<td>0.136</td>
</tr>
<tr>
<td>Explained</td>
<td>1265.631</td>
<td>3</td>
<td>421.877</td>
<td>9.548</td>
<td>0.000</td>
</tr>
<tr>
<td>Residual</td>
<td>1634.760</td>
<td>37</td>
<td>44.183</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2900.390</td>
<td>40</td>
<td>72.510</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(N=41)
Hypothesis Two

Hypothesis Two stated that inpatient treatment subjects participating in the two treatment groups would experience decreased depression as compared to the control group measured by the Beck Depression Inventory (BDI). To test the hypothesis, posttest data was subjected to analysis of covariance which adjusted for pretest differences among the higher level inpatient therapy group, the structured didactic group, and the control group. An analysis indicated that pretest scores were significantly related to posttest scores with an F-ratio of 16.800 and $p<.002$; thus the pretest explains much of the variance in the posttest scores. The calculated F-ratio determined by comparing posttest mean scores for the higher level inpatient therapy group, structured didactic group, and control group covarying for pretest scores was 0.713, $p=.497$. This was not significant at the 0.05 level of confidence. Table 4.3 presents the data pertaining to this hypothesis.

The research hypothesis that there would be a significant difference among the two treatment groups and control group in terms of the score of the BDI was not supported. There was statistically no significant differences among the two treatment groups and control group relative to the depression score at the 0.05 level of significance. An examination of the means indicates a trend in the direction of decreased depression for both treatment groups which had been anticipated; however it was not anticipated.
<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
<th>SIG OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariate (Pretest)</td>
<td>337.596</td>
<td>1</td>
<td>337.596</td>
<td>16.800</td>
<td>0.000</td>
</tr>
<tr>
<td>Treatment</td>
<td>28.648</td>
<td>2</td>
<td>14.324</td>
<td>0.713</td>
<td>0.497</td>
</tr>
<tr>
<td>Explained</td>
<td>366.244</td>
<td>3</td>
<td>122.081</td>
<td>6.075</td>
<td>0.002</td>
</tr>
<tr>
<td>Residual</td>
<td>743.512</td>
<td>37</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1109.756</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(N=41)
that there would be a large decrease in depression scores for the control group.

**Hypothesis Three**

This hypothesis stated that subjects participating in the two treatment groups would experience significantly greater changes in a positive direction on the Intraception Scale of the Adjective Check List (ACL) compared to the control group. As with the first two hypotheses, posttest data was subjected to an analysis of covariance which adjusted for pretest differences among the higher level inpatient therapy group, the structured didactic group, and control group. An analysis indicated that pretest scores were significantly related to posttest scores with an F-ratio of 21.533 and $p < .001$; thus the pretest explains much of the variance in the posttest scores. The F-ratio determined by comparing posttest mean scores for the higher level inpatient therapy group, the structured didactic group, and control group covarying for pretest scores was 3.64, $p = .036$. This was significant at the 0.05 level of confidence. Table 4.4 presents the data pertaining to this hypothesis.

The research hypothesis that there would be a significant difference among the two treatment groups and control group in terms of the score on the Intraception Scale of the ACL was supported. There were statistically significant differences among the two treatment groups and control group relative to the Intraception Score at the 0.05 level of significance.
TABLE 4.4

ANALYSIS OF VARIANCE FOR THE INTRACEPTION SCALE OF
THE ADJECTIVE CHECK LIST COVARYING FOR PRETEST SCORES

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
<th>SIG OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariate (Pretest)</td>
<td>930.586</td>
<td>1</td>
<td>930.586</td>
<td>21.533</td>
<td>0.000</td>
</tr>
<tr>
<td>Treatment</td>
<td>314.470</td>
<td>2</td>
<td>157.235</td>
<td>3.638</td>
<td>0.036</td>
</tr>
<tr>
<td>Explained</td>
<td>1245.056</td>
<td>3</td>
<td>415.019</td>
<td>9.603</td>
<td>0.000</td>
</tr>
<tr>
<td>Residual</td>
<td>1598.993</td>
<td>37</td>
<td>43.216</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2844.049</td>
<td>40</td>
<td>71.101</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(N=41)
A careful analysis of the results of this hypothesis indicates a trend in a positive direction for both treatment interventions compared to the control group. There was no significant differences between the two treatment groups. A post hoc analysis of adjusted independent group means was conducted for the purpose of identifying differences between individual groups in addition to differences between all three groups. The analysis of differences between pairs of group means revealed significant differences between didactic and control groups (t=2.34, p<.05) and differences that approach significance between the higher level inpatient therapy group and control group (t=1.9, p<.10). These results are summarized in Table 4.5.

**Hypothesis Four**

Hypothesis Four stated that subjects participating in the two treatment groups would experience significantly greater changes on the Succorance Scale of the ACL compared to the control group. Posttest data was subjected to an analysis of covariance which adjusted for the pretest differences among the higher level inpatient therapy group, structured didactic group, and control group. An analysis indicated that pretest scores were significantly related to posttest scores with a F-ratio of 34.038 and p <.001; thus the pretest explains much of the variance in posttest scores. The F-ratio determined by comparing posttest mean scores for the two treatment groups and control group covarying for the pretest scores was 3.90, p = .029. This was significant at the
<table>
<thead>
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<th>Self-Adjustment</th>
<th>Failures</th>
<th>Error of Difference</th>
<th>St. Error of Difference</th>
<th>Adjusted Mean Difference</th>
<th>95% CI of Adj. Mean Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.27</td>
<td>3.07</td>
<td>3.90</td>
<td>4.29/53.19</td>
<td>53.19/44.71</td>
<td></td>
</tr>
<tr>
<td>2.79</td>
<td>3.03</td>
<td>8.48</td>
<td>4.29/44.71</td>
<td>49.29/44.71</td>
<td></td>
</tr>
<tr>
<td>4.32</td>
<td>3.45</td>
<td>4.58</td>
<td>49.29/44.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.11</td>
<td>2.38</td>
<td>2.65</td>
<td>50.73/48.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.73</td>
<td>3.74</td>
<td>6.51</td>
<td>48.08/54.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.04</td>
<td>3.72</td>
<td>6.86</td>
<td>50.73/54.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.49</td>
<td>3.24</td>
<td>1.59</td>
<td>53.20/54.79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.65</td>
<td>2.86</td>
<td>7.59</td>
<td>54.79/47.20</td>
<td></td>
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<tr>
<td>2.06</td>
<td>2.91</td>
<td>6.00</td>
<td>53.20/47.20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*AND CONTROL GROUP MEANS ADJUSTED FOR PRETEST VARIANCE

**T-TESTS FOR SPECIFIC DIFFERENCES BETWEEN TREATMENT GROUPS**

TABLE 4.5
0.05 level of confidence. Table 4.6 presents the data pertaining to this hypothesis.

The research hypothesis that there would be a significant difference among the two treatment groups and control group in terms of the score on the Succorance Scale of the ACL was supported. There were statistically significant differences among the two treatment groups and control group relative to the Succorance Scale at the 0.05 level of significance.

A closer examination of the results of this hypothesis indicates a trend in a positive direction for the control group which was unexpected. Although significant differences were obtained with this hypothesis it was opposite of what was expected (it was expected that the two treatment interventions would have produced a significantly greater change than the control group).

A post hoc analysis of adjusted independent group means was conducted with the purpose of identifying differences between individual groups in addition to identifying differences between all three groups. Due to the relatively large variability of posttest scores among the control group subjects and the small number of subjects per group, differences between individual pairs of groups (any two groups) were not found to be significant.

An analysis of adjusted group means suggests that differences may exist between the control group (\(\bar{x} = 54.59\)) and didactic group (\(\bar{x} = 48.08\)) with the control group scoring higher on the Succorance scale than the didactic group. Mean scores between the higher level inpatient therapy group (\(\bar{x} = 50.73\)) and didactic group (\(\bar{x} =

94
TABLE 4.6

ANALYSIS OF VARIANCE FOR THE SUCCORANCE SCALE OF THE ADJECTIVE CHECK LIST COVARYING FOR PRETEST SCORES

<table>
<thead>
<tr>
<th>Source of Variation</th>
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<th>MS</th>
<th>F</th>
<th>SIG OF F</th>
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<td>Pretest</td>
<td>1559.212</td>
<td>1</td>
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<td>178.739</td>
<td>3.902</td>
<td>0.029</td>
</tr>
<tr>
<td>Explained</td>
<td>1916.690</td>
<td>3</td>
<td>638.897</td>
<td>13.947</td>
<td>0.000</td>
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<tr>
<td>Residual</td>
<td>1694.871</td>
<td>37</td>
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<td>Total</td>
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<td>40</td>
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</table>

(N=41)
48.08) were not sufficiently different to warrant further investigation. Table 4.5 summarizes this data.

**Hypothesis Five**

The final hypothesis stated that subjects participating in the higher level inpatient therapy group would experience significantly greater changes on the Personal Adjustment Scale of the ACL compared to the structured didactic group and control group. An analysis of covariance which adjusted for the pretest differences among the higher level inpatient therapy group, the structured didactic group, and the control group was utilized which examined posttest data. An analysis indicated that pretest scores were significantly related to posttest scores with a F-ratio of 13.346 and $p<.001$; thus the pretest explains much of the variance in posttest scores. The F-ratio determined by comparing posttest mean scores for the two treatment intervention groups and control group covarying for pretest scores was 3.89, $p=.029$. This was significant at the 0.05 level of confidence. Table 4.7 presents the data pertaining to this hypothesis.

The research hypothesis that there would be a significant difference among the higher level inpatient therapy group, structured didactic group and control group in terms of the score on the Personal Adjustment Scale of the ACL was supported. From a statistical perspective significant differences occurred at the 0.05 level of significance.
TABLE 4.7

ANALYSIS OF VARIANCE FOR THE PERSONAL ADJUSTMENT SCALE OF
THE ADJECTIVE CHECK LIST COVARYING FOR PRETEST SCORES

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>DF</th>
<th>MS</th>
<th>F</th>
<th>SIG OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>772.227</td>
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<td>772.227</td>
<td>13.346</td>
<td>0.001</td>
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<td>Treatment</td>
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<td>224.911</td>
<td>3.887</td>
<td>0.029</td>
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<td>Explained</td>
<td>1222.048</td>
<td>3</td>
<td>407.349</td>
<td>7.040</td>
<td>0.001</td>
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<tr>
<td>Residual</td>
<td>2140.927</td>
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<td>57.863</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3362.976</td>
<td>40</td>
<td>84.074</td>
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</table>

(N=41)
Upon a careful analysis of the Posttest mean results of this hypothesis, a trend exists indicating a change in a positive direction for the higher level inpatient therapy group which was expected; however it is not much greater than the structured didactic group as indicated by the analysis of covariance.

A post hoc analysis of adjusted independent group means was conducted with this hypothesis. Significant differences between the didactic group and control group (t= 2.79, p < .05) were noted. No other significant differences were found between groups. An analysis of adjusted means suggest that the higher level inpatient therapy group did have a higher mean than the control group which approaches significance and may have produced significant results with a larger sample size. Table 4.5 summarizes these results.

Summary

The results presented in this chapter may be summarized according to the hypotheses as follows and a summary of tests of statistical significance for all hypotheses may be found in Table 4.8.

1. The analysis of covariance pertaining to the Present Feeling scores of the TRIG did suggest a positive change for the two treatment groups. There was a decrease in both the higher level inpatient group and structured didactic group, but not to the extent that the difference was statistically significant.

2. The analysis of covariance pertaining to the BDI scores for the three groups yielded nonsignificant differences.
### TABLE 4.8

**SUMMARY OF TESTS OF STATISTICAL SIGNIFICANCE FOR ALL HYPOTHESES**

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<thead>
<tr>
<th></th>
<th>Treatment 1</th>
<th></th>
<th>Treatment 2</th>
<th></th>
<th>Control</th>
<th>F</th>
<th>SIG</th>
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<tbody>
<tr>
<td></td>
<td>Pre  Post  Adj</td>
<td></td>
<td>Pre  Post  Adj</td>
<td></td>
<td>Pre  Post  Adj</td>
<td>F</td>
<td>SIG</td>
</tr>
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<td><strong>TRIG</strong></td>
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<tr>
<td>Present Feelings</td>
<td>51.13  44.63  42.41</td>
<td></td>
<td>47.50  39.08  39.07</td>
<td></td>
<td>43.00  41.58  44.58</td>
<td>2.11</td>
<td>P=.136</td>
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<tr>
<td><strong>BDI</strong></td>
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<tr>
<td></td>
<td>18.31  9.5  8.41</td>
<td></td>
<td>12.92  6.92  7.64</td>
<td></td>
<td>13.08  9.08  9.75</td>
<td>.713</td>
<td>P=.497</td>
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<td><strong>ACL</strong></td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Intraception</td>
<td>44.13  52.56  53.20</td>
<td></td>
<td>48.42  54.33  54.79</td>
<td></td>
<td>44.77  46.85  47.20</td>
<td>3.64</td>
<td>P=.036*</td>
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<tr>
<td>Succorance</td>
<td>60.38  57.38  50.73</td>
<td></td>
<td>51.09  46.42  48.08</td>
<td></td>
<td>51.08  52.92  54.59</td>
<td>3.90</td>
<td>P=.029*</td>
</tr>
<tr>
<td>Personal Adj.</td>
<td>38.44  48.00  49.29</td>
<td></td>
<td>44.50  54.42  53.19</td>
<td></td>
<td>42.62  45.15  44.17</td>
<td>3.89</td>
<td>P=.029*</td>
</tr>
</tbody>
</table>

(N=41) *P<.05
However, both the higher level inpatient therapy group and the structured didactic group showed indications of a trend toward a decrease in depression greater than that of the control group.

3. The analysis of covariance pertaining to the Intraception scores of the ACL yielded a statistically significant difference between the two treatment groups and the control group. Therefore, the hypothesis that subjects participating in the two treatment groups would experience greater change on the Intraception Scale was supported.

4. The analysis of covariance pertaining to the Succorance scores of the ACL yielded a statistically significant difference between the higher level inpatient therapy group and control group. However, the structured didactic group showed indications of a trend in a decreased direction in Succorance which was not expected.

5. The analysis of covariance pertaining to the Personal-Adjustment scores of the ACL yielded significant differences and therefore the hypothesis that subjects participating in the higher level inpatient therapy group was supported. However, it was also observed that there was a significant increase in the structured didactic group which was not much less than the higher level inpatient therapy group. There was also a slight increase in the control group regarding Personal Adjustment.
CHAPTER V

Summary, Conclusions, Discussion, and Recommendations

This chapter provides a summary of the present investigation, reviews the hypotheses, reports the findings and discusses the results and conclusions. Recommendations for future research are made based on the findings of this study.

Summary

The purpose of this study was to investigate the differential effects of two group counseling approaches on adult patients who had been diagnosed as a substance abuser and having an unresolved grief reaction to prior losses. Forty-one adult inpatient individuals at St. John's Hospital were the subjects of this study. All were volunteers and were assigned to one of three groups: a higher level inpatient therapy group, structured didactic group, or control group. The effects of such interventions were examined in terms of present feelings of grief reaction, depression, intraception, succorance, and personal adjustment.

In recent years there has been an increase in focusing on the relationship between an addicted individual's loss of significant persons, unresolved grief, and substance abuse. It has been well documented in the literature that there is a scarcity of systematic and comprehensive research that adequately explores this relationship. The notion of utilizing group counseling interventions with a substance abusing population is not new; in

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fact to many it epitomizes the treatment of choice. Yet when working with substance abusers, who appear to experience more losses than the general population, certain considerations must be addressed. Loss, grief, and bereavement work with this population utilizing a group counseling approach appears to be a crucial component in the recovery process. The incorporation of two different group interventions was undertaken in order to determine its effects on reducing the level of unresolved grief.

To investigate these concerns the model for the experimental design was the Pretest-Posttest Control Group Experimental Design. The subjects for this study were adult individuals who had been admitted into an inpatient hospital setting for the treatment of their substance abuse and were also identified as having an unresolved grief reaction to a prior loss or losses. The sample consisted of both male and female subjects. Random assignment to each of the groups was somewhat compromised because of logistical constraints. Pre and posttests were administered to the three groups. The pre and posttests were a composite inventory instrument comprised of the Texas Revised Inventory of Grief, the Beck Depression Inventory, and the Adjective Check List. Scoring of all instruments was done by the investigator and a computer scoring service for the ACL.

Treatment interventions were administered to the two experimental groups - the higher level inpatient therapy group and structured didactic group - and withheld from the control group. The two treatment groups met for three sessions each week for a
time period of 75 minutes per group session. Groups were open-ended and ongoing and subjects continued in the group they were assigned until each had participated in eight counseling sessions. The control group did not meet and each subject in it completed the pretest prior to their prescribed inpatient treatment regime and completed the posttest prior to discharge.

Statistical analysis of the data was accomplished by means of parametric tests of statistical significance. An analysis of covariance was employed to determine changes made by the three different groups during the period of the intervention strategies. All statistical treatments were established at the 0.05 level of confidence which was the criterion point for rejection of the hypothesis.

The following five null hypotheses were tested in order to examine the effectiveness of the intervention:

**Ho₁**: There will be no significant difference of grief resolution as to the extremity of grief reaction (α = .05) among two groups and control group as measured by the Texas Revised Inventory of Grief.

**Ho₂**: There will be no significant difference (α = .05) of depression among the two treatment groups and control group as measured by the Beck Depression Inventory.

**Ho₃**: There will be no significant difference (α = .05) on the Intraception Scale of the Adjective Check List among the
two treatment groups and control group.

$H_0_4$: There will be no significant difference ($\alpha = .05$) on the Succorance Scale of the Adjective Check List among the two treatment groups and control group.

$H_0_5$: There will be no significant difference ($\alpha = .05$) on the Personal Adjustment Scale of the Adjective Check List among the two treatment groups and control group.

**Statement of Findings**

The analysis of the statistical data presented in this investigation yielded the following results:

1. There was no statistically significant difference of grief resolution as to the extremity of the grief reaction among the two treatment groups and control groups of substance abusers who participated in the group counseling intervention as measured by the present Feeling score of the TRIG.

2. There was no statistically significant improvement of depression among the two treatment groups and control group of substance abusers who participated in the group counseling interventions as measured by the level of depression of the BDI.

3. There were statistically significant improvements between the two treatment groups and control group of substance abusers relative to the Intraception Score of the ACL, however the increase in the Intraception Score was not significantly greater for either
of the treatment interventions.

4. There were statistically significant improvements between the higher level inpatient therapy group and control group of substance abusers in terms of the Succorance Score of the ACL. The trend in a positive direction for the control group which was unexpected. The structured didactic group showed indications of a trend in a decreased direction in Succorance which was not expected.

5. There was a statistically significant improvement between the two treatments groups and control group of substance abusers in relation to the Personal Adjustment Score of the ACL, however the increase in the Personal Adjustment Score was not significantly greater for the higher level inpatient therapy group than for the structured didactic group which was unexpected.

Conclusions

The following conclusions were drawn from this study as a result of the findings of the research:

1. Adult substance abusers in an inpatient hospital setting with unresolved grief reactions who participate in either a short-term higher level inpatient therapy group, short-term structured didactic group, or a control group do not appear to demonstrate significant improvement in grief resolution as measured by the TRIG.

2. Adult substance abusers in an inpatient hospital setting with unresolved grief reactions who participate in either a short-
term higher level inpatient therapy group, or short-term structured didactic group, show improvement in depression as measured by the BDI, however this cannot be attributed to either treatment intervention due to a corresponding decrease in depression found in the control group.

3. Adult substance abusers in an inpatient hospital setting with unresolved grief reactions who participate in either a short-term higher level inpatient therapy group or structured didactic group appear to demonstrate significant improvement in the Intraception as measured by the ACL compared to the control group.

4. Adult substance abusers in an inpatient hospital setting with unresolved grief reactions who participate in a short-term higher level inpatient therapy group appear to demonstrate significant improvement in Succorance as measured by the ACL. Also, the control group appeared to demonstrate a trend of increased Succorance and the structured didactic group showed indications of decreased Succorance; both of these results were unexpected.

5. Adult substance abusers in an inpatient hospital setting with unresolved grief reactions who participate in either a short-term higher level inpatient therapy group or structured didactic group appear to demonstrate significant improvement in Personal Adjustment as measured by the ACL. Also, the control group appeared to demonstrate a trend of increased Personal Adjustment which was unexpected.
Discussion

Although the statistical analysis of the data consisted of partial support of the research hypotheses and yielded some significant findings, further examination of the results tend to suggest that the intervention strategy of a grief group with a substance abusing population has the potential to produce positive results in an inpatient hospital setting. For example, although the hypothesis that there would be a decrease in depression in the two treatment intervention groups greater than that in the control group was not statistically supported, there were indications that the subjects in both the higher level inpatient therapy group and the structured didactic group evidenced movement in the direction of decreased depression as measured by the BDI. Perhaps it may be that the sensitivity of the BDI as an assessment instrument was not sophisticated enough to discern the subtle distinctions of depression with a substance abuse population with unresolved grief reactions. The decrease in depression as indicated by the means may at the very least suggest that the subjects received some help in their adjustment to the loss of a loved one and experienced some amelioration of unresolved grief.

In regards to the TRIG, it may also be stated that although it is an instrument designed specifically to measure levels of grief reactions, further refinement to detect more subtle changes in grief reactions need to be established. Additional research utilizing the TRIG will add to the utility and refinement of this
instrument and thereby contribute to increased knowledge of validity and reliability data.

Subjects reactions to standardized pre and posttesting is an area that requires some consideration. All pretest data was gathered immediately after subjects completed the detoxification phase of the hospitalization process, but prior to beginning the treatment phase of hospitalization. Although subjects were medically stabilized and deemed physically appropriate for treatment and participation in group counseling, it did not necessarily translate that they were emotionally stabilized enough such that they responded to the pretest with complete interest and candor. It must also be mentioned that denial and resistance are an integral dimension of the addiction process and if present in the earlier stages of treatment and recovery it certainly could effect how subjects would respond to the items on the pretest. As a consequence, the results of the pretests need to be viewed with these considerations.

In conducting this study it was necessary to implement some modifications to the original design. The investigator planned to use between 45 and 60 subjects who would be randomly assigned to the higher level inpatient therapy group, structured didactic group or control group. True random assignment to the groups was compromised because recruitment of appropriate subjects was correlated to the number of admissions to the hospital and this fluctuated throughout the course of this study. There was a brief time period whereby subjects were randomly assigned to the control
group and only one of the two treatment intervention groups. Another factor in obtaining 41 subjects instead of a higher desired number of subjects as originally planned was sample population attrition.

Also correlated to the number of admissions was the total length of time of the data gathering process. It began in February and continued through early November 1989. This was longer than originally anticipated, but necessary to obtain a significant number of subjects in order to yield results that would be statistically valid and meaningful.

The composite of assessment instruments was to be administered to the participants of the treatment intervention groups immediately upon completion of each subject's eighth group. Due to scheduling conflicts and time constraints this did not always occur and a small number of subjects were provided the tests to complete in the evening during a free time period and return to their primary counselor the following morning. The investigator made the decision to allow these subjects posttest results to be included in the study for the following two reasons: (1) the time necessary for taking these tests without rushing quickly would take approximately 45-60 minutes; depending on the subjects treatment schedule there was not always ample time for the subject to comfortably complete the instrument and it was felt that hurried responses could invalidate the test results; and (2) proper test-taking procedures were stressed and the investigator felt that the reliability and validity of each subject's test results would not
be adversely effected.

Relating the results and conclusions of this study to previous research as examined and cited in the literature review reveals some interesting findings. The literature discloses contradictory results regarding a grief/loss group decreasing or resolving grief reactions with substance abusers. This study did not provide or add clarity to the conflicting findings as there was no statistically significant improvement in grief resolution as measured by the TRIG; however there was a trend in a positive direction and from a statistical perspective, results approach the level of significance that would indicate improvement of unresolved grief. As discussed earlier in the study, it may be that the assessment instrument (TRIG) was not sophisticated enough to detect subtle changes in grief reactions.

Some studies (Denny and Lee, 1984; McGovern and Peterson, 1986) that have attempted to measure the level of depression in the resolution of grief have employed the BDI, as did this investigation. The prior studies found a significant decrease in depression of the treatment participants as measured by the BDI. Although in this study both treatment groups demonstrated improvement in depression, it could not be attributed to either treatment intervention due to a corresponding decrease in depression found in the control group. However, this investigation does support the notion that the feelings addicted individuals attempt to numb, specifically depression, are the same feelings that need to be expressed so that a level of acceptance is reached
in the grief process.

Of much interest were the final three hypotheses, all of which yielded significant results. Intraception, engaging in attempts to understand one's own behavior or the behavior of others significantly improved in both treatment groups as compared to the control group. It can be interpreted that through the grief group process increased insight and awareness was obtained by the group participants. These results directly conflict with McGovern's (1986) study where he concluded that the addiction of a loss/grief experience to a comprehensive and traditional treatment program did not enhance loss identification or grief awareness; however a primary reason for his conclusions derive from his use of experimental instruments to assess loss and grief.

Succorance, or the ability to solicit sympathy, affection, or emotional support from others showed significant improvement with the higher level inpatient therapy group. The control group appeared to demonstrate an increase in succorance and the structured didactic group showed indications of decreased succorance both of which were unexpected. It is unclear as to why this occurred, however it may have been that the structured didactic group served to elicit emotions of grief without providing adequate processing of them. This may have led to the undesired reaction of emotional and/or social withdrawal as the feelings began to develop. Again, as Blankfield (1982) has suggested, the literature provides no clear and definitive conclusions regarding the relationships between substance abuse, treatment, and
unresolved grief. The present research appears to support this position.

Friedman (1984) in a study examining unresolved grief concluded that viewing the recovery of alcoholism as a loss will initiate resolution and acceptance of other losses experienced in one's life and add greatly to the quality of a person's sobriety. The significant improvement in personal adjustment measured by the ACL in the present investigation tends to support Friedman's conclusions. The psychosocial dynamics of the grief process are active and ongoing within the individuals intrapsychic functioning whether or not it is acknowledged and addressed. Without an emphasis on the grief component these issues may be approached in a happenstance manner or superficial fashion, but unless they are directly examined, these issues will continue to persist and may undermine or threaten a substance abuser's best attempts at recovery.

Recommendations

The following recommendations are offered based on the findings of this research. These were generated from the results and conclusions of this study and are presented for consideration to future research:

1. Further research is recommended to determine the efficacy of a short-term higher level inpatient therapy group and structured didactic group replicating this study with similar groups of
substance abusers with unresolved grief reactions.

2. It would be advantageous to rigorously research other theoretical approaches and treatment interventions that may have psychotherapeutic value for this population.

3. An assessment instrument that measures the severity of grief in a study such as this need to be carefully selected. Further research in the development of such instruments with sound validity and reliability data need to be designed.

4. A more sophisticated instrument that measures depression in a precise way needs to be considered. It is likely that such an instrument would capture subtle changes in depression that would yield significant results.

5. Consideration should be given to postponing the introduction of the grief groups until two weeks after each subject has completed the detoxification phase of treatment. A pretest after detoxification followed by a second pretest two weeks later immediately prior to the treatment intervention would serve as a reliability check and provide increased validity and significance to the study.

6. It would be beneficial to be more selective in determining the saliency of subject characteristics to be chosen to participate in the groups. Prior counseling experience for either substance abuse and/or grief resolution as well as years each subject was abusing alcohol and/or drugs need to be established.

7. An additional group session or a sufficient time period following each group participants completion of the final group be
developed. This would mitigate differences between subjects as to variability in completing the posttest.

8. Longitudinal studies of group work with substance abusers with unresolved grief reactions is needed. Continued treatment intervention could occur into the outpatient aftercare phase of the therapy process. There appears to be inadequate and/or insufficient information to expectations for progress and change with this population.

9. Increase the counseling staff's education and training regarding the issue of loss and grief in treatment. This would serve to generate increased referrals to the groups and have the counseling staff become more cognizant of the effect unresolved grief has on the recovery from addiction.

10. Loss, grief and bereavement issues are such an integral aspect of the recovery process. It is recommended that hospital based inpatient substance abuse programs either train a staff counselor or employ a counselor with expertise in grief issues to work with individuals, groups, and families.
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These consist of pages:

115-118

UMI
### Appendix B

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<td>2.4</td>
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DIDACTIC GROUP OUTLINE

I. Accepting the Loss

II. Process of Grief

III. Guilt

IV. Depression

V. Fears, Physical Symptoms, and Anger

VI. Powerlessness

VII. Religion/Spirituality

VIII. Additional Issues: Letting Go, Changed Roles, and Unfinished Business
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These consist of pages:
123–155
THERAPEUTIC INTERVENTION IN THE TREATMENT OF SUBSTANCE ABUSER'S UNRESOLVED GRIEF REACTIONS IN AN INPATIENT HOSPITAL SETTING: A STUDY OF TWO GROUP APPROACHES

CONSENT FORM

The purpose of this form is to request your help by volunteering to participate in a study to be conducted while you are hospitalized at St. John's Hospital. This form is designed to ensure that you understand what the project is about. Please read carefully the following information; then sign in the section marked "Informed and Voluntary Consent to Participate" if you are willing to participate in the study.

Purpose of the Research

The purpose of this study is to determine the effects of two different group counseling approaches in examining individuals who have been diagnosed with substance abuse and assessed as having an unresolved grief reaction to the loss of a loved one.

Amount of Time Involved for Subjects

The length of your participation in this study is your stay at St. John's Hospital. All volunteers will be asked to complete three forms prior to and after participation in a grief group designed to obtain and provide information about yourself. As a volunteer assigned to a treatment group, you will be asked to attend eight (8) group counseling sessions, each lasting for 75 minutes and meeting two to three times a week. All counseling sessions will be audiotaped.

Assurance of Confidentiality

All group discussions, audiotapes, and collected data of this study will be kept strictly confidential in an effort to maintain and protect the confidentiality of each subject. All tests results of volunteers will be identified by a numbering system designed and employed solely for the purpose of this investigation. The researcher, and only the researcher, will have access to data collected on individual volunteers. For purposes of analysis, individual and group data will be used. No data will be used for any purpose except that expressly specified in this study.

Assurance of Voluntary Participation

Participation in this study is voluntary. You have the right to withdraw participation at any time. Any decision not to participate will, in no way, bias or negatively affect the treatment you receive at St. John's Hospital.
Availability of Results

A written summary of the results of this study will be made available upon request from:

Alan W. Forrest, Researcher
2807 Parham Road, Suite 125
Richmond, Virginia  23229
(804) 346-9866

or

Dr. Kevin E. Geoffroy, Sponsor
Professor of Education
Department of Counseling, School of Education
College of William and Mary
Williamsburg, Virginia
(804) 253-4434

Either of the above individuals is available to speak with you if questions, comments or concerns of the study occur.

Informed Voluntary Consent to Participate

I have been fully informed and hereby consent to participate in the study outlined above. My right to decline to participate or to withdraw in whole or part at any time has ben guaranteed.

____________________________  ____________________
Subject's Signature            Date

____________________________  ____________________
Researcher's Signature         Date
CONSENT FORM

The purpose of this form is to request your help by volunteering to participate in a study to be conducted while you are hospitalized at St. John's Hospital. This form is designed to ensure that you understand what the project is about. Please read carefully the following information; then sign in the section marked "Informed and Voluntary Consent to Participate" if you are willing to participate in the study.

Purpose of the Research

The purpose of this study is to determine the effects of two different group counseling approaches in examining individuals who have been diagnosed with substance abuse and assessed as having an unresolved grief reaction to the loss of a loved one.

Amount of Time Involved for Subjects

The length of your participation in this study is your stay at St. John's Hospital. As a subject that has been randomly selected and assigned to the control group, you will be asked to complete three brief forms prior to and upon completion of your inpatient hospital experience. All subjects in the control group will receive no treatment intervention as a part of this study during your inpatient hospitalization. However, as a subject assigned to the control group, you will be offered grief group counseling at the completion of the investigation.

Assurance of Confidentiality

All group discussions, audiotapes, and collected data of this study will be kept strictly confidential in an effort to maintain and protect the confidentiality of each subject. All tests results of volunteers will be identified by a numbering system designed and employed solely for the purpose of this investigation. The researcher, and only the researcher, will have access to data collected on individual volunteers. For purposes of analysis, individual and group data will be used. No data will be used for any purpose except that expressly specified in this study.

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________________________________________   ____________
Subject's Signature                     Date

________________________________________   ____________
Researcher's Signature                  Date
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VITA

Alan Wayne Forrest

Birthdate: November 7, 1954
Birthplace: Buffalo, New York

Education:
1982-1990 The College of William and Mary in Virginia
Williamsburg, Virginia
Education Specialist Certificate
Doctor of Education in Counseling

1977-1979 University of New Haven
West Haven, Connecticut
Master of Arts: Community Psychology

1973-1977 Eisenhower College
Seneca Falls, New York
Bachelor of Arts: Psychology & Sociology

Professional Experience:
1987-Present Private Practice
Richmond, Virginia
Licensed Professional Counselor

1986-1987 Metropolitan Hospital
Richmond, Virginia
Clinical Coordinator of Chemical Dependency Unit

1983-1986 Goochland/Powhatan Community Services Board
Goochland, Virginia
Substance Abuse Supervisor/Counselor

1980-1983 District 19 Substance Abuse Services
Petersburg, Virginia
Assistant Treatment Services Supervisor/Counselor

1979-1980 St. Lawrence Psychiatric Center
Ogdensburg, New York
Mental Health Counselor
Abstract

THERAPEUTIC INTERVENTION IN THE TREATMENT OF SUBSTANCE ABUSER'S UNRESOLVED GRIEF REACTIONS IN AN INPATIENT HOSPITAL SETTING: A STUDY OF TWO GROUP APPROACHES

Alan Wayne Forrest, Ed.D.
The College of William and Mary in Virginia, February 1990

Chairman: Kevin E. Geoffroy, Ed.D.

The purpose of this study was to investigate the efficacy of two group counseling approaches upon adult substance abuser's unresolved grief reactions in an inpatient hospital setting. Forty-one adult patients hospitalized in an inpatient substance abuse treatment program were subjects in the study. All subjects were volunteers and assigned to either a higher level inpatient therapy group (Yalom model), structured didactic group, or control group. Pre and posttesting was accomplished by use of the Texas Revised Inventory of Grief, Beck Depression Inventory, and Adjective Check List. It was hypothesized that by virtue of a grief counseling group there would be a significant improvement in unresolved grief as measured by (1) the Present Feeling scale of the TRIG, (2) a decrease in depression as measured by the BDI and (3) significant improvement in intraception, succorance, and personal adjustment as measured by the ACL.

Treatment interventions were administered to the two experimental groups and withheld from the control group. The two treatment groups met for three sessions each week for 75 minutes per group session. Groups were open-ended and ongoing and subjects participated in their assigned group until each had participated in eight counseling sessions. The control group did not meet.

The research design utilized in this study was the Pretest-Posttest Control Group Experimental Design. The statistical procedure analysis of covariance was employed to determine the efficacy of the two different group treatment approaches. Five null hypotheses provided the basis for testing whether or not there were significant differences (mean=.05) between the three groups on posttest measures of grief resolution, depression, intraception, succorance, and personal adjustment.

Analysis of the test data revealed no significant differences between the two treatment groups and control group with respect to grief resolution and no significant differences in improvement of depression between the two treatment groups and control group. There was significant improvement demonstrated between the two treatment groups and control group relative to intraception, however the increase was not significantly greater for either of
the treatment interventions. Also, there was a significant improvement demonstrated in succorance for the higher level inpatient therapy group; the control group demonstrated a trend of increased succorance and the structured didactic group showed indications of decreased succorance. Lastly, there was significant improvement between the two treatment groups as compared to the control group in relation to personal adjustment.