TASKS OF MOURNING AND THE TRANSTHEORETICAL MODEL OF CHANGE:

IMPLICATIONS FOR GRIEF THERAPY

by

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Abstract

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The Tasks of Mourning and the Transtheoretical Model of Change: Implications for Grief Therapy

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This study examined 32 female, middle-aged bereaved subjects involved in a rural grief therapy group, applying the Transtheoretical Model of Change (Prochaska & DiClemente, 1982, 1983) to the tasks of mourning (Worden, 2002), with the purpose of extending the change model beyond pathological issues, while furthering the individualization of interventions for the bereaved. Individual volunteers were administered three self-report instruments including the Texas Revised Grief Inventory (Faschingbauer, Zisook, & DeVaul, 1987), the Tasks of Mourning: Self-Report

Instrument (adapted by the researcher from Worden, 2002), and the University of Rhode Island Change Assessment (McCannaughty, Prochaska, & Velicer, 1983).

The correlations between the individual stages of change and the sequential tasks of mourning were not statistically significant. Post hoc comparisons demonstrated a strong relationship between Precontemplation and Task Four and a minimal relationship with Tasks Two and Three. This may signify that Precontemplators exhibit a reluctance to express grief and to adapt to life without the deceased. The Action stage was related to Tasks Two, and Three with a limited association with Task Four of mourning. This may indicate that those involved in the mourning process actively express grief and modify their environments, and that the Action stage may be interrupted or discontinued upon fully integrating the loss. Discussion of implications for research and bereavement counseling are presented.

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CHAPTER ONE

Introduction

The research concerning human motivational processes has lent itself to empirically validated investigations. One such model reporting significant and meaningful results is the Transtheoretical Model of Change (TMC), which originated from the work of Prochaska and DiClemente (1982, 1983). This model of human change identifies one's state of readiness for change including behavioral, cognitive, and affective readiness. The TMC has been utilized consistently in the study of substance abuse and eating disorder treatment, relapse, and recovery (Levy, 1997; Prochaska & Redding, 1994; Turnbull, 2000). Research in the previous areas has yielded invaluable applications of motivation-based individualized interventions, which effectively enhance treatment protocols and client receptivity. There is a growing consensus that the stages of change should be studied under natural conditions with a universal human experience (Prochaska, 1999).

Persons struggling with addictions often experience a profound loss of a source of comfort. Many in the field of mental health counseling, particularly object-relations therapists, interpret recovery from addiction as a loss of a love relationship, similar to mourning the death of a loved one (Solomon, 1980). For this reason, the present study investigates how the stages of change coincide with the natural process of bereavement. Many theories exist concerning the adaptation to the loss of a significant person. Worden's (2002) tasks of mourning, the most empirically validated model of grief, was selected for this study. Grief is a universal human experience that lends itself to a global application of the stages of change. The present investigation of the stages of change

applied to the tasks of mourning was undertaken in an effort to assess the stages of change model across a natural human change phenomenon, while at the same time furthering appropriate interventions of bereavement therapy.

This was a quantitative analysis that first examined the correlation between the four stages of change across the sequential tasks of mourning, and second, analyzed the same data for independent variation between the independent stages of change and tasks of mourning. Individual volunteers involved in group therapy counseling were identified by a local grief therapy center. Identified individuals were given a brief introduction to the purpose of the research project, a letter describing the study, a confidentiality/voluntary participation form, and the three self-report instruments: the Texas Revised Grief Inventory (Faschingbauer, Zisook, & DeVaul, 1987), the Grief Tasks: Self Report Instrument, and the University of Rhode Island Change Assessment (McConnaughty, Prochaska, & Velicer, 1983). The data obtained from these measures were analyzed using the Pearson product-correlation coefficient, determining the correlation between the four stages of change and the four tasks of mourning. The second analysis of the data examined responses on all measures to determine the variation between variables of the four stages of change and the four tasks of mourning.

Statement of the Problem

Motivational stages of change have been applied to various addictive and psychiatric issues, but have yet to be applied to universal, nonpathogenic human experience. Concurrently, the mourning and bereavement literature remains entrenched in various theoretical models and does not provide models of intervention that attend to both universal and individual processes. Therefore, bereavement was selected for the

application of Prochaska's stages of change model to widen the applicability of the motivational model while furthering the available interventions to assist in the treatment of the bereaved.

Assumptions of the Study

It was assumed that each participant answered self-report measures honestly and accurately during the process of data completion. Scales used in this investigation were assumed to measure what they were intended to measure, and the data obtained was assumed reliable and valid. It was also reasoned that a correlation existed between the stages of change and the four tasks of mourning. This study assumed that the stages of change represented four variable terms, each independent from one another including the Precontemplation, Contemplation, Action, and Maintenance stages. This study examined both interpretations of the tasks of mourning representing first a sequential process, where each task is dependent on the completion of each preceding task, and second independent tasks that may be completed in varying orders and to varying degrees. Working from the sequential interpretation of the tasks of mourning, this study examined the correlation that may exist between the stages of change and the tasks of mourning. Accounting for the alternative interpretation of independent tasks of mourning, a one-way analysis of variance ANOVA was conducted to examine the relationship between each stage of change and each task of mourning.

Purpose of the Study

The goal of this investigation was to explore the applicability of the stages of change to a universal human process, and to further the utility of staging interventions for nonpathogenic treatment presentations. Another goal of this research is to advance the

treatment approaches for grief therapies in such a way as to move from universally accepted techniques of catharsis and goals of completion, to individualized symptom management and motivationally oriented interventions that match each task of mourning. To this end, the purpose of this investigation was to examine the stages of change across the tasks of grieving involved in the adjustment to the loss of a significant person in one's life, both with correlation as well as independent variance. This pairing was intended to increase the generalized nature of the TMC as well as to develop a more individualized treatment for persons seeking services for grief-related concerns.

Limitations of the Study

The current study has applicability limited to female, the middle aged bereaved, experiencing a loss between one and five years post death, resulting from unexpected and sudden causes from rural communities in a Midwestern community involved in a grief therapy group. The sample was also not generalized due to its convenient selection of subjects based on personal volunteering. The self-report answers to questionnaires lacked independent observational data as a validity check. Also, instrumentation of the Tasks of Mourning: Self-Report Inventory and the adapted University of Rhode Island Change Assessment were not validated independently prior to conducting this research.

Definition of Terms

Grief: "the experience of one who has lost a loved one to death" (Worden, 2002, p. 10).

Bereavement: "the loss to which the person is trying to adapt," for example spousal bereavement (Worden, 2002, p. 10).

Mourning: “the process that one goes through in adapting to the loss of the person” (Worden, 2002, p. 10).

Normal/Uncomplicated Grief: expression of grief in affect:

1. Sadness
2. Anger
3. Guilt
4. Loneliness
5. Shock Yearning
6. Emancipation
7. Relief
8. Numbness” (Worden, 2002, pp. 11-15);

somatic sensations:

1. Hollowness in the stomach
2. Tightness in the chest
3. Tightness in the throat
4. Oversensitivity to noise
5. A sense of depersonalization: “I walk down the street and nothing seems real, including me.”
6. Breathlessness, feeling short of breath
7. Weakness in the muscles
8. Lack of energy
9. Dry mouth (Worden, 2002, p. 15);

cognitions:

1. Disbelief
2. Confusion
3. Preoccupation
4. Sense of Presence
5. Hallucinations (Worden, 2002, pp. 15-17);

and behaviors:

1. Sleep Disturbances
2. Appetite Disturbances
3. Absentminded Behavior
4. Social Withdrawal
5. Dreams of the Deceased
6. Avoiding Reminders of the Deceased
7. Searching and Calling Out
8. Sighing
9. Restless Overactivity
10. Crying
11. Visiting Places or Carrying Objects That Remind the Survivor of the Deceased
12. Treasuring Objects That Belonged to the Deceased (Worden, 2002, pp. 17-20).

Pathogenic/Complicated Grief: intense reactivity, much like post-traumatic stress disorder (PTSD) when discussing the deceased. Reactivity may be observed in

the following expressions: chronic, delayed, exaggerated, or masked grief reactions. Triggers of intense reactivity may include innocuous stimuli, themes of loss, clinging onto artifacts of the deceased, embodiment of somatic symptoms related to the deceased's death, prolonged depressive or hypo-manic symptoms, compulsive imitation of the deceased's actions, self-harm impulses, existential phobias, and failure to adapt to current stressors (Worden, 2002).

Tasks of Mourning: Worden (2002) introduced a series of tasks involved in the process of mourning. His definitions of tasks demonstrate a similarity to Freud's definition of grief as a cathartic release of emotional energy, but differs on the basis of a cognitive and behavioral process rather than strictly an emotional one. "Although the tasks do not necessarily follow a specific order, there is some ordering suggested in the definitions. For example, you cannot handle the emotional impact of a loss until you first come to terms with the fact that the loss happened . . . . it is possible for someone to accomplish some of the tasks and not others and hence have an incomplete adaptation to the loss" (p. 27). Therefore, the tasks of mourning may be considered both a sequential process of one task building from preceding tasks, as well as an independently fluctuating tasks that may interact with each other.

Task One: "To Accept the Reality of the Loss . . . . it involves not only an intellectual acceptance but also and emotional one" (pp. 27-29). In other words, the bereaved must realize that the death is final and reunions will not occur.

Task Two: “To Work Through the Pain of Grief . . . . physical . . . emotional and behavioral pain associated with loss” reactions of which must be experienced and expressed individually and socially (p. 30).

Task Three: “To Adjust to an Environment in Which the Deceased is Missing . . . . a) External Adjustments . . . . adapting/compensating towards vacated roles of functioning” (p. 32). b) “Internal Adjustments . . . . how death affect(s) self-definition, self-esteem, and sense of self-efficacy” (p. 33). c) “Spiritual Adjustments . . . . The bereaved person searches for meaning in the loss and its attendant life changes in order to make sense of it and to regain some control of his or her life” (p. 34).

Task Four: “To Emotionally Relocate the Deceased and Move on With Life” where the bereaved remains connected to the memorializing the deceased while continuing to invest in present acts (p. 35).

Stages of Change: Prochaska (1999) states there are 5 discernable stages (Precontemplation, Contemplation, Preparation, Action, and Maintenance) one progresses through when experiencing a change, with interdependent levels in that any change at one level may produce change within other readiness stages.

Stage 1: “Precontemplation, which denotes an uninformed person that may experience being stuck or unaware a problem exists and will often “underestimate the benefits of changing and overestimate the costs” (p. 229).

Stage 2: Contemplation: Persons are hopeful of a change within the next six months, they are aware of benefits and risks of change, and can experience increasing levels of incongruity.

Stage 3: Preparation: People are intending to initiate a change within a month's time, are gathering information and consulting others to "formulate a plan of action " and are more receptive to "action-oriented interventions" (p. 230).

Stage 4: Action: Persons have made a change (even life-style) in the past six months, demonstrating "clinical improvement" (p. 230).

Stage 5: Maintenance: Active attempts at "preventing relapse", decreased temptation for relapse, and increased confidence to continue the change (p. 231).

Processes of Change: Prochaska (1999) discussed the following processes as facilitators between each of the stages of change. Specifically, Prochaska stated consciousness raising, dramatic relief, and environmental reevaluation assisted the movement from Precontemplation to Contemplation; self-reevaluation assisted the transition between Contemplation and Preparation; self-liberation moved Preparation to Action; and contingency management, helping relationships, counterconditioning, and stimulus control facilitate the move from Action to Maintenance.

1. *Consciousness raising* involves increased awareness and information about the causes, consequences, and cures for a particular problem. Interventions that can increase awareness include observations, confrontations, interpretations, feedback, and education such as bibliotherapy . . . .
2. *Dramatic relief* involves emotional arousal about one's current behavior and relief that can come from changing. Fear, inspiration, guilt, and hop are some emotions that can move people to contemplate

changing. Psychodrama, role playing, grieving, and personal testimonies are examples of techniques . . . .

3. *Environmental reevaluation* combines both emotional and cognitive assessments of how one's behavior affects one's social environment and how changing would affect the environment. Empathy training, value clarification, and family or network interventions can facilitate such reevaluation . . . .
4. *Self-reevaluation* combines both cognitive and affective assessments of one's self-image free from a particular problem. Imagery, healthier role models, and values clarification are techniques that can move people . . . . they imagine more how their life will be free from the problem . . . .
5. *Self-liberation* includes both the belief that one can change and the commitment and recommitment to act on that belief. Techniques that can enhance such willpower make greater use of public rather than private commitments . . . . Asking clients to choose which alternative they believe will be most effective for them, and to which they would be most committed . . . .
6. *Counterconditioning* requires the learning of healthier behaviors to replace problem behaviors . . . . Counterconditioning techniques are specific to a particular behavior and include desensitization, assertion, and cognitive counters to irrational, distress-provoking self-statements . . . .

7. *Contingency management* involves the systematic use of reinforcements and punishments for taking steps in a particular direction . . . . we emphasize reinforcements for progressing over punishments for regressing. Contingency contracts, overt and covert reinforcements, and group recognition are procedures for increasing reinforcement. They also provide incentives that increase the probability that healthier responses will be repeated . . . .
8. *Stimulus control* involves modifying the environment to increase cues that prompt healthier responses and decrease cues that are tempting. Avoidance, environmental reengineering . . . and attending self-help groups can provide stimuli that elicit healthier responses and reduce the risks for relapse . . . .
9. *Helping relationships* combine caring, openness, trust, and acceptance as well as support for changing. Rapport building, a therapeutic alliance, counselor calls, buddy systems, sponsors, and self-help groups can be excellent resources" (pp. 241-244).

Summary

This research begins by reviewing the relevant research of the TMC and its applications to various presenting concerns. Following a formal review of the literature, the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR*, American Psychiatric Association, 2000) is reviewed, for specificity of the criterion examined in the study of various typologies of bereavement responses. Next, a review of historical and modern conceptualizations of grief theory and practice is presented. The correlational

study of the four stages of change and the tasks of mourning as a sequential process is presented. This is followed by a presentation of a one-way analysis of variance between the independent variables of the four stages of change and the four tasks, and a post hoc comparison of each stage of change and each task of mourning. Finally, a discussion of the results, implications for clinical practice, and suggestions for future research are provided.

CHAPTER TWO

Literature Review

The literature review introduces a model of the process of human behavior change, its development and modern applications. The review presents past and current conceptualizations of the mourning process, bereavement typologies, and finally a review of grief theory, including research and modern therapeutic practice.

Development and Applications of the Transtheoretical Model of Change

Motivation for change has made an impact on the way practicing clinicians view change in the therapeutic context. Many researchers have attempted to apply Prochaska and DiClemente's (1983) TMC to addictive behaviors, psychiatric populations such as bulimia nervosa and schizophrenia, as well as other clinical populations (Levy, 1997; Prochaska & Redding, 1994; Turnbull, 2000). Conclusions drawn from those applications demonstrate that motivational states play an integral role in shaping cognition, affect, and behavior in clinical settings. The TMC has provided a map of the territory of change, in terms of stages and processes (Prochaska & DiClemente, 1983, 1992). The core concepts of this theory assert that there are five discernable stages of change. These authors state that the stages are not independent and that change at one stage may produce change in other stages.

Prochaska described the stages of change in a chapter of *The Heart and Soul of Change: What Works in Therapy* (Hubble, Duncan, & Mille, 1999). The first stage of change is Precontemplation, which denotes an unaware person who is experiencing a state of being stuck or unaware that a problem exists. Often, persons in the Precontemplation stage underestimate the benefits of a change and overestimate the

negative consequences of initiating a change. The second stage of change is Contemplation, where persons are hopeful of a change within the next six months, are aware of benefits and risks of change, and can experience increasing levels of ambivalence. Persons in the Contemplation stage are not yet ready for action-oriented interventions. Preparation is the third stage of readiness for change, where people are intending to initiate a change within a month's time, are gathering information and consulting others to formulate a plan of Action, and are more open to action-oriented interventions. Action is the fourth stage of readiness for change, where persons have made or attempted to change (even one's life-style) in the past six months. Maintenance is the final stage of change that denotes active attempts at preventing relapse, decreased temptation for relapse, and increased confidence to continue the change.

Within the TMC literature, studies show that interventions for enhancing motivation for change are effective in bolstering the therapeutic process (Miller, 1998). Brogan, Prochaska, and Prochaska (1999) completed a study comparing the influences of client characteristics with an individual's stage of readiness in the prediction of the termination or continuation of the therapeutic alliance. The researchers examined the longitudinal status of continuation of psychotherapy among 60 client and therapist pairs in a metropolitan university counseling center setting. Correlations of the stages of change, the processes of change, symptom checklist, levels of attribution, psychotherapy decisional balance, and therapist assessment of clinical termination status were conducted through discriminant function analysis. Three categories were correctly classified: premature termination, appropriate termination, and continuation of services categories ($p < .001$). Independent of demographic variables, the stages of change, processes of

change, and decision-making variables were predictive of premature dropout and continuation variables. Accordingly, premature dropouts favored stimulus control and environmental reevaluation processes of change, demonstrating the perception that change is external and overestimating the disadvantages of change. The following interventions were cited to promote client retention: consciousness raising, self-reevaluation, and examining the pros and cons of change. Appropriate terminators were overwhelmingly in the Action stage and focused on benefits resulting from changes, and could benefit from relapse prevention strategies. Continuers were largely in the Contemplation stage of change, and discussed issues without actively problem-solving their situations, benefiting most from reinforcements. The researchers found that the TMC stages were 92% predictive of premature termination and the continuation of therapy, where individual differences were not predictive.

Prochaska (1996) stated that client distress often presents itself in a variety of therapeutic contexts, from addiction challenges to struggles with intermittent psychoses. He notes that 90% of therapeutic efforts are designed for immediate action on the behalf of the client, yet only 20% of the population are in the Action stage. The pressure for action in the therapy session often heightens the clients' level of anxiety and further adds to their ambivalence. Therefore it is essential to use therapeutic interventions that match the client's stage of change, which ensures movement towards the desired goal of therapy.

Prochaska and Prochaska (1999) applied the TMC in an attempt to understand why people have a difficult time making the transition from a dependent lifestyle to a health-conscious lifestyle. They found that precontemplative participants seeking

treatment showed progress when receiving appropriate reinforcements, which facilitated the movement to the Contemplation stage of change. Contemplators were found to be unsure about wanting to change and need reinforcements that a change would be beneficial (pros outweighing the cons). Also, these researchers found that those in the Preparation stage often reported a sense of being dumbfounded in the implementation of a desired change. They benefited most from active behavioral interventions promoting the Action stage of change.

Levy (1997) stated that despite the successful applications of the TMC to smoking cessation, alcohol dependence, weight management, psychological distress, and eating disorders, there have been limited applications to normal life processes. The TMC was described as "an integral model for accelerating change in a broad range of problem behaviors," which may extend to normal change processes, such as bereavement (pp. 279-280). Accordingly, Riebe (1997) discussed an application of the TMC on exercising behaviors, and how its use improves client retention in programming and enhanced outcome performance. As described, early stage clients use cognitive and affective processes for maintaining motivation, and can benefit from interventions that allow for expression of feelings and obtaining more information (such as increasing awareness, dramatic relief, emotional reevaluation, and self-reevaluation). Late stage clients in Action or Preparation utilize experience and social supports to strengthen engagement in therapy (using processes of change including: self-liberation, reinforcement management, helping relationships, counterconditioning, and social liberation).

Cardinal (1995) analyzed the TMC as a predictor of exercise behavioral variables. In a study of 74 undergraduates at a major metropolitan university community, the stages

of change were compared to exercise outcome measures of leisure-time exercising behaviors, frequency of sweating, body fat percentage, physical activity ratings, difficulties with relapse, and metabolic rates. The reported results showed stages of change to be predictive of successful completion of exercising protocols as well as enhanced psychological commitment to the program. The stages of Exercise Scale was an adaptation of the five point algorithm developed by Prochaska and DiClemente (1992), which demonstrated a test-retest reliability of 1.00 ($p < .001$) using Spearman's rho. Accordingly, the five stages of change were analyzed across the above outcome measures and Preparation, Action, and Maintenance stages of change were significantly correlated with exercise program completion as well as increases in outcome measures ($n = 26$, 32.5%; $n = 20$, 25%; and $n = 34$, 42.5%).

Cardinal (1997) compared 49 female bulimic anorexics involved in exercise classes ($n = 27$) and non-exercise classes ($n = 22$), examining the interaction of both exercise behavior and exercise identity across three times (baseline, seven-weeks, and fourteen weeks). Interventions were provided based one's individual stage of change, during the first month and the seventh month of an exercise protocol. Contemplative subjects were shown to have improved likeliness of initiating exercise behavior changes, more rapidly than without stage specific intervention groups. In his report, Cardinal demonstrated that it was easier for subjects to decide on making a behavioral change than it was for the same subjects to initiate the desired change. Findings demonstrated little observed movement along the stages Precontemplation to Maintenance without appropriately applying stage specific reinforcements.

Based on 20 years of research, Prochaska (1979) has found that one's stage of change influences future attempts towards solutions. Several recent studies demonstrate that one's stage of readiness determines treatment interventions, relapse potential, and recovery likelihood across several clinical issues. Jensen, Nielson, Romano, Hill and Turner (2000) state that one's readiness to adopt new beliefs and coping responses to pain was predictive of behavioral responses and cognitive restructuring for persons with chronic pain. Keefe, et al. (2000), in a separate quantitative study of 103 rheumatoid arthritis patients and 74 osteoarthritis patients found that one's stage of change predicted the participation and responsiveness to coping intervention strategies in the management of pain symptoms. Their cluster analysis identified that 44% were Precontemplative, 11% Contemplative, 22% Preparing, 6 % taking Action, and 17% Maintaining changes made. Of their noted implications, the TMC predicted patients' participation and responsiveness to pain-coping skills training, exercise interventions, and other formalized self-management training programming. It was also suggested that outcomes of pain management programs could enhance outcomes of self-management interventions for arthritis patients by tailoring treatment interventions based on one's particular stage of change.

Based on determining one's stage of change, clinicians may be informed of various stage appropriate interventions. Levy (1997) analyzed the TMC as applied to bulimia nervosa clients in an attempt to further the treatment specialization and enhance treatment and intervention efficacy. The sample of 139 females, representative of a major metropolitan area, with current or past histories of bulimia, was split into a treatment subgroup (n = 65) and a non-treatment subgroup (n = 74) to demonstrate

homogeneity. Both groups completed a stage of change, processes of change, and treatment preference (least active group, exploration group, goal setting group, skills group, and relapse prevention group) questionnaires. As expected, the Precontemplative group chose the least active treatment ($p < .001$), the Contemplative group chose exploration interventions ($p < .001$), the Preparation group chose goal-setting interventions ($p < .001$), the Action group chose skills building ($p < .05$), and the Maintenance group chose relapse prevention skills ($p < .001$). According to specific stage of change and processes of change interactions, Precontemplators showed the least use of the processes of change ($p < .001$). Contemplators showed a significant use of consciousness raising ($p < .004$). Preparers used dramatic relief, environmental reevaluation, and self-reevaluation ($p < .001$). Action stage subjects used counterconditioning and stimulus control processes showing increased efficacy of treatment through the distinctly different and highly stage-relevant treatment ($p < .001$ and $p < .001$). Other processes and stage of change correlations are as follows: self-liberation was equally distributed across stages, helping relationships was correlated with Maintenance stages, and reinforcement management was correlated to both Contemplators and Preparers.

Turnbull (2000) assessed the applicability of the TMC in a qualitative format examining the urge to seek assistance for speech difficulties. Turnbull concentrated her attention to each stage of change and explained various examples of interventions that would fit the stages for those persons affected by stuttering and stammering. DiClemente (1991), as cited in Turnbull, shared four specific types of defenses within the Precontemplation stage: reluctance with a lack of knowledge, rebellion that argues

against change, resignation where change is not seen as possible, and rationalization that argues the problem is not a problem. Turnbull then suggested various active interventions such as empathy, appropriate feedback, providing options, carefully used paradoxes, installing hope, exploring various barriers of change, and reflective listening, all of which address initial resistances or denial. Conscious raising and self-reevaluation, and exploring the positive and negative consequences of staying the same versus changing are cited as examples of processes of change and interventions gauged facilitative for those in the Contemplation stage. These interventions are facilitative in reducing resistance and ambivalence, indicating a transition from Contemplation to Preparation stages. Therapists are urged to move at a slow pace and focus on goal setting that is manageable and encourages future progress, capitalizing on the client's brief period of resolve. Self-liberation and autonomy (assuming a position of control and self-direction) along with further goal setting processes are beneficial in the Preparation stage. The Action stage can be facilitated through helping relationships, self-liberation, counterconditioning, stimulus control, and contingency management processes. Awareness of impending obstacles often moves the client the client from the Action stage to the Maintenance stage. In the Maintenance stage participants that stammered benefited from the construction of coping strategies (mostly cognitive reframes). Within the termination/resolution stage (prolonged Maintenance), clients often revision themselves in light of the progress they have made (self-reevaluation and relapse prevention).

Prochaska and Redding (1994) stated that change does not occur automatically, but "through discrete motivational stages over time, the active use of different processes

of change at different stages, and modification of cognitions, affect, and behaviors" (p. 472). Also, it was posited that the TMC can serve as an "integrative theme for accelerating change across a broad range of behaviors" (p. 472). Accordingly, Neeliyara and Nagalakshmi (1996) state, "Assessing motivation for change in various clinical conditions is essential so that high-risk subjects can be detected and appropriate therapeutic interventions can be used to facilitate change" (p. 114).

Other Motivation-Based Interventions

Miller and Rollnick (1991) proposed a model of counseling that enhances client motivation and is the basis for interventions that increase treatment compliance and decrease ambivalence, termed Motivational Interviewing. This form of therapy attends more to the human change process and is less entrenched in therapeutic modalities, offering an innocuous medium for accelerating change. The process involves five principles including expression of empathy, develop discrepancies between what is and what is wanted, avoiding arguments that would otherwise build resistances, strategically allowing for and going with client resistances, and promotion of the client's self-efficacy that change is possible. The therapy is segmented into two phases of therapy, phase one includes the above mentioned strategies to build motivation for change, whereas phase two sets in motion several action approaches including goal planning, activity setting, experiential processing, and relapse prevention.

Maclean, Pound, Wolfe, and Rudd (2000) conducted a qualitative analysis with a randomly sampled study of stroke patients' motivation and its impact on rehabilitation. The study sampled extreme comparison groups of 22 subjects, 14 high motivation and 8 low motivation. Highly motivated subjects viewed motivation as the most important

predictor of successful rehabilitation, being informed by treatment professionals, favorable comparisons with other stroke patients, and desire to leave the treatment setting positively impacted motivation. Low motivated subjects viewed overprotection from family and nursing staff, lack of information or mixed messages from staff, and unfavorable comparisons with other stroke patients as negatively impacting motivation and participation in physical rehabilitation. Independent of stroke severity, motivational factors strongly affected their engagement in rehabilitation and recovery of physical, emotional, and interpersonal dimensions.

With their literature review concerning problem awareness and insight in the rehabilitation of persons with schizophrenia, Rusch, Nichols, and Corrigan (2002) stated that one's perceptions of the ability to change behaviors to cope with psychoses impact achievement of set goals. These authors presented the use of the TMC and other motivational interviewing strategies in the enhancement of treatment outcomes and medication compliance among schizophrenic patients. They stated that interventions designed to increase one's awareness of perceptual disturbances and the negative social consequences of these disturbances increase patients' motivation and behavior in the attendance and compliance with outpatient therapy. Specific motivation enhancing interventions include discussing ambivalence (pros and cons of change), self-reevaluation, environmental reevaluation, repetition of information, and deliberate goal setting.

Kemp, Hayward, Applewatie, Everitt, and David (1996) conducted a study examining the effects of motivationally oriented cognitive therapy on the overall compliance with treatment and social adjustment of psychotic patients. In this

randomized controlled trial, the treatment group consisted of 47 psychotic patients who received compliance therapy with motivational interviewing interventions and a control group of 25 psychotic patients who received nonspecific counseling. These patients rated themselves according to measures of compliance, and their therapists rated the patients across the same criteria: attitudes towards treatment, insight into their illness, compliance with medical treatment, attendance in outpatient therapy, and the global assessment of functioning. The confidence interval analysis demonstrated an increase across the above criteria directly following motivational interventions and at the six month time period ($p < .05$).

Swanson, Pantalon, and Cohen (1999) studied motivational interviewing intervention effects on the outpatient treatment adherence of the psychotic and dually diagnosed population. Their study consisted of 121 psychiatric inpatients, of which 93 had a substance abuse dual diagnosis. The sample was randomly assigned into two groups. The first group received standard treatment of pharmacotherapy, individual and group therapy, activity therapy, milieu treatment, and discharge planning. The other group combined the standard treatment with motivational interviewing, fifteen minutes of feedback following a motivational assessment and a one-hour motivational interview session prior to discharge. Motivationally based techniques included reflective listening, discussion of treatment difficulties (contingency management, environmental reevaluation, and stimulus control), and the elicitation of motivational statements. The treatment group having the motivational component attended the first outpatient appointment at a significantly higher rate than the group with only standard treatment for the psychotic ($p < .01$) and the dually diagnosed ($p < .01$).

DiClemente (1991) demonstrated how integration of both the MI and the TMC and the overlap of interchangeable interventions that facilitate human behavior change. Clients can be assisted through the Precontemplation stage by the identification, processing, and the revision of the "four R's': reluctance, rebellion, resignation, and rationalization," thereby raising consciousness and building resources that change is possible (p. 192). The Contemplation stage is facilitated by MI strategies of information gathering, incorporating incentives for change, building on positive reasons for change, and promoting self-efficacy building on previous efforts towards change. The Preparation stage is facilitated by realistic appraisals of what it takes to make a change along with a calm dedication towards acting from their plan, as well as preparedness for eventual barriers to change and formulation of appropriate coping responses. The Action stage can be enhanced through implementation, reevaluation, and revision of the agreed upon plan that reinforces Action and commitment. The Maintenance stage is balanced between the commitment to change and the fear and diminished self-efficacy of possible relapse. DiClemente stated that maintenance of behavior change is promoted through MI strategies of "exploration, information, feedback, and empathy" (p. 200).

The TMC has been applied to behavioral changes that lead to increased functioning and decreased symptomology, which is the purpose of the present investigation. One critique of the TMC is its application to the addictive behaviors and psychopathology, while ignoring a universal process of human change such as loss and resulting grief. However, Rusch, Nichols, and Corrigan (2002) have shown how the stages of change are now being applied to clinical issues other than problematic behaviors. For example, the TMC has been applied to stress management, attendance to

counseling sessions, and medication compliance. Of the various concerns that present themselves in therapy, grief related challenges seem to be specific clinical conditions that require appropriate assessment of motivational states. Accordingly, within grief therapy literature readiness for change may influence progressing through various tasks of bereavement, altering sets of cognitions, affective expressions, and behaviors (Worden, 2002).

Assessing client stage of motivation allows clinicians to attend to early stage clients, and to reduce attrition by initiating appropriate interventions (Silverman, 1987). According to Parkes and Wiess (1983) and Worden (2002), the bereaved may be the highest risk group of clientele presenting in therapy. More than any other treatment group the bereaved are subject to greater incidence of physiological symptomology, as well as mood instability (depression, anxiety, and post traumatic stress disorder), and various forms of maladaptive coping.

Historical Development of Grief Theory and Practice

According to Worden (2002), counselors often experience feelings of hopelessness and helplessness when counseling the bereaved. In a study of 58 master's level beginning counseling students, subjects reviewed video vignettes of several presenting issues in therapy to determine if counselors experience discomfort and struggle with empathy with bereavement related presenting issues (Kirchberg, Neimeyer, & James, 1998). Subjects viewed eight videos, four depicting death related presenting issues: recent diagnosis of AIDS, recent diagnosis of brain tumor, recent death of a spouse, and grief over child's death from leukemia. The other four videos were non-death-related issues: adjustment to physical disability, survivor of childhood sexual

abuse, marital discord with spousal abuse, and recent loss of employment. Of the various presenting issues, counselors experienced the most profound discomfort in videos depicting death-related material. Overall discomfort levels for death-related videos were significantly greater than in non-death scenarios ($p < .001$). Also, generalized discomfort scales were predictive of discomfort in future counseling related interactions for death-related scenarios ($p < .05$) ". . . . as death fear increased, counselors became more uncomfortable with counseling situations involving death and dying" (p. 104). Empathy ratings yielded non-significant results between death issues and non-death issues; however, those subjects that exhibited despair in the face of death was predictive of decreased empathy scores ($p < .05$). Overall discomfort ratings were predictive of a counseling student's struggle to empathize with grief and death related challenges. Part of this may be due to anxieties involved in assisting clients through a change process that is initiated by uncontrollable loss, rather than client initiated changes. Another explanation may be the many conflicting understandings and approaches towards grief and its therapy. Many therapies advocate the focus on relinquishing of the bond, while the client may cling to images belongings and memories of the deceased, creating a therapeutic paradox.

Reviewing the literature concerning bereavement, the dominant model of grief clinical practice was largely influenced by the seminal work of Freud's article "Mourning and Melancholia" (1917), stating that bereavement is a lost attachment, producing psychiatric complications and maladaptive coping processes. The article compares the onset and recovery from both mourning and depression including symptoms of dejection,

disinterest, limited capacity to love, inhibited behaviors, and guilt. The following is the translation of the first writings concerning the resolution of grief symptoms.

> In what, now does the work which mourning performs consist? I do not think there is anything far-fetched in presenting it in the following way. Reality testing has shown that the loved object no longer exists, and it proceeds to demand that all libido shall be withdrawn from its attachments to that object. This demand arouses understandable opposition – it is a matter of general observation that people never willingly abandon a libidinal position, not even, indeed, when a substitute is already beckoning to them. This opposition can be so intense that a turning away from reality takes place and a clinging to the object through the medium of a hallucinatory wishful psychosis. Normally, respect for reality gains the day. Nevertheless, its orders cannot be obeyed at once. They are carried out bit by bit, at great expense of time and cathartic energy, and in the meantime the existence of the lost object is psychically prolonged. Each single one of memories and expectations in which the libido is bound to the lost object is brought up and hyper-cathected, and detachment of the libido is accomplished in respect of it. Why this compromise by which the command of reality is carried out piecemeal should be so extraordinarily painful is not at all easy to explain in terms of economics. It is remarkable that this painful unpleasure is taken as a matter of course by us. The fact is . . . that when the work of mourning is completed the ego becomes free and uninhibited again (pp. 244-245).

With this deficit-based approach to grief, most clients are expected to emotionally "work through" their lost attachment figure, meaning abandoning the attachment and replacing

it with another object of attachment. Freud and Breuer (1895, as cited in J. Strachey 1945) observed the bereavement of several hysteria patients were generalized as a universal process of grief, sharing that grief involves a libidinal withdraw from the lost object, occurring bit by bit.

According to Hagman (2001), grief was described as a normal "universal intrapsychic process . . . of . . . incremental divestment of libido (decathexis) from memories of the lost object" (p. 21). Recovery is often assumed to occur by restored homeostasis, relinquishment of all ties to the deceased, and restored premorbid functioning. Thus, clinicians assert that the main feature of bereavement is the grief response of extreme pain due to built up intrapsychic energy without opportunities to cathart. Freud (1923, as cited in J. Strachey 1962; 1926, as cited in J. Strachey 1961) and Abraham (1927) stated that mourning involves loss of the object relation of the id's identification with the deceased. Like most of Freud's observations, these initial bereavement conclusions have not been empirically validated.

Years following Freud's article, Deutsch (1937) wrote an influential article entitled "Absence of Grief" that detailed the affective processes of grief. In this article, Deutsch concluded that the absence of grief is predictive of pathological grieving. Furthermore, to exhibit a normal grieving path the individual is expected to express extreme sadness and grief. Deutsch's conclusions have influenced theorists to suggest that there are complicated, delayed, and other pathogenic forms of grief. Consequently, Deutsch's sentiments led to the insistence that clinicians must challenge the bereaved's resistance to grieve, to force the expression of suppressed affect.

Grief theory has remained relatively stable since Freud's seminal works, but a recent shift in theory and practice has been moving away from prominent psychodynamic interpretations. Since Kubler-Ross' publication of *Death and Dying* (1969), a great deal of research has been conducted in the areas of bereavement and thanatology (Neimeyer, 2001). Kubler-Ross' observations were of the actual death process, not specifically to bereavement, and were not empirical in nature and were based on the stages of dying, not bereavement. Several approaches attempted to explain stages of bereavement as biological processes (Bowlby, 1961; Parkes, 1981; Pollack, 1961; Volkan, 1981). Lindemann (1944) stated that grief is a psychiatric illness marked by somatic distress, preoccupation of the deceased, guilt, hostility, and lost habits. Bowlby (1980) shared that grief involves numbing, protest, despair, and detachment, but never delineated the difference between separation and death.

Hagman (2001) summarized other traditional views of grief theory and practice. He stated that many bereavement counselors perceive mourning as a psychological process with identifiable stages and that the function of grief is to conserve one's resources and restore psychic strength. Often, traditional bereavement therapists assess for standard stages that are not unique or individualized, and must be prodded through to completion. Mourning has been associated with painful and sad affect states, while other emotions are seen as resistances leading to pathogenic bereavement responses. In the foreground for most therapists, grief therapy was to access and process primarily emotional processes, while ignoring cognitive and social processes. Most treatments focus on the central task of detachment from the deceased leading to a full resolution and a desired end point.

Current research refutes the existence of pathogenic typologies of bereavement and that the pursuit of grief reactions may have a detrimental affect on the client and adjustment to the loss. Volkan (1981) stated that forcing the expression of suppressed affect and demanding the relinquishment of attachment has damaging effects on the client's identity. Campbell (2002) shared that for normal losses (excluding unnatural and traumatic loss) "forcing well-adjusted individuals to dwell on the loss of a loved one may actually retard the grieving process" (p. 28).

Alternatively, Hagman (2001) shared tenants of post-modern grief theorists that have abandoned the stages/phases of bereavement, based on empirical invalidation. Rather than primarily focusing on affect, cognitive and interpersonal processes are regarded as vital to the restorying processes and developing a sense of meaning and integration of the loss. Modern therapists are beginning to advocate a continued relationship with the deceased, rather than leaving the relationship behind. Resolution of grief is no longer considered the end-point of successful grief therapy, where constructing and preserving meaning from an ongoing and evolving attachment is vastly becoming a more prominent practice. Furthermore, therapists have begun to abandon various stage models that require resolution or models of pathogenic forms of grief, and have revised the view of bereavement counseling to be a complex and an open-ended process. Modern practice now promotes an individualized approach that encompasses cognitive and social processes, ongoing attachments with the deceased, and an open-ended process of grief.

Neimeyer (2001) stated that over the past fifty years, the bereavement theory has shifted from a psychodynamic view of an adapting broken heart to a medically based

model of symptom reduction and universal stages for grief resolution. Although theoretical presuppositions have made the above transition, empirical research has neither provided evidence to support the sequence of universal grief stages/phases, an endpoint to grieving, nor evidence to justify normal versus pathological grief responses (Brice, 1991; Neimeyer, 1998). Another problem with traditional models of grief theory and therapy is the deficit-based approach towards assisting the bereaved through a passive process of adaptation to symptomatic fluctuations outside one's realm of control. With the heightened focus on negative, problem emotions and minimizing cognitive integration of the loss, traditional grief counseling can provoke multiple negative consequences and aspire towards unobtainable expectations. New avenues address individualized experiences of bereavement and assist the mourning process and self-empowering reconstruction of meaning and renegotiating a forever altered bond with the deceased.

Clinical Assessment of Bereavement Response Typologies

Recent research has investigated many traditional grief therapy hypotheses including assumptions of pathological typologies of grief, that not expressing grief contributes to profound difficulties with achieving pre-loss functioning, as well as many other traditional assumptions of the field. Bonanno and Keltner (1997), Bonanno and Kaltman (2001), Kaltman and Bonanno (1999) demonstrated that evidence has refuted the work of Parkes (1965) on chronic inhibited and delayed patterns, Bowlby (1980) on chronic mourning and prolonged absence of grieving patterns, and Rando (1992) on subjective complications of expressive problems, skewed aspects, or problems ending. In fact, Wortman and Silver (1987, 1989) found that direct grief work actually posed a

detriment to grief resolution. Campbell (2002) cited an estimated 50 percent of the bereaved do not demonstrate signs of grief reactions and recover quickly from a loss, while traditional psychiatrists often would assign a pathological diagnosis to these individuals.

Bananno and Keltner (1997) examined facial expressions of emotions during videotaped discussions of 38 randomly selected urban bereaved subjects at six months, fourteen months, and twenty-five months post loss. The frequency, intensity, and duration of negative emotions of anger, contempt, disgust, fear, and sadness were significant ($p < .001$). Anger at six months was predictive of lowered perceived health at fourteen months ($p < .05$) and at twenty-five months ($p < .05$). Positive emotions of smiles and enjoyment, and amusement were correlated with increased health measures at the significance level ($p < .001$). They confronted that traditional models of "working through" grief must be rejected and there needs to be an empirically based model of bereavement and grief therapy.

Despite grief theorists' insistence upon complicated grieving patterns, empirical evidence shows support only for non-pathological grief patterns (Bonanno & Kaltman, 2001). This pattern includes moderate disruptions in interpersonal, cognitive, emotional, and physical functioning occurring within the first few months following the death. Most eventually return to baseline functioning levels within one year. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision* (*DSM-IV-TR*) classifies several specific reactions comprising the V-code of bereavement including: cognitive disorganization (confusion, preoccupation, and disrupted identity); dysphoria (emotional lability, anger, instability, pining, yearning, and loneliness); health deficits

(behavioral and physical complications, decreased psychological and immune system functioning, and increased mortality rates); and social-occupational withdrawal and isolation (noticed negative effects on others, role disruptions, and difficulties with new relationships).

Bonanno and Kaltman (2001) described the varieties of grief expressions in an attempt to differentiate complicated, delayed, and other forms of chronic or pathological forms. In their review, between 50% to 80% of the bereaved experienced common grief patterns with minor disruptions in cognitions, emotions, physical, and social functioning, and most return to baseline functioning. Chronic grief reactions were present in 15% of the bereaved, which were better accounted for by major depression, generalized anxiety, and PTSD diagnoses. In their review of longitudinal studies, grief was found to produce psychological disruptions in depressive, anxious, hostile, or psycho-physical symptoms, as well as physical disruptions in the form of sick days, hospital admissions, disruption of sleep and appetite, and alcohol and other drug misuse. Peaks in symptomology were found to be experienced within one and two years post bereavement. A minority of the bereaved experienced positive aspects including positive cognitions (thoughts, beliefs, and appraisals) as well as positive affect and laughter. They reported that depressive symptoms, sleep disturbances, and substance misuse are often found within the first few months of grieving a loss. In the first year following the loss, there is a peak in emotional and behavioral disruptions; 8 years later approximately 65% return to baseline functioning, and 10 years later most symptoms have completely subsided.

Zisook, Paulus, Shuchter, and Judd (1999) conducted a study of the incidence of depression among spousal bereavement subjects. The researchers examined 328 widows

and widowers that were administered diagnostic instruments for depression at two months, thirteen months, and at twenty-five months post loss periods. The chronic bereavement typology was found better accounted for with diagnoses of anxiety, depression, or post-traumatic stress disorders. Previous major depressive disorder predicted higher rates of depression following bereavement. Among the severe or complicated grief cases, major depression accounts for 12% within the first thirteen months and 6% of all cases twenty-five months following the death. Minor depression accounts for 17% and 13% respectively, subsyndromal depression is 10% and 11% and non-depressed cases account for 62% and 70%.

Zisook, Chenstova-Dutton, and Shuchter (1998) conducted a study of 350 bereaved widows and widowers for PTSD symptoms at the two month period following the death of a spouse. The researchers demonstrated that PTSD is evident in 10% following a death as a result of chronic illness, 9% of unexpected deaths, and 36% for unnatural (suicide or accidental) deaths. Chronic symptoms of PTSD were noticed in 40% of the overall sample of spousal bereaved and there was a high rate of PTSD with comorbid depression.

Jacobs, et, al. (1990) stated that within the first year spousal bereavement, 44% experience at least one type of anxiety disorder. The study consisted of a representative sample of metropolitan area in two subgroups one assessed six months post loss ($n = 48$) and another subgroup assessed twelve months post loss ($n = 54$). The researchers reported a significantly higher prevalence of both panic disorder and generalized anxiety disorder ($p < .01$) for the six-month post-loss group. They stated that the prevalence rate of generalized anxiety disorder for the normal population is 9%, but that grieving

individuals experience rates at 25% at 6 months following a death, and 39% upon the first year anniversary. They also found that a past history of an anxiety disorder was an independent risk factor for anxiety diagnoses post bereavement ($p < .05$), and anxiety associated with severe grief symptoms were correlated ($p < .01$).

For the purpose of this investigation, bereavement symptoms were examined according to the V-code of bereavement according to the *DSM-IV-TR*. The review of literature revealed that traditional pathogenic typologies of bereavement were refuted and better accounted for by current categories of anxiety, depression, and post-traumatic stress disorders. Therefore, bereavement was examined as a universal process, neither pathological nor confined to months or years. The next section will discuss post-modern grief theory and introduce interventions assisting along the course of bereavement.

Modern Conceptualizations of Grief Theory and Practice

Grief, as defined by Bonanno and Kaltman (2001), is described as a "total disruption of daily functioning directly attributable to the loss" (p. 706). Death elicits more than the existential loss of the person, but also produces "the loss of an emotionally important image of oneself, one's family, or one's situation; the loss of what might have been; abandonment of plans for a particular future; the dying of dreams" (Bowman, 1999, p. 180). Parkes and Weiss (1983) reported death demands the bereaved to reorganize life goals and responsibilities, and that perceived efficacy enhances coping ability. Folkman (1984) stated that people internally adjust themselves prior to choosing adaptive means of action following the death. These ideals of individual phenomenology and flexibility of bereavement counseling are evidenced by many modern approaches to grief therapy. Malkinson (2001) stated that most interventions for the bereaved are "strongly linked to

theoretical conceptualizations and definitions of what constituted normal, pathological, and chronic grief" (p. 671). The following modern treatment approaches offer several interventions that could be initiated in the treatment of the bereaved. These techniques may be paired with stage appropriate means of intervention: treating the bereaved in a humane and empathic manner, while allowing the bereaved to adapt to the loss at his or her own pace.

In response to managed care and the surge of cognitive-behavioral therapy, cognitive processes are now being addressed in grief therapy. Several cognitive processes have been identified as facilitative to coping with bereavement and grief specific symptom management such as the reconstruction of shattered assumptions of the world (Figley, Bride, & Mazza, 1997). Malkinson (2001) reviewed several outcome studies for the treatment of bereavement, and found several behavioral interventions including behavioral desensitization and social reinforcement along with cognitive interventions of exposure and guided mourning demonstrate beneficial empirical results.

Hagman (2001) proposed several modern analytic approaches to grief therapy and interventions. Rather than universal expectations of relinquishing one's attachment, grief therapists now pursue goals that are unique to each client and focus on a continued (albeit altered) relationship with the deceased. Further, integrative approaches such as interpersonal communication create opportunities to co-construct meanings of events. Interventions based in meaning formulation and integration are designed to discover the impact of a continuous relationship, the internalized object with qualities of self-sustaining, positive, self-repairing, and self-regulating aspects on the self of the client. In

this interpersonal approach the therapist may provide a holding environment for support and empathy rather than focusing on primary symptoms of pain and sadness.

Narrative therapists also have influenced modern conceptualizations of grief therapy (Neimeyer, 2001). Narrative constructionists co-create empowering narratives concerning the impact and meaning of the loss, rather than reinforcing a victim stance where the client's story is one of a passive adaptation to uncontrollable external events. Through use of narration, both symbolic and in context, the client may edit or rewrite the evolving story that integrates the loss and redefines itself around a changed reality and identity. Counselors from this approach validate and assimilate the client's story into an ongoing life narrative. Using communication frames, the counselor draws on available frames of perspective (social, cultural, spiritual and familial) through the use of reframes that focus on both cognitive and emotional realities. Also explored is the "tacit" dimension where the discussion involves integrating the loss through the words one uses and the experiences that cannot be verbalized (p. 265). The narrative therapist also focuses on the client's sense of identity, because it is in a constant fluctuation between previous self-definitions and forever changed self-images as a consequence of bereavement. Therapists also facilitate narrative restoration, revisioning, and repair that accounts for the actual death including both old and new roles of functioning.

Stroebe and Schut (1999, 2001) advanced the Dual Process Model for Grief Therapy. According to their model, the bereaved must negotiate times of confronting grief and at other times avoiding grief. The process of confronting grief involves traditional grief work including crying and yearning, while avoiding grief involves restoring oneself to attend to life changes through avoidance, distraction, and emotional

modulation. Schut, de Keijser, van den Bout, and Stroebe (1996) found that although minor psychological and somatic symptom reduction occurs through direct confrontation of grief, there is limited impact on one's recovery and adjustment.

Another method of treatment proposed by Sewell and Williams (2001) has been applying constructivist PTSD treatment protocols to cases of bereavement. Building on the works of Figley, Bride, and Mazza (1997), Sewell and Williams identified similarities between grief and childhood sexual abuse trauma including: adapting to past events through coping that accepts and integrates experience and reinvestment into the future; social stigmatization that complicates mourning the loss of identity, trust, and security; the closer the relationship the more intense the feeling of loss; and the importance of developing a balanced self-image of the damaged parts and the survivor image. Brown (1998) showed that symptoms of decreased trust, impaired self-love, flashbacks, amnesia, and hyper-arousal surrounding both childhood sexual abuse and bereavement are facilitated through grief work. Sewell and Williams (2001) stated on top of narrative meaning making, interventions address symptom management, life review, trauma reliving, constructive bridging, intentional meta-construction, and constructive bridging revisited. Specific cognitive behavioral interventions for symptom management include instilling hope, relaxation, thought stopping, self-talk modification, and breathing retraining. Grounding techniques include a focus on bodily sensations, listening to the therapist's voice, and touching techniques that alleviate dissociative symptomology. Other symptom management techniques include interpersonal skills training, addressing substance abuse, and pharmocotherapy through antidepressants and sleeping agents.

Sewell and Williams (2001) stated the life review, focusing on traumatic experiences, can facilitate personal accountability and increase one's motivation to overcome tribulations. The counselor discusses childhood, adolescence, and other significant experiences prior to the trauma/loss. The counselor structures an autobiographical discussion of "who they were" prior to the trauma in actions, experiences, stressors, motives, values, and circumstances. Another intervention is trauma reliving, which involves giving a voice to the trauma experience rather than relaying the facts of what occurred. The client is guided through the reliving with focus on sensory input, and reframes to elicit a more fluid perspective of experience. Constructive bridging allows the client to sketch new understandings of the reflective (past) and experiential (present) perspectives of the lost relationship. Intentional metaconstruction involves devising, journaling, and experimentally enacting new and various futures as a means of integrating an altered sense of self. Again, constructive bridging is used to accommodate for the trauma experience as a life-changing situation not an ongoing determinant of life.

Fleming and Robinson (1991) introduced the "Grief Process Model" that incorporates cognitive, affective, and narrative meaning making principles in the treatment of the bereaved and childhood sexual abuse populations. Although bereavement is not included as a partial definition of a traumatic event, clinical reality reflects that a connection may exist. Later, Fleming and Belanger (2001) stated grieving styles and childhood sexual assault survival are remarkably similar in their recovery process. These authors stated that victims work through intense pain, reassess the relationship with the individual in question and impact of the event, and eventually

attempt to take control of the past. Through acceptance of reality and accepting and releasing emotions associated with the events, the client may be more apt to adjust to life as an empowered survivor. According to this therapeutic approach, bereaved individuals must befriend the pain through knowing and living the grief, to access the transformative powers of mourning. By transformation, the bereaved modify assumptions of self and the world to fit into the perspective of having loved the deceased and yet maintain purposefulness concerning future attachments (connected yet separate affective attachment with the deceased). The Grief Process Model accounts for task-oriented coping styles of problem focused symptom reduction, as well as affect-oriented coping styles of interpersonal reassurance and catharsis. According to Fleming and Robinson (1991), the bereaved engage in a fluid process of the loss experience and narrating the pain in handicapping, consumptive, or transcending means.

Potocky (1993) conducted a content analysis of empirically validated therapies for bereaved spouses. Effective programs were defined as those therapies showing decreased symptomology across the following outcome measures: depressive symptoms, anxiety symptoms, insomnia, alcohol and drug abuse, social withdrawal, work disruption, disabling illnesses, and suicidal death preoccupations. Although the sample had limited applicability (middle-aged, Caucasian, Catholic or Protestant, bereaved women mourning their spouses' loss due to progressive illness), the study had high internal consistency, randomly assigned groups, low attrition, and equivalent pretreatment and control groups. Interventions were effective for high-risk and high-distress clients, but not for asymptomatic bereaved clients, or traumatic loss groups. Effective groups were short term (weekly meetings less than 7 weeks), had in-home meetings, and well-defined

behavioral goals (prevention or reduction of depression, anxiety, and physical symptoms; restoring social functioning; and focus on problem solving). There were no significant differences impacting therapeutic change by modality (individual, group, or family sessions) or theoretical orientation. Another finding was that "clients with sudden loss appear to be a special high-risk group that may require a uniquely tailored program" (p. 290).

Empirically Validated Models of Grief Therapy

Worden (2002) is a leader in the bereavement research domain and has presided over the Harvard Bereavement Studies. His research into the processes, stages, and tasks of mourning has led to a series of publications reporting the existence of four tasks of grieving which is a significant contribution to the way some grief therapists currently operate. Worden's task model of mourning includes influences from Freud's early works concerning the adaptation to bereavement. Initially, Worden included language similarities ("working through the pain of grief" and "withdrawal of emotional energy to the deceased"), but Worden later developed a cognitive and behavioral model of adaptation that has become the most validated model for grief counseling over the past 20 years (p. 27). During his initial investigations into bereavement, Worden (1976) attempted to examine children's reconstruction of a dead parent. The children's responses demonstrated that bereavement is not an immediate process of adjustment, and that there are discernable tasks involved in the process (Silverman, Nickman, & Worden, 1992).

The first task of mourning is the acceptance of the reality of the loss, including the realization that death is a reality and there is no chance for reuniting in this lifetime

(Worden, 2002). Once acceptance is accomplished, searching for the deceased dissipates. The second task is experiencing the pain of grief, including owning the emotional pain (without avoidance or suppression) while also meeting societal demands with resolve. The third task of mourning is the adjustment to the environment void of the loved one. This involves integrating the loss, while constructing meaning from the experience of the loss and readjusting functional roles that accommodate for the loved one. Finally, the fourth task has evolved linguistically from a withdrawal of emotional energy to one that reads, an "emotional relocation of from the deceased and moving on with life" (Worden, 2002, p. 25). This involves loosening the clinging to old functional roles that characterized the relationship (without dishonoring the memory of the loved one) and turning to new means of emotional and psychological energy. Supporting Worden's claims, Bowman (1999) stated that accepting the reality of the loss through naming and addressing the loss dissipates any disenfranchised grief. He also stated that reinvesting in other relationships is associated with honored stories of hope and joy, allowing for the pursuit of these ideals in future relationships.

Grief is never completed per se, but the process of mourning eventually reduces in intensity. As Worden (2002) stated, grief takes much longer than the standard 3-6 month timeframe adopted by the *DSM-IV-TR*. Time proves that grieving never is completed, but when a person accesses meaning of the loss or finds some rationale for why the death occurred, their coping is enhanced (Sheldon, 1998). Likewise, TMC researcher Turnbull (2000) stated that change is not a desired state of achievement, rather, change is an evolutionary process that fluctuates and accommodates to the requirements of the environments.

Worden (2002) stated the following goals for uncomplicated grief counseling:

1. To increase the reality of the loss
2. To help the counselee deal with both expressed and latent affect
3. To help the counselee overcome various impediments to readjustment after the loss
4. To help the counselee find a way to remember the deceased while feeling comfortable reinvesting in life (p. 52).

Worden stated that effective grief counseling attended to several areas. First, therapy must assist the client through actualization of the loss by reviewing the circumstances of the death (how it happened where it occurred, what the funeral was like, etc.), and gravesite visits. Second, therapists must assist clients with identifying, expressing, and processing emotions involved in bereavement (anger, guilt, anxiety, helplessness, and loneliness). Third, therapy attends to solving immediate challenges of living without the deceased through decision making approaches. Fourth, counseling facilitates the process of finding "meaning in the death of a loved one" (p. 63). Fifth, counselors can be instrumental in the negotiation of maintaining a place for the deceased while reinvesting in relationships that fill the void. Sixth, counseling must allow for emotional processing and expression in times that remind the bereaved of the loss (three months following the death, the first anniversary, and holidays). Seventh, normalizing common grief behaviors assists clients in accepting their own process and eighth, allows for idiosyncratic reactions. Ninth, after forging a trusting therapeutic bond clinicians can help clients examine defensiveness and coping styles. Tenth, and finally, clinicians must also

acknowledge and refer clients that exhibit pathological reactivity such as complicated mourning, PTSD, and major depression.

Worden (2002) suggested several techniques that assist in the process of grief therapy. Counselors are advised to use realistic and evocative language such as "your mother died" or references of the deceased in the past tense. Using symbols like photographs or possessions of significance anchors the discussion and the bereavement. Grief letters allows clients to express directly their yearning or searching behaviors and desires to complete unsatisfied communications. Art therapy often allows for expressions of affect, free from defensiveness. Another affective technique is use of role playing to facilitate or model skills of coping with awkward circumstances. Cognitive restructuring assists clients to identify and assess their own thoughts in relation to reality. Another technique is the use of memory books which families construct from stories, photographs, and other meaningful items that gives focus for grieving expression. Directed imagery has the client imagine the deceased, while communicating verbally what was left unsaid. Finally, Worden states that metaphors, such as linking the loss with that of an amputated limb and ongoing "phantom pains" that suddenly reoccur, assist in developing a language that is bearable to the client.

Worden (2002) stated that a benchmark indicator that grief has been integrated is whether the grieving process ceases to produce physiological and psychological symptoms as evidenced by "fewer body aches and abatement of the symptom(s) which originally brought them in for treatment" (p. 16). More specifically, the bereaved individual no longer experiences the twinges of sadness and suffering. Accordingly, the individual is free from the regrets of the past and is willing to reinvest in life. Another

indication of the integration of grief is when the above mentioned tasks of grieving have been accomplished. Finally, another indicator that grief has been integrated is when individuals respond favorably to other's condolences of their loss.

An example of multiple therapies applied to the tasks of mourning model (Worden, 2002) is Schut, de Keijser, van den Bout, and Stroebe's (1996) study of the efficacy of integrated behavior and art therapy. Art therapy has been validated in previous research as a beneficial method for grief therapy in that it offers cathartic release, a focal piece for different dimensions of the loss, a medium for identifying unexpressed emotions, and a source of diagnostic criterion (Irwin, 1991; Mango, 1992; Schimmel & Kornreich, 1993). Initial behavioral interventions included constructing an individualized hierarchy of problematic grief-related emotions for systematic desensitization (assessed and prioritized). Art therapy in the form of Kinetic Family Drawing, House-Tree-Person, or drawing feelings about loss, elicited exploration of distress to be processed and accepted by concentrating on emotions while playing music and painting the emotions (guided fantasy); attending to Worden's Task One. The researchers also had subjects identify cognitive barriers and subconscious resistances of experiencing strong grief reactions through behavioral desensitization, cognitive restructuring, and contrasting visualization of "disasters and jewels;" by means of paint, clay, cloth, etc.; attending to Worden's Task Two. The researchers then examined behavioral approaches for Worden's Task Three by social skills training, assisting clients in sharing personal experiences of non-supportive interactions for the group to rework. Other interventions included cognitive modifications that change the "often-present passive victim perspective in the bereaved" (p. 359). Interventions designed to attend to

reinvesting in other life endeavors were comparisons of mourning and saying goodbye with symbolic rituals, relaxation training, mentoring, and gymnastics.

The study examined the progression through Worden's tasks of grieving with inpatient, non-psychiatric ($n = 52$) clients participating in group therapy for a period of three months in a Dutch health care center. The 52 subjects within the treatment group were psychologically screened and participated in 12 two-hour behavior therapy sessions and 8 two-hour art therapy sessions over a three month time frame (Schut, et al., 1996). The control group consisted of 17 bereaved individuals that received and attended individual and group therapy grief counseling sessions focused on relaxation, social skills training, and grief topical discussions, without integrated behavior and art therapies. Treatment and control groups were then organized into three to five member closed ended groups. Both treatment and control groups were administered a symptom inventory, General Health Questionnaire (Goldberg & Hillier, 1979), measuring psychological problems following bereavement by using scales for depression, somatic complaints, anxiety/sleep disorders, and problems of daily functioning. Both groups tested at baseline, upon discharge, and four months after discharge. Findings included "diminishing distress over the course of the study in both groups ($p < .001$). However . . . a significantly different course of symptomology over time, ($p < .05$) . . . . the patients in the new treatment condition reported more stable improvement than the regular patients (control group)" (p. 361). Treatment conditions that included discussion and expressive techniques, provided structured session agendas, arranged for homogeneous group members, and integrated treatment modalities offered benefits to individual participants.

Critique

Of the relevant literature concerning the TMC, most studies have been concerned with addictive and compulsive behaviors, while largely ignoring applications to more universal processes of human experience. Its development and application have enhanced many fields of practice, but have been limited to only pathological concerns. Bereavement therapy has practiced under principles that have largely been disproved by empirical studies, while interventions continue to provoke intense emotional complications. The high-risk nature of the bereaved population begs the consideration of applying new theoretical principles in the pursuit of empirically validated strategies of intervention to assist in the tasks of mourning.

Summary

Many counselors use the TMC during day to day clinical practice, but the model has yet to be studied under a non-pathological, universal human change process. Also, the grief counseling field has operated from theoretical presumptions that are largely being disproved in the literature. Techniques based on these understandings have shown to have some success, but there have been failures, in the form of re-traumatization and premature termination. This study examines the applicability of the TMC to the tasks of mourning in an attempt to further enhance the humane treatment of the bereaved.

CHAPTER THREE

Methodology

Rationale and Purpose of this Study

The goal of this investigation was to explore the applicability of the stages of change to the universal human process of grief, and to further the utility of staging interventions for non-pathological treatment scenarios. Another goal of this research was to advance the further treatment approaches of grief therapy in such a way as to move from universally accepted techniques of catharsis and completion to individualized symptom management and motivationally oriented interventions that match each task of mourning. To this end, this study categorized participants based on both their current stage of change and their task of mourning, examining correlations between tasks and stages.

Working from the assumption that the tasks of mourning progress sequentially and one task must be completed prior to moving onto the next task, it was first hypothesized that a correlation exists between each stage of change and the tasks of mourning. The null hypothesis of this study stated there was no correlation between the four stages of change and the four tasks of mourning. Second, working from the assumption that the tasks of mourning represent individually independent tasks it was hypothesized that there would be an association between the stages of change and the tasks of mourning. The Precontemplation stage of change was expected to relate with Task One of mourning, Contemplation and Preparation stages were thought to relate with Task Two of mourning, the Action stage was expected to relate with Task Three, and

Maintenance with Task Four. The null hypothesis stated there would be no interaction between independent variables of the stages of change across the tasks of mourning.

Research Design

The study was a quantitative analysis of the relationship between subjects according to the stages of change and the tasks of mourning. Assuming that the tasks of mourning were sequential in nature, this study first examined the correlation between each stage of change across the tasks of mourning, using the Pearson correlation coefficient statistical method. Following this procedure, the second analysis examined the overall variation between each stage of change and each task of mourning, by means of a one-way analysis of variance ANOVA. Subsequently, a post hoc comparison, using Newman-Keuls method, was conducted to calculate significance of relationships between each stage of change variable and each task of mourning variable.

Description of Methodology

The current study examined 32 bereaved individuals from a rural grief therapy center. Participants were engaging in group therapy with grief presenting concerns. The 32 volunteers completed three self-report measures concerning a grief symptom instrument (TRIG), a stages of change scale (URICA), and a mourning task identification form (TM: SRI). First, an analysis of the correlation between each stage of change and the sequential tasks of mourning was conducted using the Pearson correlation coefficient. Second, the questionnaires were examined based in the stages of change and tasks of mourning self-report categories in a 4 X 4 quantitative design, using the one-way analysis of variance ANOVA procedure. Following this examination, a post hoc comparison

using the Newman-Keuls method was used to examine independent variation between stages of change and tasks of mourning variables.

Subjects

Participants in this study were obtained from the local grief therapy center in a Midwestern city in Wisconsin. Participants were chosen on a voluntary basis, informed about confidentiality and signed an informed consent agreement before completing the self-report instrumentation (Appendix D). Inclusion in this study was based on the experience of a significant loss (parental, spousal, sibling, or child). Differences were noticed among participants based on the temporal proximity of the loss and also according to grief specific reactions.

Instrumentation

Texas Revised Inventory of Grief

Neimeyer (2000) conducted a meta-analysis of grief research between 1975 and 1998, where 23 studies were scientific outcome studies. Of the results, Neimeyer found instances of treatment deterioration in 38% of group therapy cases, treated individuals fared only 55% better than non-treatment groups, many seeking treatment vary in timing for seeking services, and grief therapy is most efficacious for protracted, traumatic, and complicated grief reactions. Within these findings, research in grief therapy has been medically based, noticing physical symptomology rather than grief specific reactions. Through the history of grief theory and practice, much of the literature has concerned itself with medical models of general functioning, rather than grief specific symptomology (Brice, 1991). Malkinson (2001) stated that the majority of empirical investigations for beneficial grief therapies often include generic non-bereavement

specific symptom scales, which miss the core of cognitive restructuring involved in the adaptation to loss. Bonanno and Kaltman (2001) have used the Texas Revised Inventory of Grief in the study of normal versus abnormal reactions to grief and found that the instrument demonstrates the ability to grasp grief specific symptoms.

The Texas Revised Inventory of Grief (TRIG) was used to identify various demographics of the participants, the proximity of the loss, as well as grief specific symptomology (see Faschingbauer, Zisook, & DeVaul, 1987). The TRIG consists of 35 questions concerning demographics of the bereaved and the deceased, and sub-scales examining past life disruptions, present emotions of grief, and related facts of the bereaved in a 5-point Likert Scale format ranging from completely false (5) to completely true (1). Specific items of the TRIG include interpersonal functioning, occupational functioning, emotional functioning, and physiological functioning. The reliability of this measure was .81. Internal consistency of the measure was examined for the sub-scale past life disruption found a Cronbach alpha of 0.77, and a split half reliability of 0.74. The present emotion sub-scale had a Cronbach alpha of 0.86 and a split half reliability of 0.88.

Tasks of Mourning: Self-Report Instrument

The Tasks of Mourning: Self-Report Instrument (TM: SRI) was adapted by the researcher from information provided in Worden's book *Grief Therapy and Grief Counseling: Interventions for the Mental Health Practitioner* (1991). The four item instrument asked participants to select one of the following grief tasks that they subjectively perceived themselves experiencing: accepting the reality of the loss, experiencing the pain of grief, adjusting to life without the loved one, and withdrawing

emotional energy and reinvesting in other relationships (Appendix A). The validation and reliability alphas have not been studied as this was a new application of Worden's work in the grief therapy field.

University of Rhode Island Change Assessment

Blume and Marlatt (2000) used short form University of Rhode Island Change Assessment (URICA) instrumentation with co-morbid psychiatric populations and found that exploring the costs and benefits of behaviors was facilitative in resolving ambivalence and encouraging more action towards change. These researchers found that recent losses are associated with increasing levels of readiness including a movement from Precontemplation to Contemplation.

The URICA was adapted for this research by changing the words "problem behavior" to "grieving" (Appendix B). The URICA is originally a 32 question instrument using a 5 point Likert Scale ranging from strongly disagree (1) to strongly agree (5). The first sub-scale representing the Precontemplation stage included questions 1, 5, 11, 13, 23, 26, 29, and 31. The second sub-scale representing the Contemplation stage included questions 2, 4, 8, 12, 15, 19, 21, and 24. The third sub-scale representing the Action stage included questions 3, 7, 10, 14, 17, 20, 25, and 30. The fourth sub-scale representing the Maintenance stage included questions 6, 9, 16, 18, 22, 27, and 28. Specific questions were designed to classify one's readiness to change across the four major stages including Precontemplation, Contemplation, Action, and Maintenance. For the purpose of this study, one question was excluded from this study, as it did not apply to the process of mourning. The excluded question stated "After all I had done to try to change my problem, every now and again it comes back to haunt me" (McConnaughty,

Prochaska, & Velicer, 1983). Prochaska and colleagues are currently in the process of establishing reliability and validity alphas for the instrument.

Procedures

The director of a local grief therapy center informed prospective volunteers involved in grief group therapy meetings and individual grief therapy sessions of the research study and the various self-report instruments. Participants were then provided a letter from the researcher describing the goals of the study and were asked to read and voluntarily sign the consent to participate in research form. Participants that volunteered were then provided research packets, which included the TRIG, the URICA, and the TM: SRI. Participants were instructed that it would take approximately 10 to 30 minutes to complete the survey packets, and that the information will be provided to them following the completion of the data processing procedures.

Data Collection

Instrumentation was distributed to the participants who volunteered to complete the survey packets directly following the completion of the final session of the grief-group therapy session. Participants completed the self-report measures within the approximated 10 to 30 minutes, and sealed the instruments in envelopes provided. The director of the grief group therapy center then collected the envelopes of completed instruments and later returned them to the primary researcher. Instruments were coded by serial numbers and identifying information was known only to the researcher. Later, this information was destroyed.

Data Analysis

Data analysis was conducted using the research assistance center of the local university using SPSS/PC software version 7.5. The data obtained from the TRIG was categorically analyzed based on the demographics of the participants (age, gender, the person who died, closeness of the relationship, the temporal proximity of the death, and whether the loss was expected or not). The information was used as a categorical identifier of participants and for the type of loss.

Data obtained from both the URICA and the TM: SRI was first analyzed nominally, coinciding with the first assumption that the tasks of mourning progress sequentially. The URICA was then analyzed as a categorical determinant for persons in a prospective stage of change. The TM: SRI and the URICA categories were then analyzed according to correlation, using the Pearson correlation coefficient method.

Next, data obtained by the TM: SRI was used as ordinal data, using the assumption that each task of mourning was independent from each other. The stages of change were considered independent variables where each stage was assumed to be independent from each other. Applying both the URICA stages of change and the TM: SRI tasks of mourning, a 4 (stages) X 4 (tasks) comparison was examined using a one-way analysis of variance ANOVA statistical method. A post hoc comparison using the Newman-Keuls method was used to specifically analyze significant relationships between each stage of change across each task of mourning. Accordingly, the method analyzed relationships, using a subset alpha of .050, between the stage of change and each task of mourning according to mean averages where low mean averages

demonstrated a weak relationship and higher mean averages demonstrated a stronger relationship.

Limitations

The findings of this study may be generalized to only Midwestern rural community residents participating in grief therapy group environments, and may not represent similar experiences of non-treatment populations. This study may be limited based on a small sample size comprising of 22 females and 9 males, with one failing to identify gender. This study may be generalized to female, middle aged bereaved, experiencing a loss between one and five years post death, resulting from unexpected and sudden causes. Methodological limitations include that reliability and validity values were not established for the adapted URICA and the developed TM: SRI.

CHAPTER FOUR

Results

Introduction

This study examined 32 subjects in a Midwestern Wisconsin rural community engaging in a grief therapy group. Subjects completed the three self-report measurements including the demographic measure TRIG, the tasks of mourning measure TM: SRI, and the assessment for the stages of change URICA. Analysis first examined the correlation between each stage of change and the sequential tasks of mourning. Second, an analysis of variance between each stage of change and the independent tasks of mourning was conducted.

Descriptive Statistics

From the Texas Revised Inventory of Grief, demographics of the 32 total participants were derived. The average age of respondents was 53.96 (25 responded with 7 missing data), and 57.97 years old for the deceased (31 reported with 1 missing data). Females outnumbered males (n = 22 females and n = 9 males; 1 missing). The majority of the sample experienced the death of a husband (n = 17), some experienced the loss of a father (n = 3), a wife (n = 3), a son (n = 3), a daughter (n = 2), a mother (n = 1), a brother (n = 1), and a grandparent (n = 1) (N = 31, 1 missing data).

The majority of subjects rated the closeness of the relationship as closer than any other relationship (n = 22). Other responses included closer than most relationships (n = 8) and closer than most relationships (n = 1) (N = 31, 1 missing data). Temporal proximity from the death was also reported within the past three months (n = 2), between three and six months ago (n = 4), between six and nine months (n = 4), between nine and

twelve months (n = 4), between one and two years ago (n = 7), seven between two and five years ago (n = 7), between five and ten years ago (n = 2), and between ten and twenty years ago (n = 1). The final descriptor was the expected nature of the loss. Five persons expected the loss, the loss was unexpected for fifteen, one experienced a slow death, and four were sudden deaths. Six persons reported multiple responses where five reported an unexpected and sudden death, while one reported an expected and slow death.

Results

The Tasks of Mourning: Self-Report Instrument asked subjects to describe how they viewed their mourning over the past week. The majority of subjects reported working on Task Three of Mourning, as they adjusted to life without the deceased (n = 14). The remaining tasks from order of most prevalent to least prevalent were as follows: Task Two (n = 8), Task One (n = 5), and Task Four (n = 3). Findings are reported on Table 1.

Table 1

Tasks of Mourning: Self-Report Instrument Responses

Task of Mourning	N	Percent	Valid Percent
1. Accepting reality	5	15.6	16.7
2. Experiencing grief	8	25.0	26.7
3. Adjusting to new life	14	43.8	46.7
4. Reinvest emotions	3	9.4	10.0

Note. Completed TM: SRI surveys had a total of 30 subjects, and two were not completed (accounting for the missing 6.3 percent).

The URICA was divided into four sub-scales determining the four stages of analyzed during this research: Precontemplation, Contemplation, Action, and Maintenance. Results on the URICA instrument demonstrate a general lack of variation and show midrange answers that differed little from one subject to another range between mean scores of 2.13 to 3.69, where "1 = Strongly Disagree. . . 3 = Undecided. . . 5 = Strongly Agree."

Based on the first assumption that the tasks of mourning are sequential, an ordinal data set was analyzed. The results of the Pearson correlation coefficient yielded minimal results and are provided in Table 2. Findings showed a correlation existing between all stages of change responses, but no correlation existed at a significant level between each stage of change and the tasks of mourning. The stages of change were correlated within themselves following the two-tailed test of significance. Specifically, Precontemplation was correlated with Contemplation ($p < .05$), Action ($p < .001$), and Maintenance ($p < .05$). Results also show that correlations between other stages of change were nonexistent ($p < .000$).

To assess the individual relationships between the stages of change model and the tasks of mourning, as separate and independently achieved tasks, a second analysis of the data was conducted. Treating the tasks of mourning as nominal data, the results of a one-way analysis of variance ANOVA yielded limited interactions between the stages of change and the tasks of mourning. However, two significant interactions were noted. The between groups analysis indicated that the Precontemplation and the Action stages of

change were related to the four tasks of mourning ($p < .05$ and $p < .01$ respectively). More specifically, the Precontemplation stage had $df = 3$, $M = 1.560$, $F = 3.934$, $p < .019$ and Action had $df = 3$, $M = 2.184$, $F = 4.854$, $p < .008$. No other interactions were observed at the significant level. Complete ANOVA results can be found in Table 3.

Table 2

Pearson Correlation Coefficient Matrix

Stages of Change	N	Pearson Correlation Coefficient*	Significance (two-tailed)
Precontemplation	30	.223	.236
Contemplation	30	- .056	.769
Action	30	.004	.980
Maintenance	30	.094	.602

* Pearson Correlation Coefficient is compared to ordinal data of the Tasks of Mourning.

A post hoc comparison, using Newman-Keuls method, assessed the interaction between Precontemplation and Action stages across each task of mourning. The analysis used means for groups in homogeneous subsets, using harmonic mean sample size of 5.481, and Type 1 error was not guaranteed. The method analyzed the associations between each stage of change and the tasks of mourning, which determined significance of relationships. Post hoc comparison of relationships between means demonstrated a significant relationship ($p < .05$) between Precontemplation and Task Four (subset alpha = 3.375) as compared to the minimal relationships with Tasks Two and Three (subset alpha = 1.969 and 2.41), and an inconclusive relationship with Task One was observed

(subset alpha = 2.675). The results of the Action stage of change across the tasks of mourning yielded a significant relationship ($p < .01$) with Tasks Two, and Three (subset alpha = 3.680 and 3.882) compared to the mean relationship with Task Four of mourning (subset alpha = 2.417), and an inconclusive relationship between Task One was again observed (subset alpha = 3.100).

Table 3

Analysis of Variance For Tasks of Mourning

Stages of Change	Sum of Squares	df	η2	F
		Between subjects		
Precontemplation*	4.681	3	1.560	3.934
Contemplation	1.748	3	.583	1.176
Action*	6.552	3	2.184	4.854
Maintenance	1.043	3	.348	.799
		Within subjects		
Precontemplation	10.311	26	.397	
Contemplation	12.876	26	.495	
Action	11.699	26	.450	
Maintenance	11.316	26	.435	

*Signifies significance at the $p < .05$ level.

**Signifies significance at the $p < .01$ level.

Evidence

The hypothesis that a correlation exists between the each of the stages of change and the sequential progression along the tasks of mourning was rejected. The null hypothesis was retained. Next, the hypothesis that a relationship existed between each independent stage of change across each independent task of mourning was examined, found partial acceptance. An hypothesized relationship between the Precontemplation stage of change and Tasks One and Four of mourning found partial acceptance, as Precontemplation was found to be significant with Task Four but was inconclusive with Task One. The hypothesized relationships between the Contemplation stage and the Task Two of mourning and between the Maintenance stage and Task Four were not significant and were rejected. The Action stage was associated with Tasks Two and Three, minimally with Tasks Four, and inconclusive with Task One.

Unanticipated Findings

During the study of the interactions between the stages of change and the tasks of mourning, a variety of unanticipated findings resulted. An unanticipated finding of this study was the interaction between each stage of change, whereby the Precontemplation stage determined that one would engage in each of the other three stages of change examined in this study. However, the remaining stages of change were less predictive in that the Contemplation, Action, and Maintenance stages predicted engaging only in the Precontemplation stage, but no other interaction was exhibited.

Treating the tasks of mourning as nominal data produced mixed results, but unexpected interactions were evidenced. It was not initially expected that Task Four would be strongly related to the Precontemplation stage of change. This relationship may

reflect the aptitude for bereaved individuals to not engage in the active and cathartic tasks of mourning. This demonstrated that Precontemplators may engage in reinvesting emotions when not engaging in the preceding tasks of mourning. Also, it was not expected that the Action stage of change would be strongly associated with the middle tasks of mourning, minimally with Task Four, and inconclusively with Task One. This strong relationship may demonstrate a willingness of the bereaved to engage in the middle tasks of mourning, but not towards accepting the reality and withdrawing energy, and therefore begin to initiate and disengage in the active change process.

Summary of Findings

Findings from this research indicate that the research questions of this study can be empirically examinied. From the assumption that the tasks of mourning were progressed sequentially, the null hypothesis that no correlation exists between each stage of change and the tasks of mourning was accepted. However, when assuming each stage and task are independent of each other, the null hypothesis that no association exists between variables must be partially rejected. These results suggest that the Precontemplation stage was strongly associated with Task Four and minimally with Tasks Two and Three, and that the Action stage was associated with Tasks Two and Three and minimally with Task Four.

CHAPTER FIVE

Discussion

Summary

The study examined several aspects of human change. The literature demonstrated the TMC as a clinically useful tool in predicting treatment efforts in therapy for pathological presenting issues and made a case for its study in a natural human change process. The literature also demonstrated a transition from the traditional views of mourning as a potentially pathological presenting issue that must be catharted, to a post-modern view of adaptation and intervention as varied as the population served. It was attempted to further the utility of both the TMC and the tasks of bereavement, through correlational and independent variance analyses. Although the correlational hypotheses were rejected, interactions between the stages of change and the tasks of mourning were discovered, which may extend the TMC to universal change processes, and offer new approaches towards intervention with the bereaved.

Limitations

A limitation of this research project was the relatively small homogenous sample of rural, middle-aged, females, spousal-bereaved, within the past one to five years. Another limitation of this study was its reliance on the adapted URICA and the developed TM: SRI instruments as they lacked reliability and validity substantiation. Accordingly, a methodological limitation was that the URICA offered challenging questions, of which some subjects found to be intrusive and insensitive.

Conclusions

This study examined the correlations between the stages of change across the sequential tasks of mourning and found no relationship to exist. It is not disturbing that this research did not demonstrate correlations between the stages of change and the sequential tasks of mourning, due to the alternative assumption that the tasks, and the stages of change, represent varied and independent processes. This research found several intriguing results when analyzing the relationships between each stage of change and each task of mourning. The high mean average for Task Four and minimal mean average relationships with Tasks Two and Three may indicate that those in the Precontemplation stage are engaging in activities toward attempting to integrate the loss, thereby avoiding the experiencing of grief or reinvesting in a life without the deceased. In other words, Precontemplators may expend energies towards attempting to make sense of the death and integrate the loss, rather than actively grieving and reinvesting in life activities. Concerning the Action stage, the low mean average for Task Four may represent those who are making efforts to express one's grief and modify their environments and have therefore completed most of the work towards integrating the loss.

Clinical Implications

Although many of the findings of this report are applicable to a limited group, a presentation of the risk factors and facilitators of bereavement counseling may prove beneficial. These suggestions mark general principles and also aid the bereavement counselor in prioritizing specific clinical protocols. Factors associated with poor treatment outcomes include ambivalent or dependant relationship with the deceased,

young or old age of the bereaved, young age of the deceased, unexpected losses, blocked practices of rituals, unwanted stigmas surrounding the death (murder, suicide, AIDS, alcohol or drug induced), and perceived inadequacy of social supports (Sheldon, 1998). Alternatively, Sheldon (1998) reported the following facilitators of bereavement: identifying persons at risk, participation in rituals following the death, normalizing of emotions and thoughts, counseling, and utilization of available resources. Bowman (1999) reported several protective themes within narratives of positive outcomes of grief therapy including emotional stability of the bereaved, problem solving abilities, competence, identification with role models, and having aspirations.

Fleming and Belanger (2001) advocated a method of assessment prior to grief therapy initiation including pre-loss conditions, nature of the loss, and post-loss contexts. Pre-loss conditions to be assessed include the bereaved's self-esteem, tendency to suppress or inhibit emotions, dependency, or a "grief prone personality" including excessive reactivity to previous losses, limited ability to express emotions, and heightened anxiety levels. Counselors often initiate a narrative by asking "Describe to me who you were before the loss, and explain to me how you think you coped." Secondly, the nature of the relationship is assessed by the type of attachment between the client and the deceased in terms of conflicted, ambivalent, and/or dependant. Also, the nature of the loss is assessed by examining the context of the loss whether anticipated, natural, suicide, homicide, while exploring core attributions (distorted or not) concerning self-blame and cognitions of preventability. Thirdly, post loss conditions are assessed in terms of perceived availability and quality of social support networks. If social responses

are perceived to be adequate and beneficial for immediate and future distress, clients have less difficulty adapting and integrating the death.

This study examined the relationships between the stages of change and the tasks of mourning, and was not intended to represent interventions of the TMC in the treatment of the bereaved. However, the following is a presentation of the stages of change, which may enhance treatment efficacy across the tasks of mourning addressed within the bereavement counseling process. Petrocelli (2002) found that using the TMC in counseling integrates natural dynamics of behavior change and health psychology. The stages of change can be pace a client's adaptation to experiential reactions, facilitating the development of greater competencies and satisfaction. Based on their observations, the stages of change can be summarized as a progression from symptom or situational problems, maladaptive cognitions, current interpersonal conflicts, family system conflicts, and interpersonal conflicts. Likewise, Worden's tasks of bereavement involve cognitive, affective, and behavioral components in constant fluid change indicated by the above issues. It would reason that the five stages of change and the four tasks of change would coincide with their attention to process. Specifically, both models track the predictable processes of human adaptation which have demonstrated substantial empirical validation.

Norman, Velicer, Fava, and Prochaska (2000) stated the TMC lends itself to develop individualized approaches for change. Individualized interventions result from the client's stage of change, which dictates which process of change being utilized. These processes are then integrated into the style of therapy used by the therapist, as a means of enhancing the client's motivation to make a lasting difference. Generally

speaking, those persons in the early stages of change are to engage in experiential processes, while Preparation, Action, and Maintenance stages require behavioral process interventions (Prochaska, Velicer, DiClemente, & Fava, 1988).

Considering the results of this study, it would follow that bereavement counselors may facilitate treatment protocols by motivationally-based interventions. The bereaved self-identified as Precontemplative engaged in reinvesting emotions in a forever changed reality. These clients may benefit from TMC interventions gauged towards addressing behavioral processes such as self-reevaluation interventions. The bereavement counselor may facilitate this intervention by promoting positive imagery of coping and integrating the loss, while maintaining current role functioning. Also, this study may demonstrate that evocative experiential interventions may increase resistances and therefore delay the process of overcoming initial reactivity and the active engagement in Tasks Two and Three.

The other significant finding suggests that the bereaved individuals who self-identified as engaging in the Action stage reported significant involvement in experiencing grief and adjusting to a new life without the deceased. To capitalize on this, a bereavement counselor may coordinate motivational strategies that address experiential processes such as dramatic relief and environmental reevaluation. For instance, the bereavement therapist may use dramatic relief by assisting the client express the emotions related to the loss and process the overall disruption the death has caused. Environmental reevaluation may be utilized through processing issues related to finding environmental support structures of family, friends, and other community services. These interventions may assist in the transition from shock and disbelief towards emotionally coping with the

reality of the loss and integrating the reinvestment of emotions, marking this as an affect-dominated stage of adaptation. Other bereavement motivated interventions may include learning healthy ways of adapting to the loss, adapting rituals for anniversaries, developing self-rewards that integrate the loss, reinvention of one's environment free from painful reminders of the deceased and displaying special uplifting symbols of the relationship, and finally developing a system of personal supports that allow for free expression of grief and memorializing of the deceased.

Recommendations for Future Research

It is recommended that future research be conducted concerning the application of the TMC to a variety of universal change processes, as a means of increasing applicability of the model. For future research it is recommended to use the five stage algorithm for the stages of change rather than the URICA as the algorithm is easily adaptable to various areas of exploration, whereas the URICA is a measure better designed for problematic and pathological conditions. Accordingly, Norcross and Prochaska (2002) formulated several questions that assess one's stage of change. Precontemplators were asked if they intend on dealing with this issue within the next six months. Contemplators were asked if they are seriously considering change in the next six months. Persons in the Preparation stage were asked if they had acted on changing within the past month. Persons in the Action stage were asked if they committed time and energy towards improvement in the past six months. Persons in the Maintenance stage were asked if they have experienced symptom free behavior and or substituted for it for more than six months. It would prove beneficial to have a model of universal human

change process so that researchers and clinicians have a systematic method of studying and assisting in promoting positive behavior change.

It is also recommended that the tasks of mourning be studied with new language that reflects the current edition of Worden's (2002) work. For example, relocating energy and memorializing the deceased has a considerably different meaning than withdrawing emotions and reinvesting in other relationships. Another reason for this shift is that it demonstrates a larger move away from emotional catharsis that was advanced by Freud and refuted by current research. Furthermore, the language would be less offensive to prospective subjects in the future.

Another area for future research concerns other methods of clinical intervention associated with specific tasks of mourning. As discussed earlier, motivation is involved in human change processes. The use of the TMC as well as MI and other theory-independent models of intervention has promise for the clinical treatment of bereavement. The bereavement literature may benefit from the meta-analysis of beneficial TMC and MI interventions across the tasks of bereavement that promote self-efficacy and coping ability. Interventions that offer freedom from the negative pressure to adapt in a time-limited manner, as proposed in the *DSM-IV-TR*, and promote the individual course of mourning may provide more effective services to those bereaved.

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Appendix A

Tasks of Mourning: Self-Report Instrument

Of the following four tasks of mourning, please choose the number which best describes how you see yourself (over the past week):

1. Accepting the reality of the loss.
   Individuals in this task of grieving learn to realize and accept that the death is real and final. Also, individuals notice that their searching for their loved one is decreasing.

2. Experiencing the pain of grief.
   Individuals in this task of grieving learn to experience the full extent of their grief, and no longer attempt to avoid or suppress their feelings about the loss. People also begin to meet social pressures and expectations with more resolve.

3. Adjust to a new life without the loved one.
   Individuals in this task of mourning learn to incorporate the loss in their daily living, and begin to construct a sense of meaning from the experience of loss. Also, people become more able to compensate for the lost roles that the loved one used to perform.

4. Withdraw emotional energy and reinvest it in another relationship.
   Individuals in this task of mourning begin to loosen their clinging to the relationship with their loved one, and start turning their efforts towards reinvesting in new relationships and interests.

Appendix B

The University of Rhode Island Change Assessment Scale (URICA)

URICA asks the client to rate 31 items on a continuum form Strongly Disagree (1) to Strongly Agree (5). The URICA can be given several times to track a client's change in motivation.

Instructions

Make your choice in terms of how you feel right now, not what you have felt in the past or what you would like to feel. For all the statements that refer to your *"problem,"* answer in terms of problems related to your grieving. There are five possible responses to each item.

For each question, circle the number that best describes your response:

1. Strongly Disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly Agree

1. As far as I'm concerned, I don't have any problems that need changing.
   1 – 2 – 3 – 4 – 5
2. I think I might be ready for some self-improvement.
   1 – 2 – 3 – 4 – 5
3. I am doing something about the problems that have been bothering me.
   1 – 2 – 3 – 4 – 5
4. It might be worthwhile to work on my problem.
   1 – 2 – 3 – 4 – 5
5. I'm not the problem one. It doesn't make much sense for me to consider changing.
   1 – 2 – 3 – 4 – 5
6. It worries me that I might slip back on a problem I have already changed, so I am looking for help.
   1 – 2 – 3 – 4 – 5
7. I am finally doing some work on my problem.
   1 – 2 – 3 – 4 – 5
8. I've been thinking that I might want to change something about myself.
   1 – 2 – 3 – 4 – 5
9. I have been successful in working on my problem, but I'm not sure I can keep up the effort on my own.
   1 – 2 – 3 – 4 – 5
10. At times, my problem is difficult, but I am working on it.
    1 – 2 – 3 – 4 – 5
11. Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.
    1 – 2 – 3 – 4 – 5

12. I'm hoping that I will be able to understand myself better.
    1 – 2 – 3 – 4 – 5
13. I guess I have faults, but there's nothing I really need to change.
    1 – 2 – 3 – 4 – 5
14. I am really working hard to change.
    1 – 2 – 3 – 4 – 5
15. I have a problem, and I really think I should work on it.
    1 – 2 – 3 – 4 – 5
16. I'm not following through with what I had already changed as well as I had hoped, and I want to prevent a relapse of my problem.
    1 – 2 – 3 – 4 – 5
17. Even though I'm not always successful in changing, I am at least working on my problem.
    1 – 2 – 3 – 4 – 5
18. I thought once I had resolved the problem, I would be free of it, but sometimes I still find myself struggling with it.
    1 – 2 – 3 – 4 – 5
19. I wish I had more ideas on how to solve my problem.
    1 – 2 – 3 – 4 – 5
20. I have started working on my problem, but I would like help.
    1 – 2 – 3 – 4 – 5
21. Maybe someone or something will be able to help me.
    1 – 2 – 3 – 4 – 5
22. I may need a boost right now to help me maintain the changes I have already made.
    1 – 2 – 3 – 4 – 5
23. I may be a part of the problem, but I don't really think I am.
    1 – 2 – 3 – 4 – 5
24. I hope that someone will have some food advice for me.
    1 – 2 – 3 – 4 – 5
25. Anyone can talk about changing, I'm actually doing something about it.
    1 – 2 – 3 – 4 – 5
26. All this talk about psychology is boring. Why can't people just forget their problems?
    1 – 2 – 3 – 4 – 5
27. I'm struggling to prevent myself from having a relapse of my problems.
    1 – 2 – 3 – 4 – 5
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.
    1 – 2 – 3 – 4 – 5
29. I have worries, but so does the next guy. Why spend time thinking about them?
    1 – 2 – 3 – 4 – 5
30. I am actively working on my problem.
    1 – 2 – 3 – 4 – 5
31. I would rather cope with my faults than change them.
    1 – 2 – 3 – 4 – 5

Appendix C

Letter to Participants

To Who it May Concern:

My name is James Davis, a student at the University of Wisconsin-Stout, and would like to ask you for your help. I am currently in the process of completing my thesis for the degree of Mental Health Counselor. My research paper is about the grieving process and how people are able to use coping skills to adjust to life without their loved one.

Last year, I experienced the sudden loss of my father. Since then, I have noticed that most grief therapists attempt to treat each grieving person the same. However, most people adjust to life without their loved one in different ways and at variable speeds.

With your voluntary participation, you would be asked to complete three questionnaires assessing your current grief, the task by which you are managing your grief and the stages of change you are involved in. The goal of this research project is to learn more about the ways to successfully mourn the loss of a loved one. Based on the results of this project, I hope to develop a model that will assist the grieving process with a more individualized approach.

Your participation in this project will be kept confidential. Also, upon completion of this project, participants will be informed of the results. Thank you for your precious time.

Sincerely,

James Davis

Appendix D

Consent for Research Participation

This research examines various grief symptoms, the tasks of grieving a significant loss, and the readiness for making coping decisions. The goal of this study is to learn which stages of change correspond with the specific tasks involved in the course of bereavement. The resulting information may provide better treatment strategies for individuals adapting to the loss of a loved one. This is a study which approximately 30 volunteers will complete 3 brief instruments that examine current symptoms of grief, which task of mourning is currently being utilized, and which stage of change individuals are using to cope with the loss.

You are invited to participate in this study by volunteering to be interviewed by the researcher.

There is little risk to you in participating in this study, though there may be some emotional reactions associated with reporting your reactions during this time in your life. Your responses are completely confidential.

Your participation in this project is completely voluntary. If at any time you choose to stop participating in this project, you may do so, without coercion or prejudice. Please feel free to simply inform the researcher. As a willing volunteer, you will not receive any form of compensation, for your participation in this research.

Once the study has been completed, the analyzed findings will be available for your information.

Any questions or concerns that you may have before, during, or after the research project should be addressed to the following individuals:

Researcher – James Davis davisjam@uwstout.edu
Research Advisor – Steve Shumate shumates@uwstout.edu

Questions or complaints about the rights of research subjects can be addressed to Sue Foxwell, Human Protections Administrator, UW-Stout Institutional Review Board for the Protection of Human Subjects in Research, 11 Harvey Hall, Menomonie, WI 54751, phone (715) 232-1126.

I, _____, understand that by signing this form, I am giving my informed consent as a participating volunteer in this study. I am aware of the basic nature of this study and agree that any potential risks are exceedingly small. I understand the potential benefits from the successful completion of this study. I understand that the researcher will protect my confidentiality as a participant by concealing all identifying personal information about me. I realize that I have the right to refuse to participate at any time during this study without coercion or prejudice.

_____(Volunteer) _____(Date)