Group Work with Bereaved Individuals: The Power of Mutual Aid

Article *in* Social work · March 2014

DOI: 10.1093/sw/swt050 · Source: PubMed

CITATIONS
11

READS
1,448

2 authors:

Carolyn Knight
University of Maryland, Baltimore County
37 PUBLICATIONS **468** CITATIONS

SEE PROFILE

Alex Gitterman
University of Connecticut
62 PUBLICATIONS **781** CITATIONS

SEE PROFILE

Social Work Advance Access published December 30, 2013

Group Work with Bereaved Individuals: The Power of Mutual Aid

Carolyn Knight and Alex Gitterman

Group work has been underused as an intervention with grieving clients. This is despite the fact that group membership offers bereaved individuals a number of unique advantages. In this article, the use of group work with bereaved individuals is examined, based on current theory and research. The role and skills of the group worker are identified and illustrated through the use of case examples. Challenges associated with working with groups for bereaved individuals also are discussed.

KEY WORDS: *bereavement; death and dying; grief and loss; group work*

A surprising lack of literature exists on group work practice with bereaved individuals. Furthermore, much of the available literature on death and dying has been generated by the fields of nursing, medicine, and psychology rather than by social work. In this article, we examine groups for adult clients who are dealing with loss and grief from a social work perspective. The distinct advantages of group participation for bereaved individuals are identified, as are the role and skills of the social worker leading the group. Case examples illustrate professional methods and skills.

GRIEVING THE LOSS OF ANOTHER

Death is a natural, indeed inevitable, aspect of life. Yet, in American culture, it remains a taboo subject and is off limits for discussion. Thus, individuals dealing with the death of a loved one struggle in silence or maintain a stoicism that prevents them from acknowledging or dealing with the range of feelings that accompany their loss (Hart, 2012).

Disagreement exists about what constitutes "normal" grieving in terms of timing, reactions, means of coping, and the like (Altmaier, 2011). Scholars do concur that there is a distinction between bereavement and loss. Zhang, El-Jawahri, and Prigerson (2006) defined bereavement as "the experience of losing to death a person to whom one is attached" (p. 1188). The authors differentiate grief as "the emotional distress associated with that loss" (p. 1188). Whereas bereavement is associated only with death, grief can result from other types of losses (Howarth, 2011).

Scholars also agree that grief is a natural process that consists of a range of emotional, physiological, cognitive, and behavioral reactions that are influenced by cultural, familial, and individual factors. The most common reactions include avoidance or denial, sadness, anger, guilt, changes in weight (usually in the form of weight loss), sleep difficulties, a preoccupation with the death specifically and dying generally, and difficulty with concentration (Fitzgerald, 2008).

For most individuals, a period of intense emotion, which can be accompanied by feelings of numbness and a sense of unreality, is followed by gradual acceptance of the loss. Research suggests that 80 to 90 percent of individuals begin to achieve some sense of resolution and move beyond the intense feelings of grief at about six months postloss (Prigerson, 2004). Based upon available evidence, a variety of tasks must be accomplished during the bereavement process in order for this adaptive resolution to occur (Bonanno, 2004; Kubler-Ross, 1997). These approach-oriented coping strategies include (1) accepting the reality of the death; (2) directly experiencing the full range of emotions that accompany the loss; (3) adapting to daily life without the deceased's physical presence; (4) integrating aspects of the deceased into one's identity; (5) maintaining a relationship with the deceased through memories; (6) finding meaning in the deceased's passing; and (7) recommitting to ongoing and new relationships. As one task is completed, the accomplishment of other tasks is facilitated. In contrast, if the bereaved individual is unable to accomplish one task, then achievement

doi: 10.1093/sw/swt050

of other tasks becomes more difficult (Bonanno, 2004; Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010).

In contrast, avoidant coping, which actually is reinforced by cultural responses to death and dying, leads to denial and suppression of feelings and postpones the tasks that lead to acceptance and moving on with life. Adequate social support, whether it is formal or informal, is critical to achieving these tasks and processing grief (Bisschop, Kriegsman, Beedman, & Deeg, 2004). Such support normalizes and validates the feelings of bereaved individuals. Evidence suggests that this sort of support is often not available, particularly in the bereaved individual's informal social network, given the taboos associated with death and dying in American culture (Hart, 2012).

COMPLICATED GRIEF

People who are experiencing complicated grief (CG) "are essentially frozen or stuck in a state of chronic mourning" (Zhang et al., 2006, p. 1191). An assessment of CG is considered appropriate for adults if the loss occurred at least 12 months earlier and the individual experiences, among other symptoms, persistent yearning for and preoccupation with the deceased; marked difficulty accepting the death; feelings of being shocked, stunned, and emotionally numb over the loss; a sense of being alone in the company of others; and a belief that life is meaningless as a result of the deceased's death.

CG includes symptoms that are analogous to posttraumatic stress and leads to the same level of emotional and physiological distress that accompanied the original loss (Barry, Kasl, & Prigerson, 2001). Individuals struggling with CG often defend against the intense affect that results from loss through avoidance and numbing strategies; this, in turn, keeps them "stuck" in their grief. The longer the individual struggles with CG, the more likely he or she is to develop significant mental health problems, most notably, major depression and anxiety (Boelen, van den Bout, & de Keijser, 2003). Physical and medical problems such as cancer, hypertension, and cardiac events also are more common among individuals who experience CG (Prigerson et al., 1997; Shear, Frank, Houck, & Reynolds, 2005). Risk factors for CG include sudden and violent death, death resulting from suicide or homicide, close kinship, lack of social support and social isolation, and preexisting mental health issues for the bereaved individual (Kristensen, Weisaeth, & Heir, 2012).

INTERVENTION WITH BEREAVED AND DYING INDIVIDUALS

Available intervention literature focuses primarily on individual counseling and emphasizes the importance of the therapeutic alliance. The clinician's empathic presence in the absence of clichéd and superficial reassurance normalizes and validates the bereaved individual's feelings and reactions (Altmaier, 2011; Hart, 2012). Most people will move through the bereavement process, regardless of whether or not they receive professional help, if they have proper support (Bonanno, 2004; Bonanno, Westphal, & Mancini, 2011; Neimeyer, 2006). Therefore, Love (2007) suggested that the focus of helping should be "to ensure that individuals receive appropriate support while they experience and express their grief in their own manner" (p. 80).

Individual counseling actually may slow down the natural process of grieving for bereaved clients (Jordan & Neimeyer, 2003; Neimeyer & Currier, 2009; Stroebe, Schut, & Stroebe, 2005). Rather than normalizing the grieving process, individual therapeutic intervention can pathologize and stigmatize it. Evidence suggests that this occurs when practitioners provide overly glib and simplistic reassurance to bereaved individuals, which leaves them feeling more, not less, isolated and alone (Kouriatis & Brown, 2011).

Intervention in the form of individual treatment usually is advocated in cases of CG (Howarth, 2011; Shear et al., 2005; Vlasto, 2010). The social worker maintains a dual focus on assisting the client in managing the trauma symptoms and helping her or him to work through the tasks associated with approach-oriented coping (Lobb et al., 2010; Zhang et al., 2006).

GROUP WORK WITH BEREAVED INDIVIDUALS

Abundant evidence drawn from various disciplines supports the efficacy of the group modality in a broad range of settings and contexts with a wide variety of client populations (Barlow, Burlingame, & Fuhriman, 2000; Burlingame, Fuhriman, & Johnson, 2004; Rubel & Kline, 2008). Membership in a group has been found to be at least as effective as, and in some studies more effective than, engagement in individual counseling (Vlasto, 2010).

Group work has been an underutilized intervention in helping bereaved individuals. This is despite the fact that available research suggests that group participation may be particularly helpful in reducing social isolation and assisting bereaved individuals in moving through the bereavement process more quickly (Forte, Hill, Pazder, & Feudtner, 2004; Piper, Ogrodniczuk, Joyce, & Weidman, 2011; Piper, Ogrodniczuk, Joyce, Weidman, & Rosie, 2007).

Some research has been directed at ascertaining the efficacy of different group formats in helping bereaved individuals. Although still evolving, there is a clear preference for time-limited, closed-membership groups of between six and eight members (Clark, Brethwaite, & Gnesdiloff, 2011; Piper, Ogrodniczuk, Joyce, & Weidman, 2011; Piper, Ogrodniczuk, Joyce, Weidman, & Rosie, 2007; Schneider, 2007). Groups tend to combine education about the grieving process with the opportunity for members to acknowledge and discuss their feelings with one another.

Advantages of Group Membership

In social work, the therapeutic benefit of group membership is conceptualized as stemming from mutual aid (Gitterman, 2004; Schwartz, 1974; Shulman, 2008). The experience of being with others with similar life challenges is empowering and validating, as members discover that they are not alone and that others share their experiences, feelings, and reactions.

This realization has been variously referred to as the "all-in-the-same-boat phenomenon" (Shulman, 2008) and "universality" (Yalom & Leszcz, 2007). In individual counseling, the practitioner can reassure clients that they are not alone and that their thoughts, feelings, and experiences are understandable. However, reassurance is more meaningful when individuals hear from it from similarly challenged group members. Group members walk in the same shoes and, therefore, have a keener understanding of each other's life stressors, challenges, and distress. Their provision of support and demands for work have a unique impact, given the credibility that comes with being in the same boat (Shulman, 2008). Small, time-limited groups are particularly likely to lead to the intimacy and cohesiveness necessary to promote mutual aid.

The benefit of *altruism* refers to the experience of a member giving, not just receiving, assistance to another (Yalom & Leszcz, 2007). In a group, members have the opportunity to give and receive support, understanding, comfort, suggestions, and the like. This ability to give to others is empowering and enhances feelings of self-efficacy, which promote approach-oriented coping in bereaved individuals.

Other relevant advantages of a group include its function as a forum for sharing information, whereby members learn from hearing each others' perspectives. Bereaved individuals can discover new ways of coping and managing their grief as they listen to the experiences of others. Members who are further along in the bereavement process are reminded of the gains they have made as they learn about the difficulties of other members; in turn, members who remain more challenged are encouraged by the progress they observe in others. This process instills hope in all the members (MacNair-Semands, Ogrodniczuk, & Joyce, 2010).

Role and Skills of the Social Worker

The primary role of the social worker leading a group is to encourage and support members' helping relationships with one another. The worker does not need to have all the answers to members' concerns or be the sole, or even the main, source of support. In fact, the worker should avoid attending only to individual member concerns, which can lead to individual counseling in a group context—also known as "casework in the group" (Kurland & Salmon, 2005). The group worker's role is to connect the bereaved individual to the group and the group to the individual, building upon members' commonalities.

When bereaved individuals discover they are not alone in their intense feelings of grief and loss, their sense of isolation is decreased; this frees them up to begin to work through the bereavement process. With the worker's encouragement, bereaved individuals develop connections that afford them the chance to share stories and reactions with others who can uniquely understand their distress, as the following example adapted from Gitterman (2004) reveals.

A social work intern in a large hospital formed a short-term group for people who had experienced the death of someone they loved to cancer. The group members who lost a spouse described feeling alone and incomplete. Those who lost a parent bemoaned the loss of their longest and most precious relationship. Group members described how

friends and relatives urged them to bury their grief and move on with their lives. The group provided a safe place for grieving members to share their pain, their loneliness, and their memories, as well as their struggles to cope and survive. A vignette from the third session is especially poignant (all names have been changed to protect client confidentiality):

Jackie: I hear what my family and friends are saying. But I don't understand how do I simply forget my mother and go on with my life?

Rebecca [social work intern]: Your friends tell you to forget your mother in order for you to move on?

Jackie: That's how they make me feel [begins to cry]. . . . I don't want to forget her. We loved each other.

Rebecca: Do others feel the pressure to forget and get over your grief [looking around the room]?

Eva: No matter how hard I try, I can't forget and I won't. [Others verbalize agreement].

Joan: I feel like I have to forget my mother, place her behind me, or I'm never going to be okay again, but I think about her all the time.

Rebecca: Maybe you can stay connected on some level while still trying to go on with your life.

Gina: Yeah, I never want to lose that connection. I mean, I know my husband is dead, [do I] want to forget him?

Betty: [nodded] If I forgot my husband, it would be like he never existed—like my life never existed. Why do people want us to forget?

George: Maybe they think that by telling us to forget, our pain will go away. They do not realize that they increase our pain.

Rebecca: [noticing that Debbie looked like she wanted to speak and that tears were streaming down her cheeks] Debbie, you are feeling a lot right now.

Debbie: Everyone is talking about forgetting, but I can't forget my husband. Maybe I am crazy, but I feel him with me all of the time. At night I wait for the door to unlock at 6:30. Sometimes I even hear his voice. I must have something wrong with me, right?

Gina: If there is something wrong with you, then there is something wrong with me too. I'm sure I'm going nuts [laughs]. My husband loved his car—he had it washed every week. Well, I was out driving it the other day, and I realized that the car had not been washed in several weeks. I heard his voice asking why I hadn't washed it lately. So, if anyone is crazy it's me. [Group members laugh]

Rebecca: It is very common to feel a sense of presence or to hear the person saying things that they said before. It's how we all handle loss. I know I did when I lost my father.

Gina: [laughing] Whew . . . so you mean I'm not going nuts.

Rebecca: Certainly not, but worrying about going nuts must be scary [looking around the room].

Linda: I don't feel my husband's presence or his voice, but I want to. I want to remember him and feel his presence more than anything, but I can't. I only remember his sickness and his pain. His illness lasted so long that I can't remember him any other way. It's funny because I find myself talking to him, asking him to let me know that he is out of pain now. I also ask him every day questions. I just wish he could answer me.

[Group members are silent.]

Rebecca: [remaining silent to let members process what had just been discussed]

Group members' ability to express the depth of their pain and confusion in this excerpt is especially moving and is typical of a group for bereaved individuals. Their yearning for their loved ones is readily apparent, as is their sense of isolation. The social worker skillfully points out their underlying commonalities, most notably, their anger and frustration over significant others' reactions to their loss, and directly connects members to one another. With the worker's encouragement, members turned to each other for support, discovering that they were not alone, especially in their worries about losing their sanity.

Groups for bereaved individuals should help members develop a way to keep an active connection with their loved one after death. Thus, in another session of the group, the worker asked members to bring in and share photos of their loved ones. In the discussion that ensued, tears were shed, but members were able to reminisce about the good times they shared with the deceased.

This activity led to much-needed socialization between members. Enjoying snacks before or after the formal group session, making a memory book that can include photos and personal reminisces, and listening to or writing songs and poetry reduce the risk of isolation and are typical components of groups for bereaved individuals (Bisschop et al., 2004; Fitzgerald, 2008; Kohut, 2011; Krout, 2005). Bereavement groups often intentionally include such a socialization component. This subtly but powerfully promotes resilience, conveying to members that their lives will and do go on and that they can and will experience happiness again (Kohut, 2011; Magill, 2009).

The next example illustrates the importance of the worker creating an environment in which members can talk honestly about their loss. In a group for bereaved individuals, the worker promotes and engages in honest discussion, avoiding

the empty platitudes and awkwardness that often accompany discussions with significant others (Steiner, 2006). This encourages members to adopt the approach-oriented coping that is associated with adaptive responses to bereavement (Smith, Tarakeshwar, Hansen, Kochman, & Sikkema, 2009).

The group is housed within a hospice program and includes caregivers and loved ones of dying and deceased individuals. This group is an especially difficult one to facilitate, because members are at different places in the grieving process: Some are actively grieving the loss of their loved one, and others are engaged in anticipatory grieving at the prospect of their loved one's impending death. Ideally, the agency would sponsor different groups for members at these different phases of the bereavement process; however, it is a small program with only a small number of patients, so only one group can be mounted at a time. The social worker, therefore, has to work especially hard to find the underlying commonality that binds all members together.

Unlike most groups described in the literature, this group is ongoing; at any one time, six to eight members are in attendance. In this particular session, two members are dealing with the imminent loss of their loved one. The other five members have already lost their loved one. Members range in age from 35 to 78 years; four are women and three are men. Members are dealing with the loss or impending loss of a parent, a spouse, and, in two cases, a sibling.

Meg [worker]: In our last session, we skirted around some issues that I think need to be acknowledged directly. [Silence]

Meg: This is awkward and difficult I know, but I get the feeling that some of you—maybe most or all of you—struggle with guilt over some of the feelings you have about the loss of your loved one. It's not unusual for survivors to feel some sense of relief—for their loved one, for themselves — over their loved one's passing. It's also not unusual for people to feel angry and resentful. . . .

Joe: [interrupts] Thank God, Meg. Thank God you said this. I feel so guilty, like such a horrible person. I have prayed for Mary [sister with advanced liver cancer] to die. I *want* her to die! I can't believe I am saying this, but she's not living, and I'm not living. I am just in a state of limbo—spending all of my free time here just waiting.

Sally: That's how it was for me, too, Joe. Just sitting around waiting for Rob [husband] to die. I just put my life on hold. It was—it is—awful! [starts to cry]

Meg: Sally, I know your tears are of sadness, but I sense it's something more.

Sally: I feel so guilty. I felt such relief when Rob finally passed. I miss him like crazy. I still feel his presence in our home, but I felt relief! I was *glad* when he passed. I couldn't take it much longer—his pain, his suffering, spending all my time here 24/7.

Meg: It is pretty confusing isn't it? To mourn the loss—or impending loss—of your loved one, but to also want them to pass.

Morgan: Honestly, it's not just relief that I feel, it's also anger. This is so hard to say [starts to cry], but I find myself being angry with Mom for putting me through this. Maybe it's God I'm angry at, but I think it's also her. I've been to hell and back dealing with her cancer all these years. I am tired! I need a break! I just want it to end [crying hard].

Meg: It takes courage to admit what you just did, Morgan. You might feel like you are the only one, but I suspect you aren't.

[Several other members nod their heads in agreement.]

Sam: Don't be so hard on yourself, Morgan. I have been angry, too. I have been so wrapped up with Pam's [wife] illness, that I feel like I don't have a life. I hate to say it, but I resent her for it.

Meg: What you all are describing is a vicious cycle. You are angry at your loved one[s], resent them. And this leads to feelings of guilt, and then you feel angry that you feel guilty. Your feelings are totally understandable. Your lives have been turned upside down. What you don't need to feel is guilty. It's *normal* to feel some resentment and anger, and I bet if you really examine your feelings, you'll realize that it's not so much anger at your loved one, it's at the awful situation that you all are in.

Initially, Meg has to reach for members' feelings of resentment and anger. Understandably, they are reluctant to reveal such taboo emotions. However, the members' sense of urgency to discuss these feelings is clear, as is the culture of open discussion that Meg has created in the group. If members are going to successfully work through their grief, they must be able to openly acknowledge the full range of feelings they are experiencing. Feelings of sadness and loss are considered normal, but anger, bitterness, and resentment, although very common grief reactions, are not considered appropriate or acceptable. The group normalizes and validates these feelings, thus reducing the members' feelings of guilt and isolation (Clark et al., 2011).

The final example reveals the importance of the worker attending to composition issues, particularly members' readiness for the help the group has

to offer. Bereavement groups, by definition, comprise individuals with a heightened sense of urgency. Thus, they are generally able to swiftly connect to one another (Schneider, 2007). Yet, an important, but not always easy, task for the professional is to determine in what ways the group should be homogenous and in what ways it should be heterogeneous. Gitterman (2005) provided valuable guidelines:

> Members usually tolerate and use greater diversity when common interests and concerns are experienced intensively. Thus, for example, the author organized a group of women with limited life expectancy due to advanced breast cancer. Their profound commonality made differences in age, class, and ethnicity seem inconsequential. (pp. 81–82)

Thus, the leader must attend to goodness-of-fit issues. For example, one study found that mutual aid was lessened when bereaved individuals did not feel connected to others because their loss differed significantly (that is, suicide versus natural death) (Steiner, 2006). Other studies have demonstrated the need for bereaved individuals to possess at least a rudimentary ability to relate to others to avoid premature dropout (Joyce, Ogrodniczuk, Piper, & Sheptycki, 2010).

In this final example, the group meets for eight weeks and consists of six members; three lost their spouse, two lost a parent, and one lost a sibling. All of the deceased individuals died of natural causes, typically cancer or heart disease, and most members had lost their loved one within the last eight weeks. The excerpt comes from the third session in which members had been discussing their intense pain and sadness as well as the accompanying sense of unreality and numbness.

Frank: I spent so much of this past week just numb and out of it. I keep thinking Marge [deceased wife] would be coming through the door any minute. I can smell her scent everywhere, yet she's not here [starts to cry].

Samantha: I know. I have the same feelings of just going through the motions of living. I am either out of it or crying. It's one or the other.

Ellen: I miss my mom so much. She was my best friend. I don't know what to do with these feelings! They are so overwhelming! I can't believe she is gone, that I will never, *never* see her again [starts to cry].

Adam: My brother [deceased] was my best friend. I get angry that he's gone, then I cry, then I just shut down. It's making me crazy.

Mark [worker]: You alternate between feeling your feelings intensely or feeling nothing at all. It's as if you can only take so much pain before you have to shut down for a while.

Bill: Well, I feel like I am just going about my business. After all, I already lost one wife, so I've been through this before. Losing Anita [second wife] is tough, but I've done it before, you know? So, it's not so bad this time around. It'll get better, folks, you'll see.

Mark: Bill, it sounds like you think you've worked through your feelings? Like having gone through it once before makes it easier this time around?

Bill: Well, yeah, of course. Anita is in a better place. She was suffering, and her death ended that. It's time to move on.

Samantha: [angry] Well, I am glad that it's so easy for you! Screw that "being in a better place" crap. I miss Rob [husband]. I miss him so much. I don't know how I'll go on [crying].

Mark: Samantha, you seem upset with Bill for how he is dealing with his loss. I wonder, Bill, whether you are just coping in the only way you know how, which is just not to think about it—just to numb out.

Bill: [angry] Don't social work me, Mark. I said I am doing fine and I am! I told you all [referring to the agency staff] that I didn't need this group, that it was a waste of my time. And it is.

In this example, the social worker skillfully attempted to connect Bill to the group by observing that Bill, like other members, might be avoiding his feelings. However, Bill was not able to appreciate or acknowledge this. In fact, after this session, he did not return to the group. In retrospect, the social worker questioned whether Bill should have been included in the group in the first place. Although the circumstances of his loss were quite similar to others in the group, his avoidant way of coping was very different, thus setting him up to feel isolated and alone.

In fact, Bill manifested a number of symptoms associated with CG. His way of coping placed him at odds with others in the group, who adopted approach-oriented ways of managing their grief. This suggests that the worker should not only attend to the nature of the bereaved individual's loss, but also to her or his way of coping with it. The evidence is limited, but research does suggest that in cases of CG, group work may be contraindicated, unless the focus of the group is specifically on CG and members' inability to manage their loss (Rosner, Lumbek, & Geissner, 2011). Individuals moving naturally through the bereavement process are likely to benefit from group membership alone.

In contrast, individuals experiencing CG may need the validation and support provided by group membership as well as the attention to their traumatic responses afforded by individual counseling (Vlasto, 2010).

Implications for the Social Worker Leading a Group

Social workers who consider leading a group for bereaved individuals must be prepared for the intense nature of such groups, as the excerpts included in this article reveal. An essential element of successful leadership of grief groups is the clinician's ability to tolerate the range of feelings that members will bring with them and to avoid clichéd responses.

Practitioners who are leading groups for survivors should seek out the guidance and support of colleagues and supervisors. Practitioners will find it easier to tolerate members' pain if they have a place to discuss their own feelings, feelings that will inevitably include loss and grief. Obviously, the social worker will experience sadness and grief in response to witnessing the distress of group members. In addition, however, working with bereaved individuals will bring up losses that the clinician has experienced in her or his life (Hayes, Yeh, & Eisenberg, 2007; Kouriatis & Brown, 2011). Just as with bereaved clients, successful management of the clinician's reactions is made easier to the extent that she or he can make meaning of death and dying, developing a spiritual view of grief and loss (Felberbaum, 2010; Golsworthy & Coyle, 2001).

CONCLUSION

In this article, the advantages of group participation for bereaved individuals have been examined from a social work perspective. The mutual aid orientation that characterizes social work with groups provides a sound theoretical framework for understanding how bereaved individuals can benefit from being with others similarly affected by loss and grief. The intent is not to dismiss the value of individual counseling for the bereaved, though some evidence suggests that an individual approach to treatment may pathologize, rather than normalize, grief reactions (Neimeyer & Currier, 2009). Our intent has been to highlight how the lesser-used group modality can uniquely benefit bereaved individuals.

The social worker has a critical role to play in creating a group culture that promotes open and honest discussion and avoids empty reassurances and superficial platitudes. The practitioner actively seeks out connections among members, using these to promote cohesiveness and intimacy. She or he also must attend to composition issues, making sure that all members are a good fit for the group and that the group is a good fit for them.

As the case examples reveal, facilitating a bereavement group is difficult and emotionally challenging for the worker. Therefore, practitioners need to be proactive in taking care of themselves, which includes giving voice to their feelings of loss and grief. SW

REFERENCES

Altmaier, E. (2011). Best practices in counseling grief and loss: Finding benefit from trauma. *Journal of Mental Health Counseling, 33*, 33–45.

Barlow, S., Burlingame, G., & Fuhriman, A. (2000). Therapeutic application of groups: From Pratt's "thought control classes" to modern group psychotherapy. *Group Dynamics: Theory, Research, and Practice, 4*, 115–134.

Barry, L., Kasl, S., & Prigerson, H. (2001). Psychiatric disorders among bereaved persons: The role of perceived circumstances of death and preparedness for death. *American Journal of Geriatric Psychiatry, 10*, 447–457.

Bisschop, M., Kriegsman, D., Beedman, A., & Deeg, D. (2004). Chronic diseases and depression: The modifying role of psychosocial resources. *Social Science and Medicine, 59*, 721–733.

Boelen, P., van den Bout, J., & de Keijser, J. (2003). Traumatic grief as a distinct disorder from bereavement-related depression and anxiety: A replication study with bereavement mental health care patients. *American Journal of Psychiatry, 160*, 1339–1342.

Bonanno, G. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59*, 20–28.

Bonanno, G., Westphal, M., & Mancini, A. (2011). Resilience to loss and potential trauma. *Annual Review of Clinical Psychology, 7*, 511–535.

Burlingame, G., Fuhriman, A., & Johnson, J. (2004). Process and outcome in group counseling and psychotherapy: A perspective. In J. Delucia-Waack, D. Gerrity, C. Kalodner, & M. Riva (Eds.), *Handbook of group counseling and psychotherapy* (pp. 49–61). Thousand Oaks, CA: Sage Publications.

Clark, P. G., Brethwaite, D. S., & Gnesdiloff, S. (2011). Providing support at time of death from cancer: Results of a 5-year post-bereavement group study. *Journal of Social Work in End-of-Life and Palliative Care, 7*, 195–215.

Felberbaum, S. (2010). Memory, mourning and meaning in a psychotherapist's life. *Clinical Social Work Journal, 38*, 269–274.

Fitzgerald, L. (2008). Healing through loss: The stepping stones. *Home Health Care Management and Practice, 20*, 250–253.

Forte, A., Hill, M., Pazder, R., & Feudtner, C. (2004). Bereavement care interventions: A systematic review. *BMC Palliative Care, 3*, 3–14.

Gitterman, A. (2004). The mutual aid model. In C. Garvin, L. Guttierez, & M. Galinsky (Eds.), *Handbook of social work with groups* (pp. 93–110). New York: Guilford Press.

Gitterman, A. (2005). Group formation: Tasks, methods, and skills. In A. Gitterman & L. Shulman (Eds.), *Mutual aid groups, vulnerable & resilient populations, and the life cycle* (3rd ed., pp. 73–110). Now York: Columbia University Press.
Golsworthy, R., & Coyle, A. (2001). Practitioners' accounts of religious and spiritual dimension in bereavement therapy. *Counselling Psychology Quarterly, 14*, 183–202.
Hart, J. (2012). Moving through loss: Addressing grief in our patients. *Alternative and Complementary Therapies, 18*, 145–147.
Hayes, J. A., Yeh, Y., & Eisenberg, A. (2007). Good grief and not-so-good grief: Countertransference in bereavement therapy. *Journal of Clinical Psychology, 63*, 345–355.
Howarth, R. (2011). Concepts and controversies in grief and loss. *Journal of Mental Health Counseling, 33*, 4–10.
Jordan, J., & Neimeyer, R. (2003). Does grief counseling work? *Death Studies, 27*, 765–786.
Joyce, A., Ogrodniczuk, J., Piper, W., & Sheptycki, A. (2010). Interpersonal predictors of outcome following short-term group therapy for complicated grief: A replication. *Clinical Psychology and Psychotherapy, 17*, 122–135.
Kohut, M. (2011). Making art from memories: Honoring deceased loved ones through a scrapbooking bereavement group. *Art Therapy, 28*, 123–131.
Kouriatis, K., & Brown, D. (2011). Therapists' bereavement and loss experiences: A literature review. *Journal of Loss and Trauma, 16*, 205–228.
Kristensen, P., Weisaeth, L., & Heir, T. (2012). Bereavement and mental health after sudden and violent losses: A review. *Psychiatry, 75*, 76–97.
Krout, R. (2005). Applications of music therapist-composed songs in creating participant connections and facilitating goals and rituals during one-time bereavement support groups and programs. *Music Therapy Perspectives, 23* (2), 118–128.
Kubler-Ross, E. (1997). *On death and dying*. New York: Simon & Schuster.
Kurland, R., & Salmon, R. (2005). Group work versus casework in a group: Principles and implications for teaching and practice. *Social Work with Groups, 29*, 1–15.
Lobb, E., Kristjanson, L., Aoun, S., Monterosso, L., Halkett, G., & Davies, A. (2010). Predictors of complicated grief: A systematic review of empirical studies. *Death Studies, 34*, 673–698.
Love, A. (2007). Progress in understanding grief, complicated grief, and caring for the bereaved. *Contemporary Nurse, 27*, 73–83.
MacNair-Semands, R., Ogrodniczuk, J., & Joyce, A. (2010). Structure and initial validation of a short form of the Therapeutic Factors Inventory. *International Journal of Group Psychotherapy, 60*, 245–281.
Magill, L. (2009). Caregiver empowerment and music therapy: Through the eyes of bereaved caregivers of advanced cancer patients. *Journal of Palliative Care, 25*, 68–75.
Neimeyer, R. (2006). Making meaning in the midst of loss. *Australian Journal of Grief and Bereavement, 9*, 62–65.
Neimeyer, R. A., Burke, L. A., Mackay, M. M., & van Dyke Stringer, J. G. (2010). Grief therapy and the reconstruction of meaning: From principles to practice. *Journal of Contemporary Psychotherapy, 40*, 73–83.
Neimeyer, R. A., & Currier, J. M. (2009). Grief therapy: Evidence of efficacy and emerging directions. *Current Directions in Psychological Science, 18*, 352–356.
Piper, W., Ogrodniczuk, J., Joyce, A., & Weideman, R. (2011). Effectiveness of individual and group therapies. In W. Piper, J. Ogrodniczuk, A. Joyce, & R. Weideman, *Short-term therapies for complicated grief: Two research-based models* (pp. 21–49). Washington, DC: American Psychological Association.
Piper, W., Ogrodniczuk, J., Joyce, A., Weideman, R., & Rosie, J. (2007). Group composition and group therapy for complicated grief. *Journal of Consulting and Clinical Psychology, 75*, 116–125.
Prigerson, H. (2004). Complicated grief: When the path to adjustment leads to a dead-end. *Bereavement Care, 23*, 38–40.
Prigerson, H., Bierhals, A., Kasl, S., Reynolds, C., Shear, M., Day, N, et al. (1997). Traumatic grief as a risk factor for mental and physical morbidity. *American Journal of Psychiatry, 154*, 616–623.
Rosner, R., Lumbek, G., & Geissner, E. (2011). Effectiveness of an inpatient group therapy for comorbid complicated grief disorder. *Psychotherapy Research, 21*, 210–218.
Rubel, D., & Kline, W. (2008). An exploratory study of expert group leadership. *Journal of Specialists in Group Work, 33*, 138–160.
Schneider, R. (2007). Group bereavement support for spouses who are grieving the loss of a partner to cancer. *Social Work with Groups, 29*, 259–278.
Schwartz, W. (1974). The social worker in the group. In R. Klenk & R. Ryan (Eds.), *The practice of social work* (pp. 257–276). Belmont, CA: Wadsworth.
Shear, M., Frank, E., Houck, P., & Reynolds, C. (2005). Treatment of complicated grief: A randomized controlled trial. *JAMA, 293*, 2601–2608.
Shulman, L. (2008). *The skills of helping individuals, families, groups, and communities* (5th ed.). Belmont, CA: Cengage.
Smith, N., Tarakeshwar, N., Hansen, N., Kochman, A., & Sikkema, K. (2009). Coping mediates outcome following a randomized group intervention for HIV-positive bereaved individuals. *Journal of Clinical Psychology, 65*, 319–335.
Steiner, C. (2006). Grief support groups used by few— Are bereavement needs being met? *Journal of Social Work in End-of-Life and Palliative Care, 2*, 29–53.
Stroebe, W., Schut, H., & Stroebe, M. (2005). Grief work, disclosure and counseling: Do they help the bereaved? *Clinical Psychology Review, 25*, 395–414.
Vlasto, C. (2010). Therapists' views of the relative benefits and pitfalls of group work and one-to-one counselling for bereavement. *Counselling and Psychotherapy Research, 10*, 60–66.
Yalom, I., & Leszcz, M. (2007). *The theory and practice of group psychotherapy*. New York: Basic Books.
Zhang, B., El-Jawahri, A., & Prigerson, H. (2006). Update on bereavement research: Evidence-based guidelines for the diagnosis and treatment of complicated grief. *Journal of Palliative Medicine, 9*, 1188–1203.

Carolyn Knight, PhD, *is professor, University of Maryland Baltimore County, School of Social Work;* ***Alex Gitterman, EdD, LMSW,*** *is Zachs professor of social work and director of doctoral program, School of Social Work, University of Connecticut, West Hartford. Address correspondence to Carolyn Knight, School of Social Work, University of Maryland Baltimore County, 1000 Hilltop Circle, Baltimore, MD 21250; e-mail: knight@umbc.edu.*

Original manuscript received November 28, 2012
Final revision received January 23, 2013
Accepted February 12, 2013