The Professional Role Within a Self-Help Model: A "Widow-to-Widow" Project

Rona Small

Program Director, YM-YWHA & NHS

and

Paul Goldhamer, M.D.

Psychiatric Consultant, Widow-to-Widow Program Services, Montreal, Quebec

The widow, according to Maddison, has two tasks: to detach herself from the lost object in order to allow her to engage in other relationships, and to develop a new view of herself as an adult woman without a partner.

Current literature reflects a new trend towards the use of the self-help group as an alternative model of intervention. Services such as Alcoholics Anonymous, the Bereaved Parents Association, Cardiami, and a variety of others attest to the validity and positive potential of peer group interaction as a therapeutic force. The National Self-Help Clearing House of New York even publishes a newsletter, *The Self-Help Reporter.*[1] This paper focuses on the function of professionals vis-a-vis the notion of the self-help group. The authors will attempt to examine some of the parameters of the self-help model with regard to a particular case in point, the Widow-to-Widow Program Services of the Montreal Y.M.-Y.W.H.A. & N.H.S.

The Widow-to-Widow Project was designed to help newly widowed women get ongoing emotional support from peers who have already resolved their grief, as well as to provide practical input re economic, social, education, and career issues. Program services include ongoing self-help groups, monthly social programs, week-end drop-in centres, Jewish holiday and festival observances, seminars and workshops, etc. There are currently 944,000 widowed women in Canada, and a recent study indicates that 32 percent "suffer marked deterioration in health 13 months after bereavement,"[2] which clearly designates them as a high-risk group in need of service. Dr. Phyllis Silverman's work suggests that the best units of support to the vulnerable recent widow are other widows who have themselves struggled with the adjustment process.[3] The Snowdon Y's Widow-to-Widow Program is designed to provide a support system which will be acceptable, as well as effective, in assisting recent widows in mastering the complications of widowhood.

Project Activities

Recent Federal Grant Funding has enabled the staffing and organization of the Widow-to-Widow Services.

The Program Co-ordinator, herself a recent widow, is a full-time staff member, who is responsible for the overall program, under the supervision of the agency's Program Director. Additional consultation is provided via a psychiatrist supplied by the Jewish General Hospital's Psychiatric Institute. The Program Director and Psychiatric Consultant are involved in handling training of outreach volunteer workers, as well as assessment, referral, and screening of those widows

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[1] Naomi Curtis, ed., *The Self-Help Reporter,* (New York: University of New York Graduate School).

[2] D. Maddison and A. Viola, "The Health of Widows in the Year Following Bereavement," *J. Psychosom.* Res. 12: 297, 1968.

[3] Phyllis Silverman, "The Widow-to-Widow Program: an Experiment in Preventive Intervention," *Ment. Hyg.* 53, 3: 333, (1969).

volunteering to do either outreach or self-help group leadership. In addition, the Program Director provides inter-agency contacts and ongoing supervision of the Widow-to-Widow Co-ordinator. The co-ordinator's direct responsibilities include supervision of the other two full-time staff people, widows as well, direct leadership of the Widow-to-Widow Task Force, comprised of "graduates" from the ongoing 8-10 week self-help groups, general recruitment, public relations, and program development, as well as overall administrative responsibility. In addition, the co-ordinator participates in work with Widow-to-Widow volunteer committees, i.e. Sunday Brunch Committee, News Bulletin, Hospitality, etc. The two additional staff people are an Administrative Assistant and an Outreach Worker. The Administrative Assistant handles keeping of statistics, correspondence, records, telephone and other office procedures. She works with volunteer committees in arranging for set-ups on social programs, the weekly Sunday Drop-In Centre, etc. The Outreach Worker is responsible for the development of new self-help groups, work with the outreach core group, and the organization of the Leadership Training Program for those widows interested in co-leading self-help groups with outside professionals. The Outreach Worker also co-leads a current self-help group, and follows any difficulties experienced by outreach workers in between monthly meetings with program consultants. None of the three full-time staff people has specific professional training, with the exception of the program co-ordinator who participated in a two-year Family Life Education Certificate course. The essential element common to all three staff people is the experience of their own widowhood and their ability to cope with myriad problems in a mature, productive, and sharing way.

The foregoing material clearly indicates the effective functioning of an elaborate self-help system. What then, if any, are the roles of the two professsionals involved? A comprehensive study by the Clarke Institute of Toronto indicated that the need for direct psychiatric intervention by their consultants to the Toronto Community Contacts for the widowed was as low as three percent.[4] Our experience in Montreal closely parallels this figure. The psychiatric consultant has treated three women of the over 300 seen in one year. Discussion with the Outreach volunteers as to the necessity of the consultants participating in Outreach Team meetings elicited the comment that, "We like to see you and know you're there in case we need you." The authors interpret this as substantiating the need for professional back-up as both legitimizing and support-giving. Other volunteers have expressed a feeling of increased confidence in reaching out to strangers, knowing that alternate resources are available.

The Notion of the Self-Help Group

This section will attempt to define the self-help model and examine some current literature with regard to guidelines for professionals. Does professional intervention negate or distort the self-help concept? Can a marriage of professional and indigenous intervention maximize the effectiveness of the model?

Caplan (1976) has written about the health-promoting effects of support systems, which he defines as "continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validation of their expectations about others."[5] Sumner and Fritsch, in an article on parental concerns in the first year of life, documented that the "single most important factor in helping a new mother feel confident is a group of peers with whom she can share

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4 J. Rogers, M. Vachon and W. Lyall. "Report on the Initiation and Organization of Community Contacts for the Widowed." (Toronto: 1976), p. 42.

5 G. Caplan, and M. Killilea, Editors, *Support Systems and Mutual Help-Multidisciplinary Explorations,* New York: Grune & Stratton, 1976. pp. 19-20.

concerns and validate mothering skills."[6] These are just two of many examples validating the notion of peer-group self-help. Caplan's article quotes the research of Cassel who demonstrated that "subpopulations influenced by support systems have a lower incidence of mental and physical disease than their neighbours, especially under conditions of acute and chronic stress associated with rapid physical and social change."[7] Support consists of three elements: a) significant others help the individual mobilize his psychological resources, b) they share his tasks, 3) they provide him with extra supplies to improve his ability to master the situation.

Caplan goes on to suggest that professionals should stimulate the development of non-professional support systems, particularly to help individuals cope with acute crises or life transitions. Similarly, Dumont emphasizes that natural care-taking systems exist in a society, and mental health professionals should identify such systems and enhance their effect.[8]

Self-help groups have been interpreted as performing various functions. They have been conceptualized by Marie Killilea variously as a support system, a spiritual movement or secular religion, a consumer response to an inadequate medical care system, an adjunct to the professionals, ·an alternate caregiving system, an intentional community, a transitional community, expressive social influence groups, a therapeutic method, etc.[9]

Phyllis Silverman's pioneering work with récent widows has underscored the importance of self-help groups as more than just an economical alternative to professional intervention. The recent book, *Helping Each Other in Widowhood,* documents the potential of the self-help group as a preventive strategy and highlights areas where the indigenous worker is far more effective than the professional as a result of the bonding potential of a shared experiential link. In discussing the essential componets of a self-help system, she notes that a primary characteristic is that "the care-giver has the same disability as the care-receiver, that the recipient of services can change roles, and that all policy and program are decided by a membership."[10]

Marie Killilea conceptualizes the self-help system as a "transitional community" which is particularly relevant in discussing the tasks of the bereaved and how best to facilitate them.[11]

Gelfand has suggested that in the future social practitioners should identify groups of people making the transition from one status to another and link them to peer helpers who will be sensitive to the difficulties.[12] Silverman was the first to initiate such a service for bereaved spouses with her widow-to-widow program.[13] In such programs, the widow care-giver (referred to as an aide or contact) or outreach worker reaches out to new widows and offers herself as someone to talk to. The widow aides vary in style from those who develop "friendships" with the recipients, sharing feelings equally, to those who primarily exchange information from helper to recipient, provide support to use this information in making a life transition, and listen in a warm empathic manner, based on having undergone a similar experience. The outreach worker usually finds that her offer of help is readily

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6 G. Sumner and J. Fritsch, "Postnatal Parental Concerns: The First Six Weeks of Life." *JOGN Nursing,* May/June 27-31, 1977. p. 184.

7 Caplan, *loc. cit.*

8 M.P. Dumont, "Self-Help Treatment Programs," in *Support Systems and Mutual Help,* op. cit.

9 Caplan and Killilea, *op. cit.* p. 39.

10 P. Silverman, D. MacKenzie, M. Pettipas and E. Wilson, *Helping Each Other in Widowhood.* New York: Health Sciences Publishing Corp., 1974. p. 76.

11 Caplan and Killilea, *loc. cit.*

12 B. Gelfand, "Emerging Trends in Social Treatment, "*Social Casework* 53 (3), 1972. p. 157.

13 Silverman, *op. cit.*

accepted by the new widow who perceives her as someone "who was there" and can understand her experiences. The aide discusses with the widow subjects of practical concern, including economic adjustments, legal matters, socialization, parent-child relationships. The system fulfills all the requirements of any good helping relationship.

Many widows are embarrassed by their overwhelming emotional reactions and frightened that they are losing control or going crazy. Here especially, the widow aide can provide reassurance that her experiences are not abnormal. Family and friends of the new widow are frequently unable to provide such support because of their own anxiety. Widows commonly experience feelings of abandonment, isolation, and tremendous discomfort in social situations. These feelings are understood by the widow aide who can help the new widow gradually make the transition to her new life without a partner.

Making The Transition

The emphasis on transition is essential. The successful self-help group does not inculcate dependency but strives to give members transitional skills to allow them freedom of choice. Widows groups can teach women to learn new social skills that do not apply solely to making friends in widows groups. As one member stated, "we're here to learn how to graduate." The issue of transition and ending is one where the professional consultant can be especially functional. The very nature of the essential shared experiential link can cause volunteers difficulty re: setting limits, extricating themselves from inappropriate relationships, etc. Much of the consultation provided by the authors was in these areas.

Initially, the role of the professional as co-leader in the self-help groups, or as consultant to the various program offshoots, was questioned by some participants. "You'll never know how I feel, so how can you help me?" Almost two years of operation have taught both professional and participant many lessons. The professional group worker learned that shared experience, e.g. widowhood, transcends all other indices to group composition. Widows of eighteen years helped widows of less than a year. Reluctant members came to respect and value the professional's ability to "make a demand for work" and help the group extricate itself from a quagmire of depression.[14]

The psychiatric literature discusses grief as a sequential process. This has definite implications for choosing the most appropriate interventive strategy. Greenblatt has reviewed spousal mourning, particularly in females as they are affected more frequently. (ratio of widows to widowers is 4:1). He describes 4 phases of mourning; 1) the initial reaction of shock, numbness, denial and disbelief, followed by 2) pining, yearning, depression; the resolution phases are 3) emancipation from the loved one and 4) readjustment to the new environment. Greenblatt further points out that not only does the new widow lose her partner of many years, but very often she is faced with reduced income, fading away of family supports as family moves away, change in social status in society, unmet sex needs, and loneliness.[15]

The best predictor of a good outcome, as most authors have concluded, is the widow's perception of her environment as supportively meeting her needs in the bereavement period. Unfortunately, this is often the time when families break up, and friends and relatives move away, or feel so uncomfortable with death and the plight of the widow in general, that they gradually withdraw support. Sociologists have noted that society has certain prescribed norms for dealing with stressful life tasks, e.g., two weeks for adjusting to childbirth and six weeks to cope with the loss

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[14] William Schwartz, "Some Notes on the Use of Groups on Social Work Practice," address delivered to Annual Workshop for Field Instructors and Faculty, Columbia University School of Social Work, April 21, 1966.

[15] M. Greenblatt, "The Grieving Spouse," *American Journal of Psychiatry 135*, January 1978.

of a spouse. It is no wonder that statistics indicate that many widows suffer severe depression later in the first year following bereavement as the early support of family and friends is withdrawn. This latter fact is attested to by the majority of women in our program. As one expressed it, "After the unveiling you suddenly realize that it's for real and no knight in shining armour is coming to take you away."

The agendas of the various groups in our program varied in relation to the needs of group members but several common themes emerged. The most prevalent was that of loneliness. One participant coined the phrase that the major value of the group experience was in teaching her that one can "live alone and not be lonely." Once again, group members found that both the professional and the widow group leader had distinct but equally valuable contributions to make. The professional worker's ability to remain objective and, by definition, not vulnerable to the various and real emotional crisis of widowhood was seen as particularly important.

Conclusion

Schmale states that grief is a developmental experience in which the person is forced to make a transition, otherwise he may experience a disease.[16] Parkes notes that the nature of the transition involved in bereavement requires the individual to restructure his way of looking at the world.[17] The widow, according to Madison, has two tasks: to detach herself from the lost "object" in order to allow her to engage in other relationships and to develop a new view of herself as an adult woman without a partner.[18] The latter is made more difficult by society's tendency to value couples as socially desirable, and to isolate single persons. It would appear that the self-help model in conjunction with professional consultation may constitute the most effective means of helping widows make this transition.

The Montreal "Y" 's Widow-to-Widow Program is beginning to yield data to support the foregoing hypothesis. New women continue to enter the program, recruited via the monthly Sunday brunches (on Sunday, because "Sunday is the longest day of the week") and the Outreach Program. Fifty percent of the membership of the current self-help group is comprised of members contacted via Outreach volunteers. The membership has also been widowed an average of less than six months, with some members widowed less than three months.

The advantages of a self-help program for widows in conjunction with professional intervention are both practical and theoretical. A self-help program can reach more people than a professional. As well, the outreach widow is accepted as a legitimate caregiver more readily than a psychiatrist or social worker. The outreach widow becomes a good model for the new widow, and both benefit from the intervention. Reissman has enunciated the "helper principle," "the effective helper often feels an increased level of interpersonal competence as a result of making an impact on another's life."[19] This is borne out by our Outreach volunteers who express an increased sense of efficacy and purpose as a result of their endeavours.

The Widow-to-Widow Program in Montreal appears to fully support the notion that both the professional and the indigenous worker have a role in operationalizing the self-help model. Our mutual effort has resulted in a significant number of women achieving what one described as "the transition from widowhood to personhood."

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16 A. Schmale, "Grief is Not a Disease," paper presented at the 131st annual meeting of the American Psychiatric Association, Atlanta, May 1978.

17 G.M. Parkes, "Effects of Bereavement on Physical and Mental Health—A study of Medical Records of Widows," Br. Med. J. 2:274, 1964.

18 D. Madison, and A. Viola, *op. cit.*

19 Frank Reissman as quoted by T.M. Skovholt, "The Client as Helper: A Means to Promote Psychological Growth." *Counselling Psychologist* 4 (3), 1974, p. 62.