HUMANIST FORMS FOR GRIEVING AND BEREAVEMENT

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CHAPTER I

STATEMENT OF THE ISSUE

For non-theists who experience the death of a loved one, has there been a spiritual resource or touchstone that they rely upon (or can yet discover) that provides strength, contributes to resilience, and helps enrich their lives by helping integrate the experience of loss? How can the belief system of naturalist humanism be brought to bear more effectively to serve and support those in mourning?

The goal of this project will be to assemble a group of up to eight non-theistic individuals drawn from congregations of Ethical Culture, humanist Unitarian Universalism, Humanistic Judaism and perhaps others of similar background who have experienced the death of a loved one and for whom the grief remains unresolved. Through a series of six group meetings the participants will share their stories of loss, bereavement and the struggle for resolution.

We will explore different resources for wisdom and inspiration which the participants can explore, and from which they may erect a spiritual scaffolding for integration of their experiences and for personal regeneration. Success in integrating their experience of loss and bereavement will be assessed by comparing an inventory of coping skills taken in a pre-session interview with the results of an exit interview of the participants at the end of the series of sessions.

A. BACKGROUND

When a death occurs, the surviving loved ones may experience a sense of loss and grief that is universal throughout the human family. However, the manner in which grief is handled by the mourner, as well as by the society within which he or she lives, varies widely from culture to culture. Different customs, patterns, methods and strategies are invoked in order to aid the mourner in finding meaning in the loss within the context of a life narrative. These traditions offer comprehensible answers to a loss that may defy common understanding and, ultimately, they seek to help restore the one left behind to productive community participation.

In our European-American culture, in which the dominant customs flow from a Judeo-Christian heritage, a certain set of meaning-making customs and practices are generally accepted and utilized. While variations exist, there is remarkable unanimity in a basic understanding ry-line that serves to explain death and which provides a logical framework to assist in the bereavement process. Even when that teaching may be rejected as outmoded and superstitious, many people will revert to it at times of distress and trauma for lack of other available support structures.

The basic Judeo-Christian teaching is the following:

1. There is a God who is all-powerful who has a plan that is logical and just, even if we cannot understand it.

2. There is another life into which the dead pass, although the degree of faith in life after death varies.

3. The survivors have a duty to persevere in life's journey despite the loved-one's death.

Within the traditional Western faiths, practices are patterned to be in conformity with the basic understanding and are designed to help the survivors cope with their loss. These practices are freighted with meaning drawn from, and they in turn reinforce, the traditional teaching.

These practices are sometimes set out in a strictly delineated ritual that begins at the death bed and continues through the burial, and sometimes for a prescribed period after that. The process to a lesser or greater degree dominates the attention and the activities of the grieving persons from the moment of death until a defined termination point, after which it is more or less expected that the mourner will resume a normal routine. This close attention serves to channel the mourner into the traditional course of supervised grief and formalized recuperation.

For example, traditional Jews practice a highly regulated and ritualized practice of mourning referred to as "sitting shiva." First, the deceased is buried quickly, generally within 24 to 48 hours of death. Then, for a period of seven days, the closest family remains shut-in at home, sitting on wooden stools with all the mirrors covered. This is followed by a thirty day period during which prayers for the dead are to be regularly performed. For the remainder of a year, the principal male mourners are to stand up at sabbath services and publicly offer a special prayer. There is an active role for the congregational community to visit the mourners at home

and attend at the first week's shiva ritual. Other congregants participate with the mourners at the special prayers during the year. Lamm (2012) describes the process in great detail.

Among many Catholics, there is an observation period from the time of death which may last from two to seven days when the closest family is to maintain a vigil and the community may visit the corpse in repose. There will then be a communal event, the "wake," which is partly celebratory and at which the body of the deceased is present, virtually as a participant. Thereafter, a burial formally terminates the process. (McDermott (2009).

Aside from those who rebel against it, these traditions embrace the mourners with a firm grip of ritual and subliminal messaging. Through powerful symbolism, the basic and accepted subtext of meaning is conveyed, relied upon and, of course, perpetuated.

At the same time, however, these practices have evolved over centuries, if not millennia. They represent a community's response to the deep psychological needs of its people in times of grief and are an effort to minister to these needs in standardized and recurring ways. By their longevity, one can surmise that, on the whole, the relevant communities have found these practices fulfilling and healing (Mead, 1964).

B. THE NEED AMONG HUMANISTS TO BE MINISTERED

It would be stating the obvious to point out that strict observance of these rituals has declined dramatically in our day. Part of the reason is the decline of belief in the traditional teachings. A cause can also be attributed to the dispersal of many traditional communities as well as the reduced stature of community authority and the pressures of modern life. However,

as the traditional rituals are being lost, some important, time-tested methods have also been abandoned by which mourners have been served and nurtured over the generations.

Ethical Culture is a modern religious humanist, congregational movement which seeks to create a nurturing community that serves its members in times of important life passages. Ethical Culture traces its philosophical roots to the same historical antecedents as the rest of Western culture. However, it adopts a naturalistic humanist philosophy which rejects much of the Judeo-Christian teaching - - in particular, those parts which assert that behind natural events such as death there stands a "supernatural" and all-powerful god who has a logical purpose and plan, and that there is the promise of an after-life. In its place is a naturalistic explanation that finds inspiration and solace in the natural order of things.

But while so much of the traditional Judeo-Christian teaching has been abandoned by members of the Ethical Culture Movement, also left behind were many of the practical traditions that guided those in grief. Gone are the prescribed behaviors and ritualized duties. But what exists in its place? Is the loss of traditional practices leaving the community with a troubling void?

While it is common and expected that an Ethical Culture Clergy-Leader will be called upon to attend the mourning family at the critical moment of grief - at the bedside, in the hospital, or soon after the fatal accident, there is no continuing process of a ritualized passage during which the mourners may be gently led over a period of time through a processing of their grief.

Lacking such rituals, the Ethical Culture family may still benefit from a pastoral care visit during the mourning period. There may be additional pastoral visits as the need is perceived by

the Ethical Culture Leader based upon a social work/pastoral care model, but there is no tradition that insists they occur. In addition, there may be little formalized community support until a memorial service is conducted by the Leader perhaps a month later. Most of the relevant literature in Ethical Culture concerns the performance of the memorial service (Black, 1974).[1]

In particular, there is no role laid out for the rest of the Ethical Culture community to aid the family in mourning. Query: should there be? Without a call upon the community, the Ethical Culture family in mourning is left on its own to process their loss and to restore balance to their family system.

This may reflect much of what exists today in the broad sweep of the modern American landscape. Members of Ethical Culture are very much part of their cultural context. However, to the extent that Ethical Culture offers a congregational community that can serve to support its adherents in times of major life passages and help provide meaning in the experiential arc of life, then Ethical Culture should seek to clarify what its community ought to provide in concrete terms at the time of bereavement.

The question I pose is whether and, if so, how the fundamental belief system of naturalist humanism can be more effectively brought to bear to serve and support those in grief. While this may not result in a strict pattern of ritualized behaviors that must unfold in all instances of the death of a member's loved one, the project will hopefully serve to devise, identify and/or collect those practices that will serve the needs for support of Ethical Culture adherents in such times.

[1] A wonderful exception is the excellent book of consolations and meditations by Arthur Dobrin

C. RELEVANCE TO A WIDER CONTEXT

If the project results in a concrete and practical set of recommendations for practices and behaviors that would be deemed of service to the Ethical Culture community, then these findings can be of service to the entire Humanist community. Ideally, the project could result in a set of practices that can be drawn upon by Ethical Culture and other humanist communities in the future.

(1986), Leader Emeritus of the Ethical Humanist Society located in Garden City, Long Island .

CHAPTER II

PRINCIPLES THAT GUIDE AND INFORM

A. RELIGIOUS PRINCIPLES

Religion has sometimes been defined as the understanding that connects one's own experience and one's being with something larger, something beyond the self. That something may be referred to as the universal being, the force of life, chi or, in some manner, the essence of all life's experiences. It is a transformation of the individual experience into the communal and broadening the communal to the universal.

Edward Ericson (1998), a long-time Leader in Ethical Culture, explained that Naturalistic Humanism finds its universality in nature and in the natural processes of life. In this view, the natural world is not a shadow play that obscures a deeper, finer and more perfect reality that somehow exists beyond it. Instead, the natural world is itself the reality. Its exquisite complexity and elegant symmetry is the necessary, absolute and sole framework within which all our lifetimes - - as small and short as they may surely be - - will be played out.

The degree to which the notion of "spirituality" comprises an ingredient to a Humanistic grief process is a subject of continuous reconsideration and redefinition. The word itself evokes different concepts for nearly every individual, and it can draw all-too negative a reaction among some Humanists for invoking theological concepts that conflict with the life stance they subscribe to. (This reaction was manifest in the Group as its process unfolded.) Yet some form or idea of spirituality is inevitably linked to questions concerning death and bereavement, especially within a pastoral application. Clearly, there is something to distinguish the pastoral contribution from the therapist's 45 minute hour.

Bernard Moss (2002) defined the spirituality aspect simply as the set of "why" questions, irrespective of the theological framework in which they may be couched. In order to acknowledge the significance of death and its impact, one must acknowledge more than the issues of personal psychological development as experienced by the survivor. One must also respect the profound struggle in which the mourner is thrust to reorganize the constellation of one's place in the world, to reëvaluate the meanings that have underpinned one's "take" on the world, and to reimagine the path going forward. This invokes both a psychological process of healing and a philosophical process of reorientation. "Spiritual" as a word, however it may be defined in detail, signals the enhanced significance of this process of discovery more than does the dry word "philosophical."

But it may be helpful as a matter of direction to try to define "spiritual" in a context which excludes structured theologies. Attig (2001), who is a psychiatrist writing from the constructivist perspective (see below), uses the word to refer to "that within us that reaches beyond present circumstances, soars in extraordinary experiences, strives for excellence and a

better life, struggles to overcome adversity, and searches for meaning and transcendent understanding." (at p. 36) This definition does capture the elements of "significance" and of something more than merely one's own individual experience and linking it to the universal.

Recognizing the individual's experience as a reflection of the broad human experience, or even the universal life experience, is part of the effort to achieve a "spiritual" understanding. David Brandon (2000), then, defines it in this way, "The spiritual road is about living out our uniqueness, not our individualism."

On the other hand, there is also rejection of the word among many Humanists, as it is too often associated with supernatural theologies. Within Ethical Culture, people tend to support a religious definition from a communitarian, rather than theological, point of view. As Bart Worden (2011), an Ethical Culture Leader, expressed the issue recently,

> An [Ethical Culture] religious community contributes to life by providing meaningful relationships for its members and by increasing the congregation's engagement with the world around it. To me, that is what constitutes being religious—even if one doesn't see oneself as being spiritually minded. (Bracketed matter added)

It is the practical activity of mutual support that Ethical Culture seeks to cultivate, without being overly concerned with an accompanying theology. If this invites the question of defining "religion" for a Humanist religion, perhaps the following can be offered as a start. The meaning-making practices of a Humanist religion will communicate:

- the significance of one person to the community and the importance of memory,

- the connection between one, single life and the enormity of the universe,

- the beauty of the natural world of which we are a significant, necessary, and fruitful part (Lewis, 2003).

One can also recognize that there is a "spiritual" component to the other side of this pastoral equation, the care-giving experience. Bernard Moss allows that the care-giver is also motivated by a sense of spirituality. This suggests a new definition, offered by Canda and Furman (1999), by which they see spirituality as "the heart of helping. It is the heart of empathy and care, the pulse of compassion, the vital flow of practice wisdom and the driving force of action for service." It is therefore to be hoped that both the griever and the counselor will achieve growth in this process.

It is in this light that I am striving to have the Ethical Culture community to be more effectively engaged in these important life passage experiences, both from the perspective of the one in mourning as well as for the surrounding community as a participating supporter. However, this troubled relationship with the word "spiritual" helps highlight the conflicted feelings that participants have with the kind of help to be offered. If there is an overt introduction of a "spiritual" suggestion, there may be a clear and stark rejection. Language is important. There have been numerous books published in the last decade offering for non-believers, that is to say, those who do not subscribe to the theistic principles of the majority, what have traditionally been accepted as spiritual practices. However, outside of the Ethical Culture Societies and some of the Unitarian Universalist churches, there have been few, if any, lasting non-theistic Humanist congregations.

One key aim of this project shall be to draw upon the experiences of the group's participants to develop goals for community participation in aid of the grief process of the community's members. If the meaning-making function of the grieving process can be aided in ways that resonate with the philosophical life stance of Humanist congregants while also

contributing to the universal psychological needs of mourners working through their grief, such practices could be cultivated and preserved as a worthy and practical tradition.

B. CLINICAL PRINCIPLES

In recent years, new theories have been advanced to understand and to assist therapeutically in the grieving process. One goal of this project is to incorporate one such theory, referred to as *constructivism*, to help the group participants work through their own unresolved grief.

The traditional psychoanalytic framework for understanding and treating grief originated with Freud's classic essay "Mourning and Melancholia" (2007). In the traditional model that Freud described, a person in mourning is said to have suffered a trauma by the loss of a loved one that is analogous to a physical injury. The survivor introjected the loved one in important ways into his or her ego structure. In order to recover from the loss of the cathected object, the survivor must strive to decathect the lost beloved object and transfer this energy to a new object. In this model, the process is a solitary struggle which the survivor must undergo and it is expected that the process will be concluded within a reasonable period of time.

Mourning that did not cease was considered pathological and was labeled by Freud as melancholia. For example, a failure to redirect energy from the deceased might manifest in the form of unconscious complaints about the one who died that are turned against oneself. Anger towards the deceased may manifest as lowered self esteem or diminished self love in the survivor. Intent to punish the deceased may be acted out as attempted suicide (Freud, 2007).

However, in later years, after he experienced the loss of his own beloved daughter Sophie, Freud recognized that one never fully decathects from the lost loved object (Freud, 1960; Berzoff, 2004).

Other writers described the grief process as a regular and predictable sequence of stages that had to be fully encountered before one could successfully achieve recovery and restoration. These views were based on the original work of Elisabeth Kübler-Ross (1969) who studied states of mind approaching death, dividing the experience into a process of discrete stages. This framework was adopted for the bereavement process by writers such as Colin Murray Parkes (1991), who approached the issue from the point of view of attachment theory. But nevertheless, this rather mechanistic view could be characterized as a continuation of the "wound" model by which the grief is a wound that only time would eventually heal.

The Freudian analyst and writer Hans Loewald (1962) brought this concept a step further in arguing that the continued internalization of the deceased object can offer a positive transformation in the life of the survivor. For him, a loss can prove positive and transformative as the survivor may, for example, take on the ideals and values of the deceased, thereby changing his own ego ideals. In other words, the survivor need not always "get over" the pain of the loss, so much as grow with it. For example, as Joan Berzoff explains (2013), the survivor might carry on the life's work of the deceased or assume a new ideal based upon that life. Some of the 9/11 survivors, for example, assumed a passionate devotion to the memory of their deceased relatives. Susan Komen for the Cure was founded and directed by the sister of a breast cancer victim. The memory of her deceased sister launched her on a mission to find a cure for breast cancer.

Writers drawing upon attachment theory also depict the mourner as an individual who struggles to overcome the disorientation caused by the loss of the attachment figure. Attachment theory asserts that all human beings are born with an innate psychobiological system that impels them to seek others for support and companionship (Bowlby, 1980; Mercer, 2006). Patterns of relational expectations, emotions and behaviors result from the internalization of an individual's personal attachment history dating from earliest childhood (Mikulincer and Shaver, 2013). These patterns deriving from parental influences delineate the manner in which a loss of the attachment figure can be accepted and endured (Parkes, 1991). According to attachment theory, the loss triggers intense distress and a predictable pattern of responses, which Bowlby (1982) originally referred to as *protest*, *despair* and *detachment*. In successful bereavement, the process can lead to a state he called *reorganization*.

For Bowlby, reorganization represents the process of transferring one's "proximity seeking" drive for attachment to a new partner *without* necessarily detaching from the lost partner. Successful achievement of reorganization involves (a) accepting the death of the partner and forming new relationships, and (b) maintaining some kind of symbolic bond to the deceased and integrating the lost relationship within a new reality (Bowlby, 1980; Mikulincer and Shaver, 2013).

In contrast, failures in this process could emerge as "chronic mourning" which would be associated with those individuals whose patterns of attachment were characterized by "anxious" or clinging tendencies. On the other hand, a failure in the process could otherwise lead to an absence or delay in conscious grieving among those whose attachment patterns were characterized by "avoidant" tendencies. As summarized by Parkes (1991), those measuring low

in self trust were likely to cling to others and develop chronic intense grief, while others measuring low on trust in others were likely to withdraw and avoid grief.

Therapies in the attachment model begin with the formation of a new, secure attachment bond. The therapist will seek to provide what attachment theory calls a "safe haven" or "secure base" which will hopefully infuse the patient with a sense of security and allow him to explore the loss experience and be open to the pain it may entail.

A bereavement group can offer such a safe haven if organized with sensitivity and creativity (Yalom, 1998).

(i) COMPLICATED GRIEF

It is universally accepted that the loss of a loved one will cause symptoms of distress in many people who are not otherwise psychologically fragile. It is so expected that the failure to show such signs can seem strange and even arouse suspicion (Camus, 1993). Recent research by Bonanno, Boerner and Wortman (2008), however, shows that a large percentage of people will exhibit great resilience and not suffer serious impairment from the loss. Nevertheless, it is still generally considered normal for a person to be severely impacted for at least some period of time (Bowlby, 1980; Wakefield, 2013).

It has also been observed that a certain percentage of those experiencing loss will not resolve their grief within the ordinarily expected time frame and will suffer impairment as a result. This is referred to as complicated or prolonged grief. Complicated or prolonged grief is said to be characterized by persistent, intense longing and yearning for the deceased (or separation distress), intrusive thoughts or images, emotional numbness, anger or guilt related to the loss, a sense of emptiness, and reactivity in response to cues, a vacillation between an anxious

preoccupation with, and an avoidance of memories of, the deceased, difficulty redefining themselves, and difficulty forming satisfying new relationships (Prigerson, 2010; Boerner, 2013). Therese Rando (1992) argued several years earlier that occurrence of complicated grief was an emerging trend owing to characteristics unique to the American culture of our time. These features included the isolated, nuclear American family that fosters over-identification and over-dependence, the increase in (adult) child deaths as many people live so much longer, the significant rise in crime experienced at the time of the article and the violent deaths that resulted, and the lack of awareness on the part of the mental health community of the unique needs of grief counseling which Rando expected would exacerbate the problem.

There is currently a robust debate over whether there is today, in fact, a distinct disorder that is associated with complicate or prolonged grief. Through the work of Holly G. Prigerson of Yale University and others (2001), a set of criteria was devised to distinguish the disorder of prolonged grief from the more ordinary grief experience. Other proposals have also been offered by, for example, Katherine Shear (2011) and the DSM-5 Anxiety Disorder Working Group (APA, 2013). The basic elements of each competing description are compared by Boelen and Prigerson (2013).

The concept of prolonged grief disorder was adopted in the revision of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5) for inclusion in the Appendix as having been identified as a condition for further study.

The criteria adopted for the publication are the following:

A. The death of a significant other;

B. At least one of the following symptoms to a clinically significant degree persisting for at least twelve months after the death:

1. Yearning, longing,
2. Intense sorrow and emotional pain,
3. Preoccupation with the deceased,
4. Preoccupation with the circumstances of the death.

C. At least six of the following symptoms to a clinically significant degree persisting for at least twelve months after the death:

(Reactive distress factors)
1. Difficulty accepting the death,
2. Disbelief or numbness over the loss,
3. Difficulty with positive reminiscing,
4. Bitterness or anger over the loss,
5. Maladaptive appraisals about oneself in relation to the deceased,
6. Avoidance of reminders of the loss,

(Social/identity disruption factors)
7. A desire to die to be with the deceased,
8. Lack of trust,
9. Feeling alone or alienated from others,
10. Feeling that life is meaningless or empty,
11. Confusion about one's role in life or diminished sense of identity,
12. Reluctance to pursue interests or plan for future.

D. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

E. The bereavement reaction is out of proportion or inconsistent with cultural, religious or age appropriate norms.

Those arguing against defining complicated or prolonged grief as an independent disorder point out that these symptoms are not manifestations of behavioral, psychological or biological dysfunctions in an individual. They simply represent the upper end of a continuum of normal grief. To measure, as the proponents do, a spectrum of, say, 20% of all grievers who experience prolonged grief merely highlights a statistical deviation (Wakefield, 2013; Holland, 2009). Some argue that this does not identify a disorder (Wakefield, 2013; Bonanno, 2008).

But whether complicated or prolonged grief is characterized as a disorder, a debilitation or a mere indisposition, it can be troubling and impairing of ordinary functioning. Research through a large longitudinal survey has shown that 15% of the affected population exhibited unambiguous chronic grief reactions, meaning that they showed chronically elevated depressive symptoms 6 and 18 months after the death which did not exist before the death (Bonanno, 2013). An important feature that distinguished this group from those more resilient was that the resilient ones were better able to gain comfort from talking about their late spouse, more likely to report that thinking or talking about their spouse made them feel happy or at peace, had low scores on avoidance and distraction, exhibited less denial, had fewest regrets, and were less likely to try to find meaning in the death (id). These are the skills that therapists try to develop in their patients.

The symptoms identified in the DSM-5 criteria can be debilitating and disabling. Repetitive thoughts or ruminations, especially negative thoughts, can perpetuate and prolong grief (Watkins, 2013). Disconcerting or frightening hallucinations may occur in which the survivor sees the deceased in the faces of others, or they produce auditory or other sensations in which the deceased is seen, heard or sensed (Sachs, 2012). In Joan Didon's book about her experience in bereavement following the death of her husband (2005), she poignantly illustrates how continuous talk about the deceased and the events surrounding the death as well as an irrational expectation of the deceased's imminent return show that one's grip on the world of reality is not firm. Should such patterns persist, normal living will certainly be impaired.

Recent research in Japan supports the conclusion that complicated grief exists in the general population. A random survey of 979 responding residents of a community, aged 40 to

79, using the Brief Grief questionnaire revealed 22 (2.4%) respondents experienced complicated grief and 272 (22.7%) displayed sub-threshold complicated grief (Fujisawa, 2010).

(ii) THE CONSTRUCTIVIST MODEL

In recent years, a new theoretical model has emerged that builds upon the traditional theoretical models but which finds inspiration in a somewhat different therapeutic approach. It is referred to as *constructivist* theory and its proponents see grieving, not so much a solitary journey of recovery but much more of a socially contextual process of growth.

Constructivism supposes that each individual constructs a personal map of the world which is an idiosyncratic, fictive narrative of one's environment and one's place in it. Far from being a flaw to be ameliorated by redirecting the person to a more accurate acceptance of a hard, objective reality, this tendency is recognized as quintessentially human and representing the fundamental reality-creating function of the human mind (Neimeyer, 2009).

From this perspective, the immediate problem posed by loss, grief and mourning is that it will cause a disruption of this "self narrative." For this model, therefore, grief is a process of meaning-making in which one strives to revise and reestablish a coherent, meaningful narrative of one's life story in view of the change in one's defining social context and in light of the loss. This perspective recognizes that a person will create one's self definition, not in isolation, but in a social context and within a constellation of connections with others.

In addition, it recognizes that the grief process never achieves a *denouement.* It does not expect that a mourner shall decathect or sever connections with the deceased loved one. It recognizes that mourning may last the rest of the survivor's life in some form. It allows for a

continuing relationship with the deceased - - a different relationship to be sure - - but it allows that a warm appreciation that endures is also normal. As the Beatles expressed it, “I know I’ll never lose affection for people and things that went before. I know I’ll often think about them...” (Stevens, 2002).

A number of writers have contributed to this movement, of whom Robert A. Neimeyer, of the University of Memphis, is among the most prolific. His writings, as well as the writings of others, form the theoretical underpinning on which the project will be based.

I believe that the constructivist perspective is particularly well suited to serve as a theoretical clinical framework for this project because it is compatible with the Ethical Culture philosophical perspective. Ethical Culture is a religion that finds its inspiration in the idea that people make their own life-meaning, and that meaning is not delivered by revelation or imposed by authority. Further, it holds that community is the context in which we are most in touch with the essence of this meaning-making effort. We discover meaning by realizing our connections with others and through our service to others. In devising a participatory role for the Ethical Culture congregational community in an individual member’s grieving, as well as formulating a more explicit form of expression to capture the naturalist, humanist story line to assist in the meaning-making effort, a set of practices for promoting and encouraging an effective and successful bereavement journey can be offered.

The project will engage a group of people who lived through loss to review their individual grief experiences. But they will also be asked to reflect on how they felt supported by their humanist communities (or not) and how the philosophical framework of their belief structure helped or hindered in facilitating the integration of the loss. We will draw upon the

humanist cultural heritage to identify helpful and useful cultural resources for the bereavement process and for the effective reestablishment of the self narrative.

CHAPTER III

METHOD FOR CARRYING OUT PROJECT

A. GROUP PROCESS

The Project is centered on a group exploration into the bereavement experience. The group's participants are intended to be individuals who experienced a loss through the death of a close loved one and who bear a self-reported unresolved grief.

It is proposed that group process is most appropriate for this type of exploration. The stated goal is to develop community sources resources for aiding in the bereavement process. What better method for exploring community skills and resources than to experiment with a small community?

Irvin Yalom (1998) describes the benefits that a therapy group, especially a bereavement group, will offer its participants. He lists eleven therapeutic factors that such a group will offer that cannot be counted on from casual acquaintances or a non-purposeful community of well wishers.

1. The installation of hope. Hope in the future is a key factor in restructuring one's life narrative and giving it continuity. Accordingly to Yalom, faith in treatment can itself make it effective. This hope can be instilled by means of a preliminary orientation, serving to reinforce positive expectations. In this project it will occur in an initial interview.

2. Universality. Seeing others with similar problems is comforting. Often, Yalom states, people believe their problems make them unique and, in meeting others with shared problems, they are made to feel more in touch with the world. In our project, this turned out to have a powerful effect.

3. Imparting information. Shared advice and suggestions as well as direct guidance will be informative and structuring. Bereavement groups might discuss stages of grief to show what to be expected. Anxiety can be caused merely by not knowing what to expect next.

4. Altruism. Participants benefit from the gifts of others as well as from their own sense of giving. People need to feel needed and useful. When we've transcended ourselves and become absorbed in someone else's problems, we can find our own compass. This matches the advice of Felix Adler, the founder of Ethical Culture, who said that in order to help oneself in grief, one should reach out to help others (Adler, 1944).

5. The Corrective Recapitulation of the Primary Family Group. Most participants will have had difficult experiences with their primary family. Some of their conduct in the group may recapitulate relationship impediments and circumstances from long ago and which they are still working out, Yalom explains.

6. Development of Socializing Techniques. The group offers an opportunity for accurate and honest interpersonal feedback, which may be unavailable elsewhere.

7. Imitative Behavior. By observing another person who is dealing with the same problem, a new member can try on the behavior of other members while adjusting their own.

8. Catharsis. Although Yalom says that the intensity of emotional expression varies greatly among participants, it is a necessary factor, although insufficient by itself.

9. Existential Factors. The experience of loss invariably lends a deeper perspective on one's mortality. Participants give much weight to the idea that they are fundamentally on their own in having faced the basic issues of life and death. They conclude that they must take ultimate responsibility for their own lives and pledge to live more honestly and less on trivialities.

10. Group Cohesiveness. An effective therapeutic outcome depends upon a proper therapeutic relationship which must be characterized by trust, warmth, empathic understanding and acceptance. The group must allow for the necessary risk taking and intra-personal exploration.

11. Interpersonal Learning. As explained by the attachment theorists, the personality is almost entirely the product of interaction with other significant humans beings. A group offers the opportunity for interpersonal reflection and towards the correction of interpersonal distortions.

Thus, the group formed by the participants should be the best of all communities and should offer the opportunity to exercise the best skills of mutual help and understanding.

B. INTAKE PROCEDURES AND ASSESSMENT

The candidates for participation in the group were personally interviewed prior to acceptance in the project. The interview was a guided discussion that incorporated an investigation into the existence or not of symptoms generally associated with complicated or prolonged grief. There are several assessment tools that have been devised in recent years to assess complicated grief and a questionnaire was adopted to use as a guideline for intake interviews.

Assessment Tools

Before its current edition, DSM III and DSM IV treated bereavement as an Axis IV condition, a psychosocial and environmental problem that should be considered while weighing symptoms that might otherwise be relied upon to assess the existence of another condition such as depression. In the section for bereavement (V62.82), one was advised to assess the condition more than two months after the death and a series of features were listed that were intended to differentiate bereavement, which would be "normal," from a major depressive episode. These features would include guilt about unrelated actions, thoughts of death not involving the consequences of the death of the deceased, morbid preoccupation with worthlessness, significant functional impairment, and hallucinatory experiences other than transient images of the deceased person.

Until recently, there were few operational criteria for distinguishing pathological grief. In the last fifteen years, several researchers have been developing unique sets of criteria for this purpose which mainly include separation symptoms, such as negative feelings due to lost

attachment, and intrusive symptoms together with a requirement that the symptoms be prolonged and impair social functioning (Tomita, 2002) [2]

The first assessment of significance and still among the best known (Tomita, 2002) is the Texas Revised Inventory of Grief. First created in the late 1970's by Faschingbauer (1977), it was substantially revised in 1987 (Faschingbauer, 1987).

Other highly regarded inventories include the following:

1. the Inventory of Traumatic Grief created by Holly Prigerson and others (see page 13 above) (Prigerson, 1995) and as later revised into the Complicated Grief Assessment,

2. the Core Bereavement Items, designed by Paul C. Burnett (1997), and

3. the Brief Grief Questionnaire, developed by Katherine Shear, M.D. and Susan Essock, PhD.

I chose to utilize the Texas Revised Inventory of Grief because it appeared to offer a comprehensive assessment, allowed for examination into changed circumstances from soon after the time of the loss and compare it to the present, and it was relatively short. Appendix A is a copy of the assessment tool utilized to guide the oral grief assessment taken in the interviews.

In addition, an effort was made to assess the existence of depressive and anxious symptoms as measured by inventories designed for that purpose absent the condition of bereavement. It is necessary to distinguish the syndrome of grief deriving from an event of the death of a loved one from that of a possible underlying condition of depression. The treatment of the two conditions would be focused differently. There were several inventories of depressive

[2] For a review of numerous assessment tools, see the publication of the Australia Department of Health and Aging at http://www.health.gov.au/internet/publications/publishing.nsf/Content/palliativecare-pubs-rsch-grief~palliativecare-pubs-rsch-grief-3

symptoms and anxiety that I reviewed for the possibility that the intake interview aroused a concern of an underlying depression. These inventories reviewed included the following:

Hamilton Anxiety Scale

Hamilton Depression Rating Scale

Beck Depression Inventory

Zung Self-Rating Depression Scale

The assessment chosen was the Hamilton Anxiety Scale because of its simplicity and directness. A copy of this assessment is annexed as Appendix C.

The initial personal interview was scheduled for one session of at least one hour in duration and the inventory was administered orally and completed in the course of the interview. Each candidate was assessed before a decision was made to include him or her in the group. Except for one instance described below, which took place in a candidate's home, each of the interviews was conducted in the study of the Ethical Culture Society.

A qualified candidate for inclusion in the bereavement group was determined to be someone who has shown moderate to high scores on prolonged bereavement and moderate to lower scores on depression. The impossibility of assessing anyone on a depression scale for conditions as they existed prior to the death would make it difficult to judge whether the candidate had an historical tendency towards depression independent of the bereavement. It would accordingly be necessary to rely upon a self reporting by the candidate in this regard.

C. DEVELOPING THE CURRICULUM

The group was designed to meet for six (6) sessions and to have a curriculum outline for each session in order to provide a starting point for a facilitated discussion. Each session would open with a reading or a narrative of about three to four minutes which will introduce a theme for the day. Other materials may be introduced to promote discussion and reflection.

Session Themes:

1. Introduction. Ground rules for participation; general sharing and self-introduction.

2. Narrative disruption. How the loss changed my life's direction, my expectations, my goals.

3. Introduce the deceased. What made that person special?

4. What was the legacy the deceased left with us? What lives on?

5. What was your community support structure? How did it help or hinder?

6. How can we organize an effective support structure for others?

In developing the initial themes, I was assisted by the collection of essays entitled "Techniques of Grief Therapy, Creative Practices for Counseling the Bereaved" (Neimeyer, Ed., 2012). This rich resource develops the constructivist method through the contributions of numerous writers on sources and techniques.

The method for facilitating the group discussion was drawn from two principle sources. There are certain resources upon which I relied for the dynamics of group process. First, there is my experience in the H.U.C. D.Min program itself. Second, I rely on "The Theory and Practice of Group Psychotherapy" (Yalom, 2005) as a resource.

In addition, because the group experience was to be time limited and brief, I recognized that the dynamics would operate as group exploration as much as brief psychotherapy. As such, there was much to learn from the techniques of Parker Palmer as set out in his book, "A Hidden Wholeness" (2009). In this guidebook for self exploration within group process, Palmer expands on his method of creating a "circle of trust" within which participants in a short process can be encouraged to be alone together and to seek their individual realization by learning to listen deeply, to speak truthfully, and to enable each other to grow freely.

I also sought to collect resources to use as illustrations, discussion starters and tone setters. I considered encouraging participants to contribute resources of their own as well, although what the participants primarily brought were their stories and experiences.

CHAPTER IV

RESULTS

A. FORMING THE GROUP

The Method of Solicitation. I was granted the opportunity to place a notice in the monthly newsletters of each of the three Ethical Culture Societies located in the county during the months of January and February, 2013. This was a short article in which I described the project and invited participation, giving contact information. See a copy of the solicitation article at Appendix D. This effort was not very successful by itself. Accordingly, I followed up with a visit to each Society at a Sunday service and made a personal presentation. My personal presence was evidently more persuasive and that proved to be the means to my success. In each instance, during the coffee hour after the Platform program, I was approached by one or two people who expressed interest and I followed up with each person.

The notice in one Society's newsletter did generate responses from two people who were not active congregants but who were on that Society's mailing list. I made a personal visit to the home of one, a recent widow, and the interview was promising. However, she later sent me a

handwritten note backing out. My preliminary interview included the grief assessment survey in which I asked questions about feelings and expressions of grief, few of which she reported experiencing. She concluded on her own that she was unsuited to the group because she believed that she was proceeding through her mourning without undue difficulties. I wrote back to say that this did not bar her, and that the grief assessment was simply an assessment and not a description of the participant for whom the project was being addressed. Unfortunately, she did not correspond further.

The second person to respond was an elderly woman whose sister had recently died. For her, the lack of transportation to our meeting site proved to be an impediment and we did not proceed past the exploratory telephone call.

At the Sunday Platform that I attended at this first Society, Michelle approached me and asked to join. I had met Michelle some dozen years earlier at a regional picnic and spoke to her a few times on professional subjects. That seemed to be a sufficient connection for her to feel comfortable enough to join.

I also attended a Sunday Platform program at the second Society and made a personal announcement about the Group. There, I was approached by a woman whose husband died a year and a half earlier. She expressed strong interest but, when I sought to arrange for the initial interview, she backed out. Amy also approached me during coffee hour, and she did participate as described below, at least at the beginning.

At the third Society, my own home Society, I received a stronger response. Six people approached me and expressed interest in participating.

Only one out of all the responders was a male. However, that individual was someone I had counseled two years earlier I and knew him well. I deemed him to be incompatible with the others who already joined and I told him that I thought he would be uncomfortable in the group.

It was disappointing not to have any viable men to participate in the Group. However, it may not be surprising that in a sample as small as this there would be no men. A distinction in grieving styles is noted between men and women in the research of Doka and Martin (2010). Although no distinction can be absolute, Doka and Martin identify two poles of grieving styles, one tending to be more feminine and the other masculine. One, they call *intuitive* by which the reaction is affective and the person apt to participate in counseling. In contrast, the other style they call *instrumental,* by which a person exhibits physical or cognitive behaviors. The latter person will grieve by building a monument, seeking an "answer," or by staying at work in the office later than before. It is the intuitive griever who has the attention of the therapists, because he or, more typically, she is the one who shows up for therapy.

As a result of the solicitation process to this point, the viable prospects for the project added up to a group of six women. Since I hoped to achieve a group of eight, I reached out to the local Unitarian Universalist Church. They were kind enough to print my solicitation in their monthly newsletter. My connection was facilitated through the assistance of my ministerial mentor Dr. Forsey, who was acquainted with the interim minister then assigned to that church. I also impressed upon the minister the long standing relationship between the UU church and the nearby Ethical Society of which I am a member.

This solicitation resulted in one call from a recent widow, Julia, who attended the church.

Results of the Solicitation

As a result of these efforts, twelve people responded to the solicitation out of whom seven joined the project at the outset. All were women. Three were dealing with the death of a spouse, three the death of their mothers. One was concerned with the death of a child.

In some important ways the composition of the group of participants did not meet the expectations of the original plan. There were certain characteristics that had originally been deemed appropriate for the project:

- that the participants were experiencing prolonged grief;
- that people with a recent loss were preferred;
- that they were Humanist in outlook.

As anticipated, the population of people from which to draw was rather small. The three Ethical Societies in the county are few in number and each has a small congregation. Thus, I was required to reach out to the nearby Unitarian Universalist Church to seek an additional participant. Those who ultimately joined bore some of the anticipated characteristics, but not entirely so. They were Humanist. But none, for example, was experiencing prolonged or complex grief judging from the results of the intake interview. Some members had recently experienced their loss, but for four out of seven participants, their losses were suffered one, two and, in one instance, three decades ago.

B. THE PARTICIPANTS

Beth Beth is a sixty four year old single woman whose mother's death is her subject. She was a long time member of an Ethical Culture Society in a neighboring county and joined the local Society about eight years ago. A college graduate, she had several kinds of work over

the years and was most recently a salesperson for insurance services. In the middle of the program, she was laid off from that job and was once again looking for a job.

Beth's mother died of a heart condition when she was in her fifties and Beth was thirty-one. Her mother had an unfulfilling marriage to a conservative and non-communicative, traditional Italian-American man. At that time, Beth had recently given birth to her daughter, whom she was to raise on her own. She believes she did not attend enough to her mother's health and emotional problems at that time, having been absorbed by the challenges of new (and single) motherhood.

Claire. Claire is a single woman of sixty nine whose mother died a year and a half ago. She is a recently retired public school librarian with two masters degrees. She only recently joined as a member of the local Ethical Society.

Claire experienced a near fatal, clearly life-altering, automobile accident in her twenties and her life story ever since then was primarily one of a solitary struggle for rehabilitation. She had many operations of reparative and reconstructive surgery and she feels broken and misshapen but remains defiant and self reliant. At a certain point, she wanted a child and, through means of artificial insemination, she had a son whom she raised alone. When her mother became aged and frail and needed supervised care, Claire brought her from Florida to a continuing care facility in New York. She took solicitous care of her mother until she died a secure and supported death in her early nineties. Claire takes extreme satisfaction out of having been the one to have given such devoted service to her mother, to the exclusion of her more-favored older sister.

Julia. Julia is in her late seventies and she lost her husband almost two years ago. Julia comes from the Unitarian Church (her origins are in the Methodist Church), and is the only non-

Ethical Culture participant. Julia worked as an assistant librarian at a local college but is now retired. She has three children. One grown son, an unemployed nurse, lives with her.

Her husband was sick for many years and suffered from Alzheimer's disease at the end as well. He lived his last year and a half in a nursing home where she attended to him every day because the nursing care was not as attentive as she wanted it to be. Julia knew her husband all her life - - they met when she was sixteen - - and they were married for 56 years. Julia's husband Lucas, who was of Jewish origin, worked as a salesman of commercial wood products for many years.

Lucy. Lucy, who was fifty four, came to discuss the death of her husband Will ten years ago. A college graduate and a trained artist, she works full time for a wholesale party supply company doing telephone sales. Nine years ago she left the Unitarian Church and joined the Ethical Culture Society. Will died of long term alcohol abuse not long after Lucy left him and moved back into her mother's house. Lucy remained single ever since and still lives with her mother, never having returned to her marital home.

Michelle. Michelle is sixty seven and came to discuss her mother's passing. Michelle is a former nurse and a lawyer but is now retired and remains at home while her husband continues to work as a doctor. Her two sons are grown. She was an on again/off again member of one of the Ethical Societies in the county for about twenty years. Michelle is the youngest of seven children. As the only one of the siblings to still remain in the New York area, it fell upon her to take care of her mother. She attended to her at-home care, her move into a continuing care facility, the Alzheimer's disease and, ultimately, her death.

Eva. Eva is eighty years of age and a long time member of Ethical Culture, first in one of the other Societies in the county and, for the last five years, at the Society of which I am a member. She had secretarial and administrative jobs over the years and her late husband was a salesman. Their adoptive daughter is now married and lives in Florida.

Eva's husband Sammy died twenty years ago of a heart condition two weeks after his surprise 60th birthday party was held in their residential development's community room. His memorial was held in the same room just two weeks later. Eva blames herself harshly for his death - that she did not maintain a proper home, that she was inattentive, that she did not cook him meals. Nevertheless, from the details of her stories, it appears that he was indeed happy.

Amy. Amy is in her late seventies and the death of which she was concerned was that of her son. Amy grew up in Scotland. She came to America in her twenties and lived here ever since. She divorced approximately ten years ago after a marriage of many years. She was a high school math teacher and went into business with her husband, who holds a PhD in biochemistry, organizing drug trials with volunteer patients. Although Monday had been chosen for the Group's meetings partly because she had represented that it was her free day, Amy had to miss several meetings because of responsibilities to her Rotary Club (of which she soon became president) and she eventually stopped coming altogether. Amy was a member of one of the local Ethical Culture Societies for about three years.

After having three daughters, Amy had David, the youngest of the family. When David was twenty and a sophomore in college he was out with friends one Saturday night in the family automobile. He evidently cut off a Mercedes that was occupied by gangsters. The Mercedes overtook David's car and one of the passengers shot him dead. Amy spent the next decade

pushing the police to pursue an investigation until the perpetrators of the crime were found, prosecuted and, ultimately, convicted.

C. THE INTAKE INTERVIEW

I conducted an intake interview with each of the participants by appointment in the study of the Ethical Society where we were to have our meetings. This interview was conducted with four principal goals - to introduce myself and to explain the purpose of the project; to hear the outlines of the person's story; to administer a basic grief assessment for beginning data; and to judge suitability for the group.

The grief assessment that I relied upon was the Texas Revised Inventory of Grief Assessment. [Appendix A].[3] Of the assessment tools in general use, I believed that this model offered a clear and comprehensive outline of symptoms of on-going grief. It also incorporates a test of temporal variation, asking for one's experience near in time to the loss and separately asking for information about enduring experiences and manifestation of symptoms in the present. In order to assess anxiety as a factor in the grief experience, I was also prepared to employ the Hamilton Anxiety survey. [See Appendix C.]

At an exit interview after the project had run its initial course, I was able to compare the results and learn if there had been any changes reflected as a result of participation. The results are summarized in the annexed Appendix B.

It became clear, however, that while these tests are useful for eliciting a description of gross characteristics of grief symptomology, I found that a participant's level of acceptance,

[3] For a description of the grief assessment tools, see page 26 et seq.

integration, serenity and general satisfaction were too subtle to be reflected in the assessments' measurements. Had anyone suffered from complex or prolonged grief, however, I am confident it would have been revealed by the assessment scales. As explained below, the participants reported only mild symptoms, if any, among those tested for by the questionnaire.

D. COMMITMENT TO THE PROJECT

In order to impress upon the participants that their fidelity to the project and their faithful attendance was important, each was asked to sign an agreement. This agreement contained a clear explanation of the project, a set of ground rules and the duties of participation, and it also explained my own credentials and affiliations to Hebrew Union College and the Ethical Culture Society.

A copy of the agreement is annexed at Appendix E. Execution of the agreement did not guaranty full compliance on the part of all participants but it likely served to telegraph the seriousness of the undertaking.

Much of the tone and content of the agreement was drawn from the model of Palmer Parker (2009) whose format for forming and facilitating short term, goal directed groups was very useful.

E. OUTLINE OF SESSIONS

The original series of six sessions were designed to follow a general outline, as set out in the opening chapters above, but, as it unfolded, the topics varied somewhat with the interests of

the participants and the minor variation in attendance. The basic structure unfolded substantially as follows:

1. June 3. Introductions and speaking to the general question how my life has changed as a result of the loss.

2. June 10. Introductions again as Julia attended for the first time. The participants discussed their primary relations with the deceased during the later years as primarily that of care giver.

3. June 17. Introduction of the deceased to the group with photos and to relate a story or a description.

4. June 24. What was the legacy that the deceased left to me? What was the imprint that the deceased person left on my life?

5. July 1. How did community support, interfere, or impose upon my grieving? What was my experience with other people?

6. July 8. How can people best support someone in mourning. What can our congregational community creatively and compassionately contribute to someone's mourning process?

After the sixth session, five of the participants decided to continue and we conducted two more sessions:

7. July 22. Can the Ethical Society community develop a regular practice or procedure to mobilize when a member loses a loved one?

8. August 5. Once again, is there a role for the community in private grief?

F. THE INTRODUCTIONS

Session One

I measure every grief I meet
With narrow, probing eyes -
I wonder if it weighs like mine
Or has an easier size.
Emily Dickinson

The first several sessions were required for the participants to become acquainted with each other. The group established a practice of making at least one go-around during a session by which each person talked in turn going around the room and taking the time she needed to complete her story. On the first evening, when we reached the 90 minute mark we had still not heard Beth tell her story. I reminded everyone that the time was up and that we would begin the next meeting with Beth. No one wanted to wait, however, and they insisted that we give her the time to express herself. That required us to stay an extra 20 minutes, setting a new, longer timetable to which we adhered thereafter.

This formalism by which people took turns speaking one at a time, going around the circle, continued for the first four sessions. It was not until the fifth session that the process relaxed and the participants developed a more natural back and forth conversational tone.

During the first session, it was clear that there was as much posturing as self presentation. For example, Amy mentioned only a word about her son whose death had brought her to the group. Instead, she went right into her divorce which occurred ten years later. In her telling, she had two losses, but it seemed more likely that her emphasis on the divorce was a means of establishing a stature among the group members. It would not be until much later that she would link the two events by attributing at least part of the reason for the divorce as an outcome of the tensions arising with the tragic loss.

Michelle also diverged from the topic. Her "second event" was the rupture with her older son which occurred quickly on the heels of her mother's death. To her it was a puzzlement that her older son, the one with the bright future, would marry rather suddenly as he did, declare independence from his mother and then cease talking to her. The group followed Michelle's lead and concentrated on the son's story, leaving the mother's to such other time as may prove convenient. The connection between Michelle's absorption in her mother's care and her son's decision to leave remained unexplored until later.

It was rare for anyone's story about her deceased loved one to resemble a biography. No one's deceased existed except in a relation to the speaker or to other family members. Most often, people spoke about themselves and so the deceased's life was disclosed primarily in reflection. This is certainly an expression of the deep interconnectedness in our lives.

Session Two

It's not the weight you carry
But how you carry it -
books, bricks, grief -
It's all in the way
you embrace it,
Balance it, carry it.
Mary Oliver (2007)

This was more the case for those who lost their mothers. In our intake interview, Michelle had described her mother as a formidable, powerful figure. She was a medical doctor and the matriarch of a family of seven children. Her process of decline with age and the emergence of Alzheimer's disease was an epochal transformation in Michelle's eyes as she watched her mother diminish in power. However, within the group, this did not come out clearly. Instead, Michelle talked as much about her frustration with her son as she talked about the challenge presented by her mother. Was that, in fact, the greater loss? Once, another member actually interrupted her discussion about her mother to have her talk again about her son.

At the third session, the participants were to "introduce" their deceased and share pictures. Michelle chose to present her mother by means of an old newspaper clipping which contained a photograph of the whole family with all the children debarking in America under the headline that described them as the first refugees from Taiwan to arrive under a certain program for immigrating professionals leaving post- revolutionary China.

Claire's story of her mother was almost entirely about herself and her struggle for recognition. When Claire was a child, parental attention was rare and, even when given, it was not to her but rather to her older sister. Her predicament of neglect was patently obvious to all who witnessed her life including, she reported, her aunt and uncle who lived nearby. She explained that her mother's life had been wholly consumed by serving her husband, a selfish and demanding individual. When her father died after a long illness, well into his 90's, Claire's mother had her first experience living on her own outside the shadow and domination of her husband. But then her health quickly started to deteriorate, owing either to the first attention she paid to her own needs or because her fortitude was drained from selflessly serving her exigent husband.

As the mother's needs emerged, Claire saw herself in competition with her older sister over providing her care. The sister is a highly accomplished individual, a successful medical doctor living in Alaska who is also married to a doctor. The mother went to visit Alaska to see the facilities available for her there and then went to New York to see the facilities that Claire lined up for her to see. The mother found Alaska to be culturally unfamiliar and chose New York to live. Claire saw

Session 3

Mother died last night.
Mother who never dies.

Nocturne [excerpt],
Louise Glück (2006)

this as a victory over her sister, as mother chose her. Claire devoted the next half-dozen years to the assiduous care and support of her mother until she died in her 90's. Claire explains that she really only met her mother for the first time, in any significant way, during this time which they had together.

In describing her mother, there were few characteristics that she conveyed other than her bland and featureless obsequiousness under the continuous domination of her husband. The story about Claire's mother was a story about herself and her empowerment.

Beth's description of her mother was quite poignant. She described a woman who was constrained -- nearly caged-in -- by her marriage to a non-communicative and blinkered, unpleasant and distant, husband. For example, she loved to dance and to listen to jazz, in none of which her husband showed any interest or offered any support. She eventually left him when she was in her fifties and Beth described a scene of her mother in a moment of exhilaration and joy, and, for Beth, embarrassment, shouting at the top of her lungs "I'm free!!" as she moved her things out of the marital home in the New York suburbs. Unfortunately, she soon thereafter fell ill from heart disease and, after a short hospitalization, she died leaving her newly gained freedom unfulfilled.

Beth brought in six photos when we shared pictures of the deceased. Only one actually contained her mother. And, in that photo, she was not alone. Many of the pictures were of Beth herself as a young girl.

The ones whose husbands were discussed also had this tendency to lean on context in describing the deceased. Julia spoke very little about her husband as himself. She spoke about her 56 year marriage and how she knew him since she was 16. She described how he was sick

for many years, and he was able to courageously care for himself even into his declining years, until the Alzheimer's took over. Julia spoke of the assiduous care she took of him after he was moved into the nursing home and she found the staff too inattentive. She brought in a portrait photo of her husband. In the intake interview I had asked Julia what her husband did for work and she explained that he was a salesman of commercial wood products. But his work never came up in the group. Although I find his work history interesting, it is simply possible that Julia would not expect the other women to be at all interested in his work, so long as it was not one of the esteemed professions.

Eva brought in a photo of her husband Sammy which was a family picture that included Eva and their adopted daughter then in her teens. Eva's theme was one of unremitting guilt for all the things that she failed to do for Sammy and for the trouble she felt she caused him. She did tick off several of his good qualities and accomplishments, such as having built upon his experience as a taxi driver to write a book about taxi culture and tourist information which he strove to get published. He became involved in a local radio station and was often on the radio to talk about local issues. He was gregarious and made friends. All these recitations led to reasons for further flagellation. Eva felt she frustrated his ambitions by failing to maintain a welcoming home in which he could entertain, or by failing to cook for him and easing the pressures on him. She explained that she actually caused his death by frustrating his most simple and natural needs. Further discussion made it clear, however, that Sammy had terrible heart disease, a stratospherically high cholesterol level, he became overweight and he smoked. He was, in fact, a heart attack waiting to happen. And, what's more, he apparently enjoyed cooking.

Session Three

"We cannot, after all, judge a biography by its length, by the number of pages in it; we must judge by the richness of the contents...Sometimes the 'unfinished' are the most beautiful symphonies."

Viktor Fankl (1986)

This led to a short discussion on causation. How responsible are we for the bad things that happen to our loved ones? How easy is it to blame oneself for things not under one's control? It was acknowledged that ruminations of all the "but for's" are useless but inevitable. Even Julia, whose husband was so ill for so long, felt that she was inevitably a failure because she did not halt his death. As writers have observed, guilt often accompanies grief as part of the bereavement process (Lindemann, 1944; Frankl, 1986; Tatelbaum, 2008).

Lucy gave a clearer, more clinical description of her husband Will. They were married for ten years, but knew each other considerably longer having shared a social circle. Will got Lucy a job in the plumbing supply warehouse where he worked as a result of which they became familiar with the same industrial goods and they would talk shop together. In Lucy's intake interview she was more frank than she was to be in the Group about the stress of living with a committed alcoholic. Working in the same place of employment meant that she felt burdened with the need to cover up his mistakes and his absences. She had to be constantly on the lookout for his failings, in order to clean them up before they were discovered. The weight of living with an alcoholic sapped her. She overlooked her own self care. In the group, though, Lucy more or less skipped to the part where she began to feel unsafe with Will's alcohol and his guns and she ultimately left him and moved back with her mother in her childhood home.

All the participants agreed that they served as care givers to the person for whom they grieved. Only Beth demurred at that. The swift course taken by her mother's last illness,

coupled with Beth's absorption with her own new infant, meant that she did not have the time to devote to her mother's care. Actually, it was as a child that she had been placed in a position of the care giver. Her mother confided in her, burdening her with the role of confidante and parent to the parent, a likely transmission vector of inter-generational depressive symptomology (Halligan, 2007). When in her teens, her mother underwent treatment for breast cancer and Beth assumed much of the responsibility in caring for her younger siblings. But fifteen years later, when her mother was confronted with her final illness, Beth had little left within her for her mother. There seemed to be a twinge of regret in that confession how she rejected the task. Yet there was no clear, undistilled love between Beth and her mother. There was admiration and a kind of solidarity, but no closeness.

Michelle is the youngest of seven children, but as she was the only one who remained in the New York area where their mother lived, the job of caring for her fell to Michelle when the Alzheimer's disease progressed. She did not intend to be the primary care giver, but it was, as she described, a "slippery slope." Overseeing the maintenance of her mother's house as it became neglected, supervising the aides who watched over her, and finally moving her into a nursing home, became her burden to shoulder. Unlike Claire, for whom the assignment was a triumph, Michelle was ambivalent about defaulting into the position -- but she rose to the challenge. She said that later she looked back and could be proud of the way she mastered the labyrinths of insurance, social security and medicare. It was work. "Palliative care" is not passive, she summed up. "There are myriad needs to answer for."

After her mother died, Michelle felt a release; she was released, as she explained, "from the sandwich generation" in which she was being ground down from having to support two generations, her mother and her children. After the death, she experienced liberation.

G. LEGACY

Week four was devoted to the question "What legacy did the deceased leave me?" or "What imprint did the deceased person make upon my life?"

This topic was designed to explore the notion of immortality - - the characteristics, the spirit or the sense of presence of the deceased that lives on in the survivor. We always say that the deceased lives on within us and that they remain immortal so long as we remember them. So, how in fact does the deceased stay with us...as a sweet memory or as a haunting one? As both?

Session Four

Joy and woe are woven fine
A clothing for the soul divine
Under every grief and pine
Runs a joy with silken twine.

Augeries of Innocence [excerpt]
William Blake (1968)

Beth did not rise to the topic until I suggested that a legacy need not be positive; that one can be left with a burden. She first reflected on how her mother's enjoyment of music stayed with her and that she always enjoyed jazz as well. She also mentioned how when she gets angry in traffic she may react in anger, and hear her father's voice speaking through her.

But Beth also recalled that the death of her mother coincided with the migration of all her siblings, one by one, to California. Eventually, even her father moved out there. This left her completely alone in New York without any family relations. The legacy she was depicting was a reign of loneliness, of abandonment.

What Beth did not discuss, despite gentle prodding, was whether there was any reflection in her own life of her mother's frustration in marriage and her father's lack of success as a husband and father. Beth never had the fully committed relationship that she craved as she raised her daughter alone. Is her mother's true legacy a distrust of marriage and a fear of entrapment in an unhappy relationship? Was her solitude a pre-emptive rejection of any husband who might be like her father? Does her mother still warn her?

Lucy looked forward to the session in which we were to discuss legacy. When it was her turn, she had a prepared story for us, a pat, set piece. Will worked in a plumbing supply business, when they started dating, and he was professionally informed about plumbing fixtures, including the brands, styles and designs. Out at a restaurant of an evening, Will might return to their table from the men's room with a lively description of the plumbing equipment and fixtures. Lucy considered this to be a strange way to take the office home.

Soon after they were married, Will got her a job in the same plumbing supply business. As time went by, Lucy became more and more familiar with the inventory and soon they were both happily exchanging stories about the bathroom installations they saw and admired.

But over the course of the sessions, Lucy also reflected on how she hit "bottom" shortly after Will's death. When Will died, she had been left reverberating with the long-term effects of codependency, which included the pressure to make up for all his shortcomings and the overbearing burden of trying to fulfill two lives at once. Her descriptions of the aftermath were disturbingly similar to the symptoms of PTSD, which have been seen to emerge from such experiences (Price, 2007; Van den Bout & Kleber, 2013). His death meant not only that he

abandoned her, having so completely chosen alcohol over her and that he left her without the children and family she desired, but also that she had somehow failed in her support of him.

Within a couple of months she experienced a severe medical emergency of her own. She suffered a severe asthma attack in an allergic reaction to the medication administered in a routine cataract operation. It was, for Lucy, one loss and one disaster following another. In a nadir of despair while lying in a hospital bed, she felt that she was confronted with a stark and pressing choice whether to succumb to death or to struggle back to life. She recalled the moment she made the conscious choice to live.

Her firm and emphatic choice to live was realized by abandoning much of what made up her life at that time and by taking on completely new activities. Hungrily, she took courses, changed churches, sought out new people and she never moved back into her marital home. The legacy that was bequeathed to Lucy was a compulsive flight from entrapment.

Claire explained that the legacy left by her mother was the joy from having come to know her mother for the first time and for finally being accepted by her. She experienced a powerful self validation in having been able to "mother her mother." Claire found fulfillment, if not an apotheosis, in assiduously tending to her mother as she spared virtually no effort or expense in order to make sure all her needs and wishes were fulfilled. Claire felt that her mother recognized these efforts and was pleased. She was quick to say that she achieved serene satisfaction in knowing that she bested her supremely successful older sister by having accomplished all this without her aid or her interference.

For Eva, the legacy was a haunting sense of inadequacy and regret. While blaming herself for Sammy's unfulfilled life and relatively early death, she remained stuck in many ways

and did not move on. She still lives in their marital apartment. From time to time she still passes by the community room in which she held his big surprise 60th birthday party, and then his funeral gathering just a few weeks later. Passing by the community room causes her a twinge to this day. Eva has a knack for changing the subject to social causes or the plight of endangered animals whenever she gets too close to the topic of her life following Sammy's death. She began to take in stray cats after he died and after her daughter, who was 21 at that time, married and moved to Florida.

Julia's loss was much more fresh than that of the other widows. For her, loneliness and despair are a significant presence. She has also experienced a series of health problems since Lucas died. She missed one session because of a medical treatment on her knee and she can no longer drive at night, causing her to depart from the Group early as the days grew shorter to avoid the drive in the dark. Julia saw her legacy partly in her three children who are now grown. One of her two sons, an unemployed nurse, lives with her. He has health issues and his care beckoned as a new form of occupation. By the end of our program, however, he moved out of state to pursue a job opportunity. Julia's daughter lives nearby, but a tense relationship with her son-in-law makes her feel unwelcome there. So, as Julia explains it, her life is dominated by loneliness and Lucas's legacy is his palpable and unrelieved absence. He was a good companion, cheerful and gregarious. Julia never complained or recounted an unpleasant story. Recalling him, she said, reminded her of good times and pleasant memories.

Like Claire, Michelle devoted the last years of her mother's life intently engaged in her care. In trying to describe legacy, Michelle would revert to her own experience rather than the long shadow her domineering mother actually cast. She had been a successful parent, judging

from her children's success in their own lives. Michelle, as well as almost all of her siblings, are professionals. Michelle has a nursing degree and later obtained a law degree and developed an independent law practice. When speaking of legacy, Michelle divulged how, soon after her mother's death, she felt an almost giddy sense of release. She took a travel vacation for the first time in several years.

But there was the last important lesson imparted: Michelle was proud of the strength she was able to summon and the competence she exercised in order to meet the challenge that her mother's illness posed. After it was over and her duty fulfilled, she expressed pride in her accomplishment. Her mother would have expected no less.

Session Five

This is the moment when you see again
the red berries of the mountain ash
and in the dark sky
the birds' night migrations.

It grieves me to think
the dead won't see them--
these things we depend on,
they disappear.

What will the soul do for solace then?
I tell myself maybe it won't need
these pleasures anymore;
maybe just not being is simply enough,
hard as that is to imagine.

Louise Glück (2007)

H. THE COMMUNITY'S CONTRIBUTION

An important focus of the project was to investigate the role of community when a congregation member would experience grief and mourning. Therefore, I was very interested in the participants' experiences with community interactions at the time of loss and for a period thereafter.

Only one of the participants, Julia, had actually been an active member of a congregation at the time of her loss. Julia was a member of the Unitarian Universalist Church for several years. Previously, she was a member of a Unitarian Church in Brooklyn which was smaller and

more family-style. There, she found a rich, intimate and supportive community and she had numerous friends and acquaintances in the neighborhood. She moved to our county in her 60's in order to be closer to her daughter's family. Julia complained that this congregation is much larger than her old church and is cold and alienating. She also had complaints about the minister and she felt that she never felt accepted or recognized there. However, she was active in a small discussion group within the Church. Many of the members of her discussion group attended Lucas's funeral and she expressed satisfaction in that.

Julia's husband was Jewish by origin and she sat shiva for a few days in her home. Interested in Julia's experience with the custom of sitting shiva, I asked if that gave her an opportunity to share with family and friends. Julia, however, found the practice a burden. She did not want the visitors when she preferred to mourn and she resented having to offer her guests food.

Although this was a sample of only one person applying the Jewish custom, it was revealing to me how a standard practice will not serve everyone's needs.

For Lucy, the ethnic background of her husband's family was widely mixed but included some Irish blood. His family organized a wake. But the wake proved to be a terrible ordeal for her. Several people used the opportunity to confront her with inappropriate and disturbing talk which did little to help in her situation. One fellow tried to openly court her under the virtual gaze of Will's corpse. A woman of their social circle took the opportunity to say very nasty things. Here too, although there was a sample of only one family employing this form of practice, the result was not a happy one in this instance.

None of the other participants were members of a congregation and no one had that kind of a community to rely on. They all were primarily supported by, or confronted with, family.

Eva had the next most formal event, offering hospitality for her husband's family and her own in the community room of her apartment complex after the largely improvised grave side funeral. Eva chided herself for having spoken too much and too long at the grave side. She was given help by her brother-in-law in hosting the funeral gathering but, after that, she had only her small circle for support. In addition to her 21 year old daughter who resided with her, her sister lived in Boston and other family members lived in other cities. What would she have preferred to have? Eva does not say she that lacked adequate support at the time. But considering how quick she is to accept punishment for her presumed failings, it is likely that she felt her unhappiness was deserved.

Session Six

How joyous!,
passing this time alone
with your father, how bright his golden laugh
which drew you to laugh yourself uncontrolled,
how sweet the happy hour oysters you two pry
and eat,
piling wobbling shells that glisten on the table
while the pianist plays by the kitchen doors.
You find yourself reminded of what you wrote
in the eulogy: that you two would still possess
a relationship even though
he was dead, that you could still
go and speak with him
when you dreamed
and so you see the seat opposite from you seats
no one.

Cruel Cogito
Ken Chen (2013)

Beth concluded that she could have benefitted from community support at the time of the loss, but more because of the life challenges with which she was quickly confronted. All her siblings moved to California and left her with no family support structure nearby. She had a new child and had no financial help. Recalling her "community," she could only point to the Lebanese grocer in the neighborhood who would cash her paycheck and who did not reject her when the payroll checks sometimes

bounced. Eventually she joined the local Ethical Society and that community and its Clergy Leader embraced her.

Claire did not complain of a lack of support after her mother's death. She had one relative to talk to, her mother's elderly sister, and with whom she could feel connected to her family. Her principal support and consolation is always her son who was twenty when his grandmother died. While Claire did not have any kind of congregational community, there was little perceived need. While the loss was real, the death was experienced partly as the fulfillment of an assumed task. It was the completion of a job well done.

For Michelle as well, it was the immediate family that was the entire community surrounding her and supporting her after her mother's death. Although she had been the one to bear the greatest burden of her mother's care, she felt it appropriately her job to complete the final arrangements. The sudden rupture with her elder son was the event that promptly consumed her and she couldn't really mourn for her mother alone. She did not agree that the break with the son was in any way a result of the death of her mother, although she would not rule it out. Clearly the long process of caring for her and all the arrangements that had to be made and supervised, first while she remained at home and later when she was transferred to a nursing home, absorbed Michelle's time and attention leaving less for her own children. The son's resentment may have built over time. However, as a doctor himself, one would think he could acknowledge how much work the care of an elderly woman in her condition would require.

I. THE CONTRIBUTION OF THE COMMUNITY - CONCLUSIONS

Although the participants are all members of a congregational community today, only Julia was an active member of a congregation when she experienced her loss. Therefore, the discussion turned mostly on what a community, such as the one in which each is now a participant, could have provided rather than what a community actually did offer them at the time. This discussion was generated with the question, "What did you miss?" and "What would you recommend your Ethical Society do for others?"

There was a great deal of hesitancy in making a general statement and there was no agreement. Everyone's situation appeared to be different and there were few common threads.

But at the same time, it appears that two answers emerged. On the one hand, the participants did not see any specific role that they would like to have seen undertaken by people who are not in their immediate family. During the time of loss one is so vulnerable and hurting that a person ought to be hesitant to intrude at such a private moment. This was a concrete recommendation from the group. The second answer may seem to contradict the first: the need for some form of personal contact is also paramount.

The distilled answer is that a friendly and companionable presence would be welcome but a maladroit intrusion is not welcome. How to order up the first and discourage the second when working with a diverse community of inexperienced, though well-meaning, people is not simple.

The presence of a sympathetic companion is accepted as a necessary balm, even if there is no specified role being fulfilled. It is the mere presence that needs to be offered. As explained by Judy Tatelbaum (2008), there may be different people who individually possess skills appropriate to serve different companionship functions. One person may help by talking and

commiserating, while another may do some needed food shopping, and yet someone else may do nothing at all but offer a calm presence. Lucy recalled that when her father died unexpectedly sending her family into a deep shock, a simple fruit basket sent to the house was extraordinarily welcome. This small gesture served to literally nourish the whole family while they were nearly paralyzed with grief.

One practical problem seen in the functioning of a typical Ethical Society is the inefficiency of the congregational news network. If someone finds himself or herself in the hospital, there is often insufficient notice to others in the community. Even when there is a formal caring committee with identified people who are tasked to serve as middlemen and transmitters of such information, the news does not always reach them from family members or others who are knowledgeable. Because so many within Ethical Culture come from other traditions, the survivor may be the only one in the entire extended family with ties to the Society.

But, assuming that that challenge were overcome, one suggestion was to assign a special companion to the person in mourning, who would probably be that person's closest friend in the Society. That person's role could be to regulate the participation of others, through visits or more involvement in ways that will appear appropriate and responsive to the mourner's evident needs. Where the family is present and active, then such a person could take a subordinate, but supportive role in representing the entire community for the help it can offer.

J. THE COMMUNITIES WE CREATE

Where is the Community?

A central goal of exploration for the project was to understand the role of the "community" in the mourning process and its role with respect to one's integration of the grief and loss experience. The question poses several initial areas of orientation.

Primarily, there is the question of identifying one's community. In traditional or perhaps rural societies, the community is self defining. The old and traditional practices that were forged in small communities did not present a dilemma of identifying the participants. One's neighbors in the village were the community and custom dictated what their duties were in these circumstances. In a small village, where most people resided in earlier times, people were well acquainted with each other and, when a death occurred, everyone was immediately aware of the fact.

When a Jewish family in the shtetl sat shiva, the entire village came to visit and participate. When a rural Irish family conducted a wake, the whole village was expected to attend. In a French village, there would be the one church for everyone situated in the center of town. The death notice was printed in the bans and posted in the square, in case a straggler did not hear the news right away.

In our urban society, communities are defined less by geography and more by interests, activities and, to some extent still, family lines. Someone today can live in a city of a half million people and know nobody there well. One's family and childhood friends can be dispersed across the continental United States. Who among the circle of concern is within a reasonable distance to visit? ... to offer the casseroles?... to sit quietly and offer companionship?

In the Group's discussions, the participants described different experiences in identifying their own community and in receiving support. Only Eva, with her harsh self criticism, failed to complain about a lack of support. Generally, the participants expressed dismay at the lack of understanding and sensitivity among the people who attended to them.

For example, Lucy was given a great deal of support by her brother after Will's death. However, he had his own strong opinions about how Will was blameworthy and he would not accord the deceased any respect, an attitude which disturbed Lucy. His duty, as he saw it, was to pick up for Lucy after her disastrous marriage and put things aright. She was both grateful for the assistance, but deeply resentful of her brother's judgmental attitude and this exacted a toll on her. Other people from her social circle were similarly insensitive and harsh. There was no one among her community of intimates that could be of help to her in her grieving process. She had no one to talk to.

Similarly, Beth found herself in virtual solitude living with her baby in Brooklyn. Her siblings moved away from New York and she had no natural, core of support. Consumed with the challenges of starting off in her own life, she could not stop to grieve the untimely loss of her mother.

Michelle was the only one still residing along with her mother in New York out of a family of seven siblings. While her husband was her principal support, he did not share the loss as she did. Moreover, there was no other group she felt that she could turn to. Instead, she found distraction in the newly emerging problem with her older son and his sudden and puzzling rebellion.

Julia, who was a congregation member at the time of her loss, still missed the small church community and circle of friends that she had gathered back in her old neighborhood in Brooklyn. Here, she felt unconnected, lonely and poorly understood.

Claire, whose customary approach to life has always been the brave and solitary struggle, took it as a natural condition to have few people to whom to turn.

What the participants discovered was that the Bereavement Group itself formed a community and that it had certain characteristics and offered certain support that made it effective and superior to the "natural" community existing in the outside world.

Given the special attributes of a purposeful, directed and facilitated group experience that is devoted to nurturing the needs of someone experiencing grief, it is understandable that the participants would find a much more meaningful connection with the other group members than with ordinary well wishers. What with the rocky reception the participants received in their respective communities, it is no surprise that they found the Bereavement Group itself far more amenable to growth and healing.

Originally, the project was expected to solicit ideas concerning the engagement of the congregation at large in assisting in the mourning process for members. But the participants responded with the recognition that amateurs and casual well wishers do not necessarily have the sensitivity, the skill or the courage to offer a kind and reliable presence. While the attentiveness of close friends in the congregation or other members mobilized on behalf of the one in mourning can certainly be gratifying, there is still no guaranty that the help offered will not exacerbate matters by being simply inartful or inept.

It was the group itself that was recognized as the non-judgmental, accepting, and supportive community that was best suited to an individual in mourning. Instead of mobilizing the congregation at large, the conclusion offered by the participants was that the Bereavement Group should be a permanent feature of our communities - - an on-going bereavement group that would offer the presence that any newly affected person will need. Our county, with three Societies in proximity, could hopefully support this on-going project.

The shortcomings of an ordinary caring committee in any Society and the difficulty in expecting it to perform at a high level for bereavement support is apparent. Firstly, the basic mission of a caring committee is to react promptly, long before any meaningful bereavement work can begin. The extent of its activities might be the recognition of the person's loss with a floral arrangement delivered to the home and assuring a visit by the clergy leader and other members of the congregation. Second, the skills of the caring committee members may not be drawn from personal experience, as are those of the Bereavement Group members.

The experience of loss to death is sufficiently unique in life that one's first reaction is to feel set apart and different from everyone, to feel marked and branded as a kind of alien (Didion, 2008). Thus, one feels unaccountably alienated from the natural communities in our lives, such as the congregational community that we subscribe to, as well as other affinity groups and shared interest groups which we adopt and to which we belong, or our professional associations. Instead one is apt to see that we can only share this pain with someone who has also experienced loss through death.

As a result, the community to which the participants could turn was the community that they themselves had created in this grief group. This is similar to the experience of those in other

groups like veterans groups, AIDS groups, and Alcoholics Anonymous - - that only those who have also "been there" can relate to what I say and mean. As Yalom(2005) observes, this has, in fact, led to a wide array of specialized therapy and focus groups.

Sometimes, there can be quite a fine distinction to be made in defining the shared experiences for which people self-select. As described in the Postscript, below, Sarah (who joined the group after the project was officially over) found that another grief group, one specifically designed for those who lost a child, was more relevant than ours to her precise situation. She left us for that other group. Naomi, however, who was expected to join after Sarah left, found our group sufficiently relevant. She lost her elderly mother, as had Michelle and Claire, who both stayed on with the group.

The Group found that the community they created was the community they sought. So, it was our conclusion that the formation and maintenance of a special grief group would uniquely serve the needs of a Society and its members who have experienced loss.

This led to the recommendation that the Bereavement Group group continue in existence and serve the larger Ethical Culture community of the whole county.

K. INDIVIDUAL OUTCOMES

Each participant participated in an exit interview after the eighth session during which we reviewed the behaviors and conditions identified in the grief assessment tool that had been used in the initial interview in order to detect any measurable change that occurred since the project began. The purpose was to ascertain whether the experience within the group served to enhance coping skills and to enable the participant to better integrate the experience of loss into a

coherent and satisfactory life narrative so as to promote a grounded sense of well-being. The responses are summarized in Appendix B.

The assessment tools proved to be blunt instruments that sought data on only the most gross and blatant symptomology of complex grief, of which the participants reported little. The assessment tools were less helpful for capturing the more subtle conditions and feelings that were truly present. As in the intake interview, it proved more useful to engage in a guided conversation in which the participant could be asked open-ended questions about how she felt and whether she could report improvement or not.

As none of the participants had reported experiencing prolonged or complex grief symptomology at the outset, the exit interviews did not reveal anything new to suggest it. There was no reported craving or pining, confusion of role, or diminished sense of self, for example. There were no reports of anger or emptiness, enduring shock or avoidance. As explained below, only Michelle and Julia had reportable symptoms of any kind.

As for the Hamilton Anxiety Scale [Appendix C], the questions were waved off by the participants as wholly missing the mark. The survey seeks a measure of the subject's reported tension, anxious mood, fears, insomnia, and the like. The only responses of note were Julia, who experienced somatic reactions, and Michelle, who reported a new fear of death. The interviewer is to mark down if the subject, fidgets, trembles or paces. None of this occurred at the intake interview, and there was little to compare at the exit.

Nevertheless, the participants generally reported a feeling of improvement. For some, like Beth, Lucy, Eva and Michelle, there had seldom or never been an opportunity to frankly discuss the subject of their grief with others who were patient and interested enough to allow

them to share their stories and explain themselves. They reported feeling a relief from being able share their feelings and unburden themselves from the weight.

Lucy, who lost her husband ten years earlier, did find that the Group revived old feelings of sadness. She lost sleep from the renewed anxiety as the past was brought so present once again. But the opportunity to talk enabled her to recapture the good memories as well. She appreciated that there were others who listened and tried to understand what she lived through. She felt that she could have benefitted from participation in a bereavement group at the time and that it could have helped out of her "void," as she called it.

But equal to being heard herself, Lucy credited the opportunity to hear others' stories as well as her own. Seeing the way others coped with their challenges fortified her in dealing with her own. Clearly, these are among the benefits that Yalom described, which included learning from the experiences of others.

Julia lost her husband a year and a half before the group began and experienced the freshest and most intense symptoms of grief. At the outset, she had reported continued crying and a sense of abandonment and yearning. She had somatic complaints in the form of numerous health issues that emerged in the time since Lucas's death. At the exit, Julia scored negative on all the main indicators for prolonged grief.

At the exit interview, Julia reported coping much better and was concentrating on caring for her own health issues which, unfortunately, were compounding. Julia had reported somatic symptoms at the initial interview, and still reported them at the exit. It is not clear whether her health decline was the result of her grief or of having the opportunity, after caring for Lucas so intently for so long, to finally rediscover her own needs. She appreciated the Group for letting

her see what happened with others and thereby allowing her to recognize that she is not alone in her transition. She has since become involved in another grief group in addition to our own and began seeing a bereavement counselor at Westchester Jewish Community Services. She credited the opportunity to tell her story to a lightening of her burden. However, loneliness remains her biggest challenge as she seems to have few friends around her.

Eva did not report improvement. She enjoyed participating in the Group and appreciated the closeness the participants felt and shared, and she reported having realized the importance of "presence" during times of stress. She felt that the group offered something that was unavailable elsewhere. On the other hand, she said that her sense of guilt was still strong and that talking about it did not alleviate it. She wouldn't say that she grew through the experience, stating that she still has too much stress with her cats, her clutter and her late husband's disabled friend for whom she is caring as a form of "penance." Eva recapitulated some of her regrets, and she indicated that she would want to continue to participate in the Group, hoping she would have an opportunity to talk about other things as well, including her long dead mother whose shadow still looms over her.

Claire, whose mother died at an advanced age a year prior to the group's formation, reported that the group was tremendously important to her. Speaking with the other participants gave her a new perspective on her loss and pulled her "out of a narrow groove," in her words. It "helped alleviate the trauma of her loss" which she had been "carrying alone."

Claire had had no other opportunity to share in her grief and she found sharing to be the important factor in enabling her to integrate the loss. She was very eager to have the Group continue.

Michelle had reported several indicators of continuing (though not complex) grief at the intake interview. She found it hard to get along with certain other people after the loss (in particular, her elder son) and reported having lost interest in family, friends and outside activities. She found it hard to sleep and found it hard to accept the loss. Through her experience with the Group, the sad feelings she reported at the outset have been greatly relieved. She reports fearing death much less than she had at the outset.

Although the Group reopened some anxious feelings about the "process" of caring for her mother and watching her in decline, the act of articulating the experience was good for her. It was helpful to have the human contact and she felt able to connect with the others who were similar enough to herself in age, education and as articulate as she. Michelle reported "feeling better" than when the group began. She recognized now that bereavement is "not a forgetting process, but a learning process."

In contrast to the others, Beth reported that the Group only served to open old wounds and rekindled her feelings of sadness and regret. She did not want to extend her participation after the original six sessions. Beth complained that no one seemed interested in her story and that others dominated the discussion. For an example of a positive impact, she found it a "revelation" to hear another say that she forgave her mother. While Beth was not able to achieve that for herself, the experience offered a learning opportunity for her own possibilities.

Beth's experience reflects a life narrative that is firmly fixed and resistant to revision. Of course, her mother died some thirty years ago, so it does not serve as a turning point for a redirected life at this stage. However, I regretted that Beth did not see that the process of telling

of her story could serve more for her own benefit. The others are there as witnesses of her growth, not as her audience.

In an instance of revealing transference,[1] Beth spoke to me between sessions at a Sunday morning coffee and expressed anger and disappointment in me for having attempted to terminate the first meeting before she had the opportunity to tell her story. It was the other participants who had intervened on her behalf and "saved" her, as she recalled. Of course, I had been adhering to our pre-set schedule when signaling its end and I clearly announced that Beth would start the next session because she didn't have a chance to speak tonight. In her history, Beth experienced a lack of confirmed commitment from others and a continuing disappointment in others on whom she might have relied. Her lack of a long term partner was one illustration of this lack of mutual commitment. The blame to which I was treated had reënacted the rage and the repulsion with which Beth may have confronted her disappointments in much of her life.

It is clear that the impact of the project upon the individuals and their unique needs was generally positive. The grief and anxiety inventories were not as useful as anticipated. But the self assessment process of the exit interviews clearly established for all the participants except Beth, and to a lesser extent Eva, that the Bereavement Group experience helped the participants integrate their feelings and learn from each other.

[1] Transference is the redirection of a client's feeling toward a significant object from the past over to the therapist. It serves as an important tool of understanding and insight into the client's attachments and affects. (Freud and Strachey, 1989).

L. IT IS ALL IN THE STORIES WE RELATE

The most powerful aspect of the process was in the telling of the stories. The participants gauged their success by having the opportunity to *tell their story* and they learned from the others by hearing theirs. Beth's principal complaint was that she couldn't confirm that her story was heard. She apparently needed more mirroring than she received from the others and it was not until the exit interview that she revealed her dissatisfaction.

As for the format of the sessions, the offering of opening words in the form of selected poetry or the introduction of a subject was appreciated, although not expressly so. Any mention, however, of a topic bearing on the "spiritual" or what might be deemed as clichéed or formulaic was promptly waved off and ignored. This was not entirely surprising, as it is the usual reaction among many Ethical Culture adherents. See, Religious Principles, above.

The participants did not engage in formal projects such as biographical writing or art activities. The activity proposed at the first session to write a few pages at home on the meaning of legacy was mocked as "homework." Nevertheless, there was adequate opportunity for creativity and discovery in the narratives that the participants orally exchanged. The satisfaction that most participants expressed concerning the tenor of the discussions does seem to reinforce the notion that through the stories we relate, the "fundamental reality-creating function of the human mind" (Neimeyer, 2009) is unleashed and can assist in putting order and meaning into the life through which we journey.

M. CONCLUSION

I am confident to say that the project was successful in serving its two principal goals. First, it served as an effective group experience where the participants were able to confront and process their individual experiences of grief and bereavement. In the short duration of the sessions, not everyone achieved a major breakthrough. However, the group functioned well and most participants reported improvement. In the exit interviews, my own performance as facilitator received generally good reviews. The criticism that I did get was from Beth who felt that I did not monitor the discussion firmly enough, leading to her feeling blocked out at times by the imposition of "some of the others." Julia complained that my humor was sometimes "sarcastic." To one I was aloof and to the other, I intruded.

For the other goal, the development of a practice which might be instituted for the Ethical Societies in the future, I believe that we devised a group process that can be continued for the local region in which it operates now, and it can be replicated in other regions. In areas where several small Societies exist, or for a large Society on its own, an on-going bereavement group may very well offer a service that will be valuable for the community and for those who lose loved ones in the coming years.

N. POST SCRIPT

As the Group approached the sixth and last session, there was agreement among six of the participants to go on for a seventh and eighth session at two-week intervals, rather than weekly. As that deadline approached, there was a movement to keep the Group going still further, primarily promoted by Claire. However, the next sessions were interrupted by construction

which shut down the Ethical Society Meeting House for several weeks into mid-September. Then, peoples' other commitments intervened. Claire, the one most eager to continue, enrolled in a course on Monday nights and Julia said she could no longer drive at night, so we explored a Saturday morning time slot. It also appeared that some new people were interested in joining and that gave new impetus to the Group and offered an opportunity to apply our lessons to the cause of others.

On Saturday morning, November 2, 2013 we held the first resumed session. All those who expressed an interest in continuing did attend, except for Eva who warned me that she wasn't a morning person. That day we were joined by a new participant, Sarah. Just a month earlier Sarah lost her 26 year old daughter to a fatal mixture of prescription and over-the-counter medications. It was invigorating to have a new concern to share and the older members were very accepting and shared their stories economically to bring her into the circle and to leave Sarah space to share hers. Although Sarah acknowledged the warm acceptance she received, she later decided to concentrate on another bereavement group that specifically serves those who lost a child.

The next session was scheduled for three weeks later, because the facilitator had a prior commitment on the second following Saturday. Thereafter, the year end holidays intruded and the next session is scheduled, as of this writing, for January 4, 2014. Another member of my own Society expressed interest in participating - - Naomi, who lost her elderly mother in September.

O. THE RECOMMENDATION FOR THE FUTURE

Based upon the recommendation of the participants, a request is being made to the clergy-leaders of the three county Societies to adopt and support the activities of the Bereavement Group as an on-going activity. By giving more formal recognition to the Group, there is greater likelihood that new members will be referred to it. As the leaders themselves will have the earliest awareness of the loss and bereavement suffered by a Society member, it is likely that they would be in the best position to refer.

We were invited to place a new notice in the monthly newsletter of two of the Societies to inform the membership of the on-going Bereavement Group. Appendix F is a copy of the new solicitation notice.

APPENDIX A

Texas Revised Inventory of Grief (with some changes)

Part I Past Behavior

Think back to the time this person died and answer all of these items about your feelings and actions at that time by indicating the best response for each item as it applied to you after this person died, as follows:

A) Completely True,
B) Mostly True,
C) Both True and False,
D) Mostly False,
E) Completely False

1. After this person died I found it hard to get along with certain people.
2. I found it hard to work well after this person died.
3. After this person's death I lost interest in my family, friends, and outside activities.
4. I felt a need to do things that the deceased had wanted to do.
5. I was unusually irritable after this person died.
6. I couldn't keep up with my normal activities for the first three months after this person died.
7. I was angry that the person who died left me.
8. I found it hard to sleep after this person died.

Part II Present Behavior

Now answer all of the following items by checking how you presently feel about this person's death. Do not refer back to Part I.

1. I still cry when I think of the person who died.
2. I still get upset when I think about the person who died.
3. I cannot accept this person's death.
4. Sometimes I very much miss the person who died.
5. Sometimes I feel a sense of yearning for the person who died.
6. Even now it's painful to recall memories of the person who died.
7. I am preoccupied with thoughts (often think) about the person who died.
8. I hide my tears when I think about the person who died.
9. No one will ever take the place in my life of the person who died.
10. I will never be able to enjoy things any more.
11. I can't do the things I used to do now that (s)he is gone.
12. I can't avoid thinking about the person who died.
13. I feel it's unfair that this person died.
14. I am angry at (or about) the person for having died.
15. Things and people around me still remind me of the person who died.
16. I am unable to accept the death of the person who died.
17. At times I still feel the need to cry for the person who died.

Responses to Texas Revised Inventory of Grief

		Amy		Barbara		Claire		Eva		Julie		Lucy		Michelle	
Part I		Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit	Entry	Exit
	1	B		D		E		D		D		D		B	
	2	A		D		E		D		D		B		D	
	3	A		D		E		D		D		D		B	
	4	D		D		E		D		D		B		D	
	5	B		D		E		D		D		B		D	
	6	A		D		E		D		D		B		D	
	7	D		D		E		D		B		B		D	
	8	A		D		E		D		A		D		A	
		also guilt						felt aban-		also isolation		also avoidance			
Part II								donned							
	1	C	no exit	D	D	C	D	B	B	B	C	B	C	D	D
	2	D	interview	D	D	D	D	D	D	B	C	C	C	D	D
	3	D		D	D	E	E	D	D	C	D	D	D	C	D
	4	B		D	D	B	B	B	B	B	B	B	B	D	D
	5	B		D	D	D	D	B	C	B	C	C	C	D	D
	6	E		D	D	D	E	C	C	D	D	D	D	C	D
	7	E		D	D	D	D	D	D	D	D	D	D	D	D
	8	B		D	D	C	D	D	D	D	D	D	D	D	D
	9	B		D	D	D	D	B	B	B	B	D	D	B	B
	10	D		D	D	E	E	D	D	D	D	D	D	D	D
	11	D		D	D	D	D	C	C	C	C	D	D	D	D
	12	D		D	D	D	D	D	D	D	D	D	D	D	D
	13	B		D	D	D	D	B	B	D	D	D	D	D	D
	14	C		D	D	D	D	D	D	D	D	D	D	D	D
	15	B		D	D	D	D	C	C	B	C	D	D	D	D
	16	D		D	D	D	D	D	D	D	D	D	D	D	D
	17	C		D	D	D	D	D	D	B	C	D	D	D	D
										also holds onto obj					

APPENDIX C

HAMILTON ANXIETY SCALE (HAM-A)

Patient Name _____ Today's Date _____

The Hamilton Anxiety Scale (HAM-A) is a rating scale developed to quantify the severity of anxiety symptomatology, often used in psychotropic drug evaluation. It consists of 14 items, each defined by a series of symptoms. Each item is rated on a 5-point scale, ranging from 0 (not present) to 4 (severe).

0 = Not present to 4 = Severe

Score

☐ 1. ANXIOUS MOOD
- Worries
- Anticipates worst

☐ 2. TENSION
- Startles
- Cries easily
- Restless
- Trembling

☐ 3. FEARS
- Fear of the dark
- Fear of strangers
- Fear of being alone
- Fear of animal

☐ 4. INSOMNIA
- Difficulty falling asleep or staying asleep
- Difficulty with Nightmares

☐ 5. INTELLECTUAL
- Poor concentration
- Memory Impairment

☐ 6. DEPRESSED MOOD
- Decreased interest in activities
- Anhedoni
- Insomnia

☐ 7. SOMATIC COMPLAINTS: MUSCULAR
- Muscle aches or pains
- Bruxism

☐ 8. SOMATIC COMPLAINTS: SENSORY
- Tinnitus
- Blurred vision

☐ 9. CARDIOVASCULAR SYMPTOMS
- Tachycardia
- Palpitations
- Chest Pain
- Sensation of feeling faint

☐ 10. RESPIRATORY SYMPTOMS
- Chest pressure
- Choking sensation
- Shortness of Breath

☐ 11. GASTROINTESTINAL SYMPTOMS
- Dysphagia
- Nausea or Vomiting
- Constipation
- Weight loss
- Abdominal fullness

☐ 12. GENITOURINARY SYMPTOMS
- Urinary frequency or urgency
- Dysmenorrhea
- Impotence

☐ 13. AUTONOMIC SYMPTOMS
- Dry Mouth
- Flushing
- Pallor
- Sweating

☐ 14. BEHAVIOR AT INTERVIEW
- Fidgets
- Tremor
- Paces

APPENDIX D

Ethical Culture Bereavement Group

For people within the Ethical Culture community in Riverdale and Westchester a special bereavement group is forming to meet for approximately 6 weekly sessions during the late winter/early spring. This group is designed for those people who have experienced the loss of a loved one and for whom grief remains fresh and unresolved, whether the loss occurred recently or in the past.

The bereavement group will be small, comprising approximately 8 participants, and will engage in a mutual exploration into the growth to be achieved and wisdom to be learned through the experience of loss and bereavement. We will also explore what Ethical Culture and the Humanist point of view might have contributed to the experience - was it comforting, supportive, relevant, or left behind? Participation will be an opportunity for reflection, growth and enrichment through sharing one's own experiences and learning from those of others.

The group will be facilitated by Richard Koral, a long-time member of the Westchester Ethical Culture Society in White Plains. This is a project being organized by Richard in connection with his studies towards a Doctor of Ministry degree in the interfaith pastoral counseling program at the Hebrew Union College in NYC and is under the supervision of the College. Richard is in training for Leadership in Ethical Culture and the pastoral counseling degree program is a part of his Leadership training.

Please call to register your interest in the bereavement group no later than January 21, 2013. Richard can be reached at (914)763-5328 and (914) 260-2214 or at RichardLKoral@optonline.net.

APPENDIX E

Bereavement Group Participation Agreement

The Bereavement Group is intended to be an exploration and healing experience for adults with unresolved bereavement issues. It will be of limited duration, consisting of six weekly sessions, during which the participants will learn from their own and others' experiences in order to better integrate their loss and work towards reestablishing a sense of wholeness and healing.

The Bereavement Group can offer its participants a valuable opportunity to experience meaningful and enriching growth. It is the goal of the facilitator that you reap all the benefits that the Group will have to offer. In order to assure this, the Group will be structured to include the following elements:

- A safe environment in which you are able to feel respected and valued
- An understanding of group goals and group norms
- Investment by both your facilitator and participants to produce a consistent group experience.

Confidentiality. A safe environment is created and maintained by both the facilitator of the Group and its participants. A primary ingredient for a safe environment is confidentiality. Your group facilitator is bound by law to maintain confidentiality. Group participants are bound by honor to keep what is said in the group in the group. As a participant, you agree to maintain and respect the confidentiality of the statements made by your fellow participants.

Understand, however, that there are certain limits in law to confidentiality. For example, should a court of law demand that matters be disclosed, they must be. There are also legally mandatory reporting requirements concerning matters that include instances of child abuse or child endangerment, elder abuse, and the threat of future harm to oneself or to others.

Respect. Other primary ingredients are mutual respect and a chance to create trust. There are certain rules and guidelines for the manner in which the Group will interact to best promote trust, openness and free communication which are so necessary to an effective group experience. These will include listening with an open heart, non-judgmental attending, and respecting the space of others.

Attendance. Your presence in all Group sessions is important. A group dynamic is formed that helps create an environment for growth and change. If you are absent from the Group this dynamic suffers and affects your experience and that of the other participants in the Group. Therefore, your facilitator asks that you make this commitment a top priority for all the sessions. It is understood that occasionally an emergency may occur that will prevent you from attending the Group. If you are faced with an emergency or sudden illness, please contact the facilitator before the Group session begins to let him know you will not be present.

The facilitator of the Group will be Richard Koral, who is currently a candidate for the degree of Doctor of Ministry at the Hebrew Union College Interfaith Pastoral Counseling Program. The organization and facilitation of this Bereavement Group is a project for his degree program and is being undertaken under the supervision and support of the College.

I agree to participate in the Bereavement Group in accordance with the foregoing.

_____

APPENDIX F

Ethical Culture Bereavement Group Meets Bi-weekly

For those who lost a loved one and for whom the loss remains an unresolved and open hurt, whether as a recent occurrence or from long ago, a bereavement support group meets twice a month at the Ethical Culture Society in White Plains. Participants engage in a mutual exploration into the growth to be achieved and wisdom to be gained through the experience of loss and bereavement. The loss of a loved one will irrevocably change one's path in life, and finding one's new path can be a challenge of revival, redefinition and renewal, all while honoring the memory of the deceased. Drawn from the community of Ethical Culture, the Group offers a welcoming and supportive atmosphere for the reflective search for meaning and provides an opportunity to share one's experience through such a life-altering event and to learn from the experiences of others.

Meetings are held twice a month in White Plains and are facilitated by Richard Koral, an Ethical Culture Leader-in-Training and candidate for Doctor of Ministry in Interfaith Counseling at Hebrew Union College. For more information call him at 914 260-2214 or write to RichardLKoral@optonline.net.

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