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Intervention for the bereaved: Gender differences in the efficacy of two counselling programmes

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This article describes an investigation of emotion-focused versus problem-focused intervention for widows (N = 23) and widowers (N = 23) who were suffering elevated levels of distress 11 months after their loss. They were randomly assigned to an intervention condition and improvement (on the General Health Questionnaire) was compared with non-intervention controls (N = 59).

Two alternative hypotheses were considered: (1) men, since they focus less on their emotions, would benefit from problem-focused counselling, while women, focusing more on their emotions, would benefit from emotion-focused intervention; (2) each gender, having been comparatively unsuccessful in coping through these usual strategies, would benefit more from intervention directed towards the less familiar strategy. Results supported the second hypothesis: widowers benefited more from emotion-focused, widows from problem-focused interventions. Implications for supporting widows and widowers are discussed.

That bereavement can have health consequences severe enough to necessitate professional intervention is by now well established (cf. Jacobs, 1993). Following this, a number of studies have focused on the development and evaluation of psychotherapeutic interventions (e.g. Brom, Kleber & Defares, 1989; Horowitz, Marmar, Weiss, DeWitt & Rosenbaum, 1984). In broad terms, intervention programmes can be differentiated into those that provide therapy for severely complicated grief reactions versus counselling for less severe but nevertheless debilitating consequences (c.f. Worden, 1991). Evaluation studies have so far concentrated on the former, that is, on the development and evaluation of psychotherapeutic interventions for complicated grief (for a review, see Raphael, Middleton, Martinek & Misso, 1993). There has been little systematic research on the efficacy of interventions that would fall within the counselling category. This would seem an important extension of previous research, since such complications are relatively frequent (cf. Osterweis, Solomon & Green, 1984).

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Conspicuously lacking, too, has been any examination of gender-specific effects of grief counselling and therapy. Many studies have been limited to the effects of counselling widows alone (Constantino, 1981; Marmar, Horowitz, Weiss, Wilner & Kaltreider, 1988; Raphael, 1977; Walls & Meyers, 1985). Although women outnumber men among the conjugally bereaved (approximately 80 per cent of the total in Western societies), this might limit the generalizability of the results. An earlier review showed widowers to be more vulnerable to the health consequences of bereavement than widows, when these were compared with within-gender levels of symptomatology for non-bereaved (Stroebe & Stroebe, 1983). Yet it is still unclear whether men or women benefit more from grief counselling and therapy or whether gender is a specific therapy indicator.

There are reasons to assume that there might be gender differences in the efficacy of different types of counselling. In general, problem-focused coping strategies are more often found among men (Folkman & Lazarus, 1980; Pearlin & Schooler, 1978; Stone & Neale, 1984; Vingerhoets & van Heck, 1990). Emotion-focused coping strategies are, on the other hand, more often found among women (Billings & Moos, 1981; Folkman & Lazarus, 1980; Vingerhoets & van Heck, 1990). Furthermore, although studies of the gender-specific effects of coping on health are rare, some studies suggest problem-focused strategies in men to be more effective (Billings & Moos, 1984; Hovanitz & Kozora, 1989) and lack of control over oneself or the situation to have a more detrimental effect in men (Schut, de Keijser, van den Bout & Jaspers, 1991). No methodologically sound scales for coping with bereavement are as yet available, and specific items on scales for coping with stressful life-events in general are, in our view, inappropriate to bereavement (such as the inclusion of items on humour as a coping style). Furthermore, they do not assess grief-specific coping behaviour (such as retention of the deceased's possessions or visiting his/her grave). It has thus been impossible to establish gender differences in emotion- versus problem-focused coping with loss. Nevertheless there are reasons to assume gender differences along this dimension. Suggestive was the pattern of gender differences found by Stroebe & Stroebe (1989). Widowers who were coping better (low depression rates) were more willing to discuss their grief in an interview situation than widowers who were coping less well. The opposite was the case for widows.

In line with this lack of attention to gender differences, grief intervention programmes thus far have failed to take into account the fact that men and women may be coping with loss in very different ways, and may therefore need different kinds of support. If, in general, women cope with bereavement by confronting their loss more then men, by talking to others and expressing their emotions freely, as has been suggested, then it would seem plausible to expect differences between bereaved men and women in the ways that intervention helps them. However, it is unclear whether in counselling of mildly complicated grief each gender would benefit from a furtherance of their usual way of coping or from an extension of their coping repertoire. Thus it would seem timely to extend the study of bereavement intervention efficacy to differential effects on men and women.

The study described here was a controlled efficacy investigation of grief counselling for elevated levels of distress in the second year of bereavement,

focusing on gender differences. It examined the impact of two different counselling programmes on widows versus widowers. It was hypothesized that the bereaved in intervention groups would show a stronger decrease in levels of distress than those in a control group. Following the patterns of gender differences in coping described above, two equally plausible hypotheses are suggested: (1) men benefit more from problem-focused, women from emotion-focused counselling, since these programmes support each gender's 'preferred' strategy; (2) men benefit more from emotion-focused, women from problem-focused intervention, since the 'preferred' strategy had not worked well for either gender (given their mild complications).

Method

Participants

Widows and widowers under the age of 65 were included in the study in order to minimize confounding of grief and problems of old age. The bereaved were located through obituary notices in national and local newspapers in The Netherlands. They were mailed a letter introducing the study, which was followed up by a phone call to ask whether they would agree to participate. Questionnaires were mailed to the bereaved who agreed to participate. Only those bereaved who reported medium to high levels of distress (General Health Questionnaire scores 5^{+}) 11 months after their loss (baseline) were considered eligible for inclusion in the counselling programme. Accordingly, 358 (59 per cent of the participants) met the criteria and were telephoned to offer counselling, of whom 79 (22 per cent) accepted. Those who accepted had higher scores on the General Health Questionnaire at baseline than those who refused counselling (mean 14.7 (SD 5.3) vs. 13.0 (SD 5.4), $t(356) = 2.61, p < .01$). No other differences were found between the two groups. Sixty-six widows and widowers completed all seven counselling sessions, which were conducted within a period of 10 weeks, and which took place between 14 and 17 months after bereavement. The bereaved were randomly assigned to emotion-focused ($N = 33$) or problem-focused grief counselling ($N = 33$). Drop-out occurred mostly after the second session. No differences were found between the drop-outs and those who completed counselling on socio-demographic characteristics, circumstances of loss, or on baseline levels of distress. In addition to the 11-month baseline measurement, data were collected at 18 (post-treatment) and 25 months (follow-up) after the loss of the partner.

Both intervention programmes were tailored for this study and were designed for the treatment of elevated levels of distress following bereavement (de Keijser & Schut, 1991). Counselling was done by 26 experienced social workers trained in one of the two protocols. No differences were found between these two groups of social workers with regard to demographic characteristics, socio-economic background, experience in grief counselling or counselling in general. Likewise, no differences were found with regard to evaluation of the protocol, the training or their expectations regarding the benefits of the programme. Neither the social workers nor the widowed people were aware of the existence of a counselling condition other than their own.

A non-intervention control group was included in the study. This was systematically selected from a parallel study, the purpose of which was to monitor the course of grief (see Schut, 1992). A subgroup was selected to match the intervention groups on baseline levels of all major variables including distress, gender and cause of death. The total sample of 132 participants consisted of 76 per cent widows; mean age of the sample at baseline was 54.2 years (SD 9.8); the mean education level was 2.3 years (SD 1.0) on a five-point scale (1 = low, 5 = high); and the mean level of income 2.0 (SD 0.6) on a three-point scale (1 = low, 3 = high). On average, the widows and widowers had been married for 27.3 years (SD 9.3) and had 2.4 children (SD 1.4). The main cause of death of the partner was cancer (46 per cent), followed by heart diseases (42 per cent), natural causes (8 per cent) and fatal accident (3 per cent). In 1 per cent the cause of death was unknown. Extensive comparisons between subgroups were carried out to ensure equivalence on all relevant variables (see Schut, 1992). No differences between the three

conditions were found with regard to the variables itemized above, other characteristics to do with circumstances of loss, or socio-demographic variables, except for level of income, which appeared to be higher in the problem-focused condition ($F(2,126) = 3.41$, $p < .05$). Since income did not correlate significantly with distress at any time point (r ranged from –.05 to –.14), this group difference was not taken into consideration in further analyses.

Female partners of the participants had more frequently died of cancer (72 vs. 37 per cent), while the male partners had more often died of heart diseases (50 vs 19 per cent) and other causes (13 vs 9 per cent, $\chi^2(2) = 12.33, p < .01$). Male participants in general were also more highly educated than the women in the study ($t(117) = 2.04, p < .05$). No other gender differences were apparent, and since neither differentiating variable was associated with distress at any time point, this was ignored in the analyses too.

Design and measure of psychological adjustment

Psychological adjustment was assessed using the General Health Questionnaire (GHQ–28; Goldberg & Hillier, 1979). This frequently used questionnaire was designed for the detection of non-psychotic psychiatric disturbances in general communities and is generally accepted to be a reliable and valid instrument for this purpose (Goldberg & Williams, 1988). In this study one authorized adaptation of the questionnaire was made. Instead of assessing the respondent's symptom level during the previous week compared with the usual level of functioning, a comparison was made with level of symptoms prior to the loss of the partner, since the pre-/post-bereavement comparison was more relevant here. They were asked for the comparison with 'how they felt in general' before the death of their husband/wife.[1] Cronbach's alpha for the GHQ in this study ranged from .91 to .93.

The counselling protocols

Both protocols were based on the task model of grief developed by Worden (1991). Worden described the grief process as consisting of four tasks the bereaved person has to accomplish. The first is to accept the reality of the loss; the second is to experience the pain of grief; third, the bereaved has to adjust to an environment in which the deceased is missing; and fourth, the bereaved has to emotionally relocate the deceased and to find a way to move on with life.

Both protocols consisted of seven sessions, the first four on a weekly, the last three on a biweekly basis. Interventions were aimed at reestablishing the dynamics of the grief process.

In terms of coping theory (Billings & Moos, 1981; Lazarus & Folkman, 1984), the first protocol can be characterized as problem focused, specifically aimed at changing behaviours that *hinder the grief process*. This protocol was semi-structured. After a first introductory session, three sessions were spent on individual problems and the last three on social problems with the loss. The interventions contained elements of gradual exposure (systematic desensitization) and rational emotive therapy. The interventions can best be described as aimed at tackling behaviours and cognitions that complicate the grieving process, such as rumination over the loss, continuous social withdrawal, embracement of a victim perspective, sanctification of the deceased and non-acceptance of the finality of the loss.

In terms of coping theory, the second protocol can best be described as emotion focused, since it was specifically aimed at the acceptance of emotions and emotional discharge. It used specific counselling elements, such as empathy, to create an atmosphere of openness and understanding in which the bereaved could explore their emotional reactions to the loss. These ranged from sadness to relief and from anger to anxiety.

Counselling sessions were audiotaped and immediately sent to the research team for supervision purposes. The supervisors (H.S. and J. d.K.) evaluated whether or not the interventions were provided as described. All counselling sessions were judged to be eligible for the study.

[1] Although there were gender differences in causes of death, analyses showed that there were no significant differences between males and females in expectation or awareness of their partner's impending death. This result rules out the potential confound that differential post-bereavement symptomatology (and gender-related effects of intervention) could be attributable to pre-bereavement differences in distress levels, associated with the expectation of loss.

Analyses

The differences in the course of symptomatology were analysed by means of (time × condition × sex) (M)ANOVAs over repeated measures, using polynomial contrasts in order to analyse (linear and cubic) trends in changes over time. Furthermore, Cohen's *d*s were computed to assess the magnitude of change (Cohen, 1988), and the Reliable Change Indices were used to assess clinically relevant individual change in participants (Jacobson & Truax, 1991). This index offers the possibility to interpret change in individuals and subgroups in terms of improvement and deterioration.

Results

Results are presented for the 46 widows and widowers who completed counselling and who participated until follow-up (23 in the problem-focused and 23 in the emotion-focused condition), and for 59 controls with complete data sets. As for the intervention subgroups, participants in the study did not differ from drop-outs on any of the measured characteristics.

Course of symptomatology. Analyses of variance of repeated measures (MANOVA) showed a significant linear decline in GHQ scores of the participants over the three data collection points ($F_{lin}(1,102) = 49.97, p < .001$). Mean scores dropped from 14.9 (SD 5.0) before intervention, to 12.3 (SD 5.7) post-treatment ($d = .48$), to 11.1 (SD 5.7) at follow-up ($d = .71$).

Differences in counselling condition. In Table 1 GHQ scores are presented for the three conditions separately over the three data collection points.

Analysis of variance with repeated measures revealed a trend with respect to the time × condition interaction ($F_{lin}(2, 102) = 2.96, p = .06$). Univariate tests suggest a significantly smaller decrease in distress in the control group ($t_{lin} = 2.29, p < .05$). For the problem-focused condition a trend towards a decrease in time was revealed ($t_{lin} = -1.86, p = .07$). Cross-sectional ANOVAs only revealed a significant group difference in GHQ scores during follow-up ($F(2,102) = 3.57, p < .05$), with a Scheffé test indicating that this was due to differences between the control and the problem-focused condition. The magnitude of change at follow-up also appeared to be highest in the problem-focused condition ($d = 1.24$), compared with the emotion-focused condition ($d = .85$) and the control condition ($d = .49$).

Table 1. Mean GHQ scores by condition at the three data collection periods (standard deviations in parentheses)

	N	Baseline	Post-treatment	Follow-up
Problem-focused counselling	23	14.9 (4.9)	10.9 (5.2)	8.8 (4.0)
Emotion-focused counselling	23	14.7 (4.8)	12.5 (6.4)	10.4 (5.3)
Non-intervention	59	15.0 (5.1)	12.7 (5.6)	12.3 (5.8)

Table 2. Reliable Change over the GHQ scores by condition, at post-treatment and follow-up (absolute numbers in parentheses)

	Post-treatment			Follow-up		
	Improvement	No change	Deterioration	Improvement	No change	Deterioration
Problem-focused counselling	26% (6)	70% (16)	4% (1)	35% (8)	65% (15)	0
Emotion-focused counselling	13% (3)	78% (18)	9% (2)	26% (6)	70% (16)	4% (1)
Non-intervention	10% (6)	90% (53)	0	20% (12)	76% (45)	4% (2)

In Table 2 results are presented of the categorization of individual changes according to Reliable Change criteria. As the table shows, if one looks at the percentage of clients actually improving right after intervention, problem-focused counselling led to somewhat better results. At follow-up about one-third of the problem-focused intervention group had significantly improved as compared with a quarter of the emotion-focused condition and a fifth of the non-intervention condition. All in all, problem-focused counselling slightly outperformed emotion-focused intervention on short- as well as longer-term effects, and both intervention programmes produced somewhat better results than no treatment at all.

Gender differences. MANOVA showed only a non-significant linear trend in the interaction between gender and condition over time ($F_{lin}(1,99) = 2.96, p = .09$). Since the samples were small when subcategorized, it seems reasonable to assume that this is due to lack of power. Further examination of the data with regard to gender differences therefore seemed worthwhile. Magnitude of change in terms of Cohen's *d* is presented in Table 3. A clear pattern emerged from these results: Table 3 indicates that problem-focused counselling is more effective in women and emotion-focused intervention leads to better results in men. Problem-focused intervention made no difference at all to men and emotion-focused counselling hardly at all to women. Furthermore, problem-focused intervention also appeared to have a short-term impact on widows, while emotion-focused intervention had its impact only at follow-up.

While none of the widowers in the problem-focused condition showed improvement at follow-up, half of those in the emotion-focused condition did so. On the other hand, half of the widows in the problem-focused group showed improvement, while only 21 per cent of those in the emotion-focused condition did so.

Table 3. Cohen's *d* for the GHQ scores by condition and gender

	Post-treatment			Follow-up		
	Men	Women	Total	Men	Women	total
Problem-focused counselling	.02	1.17	.79	.20	1.84	1.24
Emotion-focused counselling	.32	.39	.39	1.16	.76	.85
Non-intervention	−.19	.42	.43	.24	.56	.49

Note. $d = .2$ = small; $d = .5$ = medium; $d = .8$ = large (Cohen, 1988).

Discussion

Fundamental questions addressed in this research asked whether intervention programmes for the bereaved actually help, and whom they help. More concretely, the

study focused on gender differences in the efficacy of different types of intervention.

The study demonstrated the efficacy of two counselling programmes for the treatment of mildly complicated bereavement: both emotion-focused and problem-focused counselling protocols were moderately effective in a statistical sense. Of the two, problem-focused intervention showed slightly better results. However, such a statistical finding tells us little about its clinical relevance. Actual improvement may be minimal, even if significance has been reached, and there may also be deterioration in some clients. Thus, further analyses of the magnitude of changes within conditions were conducted. The results provided, in our view, important information about what kind of counselling was better for whom.

Systematic gender differences in the efficacy of the two counselling programmes were found. These supported the second rather than the first hypothesis: widowers benefited more from an emotion-focused approach, while widows showed better results after problem-focused counselling. There was no support for the alternative hypothesis that women would benefit more from counselling aimed at the emotional impact of loss and by being more empathically supported by a counsellor, nor that men would have greater benefit from interventions focused on behavioural change.

There are at least two plausible explanations, which are complementary rather than conflicting: (1) *Extension of the coping repertoire*. As Watzlawick, Weakland & Fish (1973) already suggested, more of the same does not generally lead to successful tackling of the problem in psychotherapy and counselling. Following this line of reasoning, as well as traditional sex-role conceptions (which would seem applicable to this older sample), it would stand to reason that men could best be helped by emotion-focused interventions. After all, their usual style of problem-focused coping had not worked (they had mild complications after 11 months). Women, who are more inclined to make use of emotion-focused strategies, may best be helped by interventions not primarily aimed at the emotional impact of the event, but at being stimulated in changing their situation. (2) *Assistance in coping within less familiar sphere*. It is also plausible that the source of the difficulty in coping with bereavement lies in the other sphere (i.e. emotional orientation in widowers, problem orientation in widows). Instead of guiding the bereaved to an alternative strategy, as the extension explanation suggests, this suggests that coping deficits have occurred within the less familiar sphere. For example, widowers may have difficulty expressing emotions, particularly when they have lost the very person who would listen to them. Emotion-focused counselling would then provide the skills and opportunity to talk to a sympathetic other and thereby provide support in the sphere where there is a deficit.

What are the implications for intervention? First a word of caution is needed. In general practice people typically solicit help, while in this study, as in most grief intervention research (see Schut, 1992), participants were offered counselling. To our knowledge, no evidence is yet available in the literature to establish whether method of approach would be a relevant variable in the patterns of results. We would also like to note that pre-intervention coping styles were not directly measured in this study, due to the inappropriateness of established scales for bereavement, discussed above.

Based on our review of the literature, we assumed that the bereaved in this sample would follow the typical pattern of sex differences.

In general, the problem-focused intervention protocol led to better results for these mildly complicated cases of bereavement, and since it is also reasonable in terms of time and costs investment, there are good reasons to recommend it, despite moderate effects. However, the gender differences in the efficacy of the two protocols must be taken into account in the planning of bereavement intervention. We have demonstrated systematically different needs and benefits of bereaved men compared with bereaved women: according to our results, while problem-focused counselling seems indicated for widows, a more emotion-focused counselling programme seems more appropriate for widowers who have elevated levels of distress following their bereavement.

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References

Billings, A. G. & Moos, R. H. (1981). The role of coping responses and social resources in attenuating the stress of life events. *Journal of Behavioral Medicine*, **4**, 139–157.

Billings, A. G. & Moos, R. H. (1984). Coping, stress, and social resources among adults with unipolar depression. *Journal of Personality and Social Psychology*, **46**, 877–891.

Brom, D., Kleber, R. J. & Defares, P. B. (1989). Brief psychotherapy for posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology*, **57**, 607–612.

Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences*, 2nd ed. Hillsdale, NJ: Erlbaum.

Constantino, R. E. (1981). Bereavement crisis intervention for widows in grief and mourning. *Nursing Research*, **30**, 351–353.

de Keijser, J. & Schut, H. A. W. (1991). *Individuele Rouwbegeleiding: Een Programma voor Hulpverleners (Individual Grief Counselling: A Program for Counsellors)*. Houten: Bohn Stafleu Van Loghum.

Folkman, S. & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behaviour*, **21**, 219–239.

Goldberg, D. P. & Hillier, V. F. (1979). A scaled version of the General Health Questionnaire. *Psychological Medicine*, **9**, 139–145.

Goldberg, D. P. & Williams, P. (1988). *A User's Guide to the General Health Questionnaire*. Windsor: NFER-NELSON.

Horowitz, M. J., Marmar, C., Weiss, D. S., DeWitt, K. N. & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions: The relationship of process to outcome. *Archives of General Psychiatry*, **41**, 438–448.

Hovanitz, C. A. & Kozora, E. (1989). Life stress and clinically elevated MMPI scales: Gender differences in the moderating influence of coping. *Journal of Clinical Psychology*, **45**, 766–777.

Jacobs, S. C. (1993). *Pathologic Grief*. Washington, DC: American Psychiatric Press.

Jacobson, N. S. & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, **59**, 12–19.

Lazarus, R. S. & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York: Springer.

Marmar, C. R., Horowitz, M. J., Weiss, D. S., Wilner, N. R. & Kaltreider, N. B. (1988). A controlled trial

of brief psychotherapy and mutual-help group treatment of conjugal bereavement. *American Journal of Psychiatry*, **145**, 203–209.
Osterweis, M., Solomon, F. & Green, M. (Eds) (1984). *Bereavement: Reactions, Consequences and Care*. Washington, DC: National Academy Press.
Pearlin, L. I. & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behaviour*, **19**, 2–21.
Raphael, B. (1977). Preventive intervention with the recently bereaved. *Archives of General Psychiatry*, **34**, 1450–1454.
Raphael, B., Middleton, W., Martinek, N. & Misso, V. (1993). Counselling and therapy of the bereaved. In M. S. Stroebe, W. Stroebe & R. O. Hansson (Eds), *Handbook of Bereavement: Theory, Research and Intervention*, pp. 427–456. Cambridge: Cambridge University Press.
Schut, H. A. W. (1992). *Omgaan met de Dood van de Levenspartner: Effecten op Gezondheid en Effecten van Rouwbegeleiding* (*Coping with Conjugal Bereavement: Effects on Psychological Functioning and Effects of Grief Counselling*). Amsterdam: Thesis Publishers.
Schut, H. A. W., de Keijser, J., van den Bout, J. & Jaspers, J. P. C. (1991). Omgaan met de dood van de levenspartner: Sekseverschillen in de eerste maanden na het overlijden (Gender differences in coping with loss in the first months of conjugal bereavement). *Gedrag & Gezondheid*, **19**, 93–103.
Stone, A. A. & Neale, J. M. (1984). New measure of daily coping: Development and preliminary results. *Journal of Personality and Social Psychology*, **46**, 892–906.
Stroebe, M. S. & Stroebe, W. (1983). Who suffers more? Sex differences in health risks in the widowed. *Psychological Bulletin*, **93**, 279–301.
Stroebe, M. S. & Stroebe, W. (1989). Who participates in bereavement research? A review and empirical study. *Omega*, **20**, 1–29.
Vingerhoets, A. J. J. M & van Heck, G. L. (1990). Gender, coping and psychosomatic symptoms. *Psychological Medicine*, **20**, 125–135.
Walls, N. & Meyers, A. W. (1985). Outcome in group treatments for bereavement: Experimental results and recommendations for clinical practice. *International Journal of Mental Health*, **13**, 126–147.
Watzlawick, P., Weakland, J. H. & Fish, R. (1973). *Change*. New York: Norton.
Worden, J. W. (1991). *Grief Counselling and Grief Therapy*, 2nd ed. New York: Springer.

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