General Introduction

Objective and research questions

This thesis is about bereavement interventions for the widowed in general and about a visiting service for older widowed individuals in particular. This visiting service, which is derived from the widow-to-widow program originally designed by Silverman (Silverman & Cooperband, 1975), is a bereavement intervention administered by trained volunteers who are all widowed themselves. The objective of bereavement interventions for the widowed, like the visiting service, is simply to help the widowed cope with their grief. Whether the widowed actually need help to adapt to their loss and whether bereavement interventions really help, however, has been strongly debated (Schut, Stroebe, van den Bout, & Terheggen, 2001). This thesis will examine this topic by answering five questions:

1. Do widows and widowers need help?
2. Which widows and widowers need help?
3. Is the visiting service for older widowed individuals an effective intervention to help the widowed and for whom might it be effective?
4. Is the visiting service for older widowed individuals cost-effective?
5. For which widows and widowers is the visiting service for older widowed individuals particularly cost-effective?

Before we will further address the research questions and the way we will come to an answer, we will clarify some underlying concepts. We will briefly consider what is meant by normal and abnormal bereavement and we will briefly discuss bereavement interventions in general. Subsequently, we will present the outline of this thesis.

Normal bereavement

Bereavement (the situation of a person who has recently experienced the loss of a significant other) is well-recognized as a very stressful experience, marked by tremendous emotional pain. In most cases, bereavement can be viewed as a normal experience and most individuals are able to resolve their grief over the course of time. What normal bereavement looks like, however, has been debated for several years and is still not completely defined. For a long time, the prevailing view was that the bereaved had to go through a series of stages or phases (Bowlby, 1980) in order to come to terms with his or her loss. Several bereavement researchers, however, have questioned the accuracy of stage models to explain adaptation and recovery (Barrett & Schneweis, 1980; Silver & Wortman, 1980; Wortman & Silver, 1992). Currently, phases of grief are no longer seen as fixed and sequential. Instead, the bereaved is believed to fulfill certain tasks during the grieving process (Worden, 2002). In addition, the notion that grief must be worked through in order to resolve it is also debated (Silver & Wortman, 1980; Stroebe & Stroebe, 1991).

Abnormal bereavement

Despite the absence of a consensus on the course and timeframe of a normal grieving process, it is well-documented what abnormal bereavement looks like. In the first place, there are several psychiatric disorders that are often associated with bereavement.
The most mentioned bereavement-related disorder is Major Depressive Disorder. Major Depressive Disorder is a mood disorder characterized by either depressed mood (dysphoria) or loss of interest or pleasure (anhedonia), which is present most of the day, nearly all days, for at least two weeks. Combined with several other symptoms, such as sleep disturbance, diminished ability to concentrate, feelings of worthlessness, loss of energy, recurrent thoughts of death and suicidal ideation, this depressed mood or loss of interest causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 1994).

Other bereavement-related disorders are Post-Traumatic Stress Disorder, which is characterized by repeatedly reexperiencing the traumatic event (which is in this case the - unexpected - death of the loved one), persistent avoidance of stimuli associated with the trauma (death), numbing of general responsiveness and persistent symptoms of increased arousal (American Psychiatric Association, 1994), and Generalized Anxiety Disorder, which is characterized by excessive anxiety and worry in combination with symptoms like restlessness, irritability, muscle tension and sleep disturbance (American Psychiatric Association, 1994).

Another, often cited pattern of abnormal grieving is complicated grief. Complicated grief is not yet incorporated in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), but is widely recognized as very distressing and disabling (Jacobs & Kim, 1990; Middleton, Raphael, Martin, & Misso, 1993; Prigerson et al., 1995; Prigerson et al., 1996; Prigerson et al., 1997). In order to determine whether a set of symptoms interpreted as complicated grief could be identified and distinguished from bereavement-related depression, Prigerson et al. recruited a study group of 82 recently widowed elderly individuals. A principal-components analysis conducted on intake data revealed a separate complicated grief factor and a bereavement-related depression factor. Seven symptoms constituted complicated grief: searching, yearning, preoccupation with thoughts of the deceased, crying, disbelief regarding the death, feeling stunned by the death, and lack of acceptance of the death (Prigerson et al., 1995). The distinction between complicated grief and other bereavement-related disorders has later been confirmed in other studies (Ott, 2003; Prigerson et al., 1996).

Bereavement interventions

In the past decades, numerous bereavement interventions have been developed in order to help the bereaved cope with their grief and to prevent abnormal grieving. Bereavement interventions are defined as interventions developed to benefit bereaved persons in terms of alleviating the emotional and –to a certain extent- practical problems following the loss of a loved one. Types of intervention can vary from self-help groups to psychotherapy.

Conventionally, preventive interventions can be divided into universal, selective and indicated preventive interventions. General or universal bereavement interventions are usually outreaching interventions that are open to all bereaved persons. Access is at most limited to certain subgroups of the bereaved, such as widows or bereaved parents. However, these subgroups are not characterized as high risk groups. Selective bereavement interventions are directed towards bereaved individuals with a high risk profile. Bereaved individuals with a high risk profile are more likely to experience an abnormal form of grief. Indicated bereavement interventions are targeted towards persons who already are experiencing abnormal bereavement.
Besides some positive effects of universal prevention for bereaved children, there is hardly any evidence for the effectiveness of general or universal bereavement interventions (Schut et al., 2001). Although universal bereavement interventions that applied inreaching procedures (the intervention is offered to those who requested it themselves rather than being offered on an outreaching basis) appear to yield somewhat better results than interventions that applied outreaching procedures (Schut & Stroebe, 2005). Screening for high risk seemed to increase the efficacy of bereavement interventions. Some studies on selective bereavement interventions demonstrated modest effects, although there were some indications that this is only temporary (Schut & Stroebe, 2005; Schut et al., 2001). Indicated preventive interventions generally seem to lead to favorable results, both for bereaved individuals suffering from complicated grief (Jacobs & Prigerson, 2000; Schut et al., 2001) and bereaved individuals suffering from bereavement-related depression (Zisook & Shuchter, 2001).

**Outline of the thesis**

The first chapter of the thesis considers the question: “Do widows and widowers need help?” by presenting the results of a systematic review on the prevalence of bereavement-related psychiatric disorders. Although this review is not exhaustive, its findings indicate that the widowed have an elevated risk of developing a mood or anxiety disorder.

The second chapter deals with the second research question: “Which widows and widowers need help?”. In order to refine understanding of psychiatric and/or psychological complications in widowhood, we studied a comprehensive set of putative risk indicators in a sample of 216 older widowed individuals. Inclusion of putative risk indicators was based on the vulnerability-stress model (Brown & Harris, 1978) and relevant literature on bereavement outcome.

In the next chapters, we zoom in on a particular bereavement intervention: the visiting service for older widowed individuals. The third chapter focuses on the third research question: “Is the visiting service for older widowed individuals an effective intervention to help the widowed and for whom might it be effective?” We present the results of a randomized clinical trial on the effects of a visiting service on depression, anxiety, somatization, complicated grief and health related quality of life in 216 older widowed adults with at least moderate feelings of loneliness.

The fourth chapter addresses the fourth research question: “Is the visiting service for older widowed individuals cost-effective?”. We present the results of a cost-utility analysis alongside the randomized clinical trial on the visiting service for older widowed individuals.

The final chapter discusses the fifth research question: “For which widows and widowers is the visiting service for older widowed individuals particularly cost-effective?” by presenting the results of incremental net-benefit regression analyses for different high risk groups. This chapter leads up to the General Discussion, which contains a summary of the main findings, followed by discussion and directions for the future.

**References**
