SPOUSES OF CARDIAC PATIENTS
A Descriptive Study of a Self-Help Support Group for Wives of Cardiac Patients

Eva Schindler Oles

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A Descriptive Study of a Self-Help Support Group for Wives of Cardiac Patients

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We hereby approve the Dissertation

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ABSTRACT

The purpose of this study is to describe the emotional effects of a husband's heart attack on a group of wives and to describe the results of intervention through group process on the functioning of these women. It was postulated that the emotional effects of the heart attack on the spouse can be understood on the basis of differences in the defense mechanisms and coping styles used by different wives. It was further postulated that differences in the use of these mechanisms are based on the degree to which these spouses have reached more adaptive levels of functioning. It was also hypothesized that through the therapeutic intervention of a supportive group experience the levels of functioning vis-a-vis the husband's heart attack can be improved for all the participants.

The study uses Margaret Mahler's concept of the achievement of object constancy to understand the differences in the levels of adaptation of the spouses to their husband's heart attack. The degree of object constancy achieved by the different group members could be identified by the degree of independence they had been able to attain prior to the occurrence of the heart attack. The contrast in adaptation between the more dependent and the more independent spouses to their husband's heart attack was manifested by the exaggerated degree of hostility and guilt and other conflicting emotions resulting from difficulties in separation from the object. Since the core anxiety for all cardiac spouses is object loss, their ability to separate constituted the differences between the more and less adaptive members

of the group. The more adaptive members perceived themselves as being more independent from their husbands, whereas the more dependent members dwelled on their feelings of helplessness resulting in anxiety and depression.

As a result of two-hour monthly group meetings over a six-month period by nine group members in addition to the leader-participant, considerable improvement was noted on the part of the less adaptive members. The improvement was manifested by the lessening of the use of lower-level defense mechanisms on the part of the maladaptive members with a resulting notable decrease in their use of control. The latter coping style was seen as being the most destructive by the members both to themselves and to the marital relationship and was therefore most amenable to change. The various changes were brought about through an increased awareness of the use of these defense mechanisms via the process of mutual identification facilitated and promoted by the leader-participant. The more adaptive members served as role models for the more dependent members whose maladaptive perceptions were changed through a combination of the cognitive and experiential processes provided by the group.

The implications of these findings for the rehabilitation process, usually directed by physicians, are pointed out. The study shows the vital importance of placing an increased emphasis on the family's participation in the rehabilitation of the patient and illustrates the role of the social worker in facilitating the positive involvement of the patient's family.

To my husband, Arthur,

for his love and deep caring

over the 38 years of our marriage,

and in memory of

Dr. James C. Lewis,

for his belief in me and for his great support

as my mentor throughout my years in the

Institute for Clinical Social Work.

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To the members of my Doctoral Committee I wish to express my thanks and appreciation for their guidance and support, for their wise counsel, and scholarly contributions. They helped me expand my vistas and widen my perspective. Dr. Jim Lewis listened to all the tapes, and it was my good fortune to have been able to spend many hours with him discussing the material and benefitting from his deep understanding of the meaning of loss. Little did I know then that this would be the last year of his young life. My good friend, Dr. George Bach-y-Rita, despite his own very busy professional and personal life, generously gave of himself and spent many hours reading and reacting to my material. Because of his own knowledge of research and his wish to increase mine, he motivated me to be more "scientific", at the same time helping me more effectively to interpret my findings to the medical community. Last, but not least, the Chairman of my Doctoral Committee, Dr. Paul Saxton, gave me the courage to get the project off the ground and to carry it to its successful conclusion. His understanding and encouragement and his scholarship made this dissertation an exciting and most fruitful professional experience for me. To the members of my group who have become very special to me, I am grateful for their sharing and caring and their help in teaching me about compassion and the true meaning of support. My husband's insight into himself and his sensitivity to the

feelings of others were of invaluable help to me in increasing my understanding of the difficult issues involved. Above all, his wisdom and kindness and his infinite support of me made it possible for me to carry out this project.

Eva S. Oles

San Francisco, California
April 3, 1982

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CHAPTER I

INTRODUCTION

Purpose of the Study

This dissertation describes and analyzes the reactions and coping mechanisms of a group of wives whose husbands had suffered a myocardial infarction, and how a supportive group affected their adaptive capability.

A major illness, in particular a life-threatening insult such as a heart attack, has a significant psychological impact on the patient's family. This study describes the intrapsychic and behavioral manifestations of psychological stress on a group of patients' wives. My objective, however, was to examine the impact of such a supportive group experience on the members of a small ongoing group of wives and to describe how participation in the group led to changes in their coping ability. It was hypothesized that the sharing of concerns, fears, and coping styles with others in a small supportive self-help group would lessen isolation and give group members the strength to make whatever changes were needed to improve the quality of their lives after their husbands' heart attack.

Significance of the Study

By identifying and describing the processes that lead to positive changes, if any, precipitated by such a group situation, we may provide a useful tool to health-care professionals. If the results are beneficial, they could encourage their patients' wives to form similar groups to prevent psychological damage. Through these groups, the mental health of the patient and other family members might be maintained, which would have a significant effect on the patients' rehabilitation.

CHAPTER II

BACKGROUND

My project was prompted when, over two years ago, my husband began to participate in a research project studying men over fifty years old who had had one coronary. The study plan was, through group behavior modification, to prevent a recurrence. These ten- to fifteen-member groups have met all over the Bay Area for three years. Led by eminent cardiologists and other professionals, they have now developed into cohesive and productive working groups. Their specific purpose is to help the men (there were also women "volunteers" in the study, but far fewer) change their pattern of living from that of hard-driving and competitive individuals to more even and relaxed ways of dealing with daily life.

My husband had a myocardial infarction in October 1969, just four months after we had moved to San Francisco where he had joined the staff of Mount Zion Hospital as the Jewish Welfare Federation Community Chaplain. Our younger daughter was attending college in Los Angeles where my husband had been a pulpit Rabbi. We came into the new community in June 1969. We had no family or friends nearby when the heart attack occurred. We were very fortunate that the Mount Zion staff and my husband's new doctor were most supportive, in many ways substituting for the family and friends unavailable to us during that

difficult time. Despite my husband's good postcoronary rehabilitation, there has been a change in both our lives, especially the fears, both unspoken and spoken, of a recurrence and the question of survival should a second heart attack occur.

Through our older daughter, whose research studies towards a Ph.D. in health psychology are concentrated on the effects of emotional stress on the body, my husband became aware of the research project. Fortunately our daughter was very persistent, and by bringing him study after study on the impact of stress on coronary heart disease, she finally persuaded my husband to join the project.

This represented a turning point in both our lives. Finally, instead of having vague fears and a feeling of not knowing what to do, the research project offered us a definite program for dealing with feeling and behavior. My husband, in his work as a Rabbi and pastoral counselor to the sick, is keenly aware of the role empathy and emotional support can play in reducing stress, thereby helping to heal the body. My own experience as a clinical social worker has reinforced my conviction of the importance of the psychosocial aspects of rehabilitation.

My husband is an enthusiastic member of his group, which met weekly for the first year and monthly since that time. He has become very fond of the other men in his group and of his competent and empathic leader, who was a well-known cardiologist with a private practice in Los Angeles. Unfortunately, Dr. E. himself died of a heart attack very suddenly just a few months ago. The impact of his death on this group of men to whom he meant so much and whom he helped so much, from the same illness he worked so hard to prevent in them, has been considerable.

The closely-knit group, however, with the help of the director of the project and others, has been able to overcome this loss. They have continued to be a positive force in my husband's rehabilitation. He has been able to make significant changes in his behavior through the learning that takes place in the group. The group provides the men with an atmosphere which permits them to internalize the didactic material and make these changes.

My involvement as a spouse has been through sharing with my husband what goes on in his group and through periodic spouses' sessions led by the project field director, a registered nurse. During one of these sessions I was talking to a couple of wives I had met through the project. One in particular was sharing with me how difficult life has been for her since her husband's coronary, how he was controlling her more than ever through his cardiac symptoms by threatening another attack whenever she would assert herself in relation to her needs or was critical of his behavior. She admitted that it had been a pattern in their marriage before the heart attack, but it became much worse when his basically insecure and competitive personality had to deal with the increased fear of dependency which threatened his feelings of security after his attack. She described how he had become almost tyrannical, putting her in a double bind - if she was solicitous, he accused her of babying him, and if she assumed a laissez-faire attitude, her accused her of not caring. Moreover, he was not following his doctor's instructions well, and if she admonished him in any way about his diet or other self-destructive behaviors, he would threaten her with causing another coronary by "nagging" him. She felt this behavior had not improved despite his participation in the group. I then began to

talk to other friends of mine whose husbands had had coronaries, and a similar theme emerged: feelings of frustration; fear that if they asserted themselves in any way they would cause another heart attack. I myself, especially in the early months after my husband's coronary, had had similar fears and found myself in a similar bind. Coming to one of the spouses' sessions, which took place two to three times a year, provided an opportunity to hear what other spouses had to say and how they were dealing with the various problems having to do with their husbands' illness.

During the meeting the project field director discussed the theoretical and practical aspects of this phenomenon and how the competitive and time-pressured drives and free-floating hostility in the Type A personality result in anxiety that can explode if met by an environmental challenge that "serves as the fuse for this explosion".[1] She clearly pictured what goes on emotionally within the patient and what interactions with his environment could cause another attack. She answered a number of questions competently and clearly. The lecture was designed to be instructive; there was not time set aside for the spouses to express feelings and frustrations. During the lecture, a woman I know to have considerable psychological sophistication said, in answer to another woman's remark, "let's not forget that it isn't our fault". Following the lecture, several women gathered spontaneously in the hall outside. I heard one of them exclaim angrily that she will not have her husband any longer accuse her of causing another heart attack when she expresses her own frustration with him.

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[1]Meyer Friedman and Ray H. Rosenman, Type A Behavior and Your Heart (New York: Alfred A. Knopf, 1974), p. 68.

Following the lecture, I discussed the importance of spouses and "significant others" in such a behavior modification program with the leader of my husband's group and the project field director. Their strongest feeling was that the purpose of the project was to prevent a recurrence of the heart attack by working with the patient himself to change behavior. The spouses, though asked periodically to report back to the researchers about changes they had observed in their husbands (or wives), were not considered integral to the process.

The grant that sponsored the research was for behavior change in cardiac patients, who were called "volunteers", and any work with the spouses was ancillary; the focus of the program was the behavior change of the volunteers. At my husband's group leader's home in January 1980 I shared my observations of the spouses' feelings and needs. It was out of this discussion and through his encouragement that I began to visualize a concrete plan for the wives. Dr. E., the group leader, was very receptive to the idea and encouraged my discussing it with the people in the project, which I did.

The idea of a wives' group arose from my own needs and feelings and those I observed in the others; the idea of making such a group my dissertation project occurred almost simultaneously. All this happened during my second year at the Institute, when I had begun to think of what I might be choosing for my dissertation topic. It was a logical step to form the group. It would also provide an opportunity to use what theoretical and clinical skills I had acquired over the years. It seemed a good sign that, at my husband's group picnic in the summer of 1980, several of the wives mentioned how much the group had meant to their husbands and how nice it would be if we had a group for ourselves.

CHAPTER III

THE THEORETICAL AND CONCEPTUAL FRAMEWORK

Conceptually, the study is based on the psychodynamic orientation which views illness in terms of a threat to the ego caused by actual loss of physical functioning,

> . . . actual deprivation or loss of biological or social resources for fulfilling normal need, inner inhibition, or inner loss of the self as experienced through disturbances to the self-image, narcissistic injury, loss of an object for the expression of love or for the expression of aggression . . .[1]

All or some of these meanings of illness are experienced by families as well as by patients and can put an enormous strain on the coping mechanisms of the spouse's ego. However, effective interventions can help restore self-esteem by increasing the mastery of the crisis.

The intervention in this study is the small, supportive, self-help group experience. It was hypothesized that this would increase the integrative capacities of the ego by providing the spouses with the opportunity to find new coping mechanisms through identification with the other spouse's way of handling the situation, or finding new ones via the transcendent possibilities of the group experience. Through the

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[1]Charlotte G. Babcock, "Inner Stress in Illness and Disability", in Ego-Oriented Casework - Problems and Perspectives, ed. Howard J. Parad and Roger R. Miller (New York: Family Association of American, 1963), pp. 47-48.

group interaction, the ego's undeveloped internal resources can be activated, and through the sharing of similar concerns and open expression of fears and common anxieties, the ego can attain mastery through a strengthening of its adaptive capacities.

The spouses of heart attack victims experience hostility, anger, guilt, and other conflicting emotions which may leave them quite helpless if they are not able to express and acknowledge these feelings in themselves and others as being a normal response to a crisis situation. McGann observes, "They find that when their anger, their guilt, and their helplessness are expressed, others still accept them."[2] In the same article, the author states that ". . . our experience indicates that the families of patients who have had heart attacks need as much emotional support as the patient does. Through the group process, families seem to become less depressed, and less anxious . . ."[3] Because the illness may stir up unconscious feelings of shame, guilt, and anger and revive old conflicts of fear of parental abandonment, these feelings may be transferred to the spouse who may unconsciously be seen as the rejecting or abandoning parent. This puts great pressure on the spouse, whose efforts to help the patient may be misinterpreted by him in the light of his own anxieties and unconscious fears. The concepts of Margaret Mahler's separation-individuation phase have particular relevance to the issues of object abandonment and object loss which are involved in catastrophic illness. According to Mahler,

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[2]Marlene McGann, "Group Sessions for the Families of Post-Coronary Patients", Supervisor Nurse (February 1976): 19.

[3]Ibid., p. 19.

this separation-individuation process begins at four to six months of age when the infant "hatches" from the symbiotic orbit and the first subphase of differentiation has begun. Frustration in this phase is manifested by stranger-anxiety and beginning difficulties in separation from the love object. From the ninth to about the eighteenth month, the child becomes so absorbed with his new mastery of locomotor skills and increased cognitive abilities that he separates further from the love object, returning to her for "emotional refueling" as he becomes more aware of his separateness. If she is not emotionally available, the child manifests this in the next subphase, which Mahler calls the period of "rapprochement", extending from about eighteen months into the third year of life. The frustrated child will then exhibit "wooing" and "beseeching" behavior, wanting to share with her his exploits of the world. Finding her unavailable will prevent his reaching the stage of object constancy, which is the last stage of the separation-individuation process. In this stage the child has an inner representation of the love object which enables him to feel secure even when the mother is not there, knowing that he can count on her when he needs her because in all the previous phases she was there for him. He can now safely complete the separation from the love object. A basic mood of the child, Mahler and others after her agree, is established during this process of separation and individuation, depending on the emotional availability of the love object during these phases. It is at this time that the depressive mood originates as a result of separation anxiety and fear of object loss. What we see in the adult as feelings of helplessness, sadness, grief, and depression have their origin in this sense of loss which the very young child perceives if the mother is not

available. We see a diminution of self-esteem, resulting in a sense of helplessness, which is described by Bibring[4] and other theorists of depression as its cause. Rado describes depression as an "unconscious cry for love precipitated by an actual or imagined loss" which is perceived by the individual as endangering his security.[5]

As will be seen in the reactions of the women in the group to their fear of loss of the husband, the above concepts help in understanding the differences in the reactions of those women who have achieved object constancy versus those who have not been able to complete satisfactorily the various phases of the separation-individuation process. The latter are the dependent women in the study, those who have not succeeded in separating from the love object and whose fear of loss of the husband reactivates earlier unresolved separations with resulting exaggerated feelings of hostility, guilt, and depression.

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[4]Edward Bibring, "Mechanisms of Depression", in Affective Disorders, ed. Phyllis Greenacre (New York: International University Press, 1953).

[5]S. Rado, "The Problem of Melancholia", International Journal of Psychoanalysis 9 (1928).

CHAPTER IV

REVIEW OF THE LITERATURE

In my survey of published studies since 1967 I have found only five which focus specifically on the psychosocial problems of the female spouses of men who have suffered a myocardial infarction. I came across mention of two unpublished studies in the recently published book, Psychosocial Aspects of Cardiovascular Disease,[1] which both indicate that the "spouse's emotional makeup and life style play a greater role in the patient's postinfarction vocational adjustment than any personality attributes of the patient himself. In other words, the more stable the wife, the more likely is the patient's vocational adjustment to be successful."[2] A further study is quoted, also still unpublished,[3] which ". . . produced the same findings and suggests that disturbed thinking on the wife's part probably interferes with the patient's ability to concentrate at work, and emotionally unstable wives produce enough effect on their husbands to keep them from working effectively". The author concludes, "Since the spouse's contribution may make the

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[1] H.D. Ruskin, "Care of the Patient with Coronary Heart Disease", in Psychosocial Aspects of Cardiovascular Disease, ed. James Reiffel et al. (New York: Columbia University Press, 1980), pp. 10-11.

[2] L.L. Stein, M.A. Bailey, and H.D. Ruskin, "Rehabilitation of the Postcoronary Patient: Role of the Spouse" (unpublished manuscript).

[3] M.A. Bailey, H.D. Ruskin, and L.L. Stein, unpublished data.

difference between success or failure in the patient's rehabilitation process, it would seem worthwhile to determine her strengths and weaknesses, so that she may be helped to play a more positive role."[4]

In a particularly relevant study published in 1968, Adsett and Bruhn compared a group of six male cardiac patients and a separate group of six wives who were seen for ten sessions during a six-week period. They found that there was considerable anxiety present in both groups but that the patients were able to deal more openly with their feelings than their spouses, who seemed inhibited about expressing their negative feelings. They noted particularly the wives' difficulties with handling their anger and resulting guilt and pointed out their tendency to deny their own needs (certainly corroborated by the present study) in order to take care of their husbands. They compared the patients' free use of humor to handle their anxieties in the group with the spouses' "inhibitions of their negative affects" and found that the ventilation of conflicts improved psychological adaptation in both groups. Overall, they observed that the men dealt more with issues of self-esteem and the women were more concerned with guilt and depression.[5]

Skelton and Dominian, in their study published in 1973 of sixty-five wives whose husbands were admitted to the coronary care unit and were followed over a one-year period through in-depth interviews, described the changes in the wives' feelings from the time that their husbands were admitted to the hospital, after three months, after six

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[4]Ruskin, "Care of the Patient with Coronary Artery Disease", p. 11.

[5]C. Alex Adsett and John G. Bruhn, "Short-Term Group Psychotherapy for Post-Myocardial Infarction Patients and Their Wives", The Canadian Medical Association Journal 99 (September 1968): 19.

months, and after one year. They found that the wives' overall tensions and anxieties decreased over that time in direct proportion to their husbands' physical improvement. They pointed out that early identity and intervention of emotional disturbances in the wives could prevent unnecessary emotional stress. They emphasized the vital role played by the wife's emotional attitude and ability to cope on the course of the patient's rehabilitation.[6]

Three registered nurses, Holub, Eklund, and Keenan, in 1975 described groups of family sessions they conducted while the patient was in the hospital and found that, as a result of providing information explaining the illness and by the accepting attitude of the leaders, there was considerable decrease of anxiety in the spouses.[7] Interestingly, in their search of the literature up to 1975 they had not discovered any studies dealing with the stress of a myocardial infarction on the family. In general, they found "a paucity of material devoted to handling the stress of a myocardial infarction on the family",[8] an observation confirmed by my own search of the literature.

In 1976 another RN, Marlene McGann, described groups provided to give support to wives whose husbands were in the hospital. The group leader explained the physical and emotional problems the patient had to the wives. The author found that these meetings helped the wives by

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[6]M. Skelton and J. Dominian, "Psychological Stress in Wives of Patients with Myocardial Infarction", British Medical Journal (April 1973).

[7]Nancy Holub, Patricia Eklund, and Patricia Keenan, "Family Conferences as an Adjucnt to Total Coronary Care", Heart and Lung (September 1975): 769.

[8]Ibid.

decreasing their sense of loneliness. The acceptance by the staff of their angry feelings helped them weather their ordeal. Even though the focus was on the patient's behavior, the wives' feelings were expressed and acknowledged by the participants and the staff, making them less anxious and less depressed.[9]

Melvin J. Stern and Linda Pascale, in a fascinating article published in 1978, described the results of a study of thirty-eight female spouses they observed and tested while the husbands were in the hospital and again six months thereafter, identifying characteristics in the patients that caused difficulties for the wives. They found that when the husband was a "denier", i.e. when he refused to deal with his own dependency after his myocardial infarction, his wife who was needy and dependent prior to the infarct became anxious and depressed. Because of the staff's concentration on the patient's rehabilitation and his apparently "good adjustment" by being a denier, the wife's severe emotional reactions remained unnoticed and neglected. They therefore suggested identification of the "spouses at risk" while the patient is still in the hospital so that appropriate interventions can be instituted as early as possible to prevent further emotional damage.[10]

While the above are the only studies I could find of myocardial infarction patients dealing specifically with the problems of spouses, there is a proliferation of published articles on the psychosocial

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[9]Marlene McGann, "Group Sessions for the Families of Post-Coronary Patients", Supervisor Nurse (February 1976).

[10]Melvin J. Stern and Linda Pascale, "Psychosocial Adaptation Post-Myocardial Infarction: The Spouse's Dilemma", Journal of Psychosomatic Research 23 (1978): 83-87.

aspects of cardiac rehabilitation. From the comprehensive report on Cardiac Rehabilitation 1975 by the Royal College of Physicians of London, which stresses the significance of psychological factors on the return to work of the cardiac patient,[11] and in study after study I have read, the emphasis is on the vital importance of the psychosocial factors in determining the outcome of the rehabilitation of the cardiac patient. Successful rehabilitation as measured by return to work and sexual functioning and the absence of anxiety and depression was found to be determined not by the severity of the illness, but rather by the presence or absence of unwarranted emotional distress due to psychological and social factors in the patient's life. Indeed, quoting from H.D. Ruskin, "the heart heals long before the psyche".[12]

These studies point to the need, particularly on the physician's part, to be sensitive to these factors and to avail himself of the specialized staff trained and available to deal specifically with these psychosocial factors. The doctor himself should be free emotionally to deal with the patient's and family's fears. Allan Wynn notes, "It has been said that anxious doctors have anxious patients."[13] He goes on to say that ". . . there seems to be an urgent need to look upon illness not merely as an affliction of the patient, but as a disturbance of the whole family unit, whose suffering, indeed, may be as serious as, and

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[11]Cyril Clarke et al., "The Significance of Psychological Factors in Cardiac Rehabilitation", Journal of the Royal College of Physicians of London 9 (July 1975).

[12]Ruskin, "Care of the Patient with Coronary Artery Disease", p. 12.

[13]Allan Wynn, "Unwarranted Emotional Distress in Men with Ischemic Heart Disease", The Medical Journal of Australia (November 1967): 849.

more prolonged than, that of the patient himself . . . it has been truthfully said that whereas many men recover from a heart attack, many wives do not."[14]

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[14]Ibid., p. 850.

CHAPTER V

METHODOLOGY

Initial Considerations

To help the wife "recover from her husband's heart attack", the mutual aid and self-help group seemed ideally suited. It enables the members to cope with crisis in their lives "through internal behavioral, attitudinal, and affective changes".[1] It provides a supportive and nonthreatening atmosphere which promotes a free expression of feelings and their acceptance, leading to an ego-strengthening experience for the participants. Lieberman and Borman point out that the needs of those who join self-help groups are not met either by family networks or social interactions in the larger society, nor by the professionals within our society. If they could find relief for their pain and distress within their families or their social relationships, they would not join these groups nor would they "expect to remain in their groups indefinitely",[2] as was expressed by close to 70 percent of the members of self-help groups surveyed by the authors. In their comparison between professionally led and self-help groups, Lieberman and Borman

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[1]Morton A. Lieberman, Leonard D. Borman, et al., Self-Help Groups for Coping with Crisis (San Francisco: Jossey-Bass, 1979), p. 31.

[2]Ibid., p. 232.

found that what is important to the participants in professionally led groups is rarely as important to the participants in self-groups.

They found that members of self-help groups felt that in the professionally led group the leader represents a particular therapeutic point of view. Such a person is perceived by group members as the change agent on whom the participants depend to help them gain the insights which the therapist thinks will help them cope. According to the authors, in the professionally led groups it is the therapist's theoretical framework and behavior that influence what goes on in the group and determines how the changes are induced. In contrast, they found that in the self-help group it is the members who see themselves as being the agents of their own change through the cohesiveness, uniqueness, and similarity of their situations. This similarity unites them in their suffering and in their seeking relief from their distress. It is through the group process itself in the self-help group that the change takes place, through the expression and exchange of powerful affects and a variety of cognitive processes.

Illness in general, and most especially a life-threatening illness such as a myocardial infarction, leaves one with pervasive feelings of helplessness and loss of control. I therefore hypothesized that the self-help group experience, with its particular quality of helping the members restore their sense of control over their own lives and taking responsibility for their own responses to their crises, in addition to being in a position to be of help to others facing the same problems, would restore their sense of self-esteem and mastery. The healing aspect of the self-help group, as I perceived it, rests precisely in this area of self-restoration. Healing comes without depending on the

help of the "experts" and healers. Although I am also a clinician, I saw my primary role in the group as being that of participant. I saw my clinical skills primarily as tools to help me preserve my role as participant. They would prevent me from slipping into the therapist-leader role which I felt would deprive both me and the others of mutual support. As will be seen in Chapter VI, "Leader-Participant Role and Effect on Group", my experiences in this group did not bear out my thinking as outlined in my proposal. In contrast to what I had said in my proposal as seeing my role in the group as being "the very antithesis of the clinician-therapist who must endeavor to maintain neutrality", I learned that effective leadership includes sharing one's own feelings and that my doing so in this group added to the helpfulness of my role as leader.

I had also thought, and I quote from my proposal, that "being free to observe and analyze the group phenomenon, at the same time as being a participant, will allow me to reflect on my own experience as I observe that of the others". I found, however, that as much as I could reflect on my own experience, the feelings and problems of the group members took precedence over my own. By focusing on the group and being the facilitator of the initiation and promotion of the therapeutic group processes, I was not able to reflect on my own experiences. As a matter of fact, because I was so personally involved with the processes I was studying and analyzing, I needed to separate my own feelings and experiences from those of the others in order to be more responsive to those of the participants.

For this reason I consulted with a member of my doctoral committee who listened to all of the tapes of the group and who helped me separate

the feelings I had that might be interfering with my understanding and analysis of the others.

Procedures

The methodology, then, was to collect and analyze the data by taping every session (with the prior signed consent of each member). My subsequent analysis of each tape and my discussions with my faculty consultant, who had separately listened to each tape, completed the process. The quality of the tapes was excellent - each participant could be heard clearly - thus greatly facilitating the analysis of the data.

I used the method of Glaser and Strauss to collect the data and analyze the material to abstract general themes, patterns, and categories for the "generation of grounded theory". It is the contention of these authors that, in contrast to "verifying a logico-deductive theory which generally leaves us with at best a reformulated hypothesis or two, and an unconfirmed set of speculation . . .", a grounded theory "gives us a theory that fits or works in a substantive or formal area, since the theory has been derived from data, not deduced from logical assumptions".[3]

In this kind of research it is not the quantitative verification of the theory that counts. Identification of categories and their properties emerge from the qualitative analysis of the data.

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[3]Barney G. Glaser and Anselm L. Strauss, The Discovery of Grounded Theory (New York: Aldine Publishing Company, 1967), pp. 28-29.

In order to observe systematically the various ways participants helped each other, I used the method of isolating the help-giving activities as developed by Leon H. Levy in his chapter on "Processes and Activities in Groups".[4] He enumerates twenty-eight such activities he observed in various kinds of self-help groups. Because his categories apply to a variety of different self-help groups, I chose only ones that could be applied specifically to this group of female spouses whose husbands had a heart attack.

1. Catharsis - the group emphasizes and encourages the release of emotions.
2. Sharing - group members share past and present experiences for the purpose of letting each other know what is going on in their lives.
3. Self-disclosure - group members disclose thoughts and fantasies and emotions that are personal and that they would not normally share with other people.
4. Modeling - group members often explain how they would go about handling a problem brought up by another member and they demonstrate how they would react if faced with the person's problem.
5. Confrontation - group members often challenge each other to explain themselves or account for their behavior.
6. Behavioral prescription - the group members make suggestions to one another, such as doing this or doing that.

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[4]Leon H. Levy, "Processes and Activities in Groups", in Lieberman and Borman, Self-Help Groups for Coping with Crisis, pp. 260-264.

7. Explanation - members provide explanations that help other members to a better understanding of themselves.
8. Mutual affirmation - members often assure one another that they are worthwhile and valuable people.
9. Empathy - when a person expresses emotions in the group, other group members let that person know that they understand and share her feelings.
10. Normalization - when a person describes her actions as strange, other members assure her that they are normal.

This way of observing the group behaviors allowed me to identify the particular activity of each member that was helpful to herself or another group member. It enabled me to make sense of the myriad activities that were going on in the group and to extract from them the common themes and processes that were helpful to the participants.

CHAPTER VI

THE GROUP

Introduction

Having planned to begin the first of six monthly two-hour meetings in mid-January, I sent out the following letter on October 22, 1980:

> Dear friend:
>
> Like you, I am the wife of a participant in the Recurrent Coronary Prevention Project and thus have the anxieties and concerns that we all share. Most of us, I am sure, have often found it to be a rather lonely experience and have wished that we could join with others in easing our common burden.
>
> It is for this reason that I am inviting you to get together with me and others in a small, ongoing group designed to enable us to cope better through an exchange of thoughts and feelings. Of course, there will be no cost to you whatsoever. It will be a supportive group experience that should be of benefit to all of us who participate.
>
> We will meet one evening a month beginning in mid-January at my office at the above address. Please indicate your interest on the enclosed card and return it by November 25, 1980.
>
> Looking forward to hearing from you, I am
>
> Sincerely yours,

I sent twelve letters, enclosing a return card. I received three "Yes" cards (from members E, J, and F) and three "No" cards from people who

were living out of the city. In a telephone follow-up I learned that three women were not interested, and three wanted to come but had forgotten to send back the card (members D, K, and A). All three of the negative respondents expressed regret that they could not participate and wished the group success. One woman wrote:

> I wish your group great success - to the point of an East Bay splinter group eventually. Do you see any feasibility in a telephone support network? Are there any in our group with your counseling skills but only a quarter-hour here and there, for "easing our common burden"?

Since I now had received only six affirmative answers and planned to have a group of eleven or twelve (allowing for the possibility of one or two drop-outs), I sent a second letter on November 12 with the identical text to nine more women. I received one "Yes" card (from member B) and one "No" card from a woman expressing interest but who was not able to come because she was a nurse who worked an evening shift. I then followed up with seven telephone calls. One of these women was most interested (member C) and we had a long conversation about how she felt this group could be helpful. Another was somewhat hesitant but thought she might come (member H). The other five women were not interested. One said she was "curious . . . it was a nice idea . . . would be beneficial, but she couldn't talk about such things . . . and she had a hair appointment Thursdays" (the designated day). Another was very hostile, saying "Why do you bother me? I have houseguests." One women said, "I go to the spouses' group of the project and don't wish to join another group." Another was "not interested in going to another group". She said that "doing what I do is as much as I can do". A final contact said she was "not in need of any support - we get along fine".

Having nine women by now, and still hoping for eleven or twelve, I sent the identical letter of December 1 to eight more women, getting back two "Yes" cards and one "No" card. I attempted to call the six other women (the first who didn't answer, plus the one who answered in the negative), but was unable to reach them. I now had a total of eleven women for the group after having sent out twenty-nine letters and having made nineteen telephone calls during a two-month period, from October to December. I then sent out a reminder two weeks before the first meeting on January 15.

I had speculated that there would be a great interest in a wives' support group, based on my informal talks with some of the wives after the spouses' meeting and the wives who expressed an interest in such a group at my husband's group picnic in August. I was therefore surprised at the response to my letters and calls. It was my expectation, on the basis of my own need and that of the women I had talked with, that there would be an overwhelming response. In actuality there was a 38 percent favorable response (11 out of 29 contacted). This could be considered a good response, taking into consideration that most of the women had by now found a way of living with their husbands' heart condition.

Description of Group Members

Member 'A' is a woman in her early fifties with a son in professional school and a daughter in college. A professional, she teaches at a local university, has her own consulting business, and is writing a book. In addition, she runs another small business. Her husband had his heart attack six years ago and continues to run his own business.

Member 'B' is a woman in her late fifties with two grown and married children and two grandchildren. She recently started to work as a saleslady. Her husband has his own business and went back to work following his heart attack nine years ago. He has continued to work after the subsequent triple bypass surgery.

Member 'C' is a woman in her early sixties, married for forty years with two grown children. She has been a travel agent for many years and is also involved in her husband's business. He had his heart attack nine years ago and continues to work as a company executive.

Member 'D' is a woman is her early sixties with a married son and two grandchildren living in the Midwest. The son (a doctor) teaches in a medical school. Her husband is retired. He had two heart attacks, and after the second one, about four years ago, he decided to retire. She has never worked outside the home.

Member 'E' is a 45-year-old woman with two grown children, one in law school and one in college. She is a teacher, studying for a graduate degree in special education. Her husband had his heart attack seven years ago and continues to work as an engineer. He had a second very severe attack very soon after the first, and works many hours including traveling a great deal in his business.

Member 'F', a 46-year-old woman with two grown children, is a sales representative for an airline and travels a good deal in connection with her work. Her husband's heart attack occurred five years ago, and he continues to work as an engineer for a large company.

Member 'G' is a 45-year-old woman, married sixteen years with no children. She works as a telephone operator. Her husband had two heart attacks, seventeen and thirteen years ago, and works in the accounting department of a large company.

Member 'H', a woman in her early fifties, works in a clerical job. She raised three children, one of whom died of leukemia at the age of 31. She has three grandchildren. Her husband, an engineer in a large company, did not have a heart attack but had bypass surgery five years ago. He has been drinking ever since.

Member 'I' is a middle-aged woman who has not had the opportunity in the first six sessions to talk much about herself.

Member 'J' is a middle-aged woman with a rather severe hearing problem who also has not had the opportunity to talk about her work or her family.

Member 'K', a middle-aged woman, has not shared much about herself except that she recently resumed working and her husband's grown son lives with his paternal grandmother out of town. She attended the first session, missed sessions 2, 3 and 4, and has become more active during the last two sessions.

Member 'L' is myself, the leader-participant, a 56-year-old woman with two grown children and one grandchild. My husband's heart attack occurred thirteen years ago, and he is working as a chaplain in a local hospital.

Defenses and Coping Mechanisms of Group Members and How They Changed over Time

Member A was the first to speak at the first meeting of the group. She told the women about her work which includes teaching, writing, consulting, and running a small business. She described these activities with great intensity, and when one of the women asked if she

thought she was "hyper", she said she thought she was. She felt she had to get herself into "gear", "get her act together" after her husband's illness. First he had had cancer many years ago, and then he suffered a heart attack six years ago. She said, "I can compare two different kinds of horror, having had near-touches with two types of terror"; in fact, she repeated the words "horror" and "terror" (as in "I'm in a state of total terror") over and over. She saw her activities as a way to "counteract the feelings of fear, terror, total terror, scare". She learned her husband's business but doesn't work in it, and when he offered to help her with her business she refused, emphasizing that it is "my business". She pointed out that it is his business that supports the family, not her business or other activities. Throughout, she stressed her work as giving her a feeling of independence.

A's fear is that she will be left. She deals with this fear by doing the leaving via all her "independent" activities which deprive her husband of her support. She said he often feels neglected, like "he is not getting enough attention, but he is proud of us". She also projects her "independence" on her two children. She considers them "independent" when in fact they are both still in college and dependent on the parents. When her husband offered to help her run the business, she rejected his needs for a cooperative venture and interdependent, supportive activities and pursued her pseudo-independent strivings to cover up her strong dependent needs. Her fear of and denial of her own dependency needs deprives him of her support, which he needs. She is abandoning him at the very time he needs this support, which she is unable to give because of her fear of being abandoned by him, and her resulting anger.

This group member brought into sharp focus the basic conflict of these cardiac wives whose dependency needs had not been adequately met in their early lives and who had therefore depended on their husbands to meet their emotional needs prior to the heart attack. Now that their husbands have a life-threatening illness, the emotional survival of these women becomes threatened by the fear that they may lose their emotional support and be left on their own. They deal with this fear of being abandoned by denying their dependence and engaging frantically in activities to make them feel they are "independent".

Member A denied her dependence on her husband and projected this dependency via reaction-formation into independent activities which gave her the illusion of security and independence. These defense mechanisms with which she handled her deep inner conflicts were manifested in her behavior in the group in which she demanded and received full attention, monopolizing the group discussion, brushing off other people's remarks, and focusing totally on herself. Just as she had not talked about her husband's feelings but focused entirely on her own feelings which were so overwhelming, so in the group she was not responsive to the others; that is, she did not elicit any questions or concerns from them or for them. There was the feeling that this is how she copes with her fears, without wondering what others might be thinking about her way of handling herself. It was as if she really was not interested in what the others think or feel about her. The other group members responded to her story with total silence. When she was finished, member B proceeded to tell about herself.

Member A's help-giving activities in the group illustrated her characteristic coping mechanisms, that is, how her feelings are

manifested in her relationships with people. Just as we had not gotten any sense of her relationship with her husband in what she told us about herself, so there was no sense of her relationship to the group except insofar as she was using the group to talk about herself. Thus, on a scale of 1 to 5, she ranked a 1 (highest score) in catharsis, 1 in sharing, and 1 in self-disclosure. In all of the other help-giving activities she got a score of 5. I would like to note her score of 5 in empathy - she was not able to hear or be open to others' remarks or feelings, being so intensely involved in her own.

In view of the above, it was no surprise that a few days after the meeting, member A called to say that she would not come back. She had great conflicts about the independence versus dependence issue which she introduced and which was subsequently elaborated on by the others. I speculated that she dropped out after the first meeting because the group was a threat to her coping style of independence. The threat of the group to her perceived independence served as a narcissistic blow which activated her unconscious realization of her dependence on her husband. She took flight because the group threatened her with her terror at her dependency. She felt uncomfortable in a dependent situation such as a group because the degree of her pathogenic dependency and her defenses against it aggravated and activated her conflict around dependency, which she felt in the group experience.

Member B, in contrast to member A (perhaps because member B was intimidated by A), spoke quietly about her husband and his illness. She described in detail and with much feeling his cardiac surgery and his subsequent determination to keep on working. He enjoyed his work and wanted to keep on, despite his doctor's prompting to "go on

disability". She emphasized his "not showing any fear". When I asked how she was feeling, she denied any fears in herself. She volunteered nothing about herself, and when she was asked about herself directly by the group members, she gave brief answers. The clue that she indeed had fears of her own was that she identified with the anxiety I expressed about my husband. She said, "Just like with you tonight, each time he didn't show up, something happened." She seemed to defend against her fear by denial and identification. Her coping style in the group was to be passive, quiet, and empathetic, a response similar to the way she acted with her husband when she focused on his feelings and described his reaction to his heart attack. In her short presentation, she seemed to feel comfortable with her dependent role. However, she seemed uncomfortable talking about herself in the group and said nothing more the rest of the session. From the little she said, it was difficult to determine her characteristic ways of coping and even to score her on the help-giving activities. I sensed she was reluctant to share and acknowledge her own fears. She denied this, but she clearly felt threatened by member A's expressions of terror. I can only speculate that because of her need to defend against her own fears by denying them, the experience of hearing about someone else's intense fears was too threatening for her. She called me the next day and said she was not coming back.

Member C introduced herself by saying she had been married for forty years and had two grown daughters. She added, "We are a togetherness family, very close." This relatedness to others is her basic characteristic, and this is how she defined herself to the group from the very first communication. Yet simultaneously she talked about

her own work as a travel agent and her developing business skills in conjunction and cooperation with her business-executive husband. Member C communicated this simultaneous quality of relatedness and separateness to the group in a very clear way. It is her characteristic way of functioning in the world. Even as she described her husband's heart attack, she related its occurrence to business pressures he was having at the office. Even more significantly, she connected it to her father-in-law's heart attack and subsequent death at age 85, just three weeks prior to her husband's heart attack. She stressed how close the two had been and the impact this had had on her husband. When her husband's heart attack occurred she was visiting her parent out of town - another instance in which she was at the same time connected and giving, and yet separate from her family.

As she was connected to her family, so she felt connected to the group from the beginning. She started out by saying she felt it "interesting to listen" to both members A and D, "because I saw myself a little bit in each . . . you said your father was Victorian. My father was not Victorian . . . even just a few years made a difference". She listened, she heard, she compared herself with the previous speakers, she identified with them, and yet she also differed. Her relating to the group paralleled her relatedness to her family, and in her description of herself in this first session of the group she stressed the closeness but also carefully traced the development of her own independence as a gradually evolving process to meet her own needs.

She started out as the "old-fashioned wife", only working part-time and making sure she would not earn more than her husband. He, like most other husbands in those days, was sensitive about this. Apparently it

did not bother her, and she enjoyed their close marital and family relationship. It was not until five years ago, when she recovered from a malignancy, that she decided she would "come out of the closet". Her husband had no idea what she was talking about; he felt he had always shared his business decisions with her. It was not until her own illness that she realized that, though she knew what was going on in his business, she didn't go to the meetings. She felt she had no status; even if her husband sometimes used her ideas, they weren't acknowledged as her ideas. What she wanted was an equal status with him in the business. She "hated to put the pressure on him", especially knowing he had had a heart attack, but she said to him, "I've always lived my life the way you wanted me to and I obviously wanted to live it that way, too, but now I've got to do this, I've just got to do this." She told him, "I feel sorry for you that you have to go through this."

It was his having had a heart attack and her own illness that prompted her to confront him with her need for independence, recognizing the threat it represented to him and acknowledging it to him and to herself. She had the sense of security and ego strength to achieve what she needed to do. Because of her ability to articulate feelings and communicate them to the group, we were all able to identify with her struggle to become independent. The crises in his and her life, both their life-threatening illnesses, were the precipitating factors for the warm and gentle confrontation that came out of a warm and mutually supportive relationship and enabled her to achieve the independence she now needed.

Member C's defense mechanism is sublimation; she masters her anxiety through achieving her independence, using her ego-strengths to

cope with the crisis of her husband's illness by developing constructive and socially acceptable activities. As for her help-giving activities, she ranked a 1 in catharsis, self-disclosure, sharing, and modeling. She was able to model to the group a healthy way of handling the independence-dependence struggle brought about by the husband's heart attack. In this session she was also able to pick up the others' feelings and to identify with them.

Member C has achieved separation and individuation, object constancy, and an integrated self-concept. She can feel comfortable in the dependent, independent, and interdependent roles. Her achievement of separation and individuation was illustrated by her description of how she felt when she was traveling with her husband, having left her children with her parent at home, when she heard about the Vietnam war. They were in that part of the world at the time, and she expressed herself as recognizing that if she or her husband died, the rest of the family would and could go on - in other words, the death of one family member would not mean the death of all.

The "healthy" independence of member C manifested itself again in the second session when the group members began to recognize their anger at their husbands for getting sick, when they began to express this hostility and struggle with their guilt feelings about expressing it. When one member said that after the heart attack she couldn't scream at him when something he did aggravated her and another asked if anybody else was angry because they couldn't do this any more, it was member C who said firmly, "I still do. I let him know when something bugs me." When group members shared their frustration at their husbands for not sticking to their diets or not following doctors' orders, it was member

C who said, "It's his decision . . . he knows all the rules . . . I don't feel guilty." She now added the help-giving activity of behavioral prescription in this second session to the ones she used in the first session, in that she actually demonstrated a different way of communicating with her husband to the group members.

In the second session she told the group how she behaves differently and with less guilt than some of the group members (an activity Levy calls behavioral prescription).[1] It would give her a score of 4 (with 1 being the highest and 5 the lowest) in this particular help-giving activity in this session. However, in empathy she got a score of 1 from the beginning, as was illustrated by her call. After the first session she called me to ask how my husband was feeling, saying "I tried calling you, as I was concerned - I asked people (in the project) how your husband is . . ." When I told her about the wedding that detained him and that I had forgotten about, she laughed and said "And you couldn't even be mad at him". This incident illustrated her caring and giving and identifying with the feelings of others.

It was in the third session that member C, having experienced in the second session the conflicts members were having around the dependence-independence struggle, identified with that struggle and explained how she had resolved it for herself. She said her seeking her own identity and independence came out of the realization that she may lose her husband. This made her think, "Do we possibly see ourselves as a single person again? . . . What kind of a life do we want to have if

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[1]Leon H. Levy, "Processes and Activities in Groups", in Self-Help Groups for Coping with Crisis, ed. Morton Lieberman and Leonard Borman (San Francisco: Jossey-Bass, 1979), p. 260.

we are a single person? Does it then make us want to be a little more independent?" When her husband came home from the hospital she found herself little by little being drawn into nursing him. She was happy to do it at the time but surprised that she even questioned whether she would really want to live that kind of a life all the time. It forced her to examine her feelings. When someone suggested that maybe she was surprised at having some feelings of resentment towards her husband becoming ill, she denied that, or qualified it by saying, ". . . it [i.e. becoming more independent] is a way of perhaps preparing yourself not to resent."

Member C did not react to her husband's illness by denial or withdrawal but was able to recognize her defense of anger, was "surprised a little bit at myself, at my own reaction", but accepted it and then was able to give it up as an "unhealthy" defense against the fear of loss of her husband. She was able to make the conscious decision to compensate for her fear by acknowledging her anger about it. By decreasing her sense of helplessness, she became more independent. This is a different process from independence as a reaction-formation against dependency. The latter is an unconscious process in those women who have to deny their "pathological" dependence on their husbands. For member C, becoming more independent was a conscious decision, a way, as she herself expressed it, "of preparing myself not to resent".

It was in the third session that members C's ability to cope was enhanced by her ability to help another member (G) identify with her ego-strengths and added the help-giving activities of explanation and confrontation to make her more aware of her destructive behavior. By being very persistent in pursuing the source of member G's anger at her

husband, member C helped her become more aware of her destructive behavior. She asked her, "You said 'I resent', but I still don't know what you resent." When member G answered that she resented "the fact that this fear is constantly hanging over us", member C wanted her to get more specific: "Over him or over you?" G replied, "Over all of us." C then wanted to know, "Does he feel depressed and fearful or just you?" G said, "He wouldn't tell me if he did, because he doesn't want me to worry" (it's too scary for her to get in touch with her fear). Member C pressed on: "But can you pick up anything from him . . . they must think about it if we think about it." G responded, "Only because he chooses to ignore everything, that is why I think he probably thinks about it." C now got help from other members who immediately identified with G's anger at the husband for ignoring everything. (Member E saw herself in all of this and said, "You may have the kind of husband who uses denial - for my husband the problem simply does not exist.") Other group members also take the responsibility for what should be the husband's choice alone and not theirs. Member C's recognition at this moment that some others also had this problem and were at this moment becoming more aware of what they were doing helped her to confront G about taking all the blame for what her husband was doing. "Is that what you resent, do you resent it from him or do you resent that it's been put on you?" she asked. With the help of other members, who gave examples of husbands "having the tendency to blame someone else", member C then told member G, "Seems to me he is using you a little like a whipping boy . . . when you are sick like your husband, it helps to blame somebody, but why do you have to accept the blame?" The above illustrates how member C used her own strengths to help others to a better understanding of themselves.

In session four, member C again helped another member (member H), this time not by confronting her but by being supportive as member H expressed her feelings of frustration at her husband's drinking following his heart surgery. She did this by being empathic with her, telling her how she understood her feelings because she had felt upset in a similar way when her own father became an alcoholic late in life because of pressures he was experiencing at the time. In this way she added another help-giving activity, namely that of mutual affirmation. This helped member H ventilate her feelings and feel less ashamed. Through the support given by member C (and others), member H could share feelings with the group that she said she had not been able to share with anyone else (except with one very old lady friend in her 80s) because the group made her feel like she was a worthwhile and valuable person. Member C felt that affirmation was what this member needed to help her cope better with her feelings of depression about her situation.

Before the fifth session, member C called to say she had to cancel, feeling she had been talking too much at the meetings. Despite my reassurance that I saw her as being very helpful by being able to express her feelings and understand those of others, she thought that it was perhaps better if she did not come that time. My speculation was that she felt she was largely responsible for most of the group staying away in the fourth session (especially member G), when in reality it was the intense activity in the third session that led to the resistance in the fourth session. My hunch was confirmed when member C called right after the meeting wondering how member G was doing and being pleased to hear that member G reported having used some of the suggestions she made

to her in the third session and that they worked. It again illustrated member C's concern for others, her need to share with others the beneficial effects of her own nonconflictual behavior, and now her increasing recognition of her ability to help others cope better through the group experience.

In the sixth session member C enjoyed her ability to articulate her thoughts and feelings, sensing the group's responsiveness to her. This confirmed for her the effectiveness of her own coping and her strength in serving as a role model for those whose conflicts were greater than hers. When, after the expression and acknowledgment of anger, love and caring came through in this session, member C gave the example of how she was surprised at herself for telling family members who wished to visit with them over the summer not to come, knowing that the change of routine would upset her husband. She, who loves company and is so connected with her family, knew that her first priority was to protect her husband and to care for him. She was pleased with herself for not resenting having to tell family to stay away so she could reduce the stress for her husband.

This was an example of her picking up the theme of the group and elaborating on it. When another member struggled with guilt feelings about her control, member C helped relieve that guilt by universalizing this need on the part of all the group members to take on responsibility for what was happening. She thus added the tenth help-giving activity, that of <u>normalization</u>. This intervention helped group member I reduce her anxiety about her behavior and be less critical of herself. She connected this incident with what she saw as the objective of the group. She asked, "Is our role the mother and watcher, or can we learn from

each other what our approach should really be . . . how we can get the most enjoyment from one another . . . and not end up with guilt? What are we trying to do in these meetings? Do we want to approach it by saying have we done everything possible for this person or do we want to approach it by saying, I'm a person, he's a person . . . we are both mature people, we are responsible for our own actions . . . maybe there has to be a happy medium that we each in our own way and in our own relationships can have with our husbands." When one of the group then described a recent situation when they rode in a glider and she "completely forgot" about her husband's heart attack and felt guilty about it, a lively discussion ensued. This particular member had taken responsibility for her husband not feeling well after the incident.

Member C then concluded, "This is what I mean . . . we cannot live all our lives with that fear . . . this is what the wives' group has got to do . . . how do we alter our behavior . . . what is the happy medium . . . you are a person too. He knew when he went in that glider that something could happen to him. How responsible are we in always protecting the other person . . . you can get to the point where you feel responsible for everything, and it is not good for them and it is not good for us."

We saw changes in member C and in how the group over time helped her toward a greater appreciation of her "healthy" coping mechanisms, confirmed for her the effectiveness of her behavior, and gave her the opportunity to help others learn from her. As she sensed the group's positive response to her, it increased her self-esteem which could be seen in her enjoyment of helping the more conflicted members toward a greater understanding of themselves. She took particular pride in her

ability to articulate and generalize the feelings of the group and thereby be instrumental in helping to define goals and ways the group might reach them. Over the six sessions she gained increased confidence in herself as she gradually developed into the group leader (in contrast to my being the leader of the group). This leadership role was manifested in her sensing the theme of the group, articulating what she heard the group members saying, and then relating this to her way of handling the problem. For example, in the sixth session when the theme was caring, she told the group how she was surprised at herself that she told the relatives not to stay at their house - she was pleased how she now could protect her husband and not resent it. This, too, was a change for her, and she was pleased to see it in herself and to share it with the group.

Member D is a 63-year-old woman who has been married over forty years and whose life has been centered around her husband and their now-married son who teaches at a medical school in the Midwest. Despite the distance that separates them, they have a close relationship with him as well as with the daughter-in-law and the grandchildren. She told the group that she had met her husband in high school. They went through college together and had continued to have a very close marital relationship. She talked about having had a "Victorian father" who didn't allow her to work but who insisted she get some good business background in school so that she could manage her own affairs "if she had to". She said she never had had to work, and she seemed very comfortable with her full-time role as wife and mother. Her tone of voice was soft, in keeping with her attractive feminine appearance. At the same time there is a dignity about her comportment, her tall

stature, her slow and deliberate yet natural speech, which projected a feelings of satisfaction and pride in herself as an individual in her own right.

As she described her husband's first heart attack, she related it to their son's getting married and leaving home just prior to the attack, demonstrating her empathy with her husband around the separation from his son with whom he had been very close. Again, when she talked about his recovery at home, she identified with his feelings of confinement in the house, encouraging him to spend time with the retired men in the neighborhood. She said, "I felt he was so tied up with me all the time in the house that it was nice for him to get out. The men would walk with him . . . he got a different point of view . . . and it was good for him." Her ability to think herself into his situation was exemplified also by her being supportive of him through her participation in a low-cholesterol diet with him. As she expressed it, "We did all the right things." The feeling that was conveyed by her was one of balance, of being supportive without controlling him. She described herself and her husband as "positive people". It was a shock to them both when nine years later he had a second heart attack, when they both had been so careful to follow doctor's orders. It was here again that mutual support enabled them to reach the joint decision that his job was responsible for the stress that triggered the second attack. Because of their open communication, they could consider all the implications of his retirement and reached the conclusion that it must be done. What helped to "cut the ties to the job" was going on a long cruise and subsequent shorter cruises.

She stressed that what has helped them both is their ability to relax and have fun. They have some separate hobbies and activities, such as dancing, which they both enjoy. They can pursue these activities despite the fact that the angiogram revealed one coronary artery being completely blocked and another almost so. They know the husband is not a candidate for bypass surgery. She talked about their awareness of his physical limitations, including frequent fatigue and angina pains. She described waiting for the nitroglycerine to alleviate the pain so they would then know it wasn't another heart attack and the feelings they both had of uncertainty and concern. Despite it all, they manage to relax and enjoy. She projected a sense of satisfaction with their lives which matched her effect on the group - her stability, her caring, her ability to identify with the feelings of others. A further evidence of her caring was how she had worked out her feelings about leaving behind her 85-year-old mother when they go on cruises. Since she fully supports her mother's wish for independence by leaving her in her own home and doing things for her that permit her to continue this independence despite her age, she shows the same sensitivity when they are away. She arranges for her friends to call during the day to "say hello" to her mother. She can thus preserve her mother's sense of independence while providing needed supervision. She said she hates to leave her mother when she goes away with her husband, but she also knows that her husband's welfare comes first. Her observing ego allows her to decide on priorities in a relatively nonconflictual way and to minimize her guilt feelings by making thoughtful arrangements.

In view of all of the above ego strengths, why did member D decide to join a group that would deal with the "anxieties and concerns that we all share"? It appeared in this first session that she had found a way to cope. Her decision, she said, was based on the fact that recently her cholesterol level had gone up and she thought this might be due to stress related to her husband's heart attack. When she heard about the group she thought it might be a way for her to relieve her anxiety. Knowing how helpful the group experience had been for her husband, she wanted to have a similar experience for herself.

Member D's characteristic ways of coping were evident in the first session - the nurturing and caring qualities that characterized her relationships with her family as well as with the group members. She felt comfortable with and accepted her dependent role at the same time that she also acknowledged her needs and ability to be independent. "I could manage my own affairs if I had to", she said, and she was not afraid to contemplate her own survival without her husband. She alluded to this in the first session and further elaborated in subsequent sessions on how she would feel if her husband should die. It was in the sixth session that she described how sad it would be for her, how she would miss his love and their life together. But she stated that she could go on without him. At the same time she said a number of times that there was no guarantee that "he will go first". She was thinking of her own well-being and doing all she could to take care of herself. There was no feeling of guilt in her assertion of her own independence, unlike a number of the other members whose dependency needs had not been adequately met. Member D could be a nurturer and giver because she had apparently received sufficient emotional supplies for herself.

Member D could differentiate between her internal fantasy state and the external reality, which was exemplified by her realistic description of her husband's pathology of his coronary arteries. She was not overwhelmed by a total fear as was member A, but could see the reality of his condition and accept both the positive and negative aspects of his physical state. This ability of hers was helpful to some of the other members in decreasing their tendency to view their husbands' illness in global and therefore more frightening and hopeless terms. In her own characteristically quiet manner, member D modeled for the group members a consistently more realistic and positive way of evaluating the husband's actual disability. She looked for what actually was going on instead of fearing the worst. Member D's primary defense mechanism is sublimation, that is, she is partially mastering her anxiety through the development of constructive and socially acceptable activities, such as her hobbies, their dancing, and their trips. These activities are used by her to relieve her anxiety but not to deny it. She sees her anxiety in the form of her elevated cholesterol level, which she herself recognized as a manifestation of her stress.

As for member D's help-giving activities, she demonstrated catharsis, self-disclosure, sharing, modeling, and empathy. These more giving, soothing, and supportive help-giving activities were used by member D in preference to behavioral prescription, confrontation, normalization, explanation, or mutual affirmation. Member D's way of relating to people is less directive - she avoids challenging or explaining or suggesting or even directly assuring another person. Not only did she not use these more direct help-giving activities herself, but she was uncomfortable when she saw other members using them. For

example, when she called to let me know before the April meeting that she wouldn't be able to make it (the fourth meeting, for which there were six cancellations), she said she would not "have gone after" member G in the "pushy" way member C did. She would have let her know how she felt in similar situations and would have let it go at that. She thought member C pushed "awfully hard". A number of other members must have shared member D's discomfort with confrontation, as seen by the unusual number of absences in the fourth session.

In the second session member D began to express irritation at her husband when she said, "He can't take it when I get sick. He falls apart and he gets sick, so I have to get up and take care of him." So when she heard others expressing their anger at the husband's self-centeredness, she identified with their feelings and used the group's sharing for her own catharsis. The group catharsis triggered her own, and she thereby got in touch with her own negative emotions, for which the group provided a release, thus decreasing her own stress. This was her purpose in coming to the group meetings in the first place, as she had stated in the first session, namely to reduce her blood cholesterol level which she uses as a measurement of her own anxiety. In this example as well as in later session, we saw her feeling increasingly more comfortable with expressing her irritations, acknowledging them to herself, and getting acceptance for them from the group and from me, the leader of the group.

There is a difference, however, on the part of member D in the degree and quality of anger she feels. With her, anger manifests itself more in the form of irritation; it is not as offensive and exaggerated and overly used as the anger of those whose behavior is

more conflictual. Member D uses the expression of irritation in the service of greater caring, to reduce her own stress (as she stated many times), and thereby to enable herself to continue her nurturing relationship with her husband. By helping herself she is helping him, and the group helped her to do this.

Other expressions of irritation were helpful to her at the same time as modeling for others. In sessions three and five she stated that "We should take care of everybody, but who takes care of us?" She stressed that "we have a right to take care of ourselves" and that she was coming to the group to do just that. Member D's use of humor often helped to neutralize the anger underlying the fact that her husband is better at most of her hobbies. Whatever she does, such as ceramics, he does better. She laughingly offered, "The day he picks up a paintbrush [painting is her new-found hobby which she greatly enjoys and does with great skill], I'm quitting." It was more in the way she said it (by injecting some humor and lightness) that decreased the feeling of hostility and yet focused on the competition that came through. Again, when she told about how the men in the neighborhood are "so crazy about him", she said laughingly, "It would be nice to hear them say a few nice things about me, too." The effectiveness with which she uses humor to reduce anxiety, both with her husband and with the group, was particularly well illustrated by the episode in session five when member G told of her rage at her husband when he defends his "uncooperative" attitude by telling her, "You are married to an old man." When member G was thus caught up in her feelings of anger at him and the group identified with her frustration, it was member D who said quietly, "When my husband says this to me I tell him 'you are married to an old woman'

and we both chuckle and that takes care of that." Everyone laughed and the anxiety was relieved. It was powerful way of modeling more constructive behavior in a supportive and nonthreatening way to other group members, thus influencing the group process itself and at the same time confirming for member D the effectiveness of her own coping.

It was in the sixth session that we could see the benefit to member D of letting out her irritations at her husband in the group meetings. During the six-month period she became more aware of her caring. She had always been a nurturer, but her husband's heart attack disturbed the equilibrium by bringing uncertainties and anxieties into this positive marital relationship. Despite their managing to live with it, the "stress", as she put is, made itself felt by her increased cholesterol level which she was determined to control. As she got into the group meetings, she apparently experienced the release of her negative feelings and their acceptance by the group as a relief for her tensions and sensed a consequent reduction of her anxiety. As her negative feelings found a constructive outlet through the group meetings, she could appreciate even more her caring and nurturing qualities, of which she became increasingly aware.

This therapeutic process was illustrated by her when she described her husband's exceedingly close relationship with their son, to the sometimes very upsetting exclusion of herself, or when she talked about her resentment at having to be the disciplinarian with her grandchildren when they come to visit, so that he can be the adored grandfather. It came out when she mentioned the neighbors liking her but "being crazy about him" and wishing "once in a while to hear that I'm nice too". She resents it, but having expressed it she can recognize and accept how

important it is for him to get the recognition from people, how much he needs it, and she is willing and able to make the necessary adjustments that allow him the attention he needs.

Member D ended up saying in the sixth session, ". . . it's his need and a very great need and it must come from somewhere, this overpowering need to be loved and appreciated". Having gotten rid of the anger, she could now go back to being the nurturing wife she always was. After the anger had been discharged and accepted, she could give it up and let the love and caring again emerge. This was the subtle but important change of member D's coping over time as a result of the group meetings.

Member E, from the very first contact, had been eager to join the group. Hers was the first card to arrive in response to my first letter. She enthusiastically answered in the affirmative, despite the long distance she lives from the city. "Yes", she said with an exclamation mark, "I am interested. There is a great need for a support group." Her good feelings about being a part of the group were evident during the first meeting when she offered to pass out the refreshments and was helpful in other concrete ways with the preliminaries. She is a young-looking 45-year-old woman who introduced herself as being the mother of two college-age children who are away from home but with whom she is very close. She said, "They are my friends." Even as she talked about them during the first part of the group session, one could sense the deep meaning these relationships have for her, and one could feel her dependence on them for understanding and support. She mentioned also that she is getting a graduate degree in special education and teaches second grade.

She then told about her husband's heart attack, which occurred when she was only 37 and he was 45 years old. It happened around the holidays when he was especially tense and "hyper". His job as an engineer in a small but dynamic company is very demanding and requires travel, but she saw his perfectionism as being responsible for his intense activities, especially around the holidays. As she described the first heart attack and connected it to his great tension at the time and then followed that by a detailed account of the second and very severe heart attack which followed the first, one could sense her anger at him for allowing this to happen. Her feelings became more intense when she told about the moment when "all the monitors went haywire and he almost died". It was only because the doctors luckily were there at the very moment that his life was saved. "Now he has a second chance, and I will be angry if he blows it", she said. She then shared the frustrations she feels about her husband with the group, telling how he flies off in different directions in his job throughout the state, how he refuses to take care of himself, leaving her feeling "completely helpless".

It was then that another member asked whether this was how she felt at the last Christmas dinner of their husbands' group (both of their husbands happen to belong to the same group), which prompted her to tell the group the entire painful incident which occurred in front of the husbands, their spouses, and their leader. She broke down and "sobbed and cried in front of thirty people" when she heard her husband "saying all the right things" in front of the group but in reality "trying to kill himself". What made her feel so furious was that "here was all this help he is not taking" and "here is all this support sitting around

and all these good, right, positive, and practical things being spoken". It was then that she was unable to contain herself any longer and cried in front of the group. When they got home from the dinner her husband was very angry with her, saying she embarrassed him in front of his group. He was critical of her for "me being on his case all the time".

Member E illustrates the dynamic described by Melvin J. Stern and Linda Pascale in their study, "Psychosocial Adaptation Post-Myocardial Infarction: The Spouses' Dilemma".[2] When the patient is a "denier, he eschews dependency, does not understand it, and refuses to cope with it. His spouse on the other hand is frequently a person who is dependent on outside sources of support. Pre-infarct, she badgers to get his attention. Post-infarct, however, she is wary of confrontation lest he be hurt thereby. Faced with the impossible situation of wanting support and not being able to get it, she herself crumbles in a welter of anxiety, depression, and confusion."[3]

Member E illustrates this conflict. Her coming to the group was a way for her to get the support from others which she cannot get from her husband. But it is not easy for her to get even that, as he is very threatened by her coming for help. Any kind of help for either of them is very threatening to him. "He would never dream of going to a shrink", and she told the group how she desperately wanted to go to a psychiatrist after the second heart attack and how he would not allow it. That is why she needed the group so much. She said, he cannot say

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[2]Melvin J. Stern and Linda Pascale, "Psycholosocial Adaptation Post-Myocardial Infarction: The Spouse's Dilemma", Journal of Psychosomatic Research 23 (1978): 86-87.

[3]Ibid., p. 86.

"no" because he is also going to a group. However, he is threatened by her group. He asked her to help him with something the evening of the second meeting and she called me twice saying she was trying to work it out so she could come; she finally succeeded.

For the husband, going for help means looking into himself and acknowledging his own dependency needs. She explained how he comes from a family that is very intellectual and achievement-oriented, "not interested in people and feelings but in things". Member E intellectually understands her husband and, from her description of his personality, he handles his anxiety about his heart attack by denying his dependency. He therefore continued with his business as before the illness, "saying all the right things" but being unable to make the changes that would help him prevent another attack by accepting his dependency needs and slowing down.

We see the same dynamic in member E as in her husband. She handles her anger and frustration by intense "independent" activities: she is a full-time graduate student in special education and teaches full time. She denies her own dependency by all these frantic activities, which are a reaction-formation to defend against her fears of dependence on her husband, whom she could lose at any time. Her rage at him is because she sees him as deliberately bringing this dreaded calamity about. She said, "What he is doing is trying to kill himself", meaning she would then no longer be able to depend on his support, which she actually never had but for which she is always looking and hoping.

Whereas the denial of her dependency and her projection of "independence" constitute her two primary mechanisms of defense to handle her anxiety intrapsychically, she uses controlling behavior to

cope with her dilemma. One way of controlling him is through the doctors, the heart program, the wives' group. This, of course, in turn infuriates him because she uses what she learns "against" him. This is how he perceived her behavior at the dinner party when she broke down, and he was angry with her for using the group as a way of controlling him. It is her frustration at not finding a way to get to him directly that prompts these actions. She said, "He is so nice, he never criticizes me", so it is difficult for her to control him directly. It is his way of protecting himself from her control. The way for her to control him is by using her dependence on the doctors, on the group leaders, on me. She often turned to me at the group meetings and asked me, "What do <u>you</u> think, as the professional . . ." It is as if she needs a professional to confirm what she thinks her husband should do. She feels he will only change his ways if the advice is coming from a professional.

In view of the above, it is understandable that he would boycott her going to the meetings. She had already embarrassed him once when she broke down in front of his group. His "saying the right things" in front of his group leader is his way of denying <u>his</u> dependency needs (i.e., when he "makes believe" that he is changing his behavior he fools both himself and the group).

Her use of the group and professionals to control him is her way of denying <u>her</u> dependency needs (i.e., when she controls him she defends against her helplessness and dependence on him). She is angry at her dependence on him and is very scared of her own anger. This was illustrated by her guilt about her rage which triggered her crying in front of the group. She then felt very uncomfortable about her loss of

control. She said, "Breaking down in front of these people is not my style, it is not what I would choose to do." We can thus see how member E uses the more primitive defense mechanisms of denial, reaction-formation (projecting "independence " to defend against her dependency), and projection to defend against her fear of loss of her husband. Because her fears are so great, she cannot acknowledge them and is only aware of being very angry. By the end of the second session, I had developed the hypothesis that through identification with some of the other members of the group who could acknowledge their fears, member E's anger would diminish. I hoped for a subsequent lessening of her need to control her husband.

It was in the second session that member E began to express her anger. As she listened to others express their anger, particularly member G with whom she began to identify in this session, she allowed her own anger to come through. When member G complained to the group that her husband tells her she is not <u>supposed</u> to get angry and she thinks this in "unfair", it was member E who said, "I, too, am aware of it [i.e., my anger at him] and I've got to watch it." When another member told about how her husband resented her getting sick and expressed her anger about that by saying, "It wasn't <u>my</u> prerogative to get sick", it again helped member E to share her angry feelings with the group about that. She said, "I'm pleased to hear you say that because I really thought I was the only one who had a husband who got so upset when I ever got sick . . . I simply wasn't <u>allowed</u> to be." The group support now allowed her to acknowledge and accept her anger about that and to get some relief by expressing it.

During the third session member E became somewhat aware of her use of control and its destructive effect. This came about when she recognized this process in member G and helped her understand what she was doing. She did this by identifying strongly with the member in whom she saw the conflicts she was experiencing herself and who used the coping mechanisms she herself was using.

At the same time she identified with member C's less conflictual and more adaptive behavior which enabled her to confront member G. Whenever member C did any confronting, we saw member E agreeing with her and reinforcing the confrontation by telling member G that she is feeling the same way. For example, when member G described the vicious circle she and her husband were both caught up in because of her anger, her control, his anger, and his control, member E saw herself caught up in a similar bind and said, "You may have the kind of husband who simply won't recognize that he is ill - the illness simply does not exist." This is what makes member E angry about her husband, namely his denial of his illness, which then leads her to control him, with all its destructive consequences for both of them. She then helps member C with the further confrontations of how member G is permitting her husband to manipulate her, pointing out how she is "letting him get to you". By allying herself with the less conflicted member C to help the more conflicted member G gain insight into her needs to be the scapegoat for her husband's frustrations, member E can now see more clearly how she is letting her husband off the hook from taking responsibility for his own actions.

Member E knows this is a destructive pattern because she can now see the effects of this behavior in someone else. Knowing how unhelpful

it is, why then did member E persist in this kind of behavior? She rationalized her great need to take control by now telling the group why she has such difficulties in letting others take responsibility for themselves. She thinks it has to do with the way she was brought up, remembering her mother: "When my father would have a cold . . . I saw this woman babying this man when he was perfectly alright." She saw this as her mother playing the martyr role and therefore as her need. She is therefore "very guarded" about herself trying not to repeat this pattern with her husband, she told the group.

And yet this is what she is doing herself - not allowing her husband to take responsibility for himself because of her own need, using control to defend against her own sense of helplessness. At the end of the third session she said to member G, "Tonight you are so much more aware of how you've allowed things to happen, and that's a whole load right there." This was how member E was feeling at the end of the third session. By addressing member G, she is talking about herself, how things have become clearer to her and how "this is a whole load right there".

Member E missed the fourth session, calling twice, once to check on the date of the meeting and once to cancel. My speculation was that she, as well as many others, felt uncomfortable with their confrontations of member G. For member E there was also her increased awareness of her dependency on her husband, her anger about this, and the recognition of her resulting control which may have led to her resistance by avoiding this session.

When member E came back to the May meeting, she said she wanted to bring the refreshments for the next meeting and gave a five-dollar bill

to member G who offered to buy "especially" delicious chocolate chip cookies. She then followed this up by asking member G how things had been going with her since the last meeting. She was glad to hear that she had been following through with some of the suggestions that were made to her at the third meeting. This encounter confirmed for me that member E wanted to "make up" to member G by offering to buy the refreshments, giving the money to her, and then asking her how things had gone. After the help-giving activity of confrontation which we saw member E using in the third session, she was now showing empathy by sharing her interest and concern about how things had been going with her.

In addition to her use of the above help-giving activities, we saw her use Catharsis, sharing, and self-disclosure in the first two session, in addition to confrontation, behavioral prescription, and explanation in the third session. We then saw that by helping another member to a better understanding of her behavior by confronting her and making suggestions, member E was helping herself. We also saw her use of normalization and mutual affirmation in that she repeatedly showed how she had the same feelings as G, who is so conflicted, thereby normalizing these feelings and, by her interest and concern for member G, indirectly reassuring her that she cared and saw her as a valuable person (mutual affirmation).

In the fifth session, members E and G continued to identify with each other, which helped them both. Member E used modeling when she said that she saw herself handling the problems very similarly to the way member G handles them. For example, member E said to her, "I'm just like you, I own his problems." G then answered, "You and I are both

nervous", and member E agreed, saying, "I have become hyper." They both model conflictual behavior and its harmful effect to the rest of the group and in that way member E's use of modeling is a help-giving activity for the rest of the members.

We now see member E working on herself, trying to convince herself that she really should change her behavior. She said, "This business of owning someone else's problems is a lot of emotional time-wasting. I really think I need to let his problems be his, but I think it would be so much easier if I told him what to do and he took my advice. But he is not going to." She realizes the futility of her control but yet persists in her behavior, admitting to the group how hard it is for her to change. She said, "I can talk a good game. I can say it's his. I am very good at talking a good game but what happens is something else." Member E then turned to me (as she has done repeatedly), challenging me as follows: "You have a good thing going - you haven't shared a lot with us - seems to me you put your feelings on the table with your husband and that way you get things settled." She turned to me, as she did so many times, out of a sense of helplessness, but here perhaps with some feeling of hope that I, the professional, can tell her how to be less controlling. She is seeing more and more how futile this control is. If I can tell her that control doesn't work for me either, then maybe it would be easier for her to "let go" as well.

In the sixth session member E continued to clarify for herself what she needs to do, thinking that maybe she is too busy with her work ("maybe I'm overdoing it"), not leaving enough time to reflect on how to let her husband handle his own problems. When another member suggested that maybe it isn't all that hard to adjust, member E agreed by

answering, "I need to do a lot of tuning out and that's hard to do." In this last session, member E listened to other members having similar difficulties with "letting go". Several times she intervened to help them see how important it is to let their husbands "do their own thing". She helped member C in this session, as she had in the third session, but in this last session she could also see more clearly how a lessening of control would benefit the relationship. It came out more clearly in this session that a lessening of control leads to greater caring, so that member E could see herself make the necessary adjustments, telling the group of the small attempts she was able to make in that direction with some success.

Although member E did not become less controlling over the six-month period, she did become more aware of her defenses and tried to make changes in her coping style. She achieved this by identifying with the less conflicted and more adaptive members of the group. This gave her a sense that she, too, might become less anxious. Discussions of more adaptive ways of behaving increased her intellectual understanding of what was involved, and her participation in these discussions with more adaptive members clarified for her the advantages of lessening her control. Most important, however, was the emotional support she got from the group which seemed to strengthen her, somewhat lessening her need to use reaction-formation to defend against her dependence. Perhaps she became a little less uncomfortable with her dependence because she could acknowledge in the end that maybe she was too busy with her work.

Member F is an attractive 46-year-old woman who was born and raised in Argentina, has been in the United States for twenty years, has been

married for twenty-five years, and has two grown sons. She does a great deal of traveling in connection with her work as a sales representative for a major airline. Her husband is an engineer working for a large company. She told the group that her husband's heart attack occurred five years ago when he was 45 years old and they were on a flight to South American for their vacation. In her soft voice she slowly and in great detail described her feelings as she was watching him in the plane beside her, first sweating and then complaining of pain. She was just reading an article in a women's magazine about heart attacks and at that moment it seemed to her that her husband's symptoms resembled those described in the article. She stressed to the group that being as young as they both were at the time, neither of them had any experience with illness. She said, "Our friends are our age or younger, so I was never exposed to things like that." Despite her fears that it might be a heart attack, she said that "it was hard to believe that it really could be one". Member F had a way of observing and describing her feelings that indicated the strength of her observing ego and its capacity to be aware of and express the wide range of affects she was experiencing. One could therefore sense the atmosphere in the room, with the group being totally identified with her and the frightening feelings she was having at that time.

The uncertainties about what was going on with her husband and the resulting fears continued once they arrived in Uruguay and were greeted by their families. The big difference now was, however, that they both had the support of their families, particularly from member F's mother-in-law, whose husband (member F's husband's father) had died of a coronary some years earlier. As member F told her mother-in-law what

happened in the plane and as they both observed and compared notes about what happened subsequently, "we both agreed", said member F, "that he had the same symptoms as his father". Despite the fact that by then she was "very scared", she did not interfere with her husband when he felt somewhat better. Despite her fears, she even took his place in playing doubles in tennis when he got tired, but did suggest that he go to the hospital to get an EKG. It was some time until they could get the results as they did not have the EKG paper in this resort town and it had to be flown in from Buenos Aires. While they were waiting for this she said, "By then I knew, but I wanted to have the reassurance that when they took the EKG it was not" a heart attack. When the EKG finally confirmed the diagnosis, they had to fly to Buenos Aires where he could get the care he needed in the hospital. Member F emphasized that the cardiologist who took care of him "was not only good for my husband, but he was very very good for me, because he knew exactly what I needed". She mentioned that, although he was an Argentinian, he was trained in the U.S. She described the reassurance and support she got from him, saying, "He was just fantastic, and he reassured me that he would have the best possible care."

She explained how much she needed this reassurance and support so she could give her husband "a great deal of encouragement" in his days at the hospital. She then told the group about the difficult decision she had to make about leaving her husband in the hospital in Buenos Aires and flying back to the U.S. to tell her children and to get back to work. They talked it over together, she said. She described her feelings to the group as follows: "It was very very hard and very depressing, because I didn't know if I would ever see him again. It was

just horrible, but I knew I had to do it, and I did it." She then began to cry, saying to the group, "because I always think that it can happen again".

There was total silence in the group. I could feel my eyes fill with tears and went over to get a tissue; some others pulled out their handkerchiefs. By being so much in touch with her own feelings and sharing them with the group, member F helped us to get in touch with our own fears and share them with each other. It took several minutes before she could continue.

She then talked about her having gone for psychiatric help for herself, realizing, she said, that "I would have to be both father and mother to my children". She thought the therapy was very helpful to her. It helped her understand the meaning to her of her husband's illness. The psychiatrist explained to her, she told the group, how her fear of losing her husband reactivated her unresolved grief over the loss of her mother when she was 8 years old. This understanding, she said, helped her see why she had been feeling guilty so much since her husband's illness. Although he has done well since the heart attack, she said she feels guilty so much of the time when she thinks how the illness has affected their lives, even to the point of it having caused a problem between her husband and their older son. They sought psychiatric help for this problem as well and went for family counseling to her psychiatrist. Although this particular problem was resolved, she continues to feel guilty when she thinks that they could be enjoying their lives and how her husband's illness has affected them. This is why her therapist thought she needed therapy more than her husband, she said. Her constant guilt feelings were getting in the way because of

her early trauma. She decided she did not want to go through all this old pain but rather wanted to emphasize enjoying life. For this reason she decided to terminate her therapy, knowing that her psychiatrist "is only a telephone call away". Everyone laughed when she said why should she pay a psychiatrist when she can do the same thing with her friends for free?

She then addressed herself to one of the other women who had expressed her frustrations about her husband not being aware, saying she understood how difficult this is for a wife. Since the heart attack she and her husband seemed to both be much more aware of the simple things in life, such as a beautiful sunset. She thinks she has been able to help her husband appreciate these things as she has learned to be aware of them herself. In her quiet and gentle way, she said, "When we can be aware of these simple pleasures, it is a little bit more in our favor."

This remark is typical of how member F relates to people, in a gentle and nonintrusive way. Positive effects could be seen both in the way she handled the crisis with her husband and in the way she related to the members of the group.

The detailed account of what occurred during her husband's illness and her manner of sharing these events with the group reveal member F's characteristic ways of coping, and the ego-strengths which enabled her to deal with this crisis. She is able to acknowledge and accept her dependency needs. She does not deny them, feels comfortable expressing her needs, and is able to face her fears about her husband's illness. Although she was aware of the potential seriousness of the symptoms almost from the time they first occurred, she did not and does not

appear to need to control her husband in any way. Although denial may have played a role for both of them, there is a sense overall that she is there to be helpful to her husband. She does not need to hold on to him, she can let him be, despite her fear of losing him. She has achieved separation and individuation. She is able to contemplate losing him and can imagine her life going on without him. She did not let her fears overwhelm her, but acknowledged them and sought help for herself when she thought of possibly having to be "both father and mother" to her children.

Member F's ego is capable of feeling and sharing a wide range of affects, such as depression, feelings of loss, anger and guilt, She cried in front of the group when she reexperienced these feelings and could explain to the group the reason for her tears, namely "because I always think that it can happen again". Although she may not have integrated her mother's loss when she was 8 because she had apparently not worked through her mourning of her, she has an intellectual understanding of the connection for her between her husband's illness and the feelings it reactivates around the loss of her mother. She also has the awareness of how her guilt often interferes with this enjoyment and mentioned her problems with guilt many times in the group sessions.

Her guilt, however, is not a crippling or conflictual guilt based on hostility because of a clinging dependency on her husband. When she described her feelings of guilt when she had to leave him in the hospital and fly back home, thinking that she might never see him again, her words to the group were, "It was very very hard and very depressing, because I didn't know if I would ever see im again . . . it was just horrible, but I knew I had to do it, and I did it." What helped her was

that her ego acknowledged and recognized her needs and was capable of accepting the support of the hospital staff. She admitted her needs to herself and to others and sought the help she needed, as was illustrated when she said, "The doctor was not only good for my husband but he was very very good for me . . . he knew exactly what I needed." This in turn permitted her to leave him in their hands. She was reassured that "he would have the best possible care". Thus strengthened, her ego was freed to deal with the reality problems of her having to go back to work and tell their children what had happened to their father. She could say, "I had to face reality. I had to do it, and I did it."

As was seen in this session and will be seen in the analysis of subsequent ones, member F gets high marks in virtually every help-giving activity. She demonstrated the effectiveness of her use of catharsis, sharing, self-disclosure, modeling, behavioral prescription, explanation, and empathy. She did not use confrontation - it is not her style to challenge another human being, as this might be too threatening for them. She is too gentle for that. She did not lecture or expound, but quietly and reassuringly relates to other people, and thus makes her point more powerfully than those of us who are more direct. She therefore evokes warm and loving feelings in others, as will be seen in the sessions when group members turn to her for advice. Because she was so nonthreatening, group members turned to her frequently, feeling secure that she will not threaten them. She is particularly skilled in mutual affirmation. In her giving and reassuring ways, she could make the group members feel that, with all their conflicts, they are worthwhile and valuable people. In that way she also effectively used the help-giving activity of normalization, since she herself is aware of

the wide gamut of emotions from anger to guilt and depression and can give expression to these emotions comfortably in front of others. This way she gave encouragement to others to get in touch with their feelings, without fear of censorship or shame. This was dramatically demonstrated when she cried in front of the group and, although softly apologizing for crying, she normalized the expression of pain through tears. This was perhaps the most poignant moment in the life of the group. By what she did at that moment, she enabled us to get in touch with the same feelings within ourselves and thereby gain strength from each other by simultaneously experiencing and silently sharing our common fears.

In the second session, when the group began to recognize their anger at their husbands for getting sick and some members began to express their hostility and struggle with their guilt feelings about expressing it, member F articulated her anger as follows: "I could not forgive him for having gone through this heart attack because I kind of felt that he was going to leave me like my mother . . . before the heart attack I could scream at him and now all of a sudden I couldn't do it any more. I blamed him." When another member said that is why she is so furious, because she can't let out her angry feelings any more, member F said, "I still do. I do it, but I feel guilty . . . I'm angry and tell him how I feel, but then I feel guilty and ask myself why did I do it?" Another member said she was so afraid that if she let out her feelings her husband might get sick again. Yet she did not know how to handle having to put a lid on her feelings. She turned to member F almost despairingly, saying "there isn't an answer". Member F said reassuringly, "You will find the answer."

The above clearly illustrated that, despite her feelings of anger and guilt, she is less conflicted than the member quoted above. There is a different quality to her anger and her guilt, they are felt to a lesser degree, there is less exaggeration of these defenses against her fears. Because she can accept and admit them to herself, she can be giving to her husband as well as being reassuring to the more conflicted member who despairs of finding an answer. When she reassures her that she will find the answer, we see in member F a nurturing and maternal quality that has the effect of giving the other member a feeling of hope and confidence. She doesn't give her the answer but conveys the feeling of confidence that the other woman will find it herself.

When member F called to cancel, she told me how badly she felt about missing meetings because of her travels and wondered whether she could listen to the missed meetings on the tape. I then told her that we had discussed this issue at one of the meetings she had missed and that the group agreed that because of confidentiality we would not let the tapes out, but I would be glad to stay after the meeting for anyone to listen at my office. She accepted this readily and then told me how important the group had been to her, especially in the last week. A very good friend of theirs had just died after a heart operation. When she had left on her last trip she had been thinking about his wife, as he had been hovering between life and death. "My whole trip I prayed for him and I had the group very much in my mind . . . it helps . . . it's a consolation at times . . . other people go through the same thing . . . it helps sharing about yourself."

Member F can face her fears about the possibility of losing her husband. She therefore handles her anxiety not by denial and reaction-

formation as do those women whose dependency needs are greater, but she uses sublimation as her primary defense mechanism. She uses her work to sublimate her fears, not to deny them. This is an important distinction because it enables her to be accepting and giving to herself and to others. An example of her giving to her husband was when she told about how she urged him to develop his golf game and find friends to play with when she is in town, so that he would be able to enjoy this hobby when she is out of town on her travels. He has become very proficient at golf and therefore enjoys it, and she said, "I wanted him to enjoy something on his own." She stressed that it also makes her feel less guilty being away and adds to their enjoyment of each other when they are together, as they each have their own interests as well as the activities they enjoy doing together.

An example of her being able to accept herself is how she can accept her need to have his attention. When others told how frustrated they feel when their husbands are aloof, member F said in the fifth session, "I make it a point for him to hear me out." In the same vein, when another member told of her problems in playing bridge with her husband because of the competitive feelings, she flatly said to her (but in her characteristically nonthreatening way), "You should stop playing bridge with him." It was obvious to her that you avoid what hurts, and she can do it. She is not so conflicted about what is helpful and important but goes ahead and does what has to be done. She could also turn to me in the fifth session to tell me that she agreed with the others that I don't share enough of myself. Hearing how I handle problems might be helpful to her, but I also interpreted this as her saying to me that it might be helpful for me to share more of myself

with the group because she finds it so important for her to be sharing her concerns with others. The helpfulness to her of the group experience was also recently confirmed by the field director of the project who reported to me that member F told her she finds the group "valuable".

These examples show that her suggestions are motivated by being reassuring and giving and accepting, rather than by being confrontive. There is a nonthreatening quality about them which grows out of her need to ease the pain and to reduce the conflict.

She once said to me on the way out after the meeting that she is coming to the group not to be reminded of the pain but to enjoy life more. Her ability to do this was illustrated by the way she handled a recent conflict with her husband that she shared with the group. When her father visited, she noticed a change in her husband's behavior - he suddenly became more tense. One night she came home a bit later than usual, and he started to call her at work. This was something he would not do before, knowing she would call him if she were delayed. She thought about why he was tense and speculated it was that her father's presence made her husband more competitive. She said, "There were now two roosters vying for my attention." She decided to share her feelings with her husband and made an appointment for lunch with him, thinking they might not have the privacy at home with her father visiting. She was right, and her approach worked. Her husband had been totally unaware of his actions and the feelings that motivated them, and when she made him aware he easily changed his behavior.

Member F here demonstrated a different way of handling a frustrating situation, not by control, which would have increased her

husband's feelings of insecurity, but by open discussion and communication. It again illustrated her flexibility and acceptance of herself and others and modeled for the group the advantages of a lessening of control and the benefit to herself and the relationship of a giving and accepting attitude.

Although the group apparently had some benefits for her, which she expressed to me on the telephone and also to the field director, we saw no change in the lessening of her guilt feelings over the six-month period. This was illustrated by the incident she related to the group in the sixth session. She went up in a glider with her husband recently; they were having a good time and "for a moment" she forgot that her husband had a heart attack, asking the pilot to go higher. When he did this and swooped down from a greater height, her husband complained of not feeling well. She then felt terribly guilty and said, "I forgot all about his heart . . . for a moment I thought, 'This is going to kill him' . . . it was horrible." When she finished, the group felt she should not have taken the responsibility for this on herself, that her husband knew this might not be good for him and could have said something. She was taking the responsibility entirely on herself and was needlessly feeling the guilt.

The group's response to her made her more aware of the extent to which her guilt feelings were interfering with the enjoyment of her present life. All along, member F had been hearing the struggles of the women around this basic issue of how to diminish this sense of responsibility which they needlessly took upon themselves to their own detriment and that of the marital relationship.

In the incident with the glider, member F clearly focused on the issue and prompted one of the members to say, "This is what I mean . . . you cannot live all your life with that fear . . . you are a person, too." The effect on member F of this remark, and the impact of the many previous discussions around this issue by the group, could be seen by her response later in the sixth session when another member talked about her guilt feelings. Member F turned to her and told her not to be so hard on herself, saying, "You have to live with yourself." The group had helped her become more aware of how she was letting her guilt interfere with her present life. The source of member F's guilt may well be that she feels she has failed her husband like her mother had failed her. She therefore identifies with the maternal functions of the mother who abandoned her by taking her mother's role with her husband and with the group. Becoming more aware of the emotional burden this is placing upon her through the interactions in the group, member F may well be able to make the decision to do "what I have to do" (her words from session 2) by completing the work of mourning the loss of her mother with the help of her psychiatrist.

Member G was the first woman to arrive at the first session, quite a bit earlier than the rest, explaining that she had to come on time and leave on time, otherwise her husband would be angry with her. Her only other participation during the first meeting was her remark which broke up the tension of the group as a result of my anxiety when I did not hear from my husband. Wondering whether we had an anniversary coming up soon (which as a matter of fact we had - the following Friday), she suggested that my husband's delay was perhaps due to his wanting to surprise me by buying me an anniversary gift. Her remark resulted in

laughter by the group and a relaxation of the atmosphere of anxiety and fear, which then enabled us to continue with the work of the group. I remember thinking to myself that she is either a very well-adjusted person with a well-developed sense of humor or a person whose own fears are so great that she has to deny them. Her remark might have been prompted by her frightening feelings.

In the second session Member G heard what different members were feeling about their husbands getting ill and their hesitation about sharing their feelings with him. Since she had been sitting and listening so quietly all along, her remark was all the more startling for the group as it was said with a great deal of anger: "Is anybody else angry because we can't do this any longer?" When some others told her that they do let their husbands know how they are feeling, although at times with some hesitation and guilt, it became clearer why member G's problems in this area were greater than some of the other members. When she tries to tell him what she feels, he tells her he is not <u>supposed</u> to get excited. She thus senses his subtle manipulation of her, of which she seems somewhat aware, as she told the group, "This is why I think I'm angry . . . he may get sick again. I don't know how to handle this, I have to put a lid on it . . . at this point I think there isn't any answer."

It was in the third session that member G's conflicts, their probably etiology, and their present manifestations became clearer to both the group and to member G herself. When in the beginning of the session I tried to connect what people were saying in this session with what member G said at the end of the last session, she said, "Yeah, it's true, isn't it - I think, I feel, I describe it as anger because I

really don't know how to deal with it, because I am so aware that any minute he could go like this, you know, and I could be sitting here alone . . . all this time I didn't learn how to deal with this, and it will be sixteen years tomorrow . . . that's why I wanted to come to this group, too, to see if perhaps I could work that out too." Member G's strengths lie in the fact that she knows she has a problem, is willing to face it, and sees the group as being able to be helpful to her in working it out. This is perhaps the reason why, for member G more than for the others, the group has been a significant turning point in enabling her to begin making important changes in her life. As will be seen, the factors that contributed to this process were the support and subsequent validation she got for herself through the group experience, which gave her the strengths to take the difficult but necessary steps to initiate these changes.

Member G talked at greater length about herself in the third session, telling the group that she is 45 years old, works as a telephone operator, has no children, and has been married for sixteen years. Her husband works in the accounting department of a large life-insurance company. He is fifteen years older than she. The first heart attack occurred when he was 43, before they were married. She said it was a mild heart attack and he was well when they got married a year later. Four years later he had the second coronary and was in the hospital for forty days, and she was "so bewildered because he was so depressed . . . I never knew what to expect, although there was never anything but depression, really." Even though the doctor let him finally go down the elevator and take two or three steps, and he built up eventually, still the depression continued, and she told the group she was at a loss as to how to deal with it.

The members then began to ask her questions about his depression, wanting to know whether it was related to his not feeling well or being sorry for himself or both. She said she really did not know, "He never said - I don't think we had a heck of a lot of verbal communication at that time." Things got better and he went back to work and "everything was fine". After that he would get chest pains once or twice a year and be rushed into the hospital. She was afraid it was another coronary, but it turned out to be pericarditis each time. With each episode he got more depressed; he developed ulcers. When in 1974 he developed stomach pains and complained about continued chest pains, she suggested he go into the hospital. She was getting quite desperate and said, "They were terrific pains and he wouldn't do anything about it, and so I though I don't have anything to bargain with here because he doesn't like me to . . . he thinks I like to send him in the hospital . . . that's how he puts it, 'You enjoy putting me in the hospital' . . . boy, do I love that . . . that's a lot of fun, isn't it? We then got in the ambulance and boy, do I enjoy that. But I don't think he really means it - it's just a way, his way of compensating."

By this third session, member G felt safe enough in the group to let out this enormous rage at her husband, and this must have been a great relief to her. Indeed, the group and I were supportive of her and what happened as a result was that different members of the group, particularly member C with the help of member E and others, were able to make member G aware of what was going on between her and her husband. They particularly focused on helping member G see how she is allowing him to make her feel guilty by her taking responsibility for him. Everyone in the group then came up with suggestions as to how she could deal with her husband and let him take responsibility for himself.

One woman pointed out that it is easier for him to blame her for the things he is not supposed to eat. Member G then told the group how her husband always threatens her, saying "one fatty meal will do it" (i.e., cause another heart attack), and someone suggested she should then answer him, "I really feel sorry for you if you hate that one", and everyone then laughed. A good deal of humor was brought into the discussions, one member giving examples of how she kids with her husband when he gets "nervous" and how they then both end up laughing. By the degree and level of involvement of the group, it became obvious that every one of the women were strongly identifying with member G's anger at her husband. It could be seen from their suggestions that most of the other members reacted to and handled similar situations with their husbands differently.

Member G's great anger is due to her exaggerated fear of being abandoned by her husband. This was illustrated when she said, "I describe it as anger . . . because I am so aware that any minute he could go like this, you know, and I could be sitting here alone . . ." There was such an exaggerated fear of object abandonment in member G following her husband's heart attack that I suspected that she experienced some early childhood trauma which was reactivated by the heart attack. This was actually borne out later when she shared with me her rage at her father for the way she was treated by him. Thus we saw her using anger as a defense against her feelings of dread and fear. Her fear of loss is too frightening, so she denies it and defends against it by being angry at her husband for abandoning her through his illness. Since there had apparently been problems in communication before the illness, he was now even less emotionally available to her.

Her anger at him was therefore exacerbated because of his illness. Member G's fear and anger resulted in a total sense of helplessness, which she so well expressed as her being "bewildered", not knowing how to handle the situation. Her ego now defends against the helplessness through the mechanism of reaction-formation by becoming controlling. She thus projects a feeling of being in control, both of her husband and her own anxiety. Her control gives her the illusion that she can prevent the dreaded abandonment from occurring.

In effect, however, member G's control has a very destructive effect on the marital relationship, as it is threatening to her husband and increases his feelings of insecurity brought on by his illness. In particular, a life-threatening illness activates increased feelings of dependency in the patient, resulting in denial, anger, and helplessness, all of which greatly exacerbate the spouse's needs to be controlling. Member G thus reinforces her husband's helpless and angry feelings through her controlling behavior. He therefore retaliates by playing on her fears, as can be seen from the following example: He tells her he is an "old man"; he warns her that "one fat meal will do it" (i.e., will kill him); he accuses her of enjoying putting him in the hospital; he refuses to take care of himself and "ignores the illness". When he had thus succeeded in infuriating her, he makes her feel guilty by telling her she must not upset him.

No wonder then that member G, coming to the group with all of these pent-up, hostile feelings desperately needed and used the group to release them. For example she told the group in the fifth session, "All I hear is 'I'm an old man', and I feel like saying, 'Who gives a damn?'", and when member E asked, "Why don't you say it?" member G

answered, "Then I would feel guilty . . . that might start a fight . . . well, you can't fight because that might cause another heart attack." This illustrates how trapped she feels, how she sees no way out; as she said in the second session, "I don't know how to handle this. I have to put a lid on it (i.e. my anger) . . . at this point I think there isn't an answer." When member F then gently told her, "You will find the answer", the whole group rallied around to help her find it.

The group helped her see that she is not the only one having angry feelings. When in the second session various members expressed resentment at their husbands for becoming ill and I then normalized the feelings of hostility by pointing out the mutuality of our experience, member G felt strengthened and validated. It was safe for her to tell the group how furious she was at him for making her repress her anger. The group now gave her the permission to let it out, without feeling criticized or demeaned. This experience got her ready for the next step.

Now that the group had helped clear up one of her misconceptions, namely that she is the only one who is angry at her husband for becoming sick, she began to question some of her other assumptions, checking them out with the group. She wondered if anybody else is angry because they cannot let their husbands know when they are angry with them. Several group members told her, "I still do, I let him know" or "I still do, I do it, but I feel guilty". She learned about a different way of feeling and behaving. She could now see that although others feel resentment and guilt, they still can communicate their feelings to their husbands and don't feel that they have to repress them like she is doing. She thus became aware of the difference it makes in the relationship, with

her feeling trapped and isolated and depressed and with the others being able to maintain communication and therefore feeling better about themselves and their husbands.

Member G is afraid of her intense anger. Her dependency needs had apparently not been adequately met in her growing-up years, which was confirmed when she later shared with me privately her hostile feelings about her father of whom she was terribly afraid. Not having gotten her needs met by her apparently punitive father, and not having ever worked out her feelings about that, she transferred this unresolved rage to her husband, looking to him for the support of which she was deprived. She now depended on him to get what she never got before, and she was continually disappointed. Not having gotten her needs met in the marriage, and being angry about that, her husband's heart attack heightened all of her feelings because there was now added the real threat that she might lose him. Because of the emotional meanings of the heart attack to him, he becomes more preoccupied with himself and emotionally even more distant than before. This increases member G's hostile feelings to him, which she expressed as follows: "The cat makes him feel more important than I do. The cat is his therapy . . . I cannot get his attention . . . he communicates in a negative way", and she added, "maybe it's me". She tries all kinds of ways to get his attention; as she once told the group she said to him, "Have you heard around the neighborhood, I had an affair with the milkman", and there was no response from him.

Member G's anger now becomes much more intense, she is full of rage because her husband is depriving her of the support she is seeking for herself. Because of the guilt she is feeling as a result of her rage,

her anger has no outlet and she is therefore turning it against herself in the form of depression. Again the article by Melvin J. Stern is applicable here, when he says:

> For those spouses who needed support, being married to a major or moderate denier frequently meant that they had to badger, threaten, and in some cases create 'a scene' to have their needs met. Pre-infarct, many had existed in this situation feeling lonely and deprived of warmth and companionship . . . postinfarct, these spouses felt even more constrained. Signs of discomfort were suppressed lest the patient become disturbed and have a relapse. A highly anxiety-laden situation was thus created . . . resulting in her 'feelings of frustration and anger' . . . resulting in 'spouse pathology'.[4]

Although denial was not her husband's characteristic way of dealing with his illness, we saw him using it as a way of getting back at her for her increased control of him, which she now uses as a method of coping with her anxiety and depression.

All of the above conflicts caused member G to have low self-esteem, which she once expressed directly to the group by saying she thinks she is "bad". She thus becomes an easy target for her husband's frustrations, while he in turn gets some relief for himself by directing his anger about his illness at her. Feeling "bad" about herself for having so much hostility toward her husband and therefore feeling very guilty, she acts out with him the bad feelings she has about herself. She thus permits him and unconsciously provokes him to use her, as a form of punishment for her hostility, thus temporarily relieving her guilt feelings.

The group helped her clarify and become much more aware of what she is permitting her husband to do to her because of her own bad feelings

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[4]Ibid., p. 85.

about herself. By confronting her in sessions three and five, the members helped her understand what she is doing, helped her see how she is making her situation worse for herself because of her feelings and behavior, and modeled for her that there is a different way of feeling and behaving that can ease the stress of their husbands' heart attack.

Because of the security she now felt in the group, she was able to accept their confrontations and benefit from their suggestions. The group helped her focus more directly on the reasons for her anger. They helped her see that she resents his putting his problems on her and that is what makes it so much worse for her. When member G talked about her anger being "because of the fear that's hanging over us", member C helped G by focusing on herself when she said, "Is that what you resent (i.e. the fear of losing him), do you resent it from him or do you resent that it's been put on you?" When member G again avoided acknowledging what she is doing, member C demonstrated to her how she is letting him put the blame on her when he kept blaming her by telling her, "One fat meal will do it". Member C then told member G how she used to do the same thing herself, blaming herself for her husband being a "chocaholic", telling herself "why did I let him eat all this chocolate?" She emphasized, "He didn't say it, but I did. I was the one who felt guilty." Member C went on, "Seems to me he is using you a little like a whipping boy", and member E then chimed in, "and you are letting him do it". When she heard other comments such as, "You have accepted the responsibility", "You accept the blame", she became conscious of how she had brought this situation on herself.

In the fourth session many members were absent, perhaps because of the guilt they felt about the confrontations with member G. In the

fifth session there was an outpouring of interest and concern about how things had been going for member G and how she and her husband had been getting along. Member G, looking much more relaxed than I had seen her, apologized for having had to miss the last meeting because of dental problems. She reported to the group that things were much better for her. She had thought about what the group had told her and was able to approach her husband with some suggestions about doing things together. She told the group that she said to him, "The group thinks we should have more time together for ourselves." When she then asked him if he would like to go to the beach and he said, "That would be nice", she was surprised that he wanted to go. She went on, "Talking about it helped somewhat - we haven't made it yet - at least we are thinking about it. Maybe we should pursue this further. We are trying to work things out together. We haven't made it yet, at least we are talking about it. I hope to report more."

The group, feeling pleased to hear this progress, then came forth with many other positive suggestions, such as their going shopping together, or going to the wine country, and she reported they had already gone up, despite the fact that her husband said the grapes weren't ripe yet. At this, both she and the group had a good laugh. To a significant extent her tensions, so obvious before, were relaxed as she related to the group what had gone on since last she had spoken to them.

She came early to the fifth session and was very talkative, telling me she had discussed going for counseling with her husband. She said she had been doing a lot of thinking since the last meeting, trying to implement some of the suggestions made by the group members and decided

there were serious problems with communication between her and her husband. Would I know of a marriage counselor? She thought it would be better if they did not come to me, as then her husband would feel I might be on her side. I gave her the name of one of my colleagues. When she had to miss the sixth session because of an asthma attack for which she had to be hospitalized, she wrote a letter apologizing that she had to miss a second meeting and telling me that they are also "taking care of the marriage counselor appointment this coming Monday, so all in all I am trying to get my act together." Ending the letter, she said, "Thank you for your understanding, as I am really interested in attending out meetings."

As a result of the supportive group experience, we see a number of positive changes in member G's perception of herself and others. She has become more relaxed, less rigid, more reflective, less defensive, more open to other people's opinions, doing less projecting and therefore being able to deal with reality by working on solving her problems rather than denying them. She knew she had problems when she came to the group, but their very vagueness made them overwhelming and frightening. Through her help-giving activities of catharsis, sharing and self-disclosure, and modeling more conflictive behavior, the group could then provide her with empathy, normalization, and affirmation. This afforded her the support she needed so that she could then accept the confrontation, behavioral prescription, and explanation of the group to help her change her behavior. The group provided her with the opportunity to identify with both the more and less conflicted members which helped her understand and clarify her behavior and enabled her to make the changes by experiencing the benefits to herself of a more flexible and adaptive way of functioning.

Member H is a rather shy and retiring woman whose comments in the first three sessions were confined to saying in the third session, "You shouldn't just sit and wait, but you should take one day at a time and enjoy each day." She said this in response to the frustrations expressed by members who didn't know what to do when their husbands are emotionally unavailable. When, as a result of her comment, there were a series of suggestions of how engaging in mutually enjoyable activities can help with the uncertainties of the husband's illness, she went on to say, "If it happens the day after tomorrow, you will be very sorry you didn't enjoy yesterday and the day before." Her remarks were primarily directed at member G when she and the group were helping that member see a different way of dealing with the husband's heart attack. Although these were her only words in the group until the fourth session, member H was visibly very much involved in what was going on and missed only the May session, when she was away in England on her vacation.

It was perhaps fortunate for member H that there were so few members present at the fourth meeting because the very small and intimate group made it easier for her to talk about herself. After I had given my introduction about how we can be better caretakers to the extent that we can be more independent and giving to ourselves, she commented by saying she felt she was independent, otherwise she would not be going to work. She would be staying home taking care of her husband all day, which she doesn't do. She does take good care of him when she is home, she said. "Unconsciously it gives me peace of mind in this situation where his health is not so sure and he doesn't know if he will see tomorrow or not." She then went on to tell us that "a very wise" 84-year-old woman friend of hers who has had heart trouble for

twenty years told her that "people with heart problems are hard to live with because they are so afraid that they might not live till evening." She said that what her friend told her helped her because "when my husband is not nice . . . that's the reason - his own being scared." We see then that member H harbors quite a bit of hostility toward her husband and, having heard how other members felt in the previous meetings, she felt comfortable expressing it to the group, albeit with the rationalization that his unpleasant behavior is due to his fear.

Member H than went on with her story, saying they had been "luckier than most" in that her husband did not have a heart attack but started having problems with his heart rhythm about twelve years ago. When there was continued pressure and very fast heartbeats they went for a checkup. The physician recommended bypass surgery, which was done by an eminent heart surgeon. He has done well since the operation and went back to work six weeks later, but since then he has started drinking. While still in the hospital he started with two glasses of wine for dinner, which has increased to twelve a day. To the query by one of the members whether he is an alcoholic, she answered, "almost an alcoholic". The problem is not one of a personality change - he is irritable and impatient - but even more so that he refuses to admit he has a problem. He yells at her, and when someone asked her what she does then, she answered, "I know we are not to excite our husbands, but sometimes if it gets too much, I yell back at him." When member I wanted to know his reaction when she yells at him, member H went on, "Surprisingly, he does quiet down", even though the things she then says to him when she is upset are things that "if people said them to me, I would never speak to them again". After that, for a few days he will be just fine. Member I

thought that her yelling at him maybe calms him down. Member H somewhat agreed, saying, "When I am not exploding, that excites him." When I suggested that maybe it is a way for him to get attention, member I added that maybe this is what he grew up with, that the only way in his original family to get attention was if you would yell.

Member H now went on to tell us more about her family which consists, as she put it, of "two generations of children", ages 33, 32, and then the youngest, nine years younger, who is 21. In passing, she mentioned that they lost their 33-year-old son when he was 31. The 32-year-old son still lives at home, and their married daughter lives out of town with their three grandchildren. When they come to visit, her husband is worried they will break something, and this interferes with his enjoyment of them. She then remarked, "He really doesn't care that much about children as children, only as toys." She observed further that it's ok to hug them or hold them, but as soon as they want to do something, he won't permit it. She explained that he was very similar with his own children: "The living room was just for friends and for him, not for his children." Member C then made the observation that this is the case with many European families, which then led to a discussion about their background.

Both member H and her husband are from Latvia, and they met in Germany. She pointed out that her husband's father and all of his family, which was a large one, died young and most of them of heart trouble; none lived to be sixty. His own father died of heart trouble when her husband was only a teenager. That is why she thinks he is so worried about his own life, and she "imagines" this is also the reason for his drinking although, she added, he drinks more since the death of their son.

Member C then wondered if member H resents her husband for not having gotten support for himself, or some kind of help, around the tragedy of losing their son. She added that especially European men have to be strong and "the heart problem is one thing, but there are a lot of other things involved here". Member H agreed, remarking that her husband is not close with his only brother still living in Germany because the "brother has been mother's favorite and the two never got along". So the drinking, which is much heavier now, goes back a long time and was already very upsetting to their son who died. The latter had a close feeling for his father and especially moved home after the father's operation so he could help drive him back and forth to the hospital. It was at that time that the leukemia started. It was a year before he died, and he talked to his father about his drinking, once saying to his mother, "Father couldn't be very worried about me if he continues to drink." She cried softly at this point, and the group was empathetic, one member saying she could remember her father becoming an alcoholic late in life when he couldn't face getting old, so she can understand her husband now, with all his pressures, needing alcohol. Another wondered about his nearing the age when all of his family died and now needing the alcohol to get "all he can out of life", not even being aware of it. Member H agreed that the alcohol must "meet a deep need, otherwise he would not do it, knowing how harmful it is". She then mentioned that alcohol had affected his attendance at work, which is in a large company where he is an engineer. Her work is of a clerical nature in a large company.

The group support of member H continued when we all let her know how we understand her feelings of frustration at their lack of communi-

cation, how it prevented them from resolving the loss of their son and sharing their common fears about his heart condition.

Member C then wondered about member H's comments so far in the group, which were mainly saying that we should take care of our husbands, that it's our duty. Did that mean that she is taking responsibility for him, that she is feeling this pressure, especially since his heart operation, and that perhaps for her the pressure is even greater because of their cultural background? She agreed that this was so, saying, "He might be killing himself and it bothers me that I can't tell him not to. I'll feel guilty if I don't do something." She said she realizes that she covers up for him when he misses work, but she can't help it, that is the way it is for her. She feels helpless as there is no way to get through to him. She is only glad she has her work because "without it I would be a nervous wreck. Work keeps my mind completely blank for quite a few hours a day." I ended up saying the sad part is they each get their escape separately because they can't communicate together and she then answered, "It's too bad we can't get together, but at least I could share my feelings with the group today. I can't talk to anybody - it is too personal."

Member H uses denial as a defense against her dependency on her husband, saying she is independent because she goes to work. She wants to take care of him and needs and wants his support, which is not available to her. She has no outlet for her negative feelings, saying, "I can't talk to anybody . . . it is too personal". There is a sense that she is ashamed because of the drinking to share her feelings with her friends. Her anger, not having an outlet, is turned against herself in the form of depression, which she seeks to escape through her work.

Much of their behavior is culturally determined in that the man is the boss in the family and the standard is for the wife to suffer in silence, neither sharing problems with the other. Neither of them knows how to share feelings, which leaves her anxious, frightened, and depressed. Her way of coping has been by trying to control him, but she realizes it does no good. She tries to tell him to drink less, but it is useless. Moreover, the threatened loss of her husband reminds her of the actual loss of her son, with which neither of them have been able to deal because of their inability to share their feelings and thereby get relief for their psychic pain. Because of her background and lack of emotional support for herself up to this point, member H's ways of coping did not allow for affect discharge nor for the integration of affects into her ego. Also, because of her relative emotional and social isolation which she talked about, member H has not had the opportunity for the multi-differentiation of perception of herself and others. The combination of all these factors make for a poor adaptation to any life difficulties, let alone to a husband's heart disease and to the loss of a child.

The group therefore had a significant impact on her emotional state. Although she was hesitant about coming from the start and said little for the first three sessions, by the time she spoke about herself in the fourth session, she had experienced the meaning of group support. It was primarily in the area of gaining validation for herself as a person that the group was so important for her. For hours she had silently listened to how people were sharing their feelings and how, despite that, they were not demeaned, as she had imagined they would be. On the contrary, people were accepted by each other and therefore could

take the risk of sharing more. We therefore saw her use the help-giving activities of self-disclosure and sharing which led to the liberation of her for-so-long pent up emotions through catharsis. The group therefore could reach out to her with great empathy, normalizing her negative feelings and thereby affirming her as a worthwhile and valuable person. We saw several concrete evidences of these changes.

For one thing, member H's appearance changed. She dressed more colorfully and changed her hair-do. It wasn't that she became more glamorous, as that was not her style, but she visibly paid more attention to herself and looked more attractive. Also she became more talkative in subsequent meetings, so that at one point member E remarked it seemed to her that member H really feels less responsible for her husband in contrast to herself, who only can talk about it but not implement the necessary changes. Member H then broke out in a big smile, agreeing that this was so and saying what a big change it has made in her outlook. She offered to help member E with this in future meetings. She wishes, she said, the men in their meetings would talk to each other more, to know what they each feel and think. This is what helped her in our women's group, knowing what others feel and think. The card she sent to me from her vacation in England she signed, "Gratefully yours".

Member I was on a cruise when the group started in January and had told me she was sorry to miss the first meeting. She was silent during the second session, and we began to hear from her in the third session when she expressed a different point of view from what was being discussed. When the group was saying that perhaps we were taking too much responsibility for our husbands to the detriment of ourselves,

member I said, "Maybe we are happy doing it - that's the way that generation was." She became more active in the fourth session, being supportive of member H when she told about her husband's drinking, however focusing on rationalizing the reasons for his drinking as a way of "getting what he can out of life" rather than focusing on what member H was feeling about it. Since she had said so little up to this point, I was surprised when she called to tell me she could not be at the May meeting because her daughter from out-of-town was giving her a surprise party that night. Her husband had remembered about the wives' meeting and told her about the party. She could not disappoint her daughter, of course, she said, but she planned to tell her after the party to never schedule anything for her on the third Thursday of the month, when our meetings were held. I had no idea how much the meetings meant to her.

When in the sixth session the members shared their frustrations about their husbands' emotional distance from them and their preoccupation with themselves, member I turned to the group and asked, "If I keep at him, am I hurting him?" She said people tell her she sounds "like a shrew" when she tries to get him to talk, because he "keeps everything in". She feels she is "being tuned out" by her husband. She asked the group "if it is better to let people think she's a good person and forget about it (i.e. not shout at her husband when he doesn't respond), or keep at him", which is what she had been doing out of sheer frustration for being shut out. She went on, "He never gives me the feeling he is angry . . . I wish sometimes he would . . . he doesn't seem to mind my shouting at him . . ." Member I had not told the group much about herself, but here she shared with us that she did not know for a long time that her present and her first husband, from whom she

was divorced because of all the fighting they did, knew each other. When the two recently met, her present husband said her first husband never spoke badly about her. She was surprised because she thinks that now she drives her present husband nuts. When people suggested that maybe he didn't mind it, otherwise he would object, she kept asking and wondering whether it was ok for her to probe, to want to know what he is thinking. She told us that her friends call her a nag and tell her to leave him alone.

Because she is so critical of herself for her control and her friends are so critical of her, she unconsciously expected the group to also criticize her behavior, which intellectually she knew would not happen. All that did happen was that a more conflicted member (E) told how her husband is not there for her as he is so "terribly absorbed", whereas a less conflicted member (D) told how she thinks it is good for the husbands to get absorbed in something that interests them. As she expressed it, with the equanimity which is so characteristic of her more adaptive way of functioning, "My husband gets absorbed in his hobbies - now it's computers and he is having a ball - it may be a little hard for anybody around them, but it's great for them."

Since she did not feel attacked, as she knew she would not be, nor even mildly criticized, she could then go on and share with the group her great fear about her husband, how at night he breaks out in sweats, how she takes his pulse to make sure he is ok. She is scared and wakes him up because "I don't want him to go any deeper". Being critical of herself again, she asked the group if she is over-anxious. On the contrary, the members told her, they agree that something is wrong about these sweats, that she should check it out with the doctor, that they

too would be concerned if it happened to their husbands. Later on in the session she again wondered if she is manipulating her husband. The topic was how by controlling the husband less and being giving to ourselves more, we can be better nurturers. Various people were comparing how they handled similar situations. Member D, one of the more adaptive members, gave an example of how not to take all the responsibility on herself. They had had several weeks of company and they both were tired, and she wondered if they should go to their weekly dancing-out evening since it might be too much for her husband. They talked it over and decided to go, and she suggested that he sit out a dance if he got too tired, which he did. She stressed that she didn't take away the choice from him by making a decision herself of what was good for him. He decided, and took the responsibility himself, to "sit one out" if he got tired. She explained, "I gave him the choice - I wanted to go too, but I didn't control him."

Member I then said what happens with her in a similar situation is that if <u>he</u> really wanted to go but <u>she</u> felt it was too much for him, then even if she would very much <u>like</u> to go, she would say she is too tired because "I would be too scared for him to go". She then asked the group, "Is this manipulation?" Again and again she got back to the same point. What we heard with member I is her self-doubt around the control issue about which she feels very guilty. Her controlling behavior is motivated by her fear of being abandoned, which she unconsciously wishes to prevent through her control. She is very harsh on herself because of her anger, and she exaggerated her control in front of the group because she feels so guilty about it. She was looking to the group to relieve her guilt. This they did, by telling her when she questioned

whether she is manipulative, "Don't be so hard on yourself - you have to live with yourself." The group sensed that she was struggling to let go of some of the control, a thing very difficult for member I to do. Being hypercritical of herself, she sensed the group as being non-critical, merely exploring the issue with her.

We see in member I some of the same defense and coping mechanisms used by some of the less adaptive members - dependency and its denial, anger, and the fear beneath the anger. Like some less adaptive members, she tries to cope with all these conflicts through controlling behavior, which in turn makes her feel guilty. The guilt about her controlling behavior may well be a result of her attendance at the meetings, which enabled her to experience the benefits of exerting less control through her identification with the more adaptive members.

The control issue, a key issue throughout the six meetings, helped member I and other members become more aware of the use of this harmful coping mechanism. Through discussion, it came to be seen as ego-alien rather than ego-syntonic, as it had been for many of them before. Hence we saw member I's guilt about it and the group's empathetic handling of her conflict, thereby reducing her guilt and lessening her use of control which she so much wished to do. Member I's ego strengths were seen in her use of the help-giving activities of <u>self-disclosure</u> and <u>sharing</u> with the group her concerns about her own behavior. We also saw her use of <u>catharsis</u> when she told the group about her great fear of losing her husband and how she would wake him up at night, fearing he would "go deeper". She also used <u>modeling</u>, telling the group how she handles a situation differently from some of the others, how she exerts more control. She also demonstrated her use of <u>empathy</u> in the way she

was supportive to member H having to cope with her husband's drinking problem.

Member J was very limited in her participation in the group because of a severe hearing problem. Despite the fact that she wore a hearing aid, she apparently could not pick up enough of the discussion, as her comments were often not to the point. She tried very hard to be a part of the group, but it was apparently too frustrating for her. When she did make comments they were usually of a humorous nature, for example her suggestion to member G to "kid" with her husband when things get tense. She then told of a humorous incident with her husband which helped them both relax. Member J is a tall and attractive woman, always well groomed, who seems cheerful on the surface, but due to her difficulties in communication it was hard to know just what she was feeling. When I once called at home when she had missed a meeting and did not call to cancel, I talked with her husband and later also with her. It was on the phone that I got a sense of some of her frustrations at the meetings.

Her husband told me she did not come because she was upset about the two women who talked so much. It made it so hard for her to participate in the meetings because she had so much difficulty, her husband told me, picking up what was being said. He explained how the sounds in the hearing aid get garbled when more than one person is talking. He said he wanted to let me know how his wife felt about the meetings. When I called her later, she told me "somebody besides the two ladies should have something to say". I knew she was talking about herself wanting to be more active in the group, and I encouraged her to come, stressing how much we enjoyed her comments when she made them.

She said she liked coming despite her difficulties. At the end of the conversation she said she could understand member E talking so much at the last meeting because she was very troubled and needed the group to let off steam. When in the sixth session member I talked about her frustration when her husband does not answer her, it was member J who suggested that maybe her husband was so quiet because "he is hard of hearing but he doesn't like for you or anybody else to know it . . . I'd rather for people to know that I'm hard of hearing than for them to talk to me and for them to think 'what's the matter with that stupid thing'".

I was very tempted at that time to ask her if this is how she feels in the group (which I know she does), but I decided the time was inopportune - we were in the middle of helping member I deal with her questions about being too controlling of her husband. I once approached member J privately about getting help in communication through the Bay Area Hearing Society, but she did not seem interested.

Member K called me the evening of the fourth meeting, saying she had every intention of coming to the meeting that evening but had been locked out of her house. She had only attended the first meeting. When I told her that we missed her, she said she hesitated coming back because her concern was that people were talking about themselves so freely and she felt she really didn't have that much to tell. I said she need not feel pressured to talk, there was much to be gained from just listening. She came to the fifth session.

Member K is an attractive and gentle, middle-aged lady with a pronounced English accent. In her reserved manner, she once told the group about England because one of the members was going there on vacation. After listening most of the session to some of the frustra-

tions of the other women, she told about a problem with her husband centering around their bridge-playing. When member G remarked, "At least he plays with you", member K answered firmly, "No more". She then described her husband as a charming and delightful man who "kisses all the ladies" at the bridge club where they play, but "when he sits down with me, everything changes; he becomes a Jeckyll and Hyde. His group leader at the heart project has told him not to play with me, but we are drawn to playing together." The group tossed this around and thought it was due to heart patients often being insecure and competitive. Member K then expressed considerable hostility toward her husband by stating, "He makes a scene in public. I can't say anything in public and I wouldn't want to, but he can say what he likes and gets away with it." On another occasion during the session, she expressed annoyance at her husband not taking enough responsibility. She tells him frankly and firmly what she thinks he should do. From the little I know of her, she seems like a person with a good sense of self who feels comfortable telling her husband when she has something in mind but who has difficulty resolving the question of bridge. She cancelled the last meeting, saying they had to go and play bridge with a sick friend in the hospital. Member K seems to have some ambivalent feelings about coming to the group, but she does involve herself when she comes. She has not yet shared with the group the history and circumstances of her husband's heart attack and how it has affected her life, except in the area of bridge, which seems to be a continuing problem for her. I am not sure, however, whether the problem with bridge is a result of the heart attack and what their relationship had been in the area of competition before her husband became ill.

Because of her infrequent attendance, I have not been able to observe her interactions nor do I know enough about member K to describe or identify her defense mechanisms or coping style. Through her use of the help-giving activities of sharing and limited self-disclosure, she has been able to define her problem to the group, and through her use of catharsis she had been able to release some hostility about her husband's irrational behavior. Hopefully these activities have helped her experience the support the group can offer her, so that she might be able in the future to work out the difficulties she is experiencing as a result of her husband's heart attack.

Leader-Participant Roles in the Group

In my proposal I stated, "Although I am also a clinician, my primary role in the group is that of participant, in order to preserve and promote the self-healing potential of its members. I see my clinical skills primarily as helping me preserve my role as participant and preventing me from slipping into the therapeutic role which would . . . deprive both myself and the others from the mutual support . . . the group can provide." This was my hypothesis about my role in the group, namely that by emphasizing the participatory aspect of my role, I would enhance the therapeutic potential of the group process. My thinking was based on the assumption that the more the members see me as one of their peers, with the same fears and uncertainties, the more this would serve to promote the commonality of the group feelings and thereby facilitate changes in the group members. My feeling was that by not

being the leader but the participant, I would decrease their feelings of helplessness by enabling them to gain mastery over their situation and thereby diminish their anxiety.

Thus, probably because I went into the first group meeting with the firm resolve of being the participant above all else, the particular circumstances of that meeting conspired to help me play the participant role from the moment the women arrived at my office. Although I had had contact by mail and by phone with most of the women prior to the meeting, I sensed a good deal of anxiety on their part. This was intensified by my own anxiety about not having heard from my husband all day, an unusual occurrence which worried me a great deal and which I shared with the women as they arrived. My husband had told me several days before the meeting that he would not be home until late the evening of the meeting, nor would he be in his office most of the day, as he was going to be busy arranging for the unusual occurrence of a wedding in the hospital that evening. Probably because of my own preoccupation with the first meeting of the group, I had completely forgotten about this and became quite alarmed when I could not reach him at home nor at the office. I remember thinking to myself that sharing my concerns with the women would be helpful to me and would only hasten the process for which we were coming together, namely to be of support to one another.

In no way did I anticipate the effect of my anxiety on the women nor the effect of their support on me. As the introductions were made, one told the other of my concerns and they came forth with different suggestions - to call the hospital, the doctor, a neighbor who had the key to our house to look and see if anything had happened to him. Other women got busy pouring coffee and passing around the cookies I had

prepared. Everyone was involved in one way or another to help me. The first meeting thus got started in a very powerful way before my opening remarks about the structure, the taping, the signing of the human subject consent forms, and whatever else I had planned to discuss. What finally broke up the tension was when one of the women (G), who had been very quiet up to that point, asked whether we had an anniversary coming up soon. As a matter of fact, our thirty-seventh wedding anniversary was the coming Friday, and she suggested that my husband might be out buying me a surprise anniversary present. This resulted in a sigh of relief and a general relaxation of the atmosphere. I was now able to "officially" start the meeting and begin my introductory remarks.

What had happened as far as the group process was concerned up to this point was that my anxiety and the anxiety of the group members resulted in a mutual identification process which stimulated appropriate coping mechanisms through mutual support. This in turn resulted in diminishing my anxiety and that of the group and strengthened my ego's adaptive capacity; I was now able to start the formal part of the meeting as the leader as a result of the support I got as a participant from a group of my peers.

Whereas up to this point I had seen my participant role as more important for the reasons stated above, I now became aware, and this awareness became stronger as the group went on, of how I used my participant role <u>in the service of</u> my leadership role. It was my clinical decision to share my anxiety about my husband with the group, to consciously <u>use</u> my awareness of how frightened I was and share it with the group, in order to establish and promote my participant role. This initiated and facilitated the group process through identification

with me as the leader and participant, one role reinforcing the other in the service of helping the group and myself. It was at the point when I was able to act as the leader that I dimly remembered feeling a sense of relief that finally I could handle what needed to be done. There was a beginning awareness at that moment, which grew as time went on, that what the women needed to do was to see me as the leader. My awareness of the importance of the leadership role to the women and consequently to myself was a gradual process over the life of the group.

As for the defense mechanisms I used to deal with my anxiety, I am aware of my use of displacement. The fact that I "forgot" that my husband had a commitment he had told me about that would prevent me from reaching him all day meant that my anxiety about the group's first meeting (i.e. my insecurities about how the women would react to having to sign the human subject consent forms and to the use of the tape recorder and generally how the meeting would go) was displaced by the more acceptable and appropriate anxiety about my husband. I had to protect my ego from the realization of how scared I was and how insecure about the meeting, and what better way to do it than by being afraid that something had happened to my husband. There was no doubt that the latter fear was very real indeed, and it was much more appropriate and even helpful to the situation to be conscious of that fear, because then I could get the support of the group to get me back on track. It is interesting and helpful to recognize and analyze this at-that-time unconscious mechanism in retrospect and to now be aware of how it served to protect my ego from the embarrassment of having the women "find out" how insecure I felt at the time.

The mechanism of mutual identification, my identification with their anxiety and theirs with mine, initiated the use of my ego-strengthening coping mechanisms which served to reduce my anxiety and promoted my development of compensation and suppression, leading to problem-solving and my use of sublimation. I could now go on with the work of the group. The support of the group enabled me to be the leader. I was dependent on the group for this support, and with it I was able to rally myself to be the leader. Through my use of "healthy" dependency I could then do the flip to "healthy" independence and the assumption of my leadership role. This illustrates my use of reaction-formation (lower-level defense) which brought about my use of sublimation (higher-level defense). The reaction-formation worked effectively in reducing my anxiety and allowing the defense of sublimation to enable me to compensate by assuming the leadership role.

In Chapter II, I explained in great detail how the idea of the group gradually evolved in my own mind over a period of several years and how "the idea of a wives' group came out of my own needs and feelings and those I observed in the others". It is for this reason, and to fill these, what I perceived to be, identical needs in myself and the other spouses whom I had met, that I decided on the format of the self-help group. From my readings early on I concluded that the self-help group rather than the traditional therapy group would be ideally suited for helping both my self and other spouses simultaneously meet our common needs for mutual support. Self-help groups ". . . traditionally have been defined as being composed of members who share a common condition, situation . . .", ". . . they enable members to adapt to life changes . . .", and many ". . . focus on adaptation and coping

through internal behavioral, attitudinal, or affective changes."[5] In Chapter V, on the methodology arising out of the use of the self-help group, I explained why I chose this mode for this study. The techniques that I used throughout, as will be seen, were ones that would facilitate the members' being able to identify with each others' experiences. I used supportive group psychotherapy in contrast to the interpretation of transference and resistance. By focusing on the commonality of our experience through the promotion of sharing and other self-disclosing activities, I was able to initiate the processes of normalization and mutual affirmation and other strengthening experiences which would eventually lead to a rise in the self-esteem of the members and in a strengthening of their egos.

In Chapter V, I describe in detail the help-giving activities that I chose for my group from the ones developed by Leon H. Levy,[6] which he found were being used in other self-help groups. I found these categories very useful in analyzing and understanding my own activities with the group and the interactions of the group members.

Once the initial meeting got underway, I explained about the consent forms, which they readily signed, and the taping, to which they readily agreed (probably a factor here was that their husbands' sessions were taped because they are part of a research project). I gave identifying information about myself. This included facts about myself and my family, my work and that of my husband, and a history of his

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[5]Lieberman and Borman, Self-Help Groups for Coping with Crisis, pp. 2-3.

[6]Levy, "Process and Activities in Groups", pp. 260-264.

heart attack and its subsequent effects on his life, including his adaptation and that of myself and the family. I thus set the format and established the structure by which the members could discuss their trauma.

As for my help-giving activities in this first session, I used catharsis by releasing my emotions of fear and anxiety, sharing and self-disclosure by letting them know my feelings and not holding back and later by telling them about myself in a more formal way. By doing what I did, I encouraged their use of empathy toward me. It was helpful for them to have the opportunity to do for me in the first session, since they had all expressed through their communications before the meeting what a good thing I was doing for them. They could now give part of themselves to me. This, in fact, constituted the first instance and demonstration of mutual support and its effect on the group. I then used modeling and, through it, normalization and indirectly also mutual affirmation. By my modeling in the first part of the meeting that it is alright to be afraid, that this is a feeling we all share and there is nothing to be ashamed of, I normalized these feelings for them. I was also able to model later in the meeting that, despite all of these feelings, we can go on and take care of ourselves and find a way of dealing with them and helping ourselves. By starting the meeting I modeled constructive behavior and the use of sublimation to deal with anxiety.

Early in the second session, one quiet and short intervention of mine, highlighting the commonality of our feelings, set in motion an important series of interactions. The result was member G's insight and the beginnings of change in her behavior, as she began to feel better

about herself. When member F told the group that before the heart attack she could scream at her husband and now she feels guilty when she does it, I made the following statement, "I guess we all get these feelings that we can't let out our anger - what if he gets another heart attack?" This elicited member G's outburst, "Is anybody else angry because we can't do this any longer?" This started the ball rolling on the significant interactions that followed, with a high level of participation in the further exchange of thoughts and feelings, explanations, and confrontations that were to last for several sessions and had such positive consequences for the entire group.

The group became so involved that I decided to intervene about fifteen minutes before the end of the hour, being concerned that we would run way over if I did not do so. I stated that perhaps at the next meeting member G (who threw the bombshell in the first place) could tell us more about herself and we could continue to share our feelings about this subject which seemed to touch us all so deeply. The group ignored my statement and pressed right on, but we did manage to stop reasonably within the time frame.

My help-giving activities in this session were primarily in the area of <u>normalization</u> of feelings such as guilt over hostility ("I guess we all get these feelings . . ."), guilt over nurturing ourselves ("It's perhaps <u>we</u> who have such a strong need to take care of everybody, so that we have trouble giving to ourselves"), guilt over dependence. By labeling and acknowledging these feelings in all of us, I enabled the women to recognize these feelings in themselves as being "normal". Here again I sensed the group's need to gain acceptance from me as the leader. For me, the confirmation of the importance of my leadership

role was when, as the leader, I precipitated G's angry outburst. If I, as the leader, can accept people having these angry feelings, then member G knows that she will be accepted by me and by the group. I thereby initiated the process of mutual identification, leading to mutual affirmation, another one of the help-giving activities I used in this session. As the group members felt affirmed by me, they could allow themselves to express their feelings and fears, and those with less guilt over these normal fears were able to serve as models for the ones with greater conflicts around these feelings.

In the third session I continued to focus the discussion on the major themes that were expressed and to promote and facilitate the commonality of our experience. These sorts of interventions seemed to activate people to share with each other. After some minutes of what sounded like chatter, the theme would be resumed by me or someone else. For example, when we had gotten into the feelings of resentment and anger at the martyr role, I turned to member G, who had alluded to her own feelings at the end of the previous session, and said, "There is an area here that we have gotten into about how hard it is for us to think about ourselves and our needs, always worrying about the husband." This prompted her to say, "Yeah, that's true, isn't it? I think, I feel, I describe it as anger because I really don't know how to deal with it, because I am so aware that any minute he could go like this, you know, and I could be sitting here alone . . ." That was then followed by her adding, "That's why I wanted to come to this group, too, to see if perhaps I could work that out too." This was then followed by the detailed account of her story and her feelings and the confrontations by the group of her self-destructive behavior.

Throughout the ensuing discussions, my role was that of listener. My decision was not to intervene because the members were interacting constructively with one another, the less adaptive members identifying with the more adaptive members of the group and learning from them.

By the end of the third meeting I was very conscious of my leadership role and that I was in no way the participant I had thought I could and would be. When I focused on the needs of the others, I could not at the same time focus on my own needs. Although my experiences were the same as those of the group members, and this was helpful, my role in the group was not that of participant or peer but of the listener, the facilitator, and the recipient of the members' projections. I was now fully aware that I could not combine the participant and leadership roles as I had thought, and this awareness grew during the next three sessions.

Because so much of importance had happened in the third session, I decided to start the fourth session by giving a summary of what I thought had occurred in the last session. I talked about the feelings of anger having to do with our dependency and our control and that we could be better caretakers to the extent that we could let go and thereby be more giving to ourselves and to our husbands. The group avoided the issues I mentioned, as well as any of the other issues that had been brought up at the last meeting. I tried in the session itself to bring what member H was discussing into the area of what we might all be feeling, but again this path of discussion was ignored. The group chose to focus on member H's husband's drinking, telling her what to do rather than sharing their own feelings about what she was saying. I felt a resistance to dealing with feelings at this session, but I also

felt that there was value in member H being able to ventilate her feelings and receiving support from the group members. I recognized that as a reaction to the last session, the group was in a state of flight, and they used member H's problems as a way of avoiding their own. Since this was a support group, I decided not to deal with their resistance but to again encourage and promote the mutuality of feelings at the next meeting. By doing so, I anticipated that through the process of mutual identification the members could support each others' higher level of defenses.

In this session, as much as in the others, I was very much the leader in that I attempted, through various interventions, to engage the members to help each other. The fact that my interventions fell on deaf ears only emphasized the need that I, as the leader, must be aware of the group processes that brought this about. It was important to recognize this phenomenon as being the group's resistance and to make the decision not to deal with this resistance. To make these observations and decisions, I could not at the same time be a participant.

My leadership role was reconfirmed for me in the fifth session when member G came even earlier than usual and discussed with me her decision to seek counseling. She was more talkative and open and seemed a lot more trusting, saying she was sorry to have missed the last session. She said she had been doing a lot of thinking since the March meeting, has tried to implement some of the suggestions made by the group, and decided there were serious problems with her communication with her husband. I then gave her the name of one of my colleagues to contact for counseling.

When the others arrived, the discussion centered around the unavailability of the husbands and their anger about it. As they were sharing various maneuvers to get the husbands to listen and be more interested in them, with the more dependent women expressing a greater sense of frustration, one of the latter (E) turned to me and said, "You have a good thing going . . . you haven't shared a lot with us." When several of the other, more adaptive, group members (D and F) strongly agreed, I recognized that they all projected the role of the unavailable husband into me, experiencing with me the same frustrations they did with their husbands. In reality, I had been very much emotionally available to them.

Because this is a support group, I decided not to encourage the expression of their anger, but to share with them that I, too, feel a sense of frustration with my husband. I also wonder how much he shares with me about his own fears. Instead of interpreting their transference projections, I acknowledged that I have similar feelings, thereby promoting the process of mutual identification and mutual support. Member E had often turned to me to get answers. Now other group members were expressing their anger at me for not giving them the answers, disguised as my "not sharing enough". I did not interpret their need to see me as the transference object and the projections onto me of their need to get the answers and their subsequent anger about their need for me. I tried to be aware of their projections, particularly when member E would so frequently turn to me to ask for my opinion, looking for the support she could not get from her husband and being angry about her dependence on me, as she is with her husband.

I opened the sixth session by remarking what a good thing it was that they could share with me their frustrations. Though I could be telling them more about myself, I was in fact sharing their feelings of helplessness and their frustration of not knowing. These feelings are normal for all women in our situation. I then said it was helpful to me to hear how the people in the group were handling situations in ways that would decrease anxiety and tension, serving as models for better ways of coping. The fantasy of the group was that they could look to me for answers. By telling the group that I don't have the answers but that by seeing how others are coping I learn from the group, I could increase their confidence in themselves for finding answers. I asserted my leadership role by negating their fantasy that I was the leader with the answers. By doing so, I helped decrease their sense of helplessness and gave them a sense of mastery over themselves.

I had chosen the format of the self-help group in the belief that, in contrast to the professionally led group, the members of a self-help group could see themselves as the agents of change rather than relying on a leader to do it for them. I saw my primary role in the group as that of participant, in order to promote the self-healing potential of its members.

I had hypothesized in the Methods section that my clinical skills would primarily be used to help me maintain my role as participant, not as leader. My developing role in the group did not support my hypothesis. I found that because the women needed to see me as the leader did not mean that I could not also be sharing my own feelings and fears with them. On the contrary, I found that sharing my own feelings and fears enhanced my leadership role and to the extent that I could do

it, I "espoused a humanistic attitude to therapy, in which the patient is a full collaborator in the therapeutic venture . . ." when "therapists abandon their traditional role and share some of their many uncertainties with their patients . . .", it leads to "a therapy based on a true alliance between therapist and enlightened patient and reflects a greater respect for the capacities of the patient and, with it, an increased reliance on self-awareness . . ."[7] This certainly was my experience in this group.

Changes in Group Themes over Time

The theme of the first meeting was how group members coped with our mutual awareness that a part of our husbands had in effect "died". Because of the heart attack a part of the heart muscle had in fact "died", and we were all aware that the process that caused this to happen, namely arteriosclerosis, goes on and that our husbands could die as a result of this ongoing process. All of our husbands are in the Recurrent Coronary Prevention Project to prevent this from happening, but we are all aware that it can happen.

The reaction I had to not hearing from my husband all day, described in the previous section, was very much based on that fear. The group's response to my reaction was based on their identification with my fears. The theme was picked up and elaborated on by member A, who used the words "horror" and "terror" to describe her reactions to

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[7] Irvin D. Yalom, The Theory and Practice of Group Psychotherapy (New York: Basic Books, 1975), pp. 206-207.

her husband's illness. She saw her activities as a way to "counteract the feelings of fear, terror, total terror, scare". After she told the group how she is coping with this frightening feeling, others shared the ways they cope. The coping mechanism that emerged in the first group meeting was the struggle for independence because of the fear that the husband may die, and the wish for, and the fear of, continued dependency because the husband may die.

What became clear in the first meeting was that members like C and D, who felt more comfortable with their dependency and who had developed a sense of mutual interdependence with their husbands, had less need for the lower-level defenses which were used by member A and others who had to deny their dependence. The latter were feeling more guilty about the assertion of their independence. There was a more intense conflict between dependence and independence in those women who were more dependent and had to deny their dependency because it is so frightening.

The independence-dependence conflict emerged as a manifestation of the spouses' attempts to deal with the feelings and fears resulting from their husbands' heart attack. This was the central issue with which they were struggling. It became apparent that the husband's increased dependency because of his illness represented a greater threat for those who felt less comfortable with their own dependency. Their way of handling this threat was to deny their dependence and project a picture of independence, as was so well expressed by member A as she was describing her frantic activities. "I never thought I was 'hyper' but now I think I am - I had to get my act together, had to get myself into gear." In contrast, members C and D, whom we also got to know during the first meeting, were able to react to their husbands' greater depen-

dency needs by being givers and supporters, which did not interfere with their meeting their own needs for independence. For them, because they felt comfortable and could accept their own needs, it was not an "either/or" choice. They could be both dependent and independent, as was expressed by member C during this session. She reported telling her husband, "I've always lived my life the way you wanted me to and obviously I wanted to live it that way too, but now I've got to do this, I've just got to do it - I feel sorry for you that you have to go through it." She recognized and empathized with his feelings, but she was able to comfortably confront him with her needs. She did not have to feel guilty about her needing a sense of independence in the face of his heart attack and her own needs of fulfillment for herself.

Whereas in the first session the central conflict was identified and defined, in the second session these feelings, their implications for the spouse, and their impact on the marital relationship were elaborated. What emerged was anger as a manifestation of dependency. In this session all the women began to recognize that they were angry at their husbands for getting a heart attack. They began to express their hostility and struggled with their guilt feelings about expressing it. However, it soon became apparent that the anger was much greater in those women whose dependency on their husbands was greater and therefore their guilt was greater as well. Their greater anger was due to their exaggerated feelings of helplessness as a result of the fear of loss, which was felt more intensely by those who were more dependent on their husbands for support. This was illustrated by member G when she described her feelings about her great fear of being abandoned by her husband if he died. The destructive impact of these intense conflicts

on the marital relationship have already been discussed in great detail previously. In contrast, member C recognized her anger when her husband first became ill when she stated that at the time she was "surprised a little bit at myself, at my own reaction". She made the decision to do something about it by becoming more independent. She saw the attainment of greater independence as a way of preparing herself not to resent.

The themes in the third session continued to be anger at the husband caused by fear of being abandoned by him because of his illness, a greater awareness that this fear is more intense in those women who are more dependent, and that the way these women are defending against this fear is by controlling their husbands. The issue of control as a defense against dependency emerged as the central theme in this session. Through the interchanges and confrontations that took place in this session, which I already described and which will again be discussed in the following section, there was a realization of the destructive effect of this control on the spouse and on the marital relationships. Again the contrast between the more and the less dependent members was evident by the degree to which they exerted this control. For example when member G described the vicious circle she and her husband are both caught up in because of her anger, her control, his anger, and his control, member E saw herself caught up in a similar bind. This is what makes member E angry with her husband, namely his denial of his illness which then leads her to control him by "owning his problems", as she expressed it. In contrast, members C and D talk about their husbands making their own decisions. Member C says, "He's a big boy, he knows all the rules", and member D tells how they went dancing even though she knew he was tired. It was through the modeling of less

controlling behavior by the less dependent members that the issue of control and its destructive effects was highlighted as the theme in this session.

The theme of the fourth session was an avoidance of facing and dealing with feelings by the group members. This phenomenon will be further discussed in the following section. Suffice it here to state that resistance to any involvement of themselves, by focusing on another member's husband and his problems, was the central theme of this session.

In session five the struggle by those who were more controlling to relax this control emerges. This is achieved through a further recognition by the more dependent members G and E, again with the help of the more independent members D and F (member C was absent) of the destructiveness of their controlling behavior. This is illustrated when both G and E realize how emotionally draining this control is. In this session member F, who is more relaxed, turned to members G and E, saying, "You are both worrying too much." It was then that member E thought that "this business of owning someone else's problems is a lot of emotional time-wasting" and member G told the group about how she was beginning to enjoy her life with her husband more by being more relaxed with him.

The theme of the sixth session was caring for the husband and caring for themselves. It seemed that after the recognition and expression of hostility by the members, when the anger had been accepted and discharged, it could be given up by the members as an "unhealthy" defense, and the love and the caring could now come through. Those who were still having problems with letting go of the control were feeling

guilty and more uncomfortable with their controlling behavior. This was exemplified by member H who turned to the group and wanted to know if the members thought she is manipulating her husband when she controls him. Her control has become ego-alien and she would like to give it up, or at least lessen it. With a general lessening of the "pathogenic" defenses, the theme of this session was a greater understanding of the needs of the husbands for support and a greater ability to be giving to them. As was expressed by member D, her husband "has an overpowering need to be loved and appreciated, and it's his need and a very very great need, and it must come from somewhere". This led into a discussion of the needs of the husbands by the group. Instead of the anger there were now some expressions of irritation, and a readiness to be more giving.

Group Processes Observed and Analyzed

In his book, The Theory and Practice of Group Psychotherapy, Irvin D. Yalom stresses the importance of the here-and-now focus of the group and the illumination of process. He says, "If the powerful curative factor of interpersonal learning is to be set into action, the group must recognize, examine, and understand process. It must examine itself, it must study its own transactions . . ."[8] This kind of process illumination did not take place in this group since its purpose was to help the members "cope better through an exchange of thoughts and feelings", as stated in the Introduction. It was a support group where

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[8] Ibid., p. 122.

the purpose was not an increased understanding of the interactions, but the interactions were a means to helping the members live more comfortably with their husbands' life-threatening illness. Had an interpersonal conflict in any of the sessions hampered the achievement of this goal, it would have had to be handled in such a way as to enable the group to continue pursuing its goal. Such a conflict did not occur. This was because the members' fears and anxieties were an overriding and unifying factor.

Yalom states that therapeutic change through the group process "is an enormously complex process and it occurs through an intricate interplay of human experiences".[9] The complexity of this process and the effect it had on its participants was certainly demonstrated in the group of cardiac spouses which is the subject of this dissertation. The group process was set in motion the moment the women reached my office for the first meeting. In a sense it had been set in motion even prior to the meeting through my letter to them offering group support and through their answer on the return cards expressing their interest, and for some, their need for this support. To several I had additionally talked by phone to discuss further and clarify their questions about the group. By the time of the first meeting, there had been a three-month period of mental preparation. My first communication went out on October 22 and the first meeting took place on January 15. Through this protracted premeeting period the women could focus on the anticipation of receiving support, which was their expectation when the day of the meeting finally arrived.

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[9] Ibid., p. 3.

As much as they were looking forward to this support, there undoubtedly were feelings of uncertainly and doubt, the feelings of dependency engendered by meeting in a therapist's office (my letter to them had been written on my office stationary), and all the feelings associated with going for help. This was corroborated by one of the women who told me after the meeting on the way out, "Coming to your office and knowing you are a therapist kind of scared me . . . now I know you are one of us and it feels good." The second part of her sentence referred to the experience she had when she and all the others came face to face with my anxiety about my husband at the moment they first met me and each other. They came expecting support from me and from each other. Instead, however, of <u>getting</u> something, they found themselves <u>giving</u> it to me, the one who had offered this support to them. It is difficult, in view of the myriad feelings in ten different women (two were absent at the first meeting) meeting for the first time, to understand all the ramifications of this unexpected reversal of roles of the members to be the givers and myself being on the receiving end. One thing I sensed, however, from their reaction to me and their tremendous support of me, was that by giving to me they were in fact the recipients of good feelings for themselves. Yalom mentions altruism as one of the curative factors where patients receive through giving and thereby feel better about themselves. By providing the women the opportunity to be giving to me at the moment they first met me, I may well have helped counteract some of their feelings of self-doubt and shame about coming for help and thereby raised their self-esteem through their being able to help me.

The second part of this member's remark, "now I know you are one of us and it feels good", also illustrated the beneficial affect of being able to identify with another's feelings - the process of mutual identification was thus facilitated through the particular events of that first meeting. Immediately upon meeting each other we could identify with one another's feelings and experience the benefits of group support. The group processes that had been initiated during the first part of the session continued to be at work for the rest of this meeting. As members A, B, C, and D told their stories, the group was able to identify strongly with their feelings after the experience of mutuality of feelings during the early part of the session. The patterns of catharsis, self-disclosure, sharing, empathy, modeling, and normalization had already been established early on, and these help-giving activities were now easily continued by whoever spoke in this first session. Although there was no evidence of behavioral prescription or confrontation at this first meeting, all the other help-giving activities in addition to explanation (such as member A explaining why she is so frantically busy) led to feelings of mutual affirmation among the group members. It was particularly through normalization of the feelings of dread, fear, and anxiety which were expressed, felt, and accepted that a sense of mutual affirmation was felt among the members.

In the second session there was an increase in group interaction with an increase in the use of the help-giving activities. As for catharsis, we saw a continuation of the release of feelings which was greatly facilitated by the members strongly identifying with each other. For example member E said, "I'm pleased to hear you say that, because I

really thought I was the only one to have a husband who was so upset if I ever got sick - I simply wasn't allowed to be." Member C added, "My husband has to have a perfect family - he is fine, I am fine." Member D said, "He can't take it when I get sick - he falls apart and he gets sick, so I have to get up and take care of him." We saw how the expression of feelings in one member elicited the expression of similar feelings in others, resulting in mutual identification and mutual support.

There was in increase in sharing in this session because people had begun to feel more secure with one another. Another reason for the increased sharing was that group members experienced its beneficial effects in the first session. They had seen how it prompted others to express similar feelings, which in turn resulted in consensual validation. It no doubt raised their self-esteem, hearing that others react to similar situations the same way. This had the effect of decreasing their sense of shame and doubt about themselves, leading them to a greater acceptance of themselves as worthwhile people. They saw during the first session that they were not ridiculed for feeling the way they did, on the contrary, that others felt the way they did. Feeling more confidence in themselves and in the others led to greater sharing and self-disclosure. This demonstrated how one help-giving activity led to others - how sharing and selfdisclosure led to normalization (i.e., it's alright to feel the way I do, others feel the same way) and mutual affirmation, a self-esteeming experience for the entire group.

The group process of one help-giving activity initiating and reinforcing others is exemplified by the following: When member F

disclosed that she went to seek psychiatric help because she would get so concerned about her husband (when there was a problem with their son) and that she would check her husband's heart at night "to see if he was still alive", there was an immediate identification with her. The whole group almost simultaneously said "I do too. I do it all the time." We all shared this common fear after F shared hers.

Member F's casual remark of her seeking psychiatric help in connection with a family problem resulting from the heart attack was an important self-disclosing activity. Not only had she shared with the group the fact of her going to the psychiatrist for help, but she had done it in a casual and natural manner. She did not dwell on it or make a big issue about it. This important piece of information and the way it was shared, coming from a more adaptive member such as F, conveyed the implicit message to the less adaptive members such as G that there is nothing shameful about seeking psychiatric help or, for that matter, admitting that one needs help. This kind of information undoubtedly helped member G emotionally to eventually seek professional help for herself. The above illustrates another important aspect of the group process, namely the mutual learning that takes place through modeling leading to mutual identification.

How self-disclosure and modeling by the more adaptive members can lead to self-disclosure and the achievement of greater awareness in less adaptive members is illustrated by the following exchanges. Member F (more adaptive) reveals, "Before the heart attack I could scream at my husband when I was angry and now all of a sudden I could not do it any more." Member C (more adaptive) emphatically exclaimed, "I still do - I let him know - after all, he is a big boy." Member F then modifies her

first statement, "I do too, but then I feel guilty." Member G (less adaptive) says, "He is not supposed to get excited, so I have to put a lid on my feelings and this is why I think I'm angry. I don't know how to handle this - he may get sick again." Member F (more adaptive) then answers, "When I feel this way I don't get as upset as I used to - I don't want to be angry, I say, 'Let's stop being mad at each other. Why should we, since we have this time together?'" Through this group process we see how member G (less adaptive) learned how others feel and act differently, without feeling attacked or threatened. On the contrary, she could feel reassured and hopeful about being able to change her own behavior when member F told her, "You [too] will find a way." Member F was conveying to member G the following message: I can understand how you feel, I used to feel this way too, but I found a less painful way. I feel less upset because I do what you don't do. I tell my husband "let's stop being mad at each other since we have this time together", it has the effect of decreasing the anger in both of us and results in getting closer. I don't put the lid on like you, on the contrary, I share my feelings with him. It was the way this message was conveyed, aside from the message itself, that was so helpful. Member F's modeling and behavioral prescription grew out of the deep sense of empathy member F felt for member G. If there was indeed going to be a change through the group process in how members who use more primitive mechanisms of defense can "move up" to use higher levels of defense mechanisms, it was through this kind of totally supportive, accepting, and understanding attitude of group members for each other.

Whereas in the second session we saw the beginnings of behavioral prescription and explanation, in the third session there is an

intensification of these help-giving activities with the addition of confrontation. This activity led to the recognition and expression of preconscious feelings, brought into conscious awareness through the group process. It is now member C (more adaptive) who confronts member G (less adaptive). The less adaptive member E identifies with both. As will be seen from the following analysis, this process affects the three members who are directly involved, as well as those who are contributing their ideas but who are primarily listening to what is going on. The result of these interchanges on the group is that many group members cancel for the fourth, following session. They all stay away except member C, who was the principal "actor" and two other generally quiet and reticent members. My hypothesis for this group resistance in the fourth session will be discussed after my analysis of the following confrontations.

After member G shared with the group in the second session her rage at her husband and the group felt the intensity of this anger, which seemed to be far greater than the anger or irritations at the husband experienced by most of the other members, member C was determined to find out the source of this intense anger. As described earlier, member C asks member G what she means when she says she is resentful. Member G answers that she resents the fact that this fear is constantly hanging over them. Member C wanted her to get more specific, "[Fear hanging] over him or over you?" Member G responds "[Over] all of us." Member C then asks if member G's husband, or just member G, feels depressed and fearful. Member G responds that her husband wouldn't tell her if he did because "he doesn't want me to worry". Member C asks if member G could pick up anything from him (i.e. whether he feels depressed). Member G

responds, "Only because he chooses to ignore everything, that is why I think he probably thinks about it."

This stirs something up in member E who is now strongly identifying with member G's anger at her husband for ignoring everything. Member E's husband is a denier as much as member G's husband. She then joins member C in pursuing member G's reason for her anger. Member E suggests that member G's husband might use denial like her own husband. For deniers the problem simply does not exist. Everyone then chimes in to agree that this denial is "typical" of Type A, but member C got back to pursuing G's anger, trying to find the reason for its great intensity. She asks member G if she resents listening for her husband's breathing at night. Again member G avoided acknowledging her anger by generalizing. She says she resents "the general condition". Member C doesn't let up, doesn't let her get away with generalizing. Again member E reinforces member C's arguments by identifying with member G. She says that her husband, too, always "puts the blame on someone else". It is at this moment that member G becomes aware of what she is allowing her husband to do to her by telling the group how he always tells her, "One fat meal will do it." We could all feel her seething inside at his remark. Member C reinforces member G's insight by telling her how she herself used to blame herself for her husband being a "chocaholic". She used to ask herself, "Why did I let him eat all this chocolate?" She points out to member G that she said this to <u>herself</u>, her husband did not say it to her. She then suggested to G that her husband was using her like a whipping boy. Member E adds, "And you are letting him do it."

At this point member E strongly identifies with member G because she knows she is doing the exact same thing, by "my owning his problems". She tells member G that she has accepted her husband's responsibility. Member E goes on to say how hard it is "not to take care of out little husbands when we've been brought up this way. But", she adds, "I'm learning."

Member C then suggests that member G might try to communicate her feelings to her husband by saying, "I wasn't conscious of it, but I found when I was discussing it in the group that this taking on your responsibility is what I really resent." Member G tells member E, "I don't think [my husband] knows he is [laying a trip on me]." Member C concludes by saying, "When you are sick like your husband, it helps to blame somebody. But why do you have to accept the blame?"

Following this interchange, the members came forth with a number of suggestions of how member G could take less responsibility. A suggestion by member C of how to tell her husband how she had come to think of different ways they could enjoy themselves was to tell him, "I couldn't believe myself what I said tonight, the things that really do bother me . . . words come out of our mouths that we weren't aware of before."

It was interesting for me to hear how member C verbalized the process of member G gaining the insights she did at this meetings as a result of what happened in the group that night: "Words come out of our mouths that we weren't aware of before." This was indeed what happened through the group process in the third session described here in such great detail. Recognition of preconscious feelings were brought into conscious awareness. This interchange illustrates the group's impact on

the individual members. Member C's ability to cope is enhanced by her ability to help another member identify with her ego-strengths. This increases her self-esteem. Member G, by being able to identify with member C, is helped to become aware of and to accept her own feelings. Member E identifies with the more adaptive member C and the less adaptive G by helping member G to "learn" to lessen her control of her husband and reduce the denial of her dependency needs.

I had thought this was a "good" session until I had cancellation calls from most of the members prior to the fourth session. This rash of cancellations had not happened before, and since the "excuses" did not seem to warrant their absence, I began to wonder what the reason might be. There was no no doubt that I was faced with considerable group resistance. Thes reasons for it became clearer as time went on. Member E, who had never missed a session and to whom the meetings meant so much, left the message that she had to "go to class". Member G called to say she had to go to the dentist. Member F called to say she was sorry to miss the meeting but had to fly off. Member K called to say she had planned to come but got locked out of her house. Members I and J just didn't show up - they never called to cancel. Member D had left the message that she was "under the weather". When I returned her call I got a hint of what might be going on with the others. She told me that she thought that at the last meeting member C had "pushed awfully hard", if it had been herself, she would not have gone after member G the way member C did. She would have asked her why she was so angry but not have been quite so "pushy" as C.

In the fourth session itself, there was resistance in the members who were there. They didn't want to discuss their own feelings. I knew

that the group was in a state of flight. This I hypothesized as being a resistance on the part of the less adaptive members to the recognition of their great dependency on their husbands. The dependency frightened them and they wanted to avoid it. For the more adaptive members, such as D and F, the confrontations of C were very uncomfortable to their nurturing and gentle personalities. They were irritated with me for letting these confrontations go on without any intervention and had unconsciously acted out this anger by missing the meeting.

These were my speculations. They were never confirmed, however, because I did not deal with this resistance or the transference to me, either at this or the subsequent meeting. As I mentioned previously, this was a support group in which the curative factors are the group processes of mutual identification brought about through focusing on the commonality of the members' experiences. The way to accomplish this was to <u>defuse</u> anxiety, not <u>explore</u> it, to <u>minimize</u> feelings of hostility and promote the positive transference.

There was, however, some confirmation about the group's irritation with me at the fourth meeting; my initial interpretive remarks about what I thought went on at the third meeting were totally ignored. Although I did not explore this any further, I remember at the time feeling that the group members' total lack of responsiveness to what I thought were important observations must have some significance. It certainly irritated me because it was so uncharacteristic of how they had reacted to my remarked in previous meetings.

I must admit I was pleased when everyone came to the fifth meeting except member H, who was on vacation, and member J, who cancelled prior to the meeting, apologizing profusely that it was due to her daughter

giving a surprise party for her. There was one more noteworthy absence, and that was member C. When she called she told me she thought she had been far too talkative, and even after I told her how valuable I thought her contributions were, she decided to stay away from one meeting. The atmosphere of this session was very positive. Member G looked more relaxed and shared with the group all the positive changes she had made with her husband. She told me at the beginning of the group about her decision to seek counseling for herself and her husband. Member G seemed pleased to tell the group about asking her husband about taking a day off from work and going to the beach with her. First she had hesitated to do this, and she was surprised he agreed. She said, "We are trying to work things out together - we haven't made it yet - at least we are talking about it. I hope to report more." In this session, more than in previous ones, people asked the group directly for their opinions, checking out what they thought. An example of their feelings of ease with one another was that they were able to tell me they felt I don't share enough of myself with them, feeling comfortable about expressing their irritation at me about this. The result of all of these group phenomena was an intensification of group support and growing trust between group members.

In the last session there was a sense of group cohesiveness, which was evidenced when people said they wanted to take turns providing the refreshments, deciding who would bring what at the next meeting. One of the women gave me an envelope with a check for $5, saying after all, "this is our group" and this was her contribution toward the refreshments. This was all spontaneous. It was interesting how many different members felt the same way regarding their wanting to have a

part in giving to the group rather than having me provide the refreshments and sending the cards. The now wanted to take turns sending out the cards and decided to make Xeroxes of the list of members and set up a system to rotate the job.

The theme of this session was definitely caring. The group members were caring for me and for each other and sharing caring feelings about their husbands. There was more spontaneity and openness and 100 percent participation. Whereas in the previous meetings there had always been some "quiet" ones, in this sixth session everyone talked very freely and felt totally at ease with one another and with me. These feelings of trust and caring for each other were highlighted when I remarked that I was thinking how good it was that they could share with me their frustration at the last meeting that I was not telling them enough about myself. I said that I, too, often have feelings of helplessness and a sense of frustration about not knowing.

There was generally in this session a lessening of maladaptive defenses, a lessening of control, a more relaxed and positive atmosphere which was reflected in how the members reacted with each other and what they reported in their relationships with their husbands. There was a sense that the members now genuinely cared for each other, having a feeling of group solidarity. We had shared a lot with one another and had given each other a great deal of support over the last six months, and we had all benefitted in one way or another through our experiences in the group.

CHAPTER VII

SUMMARY

The changes in the characteristic defense mechanisms and coping styles of the group members as a result of the group experience are illustrated in Table 1. The degree of use of each mechanism is rated on a 4-point scale, with 1 defined as 'predominantly used', 2 as 'moderately used', 3 as 'mildly used', and 4 as 'no evidence of use'.

Of the eleven members who came to the group, two (A and B) dropped out after the first meeting. It is speculated that the group represented a threat to their defense structure and coping style. Two more, J and K, did not participate sufficiently to determine their defense and coping mechanisms. J's severe hearing loss considerably interfered with her communication, and K's attendance was not sufficient to evaluate her feelings and behavior. Of the remaining seven, three (C, D, and F) used sublimation as their primary defense and represented the more adaptive and less conflictual members. As a result of the group experience they became more confirmed in their more adaptive ways of coping with their husbands' heart attack and served as role models for the remaining four members. We see no evidence of their use of the more primitive defense mechanisms and no evidence of their use of control. The four less adaptive members (E, G, H, and I) exhibited

TABLE 1

Characteristic Defense Mechanisms and Coping Styles
Judged to Have Been Used by Group Members
Before the Group and After Six Months

	Denial		Projection		Reaction-Formation		Sublimation		Control	
Member	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
A	1	n/a	1	n/a	1	n/a	4	n/a	1	n/a
B	2	n/a	4	n/a	4	n/a	3	n/a	4	n/a
C	4	4	4	4	4	4	1	1	4	4
D	4	4	4	4	4	4	1	1	4	4
E	2	3	2	3	2	3	4	4	1	1
F	4	4	4	4	4	4	1	1	4	4
G	1	2	1	2	4	4	4	4	1	3
H	2	3	2	3	4	4	4	3	2	3
I	2	3	2	3	4	4	4	3	1	3
J	Not Able to Determine									
K	Not Able to Determine									

varying degrees of the more primitive defenses and less functional coping styles before the group experience. They were the ones whose changes through the supportive group intervention were manifested by a change in the degree to which they used their characteristic ways of functioning. Except for E, there was a 2-point decline in their use of control. Although for E there was no evidence of decrease in her

controlling behavior, she became considerably more aware of its destructive effect on her husband and on their marital relationship and was determined by the end of the six group sessions to make a change in her use of this mechanism. Their use of control was viewed by the entire group as the most destructive coping style and was the result of the use of the more primitive mechanisms of defense, namely projection and denial. Denying their own helplessness, they projected it on their husbands via control.

The considerable lessening of the control was a manifestation of the changes in the lower-level defense mechanisms, where we see a 1-point decline (except for reaction-formation, of which we saw no evidence in some of the less adaptive members) at the same time as seeing a 1-point increase by some of the less adaptive members in the higher-level defense of sublimation. Since the latter was predominantly used by the more adaptive members to the exclusion of the lower-level defenses on their part, it enabled the less adaptive members to become aware, to be exposed to a different point of view, to change their maladaptive perceptions. In this study the maladaptive members were identified as the more clinging and dependent spouses who were largely overwhelmed by a sense of helplessness about their husbands' heart attack, which made them anxious and depressed. The more adaptive members, whom we identified as the more independent, served as the role models for the former. Through the process of mutual identification and mutual support, in combination with the cognitive aspects of learning from each other provided by the group, the less adaptive spouses were able to make the changes reflected in Table 1.

CHAPTER VIII

REFLECTIONS

This study is rich in its implications about the nature of spousal dynamics surrounding the psychosocial aftermath and remediation of the myocardial infarction.

Contrary to the general expectation, there appears to be no relationship between the length of time that has elapsed since the husband's heart attack and the degree of adaptation of the female spouse. No matter how much time has passed, and for the members of this group it was an average of eight years, the heart attack represents a major crisis in the life of the spouse to which she continually must adapt herself because of the uncertainty of this life-threatening illness. Because of the unpredictability of its occurrence and the severity of its consequences, the possibility of a recurrence of the heart attack represents a continuing threat over the lifetime of the patient and the spouse. In light of the foregoing, it is obvious that any program of help and/or support for the spouse is in order at any time and does not lose its usefulness because of the passage of time since the husband's heart attack.

There seems to be a direct relationship between the degree of adaptation of the spouse to this major crisis and the degree to which

she has attained a sense of independence. The greater her sense of independence, the greater seems to be her ability to adapt to her husband's life-threatening illness. On the other hand, the greater her dependency needs and her resulting discomfort with her dependency, the greater are her difficulties in making the necessary adaptations. Margaret Mahler's concepts of the achievement of object constancy as a consequence of the successful completion of the separation-individuation phase of development are relevant in this connection. In her observations of very young children and their mothers, she identified the beginnings of differentiation from the mother as early as the second month of life and based the attainment of object constancy on the child's gradual ability to gain a separate sense of self by the end of the third year of life. She particularly focused on the rapprochement subphase from 15-22 months of age, which she sees beginning with the achievement of independent locomotion and the start of cognitive development, thus making the toddler more aware of his separateness from the mother. It is this crucial period, which she calls the rapprochement crisis, that determines the child's ability to later become a separate individual who has internalized the maternal need-satisfying object and who therefore no longer needs exclusively to depend on others for approval and support. If during this vulnerable period the mother is emotionally unavailable, the toddler is seen to intensify his clinging and beseeching behavior which prevents him from becoming an autonomously functioning and separate individual.[1]

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[1]Margaret Mahler et al., The Psychological Birth of the Human Infant (New York: Basic Books, 1975).

In the absence of conclusive data, it is to be assumed that these women are the more dependent and clinging and less adaptive wives whose dependency needs have not been adequately met by the original caretaker and who, therefore, as adults are still depending on the external object for the emotional security of which they have been deprived. On the other hand, those individuals whom we identified in this study as the more independent and more adaptive ones have internalized the need-satisfying object and can therefore, in their adulthood, depend on themselves rather than looking to the external object for support. By the third year of life they had achieved what Margaret Mahler calls object constancy. Being adults, both chronologically and emotionally, they can therefore cope more adequately with the emotional consequences of their husbands' heart attack. The potential loss of the external object is therefore not as threatening to them, and they can visualize themselves as being able to emotionally survive the separation from their husbands. They are more able to deal with the reality of the situation, to accept the extent of the damage to the heart muscle, but also to see the positive aspects and potential for rehabilitation. They are not being overwhelmed by fantasies of abandonment which leave them feeling helpless.

For the dependent wife, the heart attack may have a meaning far beyond the actual heart damage. It is not only the actual loss of a part of the heart muscle which affects her, but it may mean also a loss of self-esteem, a loss of the object to which she must cling, a threat to her very existence since her existence is so connected to the object who is her husband. These reactions were seen in the more dependent wives in our study, some of whom were overwhelmed with feelings of

helplessness and perceived the heart attack as a rejection by the husband, with resulting anger at his "leaving". As pointed out in this study, these women were anxious and depressed because they experienced their situation as one of total helplessness with resulting rage at the husband for what they perceived as his having abandoned her.

The differences in the reactions to the crisis of the heart attack in the types of women described in this study can be explained on the basis of the degree to which they attained an integrated sense of self, which can be understood as being the result of their having successfully resolved the "rapprochement crisis". According to Mahler, this was when the child, around the third year of life, recognizes that the mother who loves is also a source of frustration and disappointment.[2] The same mother who had always been available is no longer there just for the child, and normally by the age of three the pain of loss of the ideal mother has been integrated. It is through this integration of the good and the bad object becoming a whole object with both positive and negative qualities that the child is able to achieve an integrated self. If this integration is not able to take place, because of what Kernberg calls a "preponderance of hostile introjections",[3] then we have the borderline personality where we see the splitting defenses which keep apart the positive and negative parts of the object, with alternating feelings of love and hate and therefore unending conflict. This person

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[2]Ibid.

[3]Otto Kernberg, Borderline Conditions and Pathological Narcicism (New York: Jason Aronson), 1975.

cannot separate from the object but clings, as a way of protecting himself against the loss of the idealized object.[4]

When, as adults, the latter experience a crisis such as a heart attack in the spouse, the early experiences with loss are reactivated, and those who have not successfully resolved the "rapprochement crisis" are now not able to deal with the crisis of the heart attack. First they protect themselves against it by denial, that is, they have to deny that the heart attack actually happened. We see this in the universal feeling of shock and disbelief which protects the ego from the realization of what has occurred. This denial is overcome more successfully by the more independent women who gradually can face and integrate the loss because they can also see the positives and know that realistically not all is lost. In the more dependent women the denial continues, and even after eight years this mechanism was still being used to protect themselves from accepting the husband's illness. They cannot deal with the reality of what <u>is</u>, because they are so frightened by what they <u>perceive</u>. The fear of loss of the husband constitutes the core anxiety for all spouses; it is the <u>reaction</u> to this fear of loss which in part makes for the difference in adaptation between the more dependent spouses because of their greater need for the husband for emotional support.

While the focus was on the husband and the fear of separation from him, fears of their own decline were present as well. It was again the more independent members who were able to express this fear and connect it with the decline of their husbands. Not only could they more readily

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[4] Ibid.

contemplate the loss of the husband, but they were able to acknowledge and confront their own decline and the fact of their own eventual death.

Because of his own increased dependency needs due to his illness, the husband is less emotionally available to his wife. The decreased emotional availability of the husband may well be a way of his needing to distance himself from his dependent spouse. It would seem likely that her very dependency places a burden on him which he feels unable or unwilling to bear. We may thus have a situation that feeds upon itself.

All the wives in this study felt and expressed hostility toward their husbands. The heart attack, with its consequence of lessened availability and function, was experienced by the wives as abandonment on the part of their husbands. This experience in turn was intensified by the very real fear of his death. Spouses thus reacted negatively to their husbands' diminished emotional availability, with the more dependent women experiencing a much greater degree of hostility, resulting in feelings of guilt with a detrimental effect on the marital relationship. Unlike many other diseases, a heart attack, with its threat to life or at least full functioning, seriously upsets the equilibrium achieved over long years of marriage. (The members of the group were married an average of twenty years.) This means that it requires a redefinition of the roles of husband and wife in the marital, social, and economic areas. The fact that the husband largely ceases to be the man of the house, or at least the equal partner in the relationship, deprives his wife of a predictable source of comfort and emotional support as well as of a reliable sexual partner. In the social sphere, she is certain to suffer a loss of status because the couple's social relationships are bound to be disturbed by the husband's

heart disease. As for the economic role, in many cases it will be the wife's responsibility to provide a major, if not the major, part of the family income whether directly through her own work or indirectly through a more significant role in the husband's business.

It is no wonder, then, that the wife experiences a sense of fear and helplessness and therefore reacts to these profound disruptions with anger at her husband for having upset their lives. Every member of the group expressed hostility, its intensity being a direct function of the degree of dependency. The wives who had not achieved object constancy and a sense of autonomy expressed rage at these losses which they perceived as a threat to their self-esteem. In contrast, the more adequately functioning wives, who had achieved a relatively well-integrated sense of self, were not overwhelmed by feelings of helplessness and therefore their hostility was not as intense. The husband has his own anxieties and feelings of worthlessness as a result of his heart attack. His wife's hostility increases his sense of inadequacy, which in turn increases the wife's feelings of helplessness and thus sets up a vicious circle in the marital relationship. The result is increasing withdrawal and a shutting off of communication between husband and wife. This is what happened in the marriages of several women in the group as a result of their husband's heart attack.

A major manifestation of hostility in the more dependent spouse is the control she exerts on her husband. The finding was that the greater the feelings of dependency, the greater the degree of control. The control is a way for the more dependent spouse to counteract the feelings of helplessness due to her exaggerated fears of losing her husband. She denies her own helplessness by projecting it on her

husband and therefore controls him. As demonstrated in this study, the more dependent wife is overprotective and assumes the responsibility that should be her husband's, for his recovery and rehabilitation. By making his problems hers, she maintains the illusion that she can determine the future course of his disease. In her unconscious fantasy, this makes her feel less helpless and decreases her guilt feelings about her hostility to him. Little does she realize, however, that by taking the entire responsibility on herself she sets the stage for even greater guilt and helplessness if there should be any deterioration in his condition. Additionally, the wife's taking control tends to further emasculate her husband, with the result that he often attempts to shore up his self-esteem by acts of secret defiance such as smoking behind her back or sneaking a piece of forbidden food. Control thus can defeat its own purpose. The dependent spouse's attempts to control her husband have a further detrimental effect on the marital relationship which has already been disturbed by the fact of the heart attack. The spouse with a greater degree of independence can help reestablish the premorbid marital relationship because of the greater degree of emotional support she can give to her husband.

Because of the frightening effects of their dependency, namely their feelings of dread at the possible loss of their husbands which they perceive as total abandonment, the more dependent spouses protect their egos primarily through the use of denial, projection, and reaction-formation. The group discussions revealed that these more primitive defenses were manifested by frantic and pseudo-independent activities and by control. They deny their own helplessness by projecting it on their husbands and by controlling them. These

activities were perceived by the spouses as evidences of independence, but in reality were ways to deny their dependence. The greater the degree of dependence, the greater was their use of these more primitive defense mechanisms by means of which they tried to cope.

Further, the misconceptions of the more dependent wives contributed to making them feel more depressed because, by blaming themselves and consequently taking on all the responsibility for the husband's recovery, they felt inadequate. When the husband's behavior would not change as a result of the wife's efforts, she would then feel even more inadequate, with a lowering of her self-esteem. This would cause her to become angry at her husband and not being able to express it because of her guilt feelings, she would then turn it against herself and become more depressed.

The study found that the small ongoing support group is a useful treatment intervention in helping change the maladaptive perceptions which add to the stress of the already anxious spouse. The more independent spouses, because their energies were not spent in denial and projection and other lower-level defenses, were more able to be supportive not only to their husbands but to the group members as well. In the supportive atmosphere of the group, the more dependent spouses were confronted by the more independent spouses with the harmful consequences of their unrealistic perceptions. All were therefore helped to change their perceptions and some, to change their behavior as well. As a result of the group experience we saw a lessening of the use of lower-level defenses on the part of the more dependent wives. The more dependent wives were more depressed because the heart attack increased their sense of helplessness. Instead of globalizing their

helplessness and feeling hopeless about their situation, the more dependent wives could see that others face similar problems and that there is a way to handle them. By learning specific ways of dealing with specific situations and seeing how the same problem can be handled by looking at it from a different point of view gave the more dependent wives a sense that the situation can be mastered.

The more independent wives tended not to personalize every incident and helped the more dependent wives recognize that the stress is due to the reality of the situation and not to their own failing. What also contributed to the dependent wives' low self-image was that they put themselves down for the feelings of hostility they had toward their husbands and were helped when they found that every one of the wives had these feelings to a greater or lesser degree. They also learned from the more independent wives that their angry feelings could be reduced by more open communication with their husbands rather than by withdrawal and self-blame. By reducing their sense of helplessness they felt more in control of themselves and their situation, with a consequent lessening of control of their husbands.

The group demonstrated the mechanisms through which these changes could occur, from the initial creation of a safe and supportive atmosphere leading to sharing, self-disclosure, and catharsis, which in turn stimulated more and other help-giving activities. We saw how one help-giving activity elicited and reinforced others by means of the process of mutual identification, with the more adaptive members modeling more adaptive behavior to the others. The process by which this mutual learning could take place was through the support which engendered feelings of mutual trust, which in turn elicited further

self-disclosures, which in turn led to the modeling of less painful ways of functioning. This in turn led to behavioral prescription, i.e. modeling better and more constructive ways through confrontations of specific bits of behavior, bringing to conscious wareness the feelings that led to the behavior. In the final analysis, it was the combination of both the mutual support provided by the group and the cognitive aspects of learning from each other that enabled the members via mutual identification to accept themselves through the acceptance they received from the leader and from each other. The learning could take place because of the acceptance they received, one reinforcing the other. The therapeutic effects of the group benefitted the more independent spouses in that they became more confirmed in the effectiveness of their behavior. Not only could they appreciate their more adequate way of functioning, but the group afforded them the opportunity of helping less adaptive members benefit by their experience. There was mutual learning and mutual support.

The study has shown that the group processes are enhanced if the leader of a cardiac wives' support group is a professional who is also a cardiac spouse. Since the primary supportive group intervention is the encouragement of the commonality and mutuality of group feelings, the fact of the leader having gone through the same experiences facilitated this process, with resulting benefits to the members. The dual role of participant and professional enabled the members to project their feelings into the leader who could then share her perceptions with them and help in the process of mutual learning and mutual identification. Whether a comparable result could be obtained with a leader who is not also a cardiac spouse remains to be tested.

As much as an intensive group experience of six two-hour sessions can have the above positive effects, it would be valuable to continue beyond this six-month period, since the group cohesion that has been achieved can lead to further insights. We saw in the study that the group needed to go through a gradual building up of trust to reach the point of becoming a cohesive group, with development of feelings of group solidarity where the members genuinely care for one another. It is speculated that this atmosphere of mutual caring can lead to a deepening of the processes that have been set into motion and can therefore lead to further "healthful" adaptations by the members to their husbands' heart attack.

CHAPTER IX

IMPLICATIONS OF THE STUDY

The finding that a heart attack has a profound effect on the patient's spouse and that a supportive group intervention can considerably alleviate the stress, corroborates the experience of this writer and that of other mental health professionals in the medical field of the importance of involving the family in the physical rehabilitation of the patient. "The family is the best therapeutic agent and the key to successful rehabilitation."[1] "Families can be the greatest help or the greatest hindrance to a successful rehabilitation program."[2] "It was found that patients with stable and supportive families are more likely to be successful in their treatment program and attain a more independent level of functioning."[3]

Quotes from these and other studies corroborate that critical experiences such as life-threatening and chronic illnesses often involve

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[1]Eva S. Oles, "Social Rehabilitation of the Patient with Hemiplegia" (unpublished paper, presented at Stroke Symposium, Rancho Los Amigos Hospital, Downey, CA, February 16, 1969), p. 4.

[2]Ruth Cox Brunings, "Social Work in a Rehabilitation Hospital", in Rehabilitation Services and the Social Work Role: Challenge for Change, ed. J.A. Brown, Betty Kirlin, and Susan Watt (Baltimore, MD: Willams & Wilkins, 1981), p. 150.

[3]Eva S. Oles, "Social Work Study of Aphasic Patients" (unpublished paper, 1966), p. 6.

considerable adjustment of the patient to changes in status and social and economic roles, as well as requiring modification in the patient's attitudes and behavior. The success of medical treatment may well depend on the patient's ability to make these changes easily and effectively. Mental health workers have been involved in motivating patients to make the necessary and often difficult adaptations to their illness and have found that one of the most important resources of the patient are his family and particularly his spouse. "We can encourage, we can motivate, but what has the patient to look forward to? Why try if no one is going to care?"[4]

The spouses, as has been demonstrated in this study, have to make their own adaptations to the changed status of the patient and are therefore in need of help themselves in coping with the new problems created by the illness. "The family has its own experience similar to that of the patient. Just as the patient must go through several phases of adjustment until there is a restitution of self, so does the family experience the same. For the family there is loss and grief, new roles, change of status, followed by realignment of individuals, social systems, and finally an adjustment to a new style of living."[5] The extent to which the patient's illness can affect the spouse has been clearly shown in this study and has been experienced by mental health professionals over many years of working with families of patients.

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[4]Oles, "Social Rehabilitation of the Patient with Hemiplegia", p. 4.

[5]Honora K. Wilson and Ruth Cox Brunings, "The Social Worker", in Orthopedic Rehabilitation, ed. Vernon L. Nickel, M.D. (New York: Churchill Livingstone, 1982).

They have found that the attitude of the family makes a crucial difference in the patient's ability to benefit from medical and rehabilitative care. The blow to the patient's self-esteem and the feelings of loss which major illness engenders and all the complicated emotional ramifications of major and life-threatening illnesses require a depth of understanding on the part of the worker to prevent the fears from escalating into major emotional barriers to recovery. The patient's family, and especially the spouse, constitutes one of the patient's most reliable sources of support in his efforts to make the necessary adaptations.

"Research has documented that patients with interested families achieved better rehabilitation results than patients with family conflict."[6] It was also found in the same study that ". . . patients with multiple social problems and inadequate adjustments throughout life do not make as good a recovery".[7] In the study of six aphasic patients and their families from 1964 to 1966 carried out by this writer, she found that "the two patients who had not made an adequate adjustment to their disabilities were the ones who had poor marital relationships. The two who were depressed did not receive adequate emotional support from their spouses. The families of three patients who had made adequate adjustments to their disabilities had positive attitudes toward the rehabilitation program and had adequate communication between family members."[8]

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[6] Oles, "Social Work Study of Aphasic Patients". Cited by Bruning, "Social Work in a Rehabilitation Hospital", p. 150.

[7] Ibid., p. 6.

[8] Ibid., p. 4.

Studies by clinical social workers in their work with families of patients have contributed greatly to a deeper understanding of the nature of family conflict due to the patient's illness. "Family members also have pain over the guilt that they experience. The guilt comes from unresolved anger, ambivalence, fears, and a desire to escape from the patient and the whole problem. When guilt is recognized, accepted, and worked through, then the family is able to move to problem-solving, to making necessary decisions, to participating with the health care team, and to remaining involved with the patient."[9] This study of female spouses of cardiac patients has added to a greater understanding of the specific dynamics found in this particular group and has demonstrated specific ways in which group intervention can decrease hostility and guilt and can lead to a more positive involvement with the patient.

As has been shown in this study, emotional support and understanding of the spouse's feelings is one of the most effective interventions in enhancing the spouse's ability to cope by raising her self-esteem and decreasing her sense of helplessness. Years of practice in the field of rehabilitation have repeatedly demonstrated the therapeutic effects on the spouse of a supportive attitude on the part of the health care professionals. The physician on whom the family depends for physical healing is also seen as a source of support by the patient and family. His attitude and his ability to understand the emotional impact of the illness on the patient and family may well make the most important difference in the success of the medical treatment.

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[9]Wilson and Brunings, "The Social Worker", p. 36.

An understanding on the part of the physician conveys a feeling of acceptance and gives hope to the patient and family that the difficulties of the illness can be overcome. The women in this study have mentioned repeatedly in informal discussions that they feel left out by the doctor for not including them in their husband's recovery program. There were feelings of resentment about their being ignored by the doctor and strong feelings were expressed by the members of the group that they need and want to be included in all aspect of his care.

As a result of the social worker's role on rehabilitation teams in hospitals over the last decades (the first medical social worker in the United States was appointed in 1905 at Massachusetts General Hospital) in understanding and interpreting to the physician the role of the family in the patient's recovery, we are seeing an increasing emphasis on the psychosocial aspects of medical care in the training of physicians. A number of medical schools, especially on the East Coast, have social workers with Ph.D.s in clinical social work or in medical sociology on their staffs to develop a curriculum that includes an understanding of the whole patient and the emotional impact of illness on the patient and his family. In many cases these social workers are on the faculties of both the medical schools and the schools of social work in the universities in which they teach. A colleague of this writer, who for many years served as the director of social work at Rancho Los Amigos Hospital in Downey, California, is now serving on the faculty at the University of Southern California School of Medicine. She has been involved for several years in the teaching of medical students through lectures and direct work with patients in the clinical medicine sequence. Where she had previously been the rehabilitation

social work director, she now brings the medical students to this and other hospitals to show them how to interview patients and how to listen and understand their feelings. These developments of recent years will undoubtedly have a significant impact on the delivery of medical care in future years. We are already witnessing a gradual change in attitude on the part of the younger doctors toward the families of patients by increasingly including them in the medical care of the patient.

We have learned through this study that to the extent that the spouse is able to deal with the reality of her husband's heart attack rather than being overwhelmed by feelings of helplessness, to this extent will she feel more in control of the situation. It increases her feelings of confidence and ability to cope and be of support to her husband. Who else but the patient's physician, by virtue of his crucial place in the process of recovery and the powers that are projected into him by the patient and his family, can be in a better position to instill this confidence in the patient's spouse? If she feels that the doctor has made her a partner in her husband's program, she will feel confirmed and supported. This will make her more amenable to other treatment interventions that might help her overcome resistances that may prevent her becoming more supportive to her husband.

This study has shown that involvement of the spouses with others faced with similar problems decreases isolation and depression and anxiety by increasing her sense of mastery and enhancing her self-esteem. In the process of involving the wife, the physician can then also make the desirable referral to a cardiac spouses' group which can help additionally in the process of increasing the wife's stability. As is understandable, the physician concentrates his rehabilitation efforts

on the patient, but in the process the wife feels left out. By understanding her emotional needs as well as those of the patient and by referring her to additional sources of help, the physician acknowledges her needs as well and can thereby prevent an exacerbation of her emotional reactions. He can thereby also help the couple achieve a new equilibrium in their marital relationship which has been disrupted by the heart attack.

Implications for Further Research

Further studies in the area of the effects of the wife's supportive group therapy on the husband's success in rehabilitation might corroborate the findings of this study and might encourage physicians to routinely include the spouse in the patient's rehabilitation program. A comparative study of the effects on the patient's recovery of spouses receiving supportive help versus those who are not receiving such support might highlight the benefits of group therapy of the spouse on the husband's rehabilitation. It also would be helpful to conduct further studies on the effects of the physician's attitude on the spouse, what she perceives as her role in her husband's recovery and how it compares with what the physician sees as her role in her husband's rehabilitation. This would then show us the difference between the physician's and the spouse's perceptions of their roles and would help the physician to modify his approach accordingly. Another study could deal with the effects of the physician's involvement of the wife on the patient's progress in rehabilitation. This would be exceedingly helpful to the physician in proving the vital importance to the wife of his

role. Another study might compare the role of the physician in his work with the spouse with that of other professionals such as the nurse or the social worker. It would pinpoint the specific role the physician plays in comparison with other members of the health care team.

It would be important to test the theoretical assumptions of this study regarding the differences in adaptation based on developmental theory by comparing the retrospective histories of the dependent and independent spouses. A follow-up study of the drop-outs from this group would also be useful, to explore in greater depth why they decided not to participate and how their adaptation compares with that of the group members. Are similar patterns of adaptation and positive effects of group intervention found in other disease syndromes such as cancer? What are the changes in the marital equilibrium when one of the partners shows organic brain deficits or any of the multitudes of changes that accompany aging? Additional studies might explore the effects of the heart attack on the marital relationship in marriages of shorter duration. The average years in this study were twenty years of marriage, and the findings may be considerably different in less stable marriages of shorter duration. A study of the effects of the heart attack on children of different ages and how this in turn affects the patient may be helpful in understanding the changed dynamics of the family as a result of the father's heart attack. Are the reactions of male spouses to their wives' heart attacks similar to those of female spouses and does a group experience have a similar impact on them? Those and similar studies may give us additional insights into the complex problems of the impact of the myocardial infarction and other life-threatening and chronic illnesses on the patient and his family and

may go a long way in helping us plan more effective treatment interventions.

"The knowledge of the family, the major factor in the patient's support system, can reinforce the physician's ability to interpret to the family what can be expected from the treatment. The family support system is the major force upon which the health team can rely for successful rehabilitation. With knowledge of the family's hopes, fears, and disappointments, the physician can better deal with their expectations for treatment and rehabilitation."[10] This study of cardiac spouses depicts the psychological suffering of family due to the physical illness of one of its members and describes what can be done through understanding and support to alleviate the psychic pain. As the complexity of medical treatment increases with greater reliance on more sophisticated machinery, there is a greater need than ever for the human factor in the healing profession.

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[10]Ibid., p. 37.

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