A Support Group for Fathers Whose Partners Died From Cancer

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Men who are raising dependent children after their spouses or partners have died from cancer face unique challenges adjusting to single parenthood while managing their grief and the grief of their children. Unfortunately, the needs of those widowers have been overlooked in the clinical literature and no published interventions are designed specifically for that population. The current article details the creation and implementation of a peer support group for fathers recently widowed because of their wives’ deaths from cancer. Initial observations and emergent themes from the group are described. Group members suggested that they benefited from participation in the support group and that this form of psychosocial support is a promising intervention for fathers in similar circumstances.

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Digital Object Identifier: 10.1188/13.CJON.169-173

Social support intervention groups have been effective in improving the psychosocial functioning of individuals affected by cancer (Adler & Page, 2008; Gottlieb & Wachala, 2007; Legg, Occhipinti, Ferguson, Dunn, & Chambers, 2011). Patients who participated in cancer-related support programs demonstrated improved coping skills, self-efficacy, knowledge, and decreased feelings of isolation (Campbell, Planeuf, & Deane, 2004; Newell, Sanson-Fisher, & Savolainen, 2002). Support groups for family members of patients with cancer also led to positive outcomes (Levy, 2011; Northhouse, Katapodi, Song, Zhang, & Mood, 2010; Scott, Halford, & Ward, 2004). Peer support programs have benefited patients with cancer and their family members during active treatment (Schneider, 2006); however, the efficacy of interventions for bereaved spouses whose partners died from cancer has not been examined fully. In addition, peer support groups for bereaved spouses, regardless of cause of death, have been limited to women or an older population of widows and widowers (Boerner & Silverman, 2001; Walter, 2004).

Men who have dependent children and whose spouses or partners died from cancer are an overlooked population. Those widowed fathers must help their children adjust to their mothers’ deaths while confronting their own grief and adapting to the challenges of single parenthood (Yopp & Rosenstein, 2012). During the terminal stage of their spouses’ illnesses, husbands assumed increased caregiving responsibilities (Lewis, Fletcher, Cochrane, & Fann, 2008), and the presence of children in the home was associated with increased depression and anxiety in bereaved spouses (Nilsson et al., 2009). Boerner and Silverman (2001) hypothesized that men traditionally do not play the role of the more nurturing parent; therefore, as widowed parents, fathers may be less likely to employ child-centric or nurturing parenting styles and more likely to feel unprepared than widowed mothers. In addition, children living with widowed fathers experience more disruption in their daily lives than children living with widowed mothers (Silverman & Worden, 1992). The importance of attending to widowers’ coping has been underscored by the well-established link between the mental health of the surviving parent and the adjustment of the parentally bereaved child (Saldinger, Porterfield, & Cain, 2004; Wolchik, Ma, Tein, Sandler, & Ayers, 2008). Those findings highlight the need to develop specific psychosocial interventions for fathers widowed because of cancer.
The current article describes a peer support group for fathers who were recently widowed because of their wives’ deaths from cancer. The goal of the current article is to facilitate the formation of similar groups to help men and, by extension, their children through the bereavement process. The potential benefits of support groups are highlighted by Allen and Hayslip (2001), who showed that the absence of social support during the bereavement process related to poorer psychosocial outcomes. In addition, O’Neill and Mendelsohn (2001) posited that widowed fathers placed more value on support received from peers in similar situations. A support group for widowed fathers may combat social and emotional isolation and offer an antidote to men who otherwise may suffer in silence.

Background

The motivation for developing a group intervention specifically for widowed fathers stemmed from the authors’ clinical experiences following a series of young mothers dying from cancer. Most of the women and their families received psychosocial support services during their illnesses and end-of-life care. Key themes from the counseling sessions included concerns about how their husbands and children were coping during the terminal stage of their illnesses and how their families would manage after they died. Following the women's deaths, the authors explored the availability of clinical services specifically for surviving husbands that could address their adjustment to single parenthood while managing their grief and that of their children. Not only were no local services available, but the needs of those fathers were overlooked in cancer- and bereavement-related literature.

A small focus group was conducted and comprised of recently widowed fathers whose wives were treated at a cancer hospital. The session occurred several months after their wives’ deaths. The focus group had the following goals: (a) gain a deeper understanding of the fathers' most pressing concerns about adjusting to single fatherhood and managing their children’s grief, (b) explore whether the needs of fathers widowed because of cancer were different from other widowers or bereaved parents, and (c) gauge interest in developing a support group intervention to address the men’s concerns.

The fathers experienced reactions characteristic of having recently lost a spouse but also described concerns specific to the challenges of being alone in their parenting role. They reported struggling to transition from having devoted their focus and emotional energy to their wives’ health and daily care needs to modifying their lives and redefining their parental roles. That adjustment was made more difficult by shaken confidence in their parenting ability and uncertainty as to whether family life would feel normal again.

A central theme that emerged from the focus group was the feeling of profound aloneness as a parent that extended beyond the loss of a spouse. The men were emotionally drained from their wives’ treatment and death and had no access to others in similar situations. Although their situations had some similarities to friends who were divorced single fathers, the men in the focus group felt a lack of kinship given the circumstances of how they became single parents. One father referred to himself as a “sole parent” rather than a single parent, as all parental responsibilities now fell solely on him. The men shared a sense of “being in this alone” with no viable road map or peers who could understand their struggles.

Constructing the Support Group

Feedback from the focus group suggested that the fathers faced mourning and parenting challenges simultaneously. That observation was consistent with the understanding that these men represent a distinct and neglected subgroup of the bereaved population. As such, developing and offering an intervention tailored to their specific needs was a priority. The support group format was selected because of potential advantages over individual counseling such as decreasing social and emotional isolation by connecting widowed fathers with their peers.

Many aspects of the support group formation were considered in the development of the intervention. A hybrid model that combined a supportive-expressive approach was used to promote the exchange of shared experiences in an emotionally supportive environment with a psychoeducational component that offered practical and concrete information (Spiegel, Bloom, & Yalom, 1981). That model was chosen to address two themes that emerged from the focus group: the fathers’ sense of aloneness and their perceived lack of competence across several domains (e.g., managing a household, addressing their children’s grief). The intervention was conceptualized as a support group rather than group therapy.

A time-limited intervention was planned for seven meetings with the authors, a licensed psychiatrist and a licensed clinical psychologist, serving as co-facilitators. Each meeting would include a brief didactic session focused on a different psychosocial aspect of widowed parenthood. Fathers in the focus group recommended spacing out the frequency of group meetings to avoid overwhelming their already stretched schedules; therefore, group meetings were scheduled to take place on a monthly basis. Meetings were scheduled to be 90 minutes, with the first 30 minutes devoted to didactic presentations and the final hour allowed for group discussion.

Potential Obstacles

Fathers in the focus group noted that a possible barrier to attending the meetings would be their need to arrange for child care; therefore, on-site child care was provided. University-affiliated undergraduate student volunteers were recruited to care for the children in an adjacent room for the duration of the meeting. In preparation for the first meeting, the facilitators discussed developmentally appropriate strategies to handle situations where the children may discuss sensitive topics with
the volunteers. The volunteers and co-facilitators debriefed together after every meeting to troubleshoot any concerns.

Group meetings were held during early evening hours to allow for the greatest attendance and not delay bedtime routines. Given the time of the meetings, dinner was provided for the fathers and children in attendance. The group was offered at no cost to reduce financial burden. Group meetings also were scheduled to take place at a clinic off hospital grounds to avoid requiring fathers to return to the location where some of their wives received treatment and died.

Collaborative Process

The facilitators anticipated that the participating fathers would provide new insight about their experiences and supportive needs; therefore, to promote a spirit of collaboration, that dynamic was acknowledged explicitly. The aim was to create a partnership in which facilitators would assist in-session group discussion and offer expertise about relevant subject matter and the men would provide education on the experiences of being a widowed father.

Efforts to recruit participants began by contacting fathers the authors had met during the wives' illnesses. In addition, the availability of the support group was communicated to caregivers in the authors' hospital as well as local hospice organizations. A total of 13 widowed fathers were identified for recruitment, and invitations were extended via phone and mail. Contact was made with six fathers who all expressed interest in attending the group. The remaining seven fathers were unable to be reached by phone and did not respond to mailings.

Intervention

Participants

Six fathers, aged 30–50 years, attended the initial support group meeting. Most of their wives had died 7–11 months prior to the group's first meeting. Each father had multiple children ranging from 18 months to 19 years of age. Two group members participated in individual grief counseling before joining the group. One father was involved with a grief support group but stopped attending because he felt a lack of connection with the other group members who were predominately older and female.

The first group meeting began with facilitator introductions and a description of the group structure. Because no established template existed for the intervention, the facilitators considered the group model and structure malleable and open to the fathers' input. The fathers were encouraged to be active participants in shaping the group so that it best addressed their needs.

The fathers were asked to introduce themselves to the group and share the circumstances that led to being single fathers. The men described their wives' illnesses and treatments, the challenges they faced in caring for themselves and their families as their wives' health deteriorated, the heartbeat of their wives' deaths, and the struggle to find their footing as single parents. The fathers intently listened to the succession of heartbreak stories, which was an emotionally challenging experience for the participants and facilitators. The intensity of the first meeting raised the concern that the experience would discourage some from remaining with the group. As a result, after introductions were complete, the facilitators processed with the fathers how difficult the first session must be and shared that they did not anticipate it to be the nature of every session. Months later, when reflecting on that first meeting, the fathers acknowledged the anguish of the session; however, they denied that the experience dissuaded them from staying with the group. In fact, all fathers present for the first meeting returned the following month.

During the first meeting, the fathers clearly valued talking with and hearing from each other. The opportunity to share their experiences with a group of their peers seemed immediately helpful. The fathers would nod at each others' descriptions and often comment, “I know exactly what you mean,” which served as evidence that listening to the other men talk about their struggles was beneficial. The group format offered what neither individual therapy or talking with family and friends could: a forum to discuss and process their experiences with others who could identify with what they were going through. Keeping with the collaborative nature of the group, altering the structure of the sessions was proposed so the entire meeting would be devoted to facilitator-led group discussion. The psychoeducational component would be added to discussion instead of delivered separately. The men in the group also proposed changing the group model from a seven-session commitment to an open-ended model. These changes were adopted by the support group.

Since then, the group has met consecutively for two years and continues to meet on a monthly basis, much longer than initially planned, which reflects the participants' sense that they benefit from their involvement. The fathers reported that the support group has been an invaluable resource in their healing process. Periodically, facilitators and fathers discuss their interest and desire in continuing to meet. The facilitators expressly communicated that the fathers are not expected to remain in the group in perpetuity and each man may reach a point when his involvement in the group no longer is warranted. However, those discussions have ended with the fathers expressing collective interest in continuing the group.

The group is characterized by remarkable stability in its membership. Of the six fathers who attended the initial meeting, five remain with the group and one stopped attending after the second meeting. No additional concerted efforts were made to recruit new participants; however, the group remained open, and three new fathers joined.

Findings

After relatively few group meetings, a sense of community emerged among the fathers. Their cohesiveness was grounded in common experiences, and they noted that for all the support
Implications for Practice

- Clinicians, including oncology nurses, should have a better understanding of the psychosocial challenges facing widowed fathers.
- Healthcare staff should promote open and honest discussions with patients and their partners in the time leading up to the patients’ deaths.
- Clinicians are encouraged to create and implement similar support groups for fathers whose partners died from cancer.

they received from friends and family, something was different about processing their experiences with their peers. One father described their connection as one where words often are not needed; instead, they intuitively know what the others are feeling.

Determining how to be a single parent in the context of grieving a spouse's death can be a confusing and overwhelming process and, at various times, each father questioned his parental competence. Meeting with others who experienced the same doubts and uncertainties helped to normalize those experiences. The men developed a sense of closeness and trust, which has been reflected in their authentic exchanges.

As the fathers’ bond strengthened, they assumed increasing stewardship of group discussions. Accordingly, the facilitators' stance as group leaders evolved from selecting and introducing topics to yielding the floor for open discussion. Often, fathers come to the meeting with issues they want to discuss or specific incidents they have been waiting to process with the group. Although the group members are encouraged by each other's successes, they provide support, guidance, and share their personal experiences during individual setbacks. The participants reported that the opportunity to learn from their peers has been invaluable in sustaining them and their families through difficult times.

The group’s cohesiveness also is reflected in the feedback and advice the fathers provide to each other. As the group matured, the fathers were more likely to challenge each other in a supportive manner. For example, when hearing other fathers make maladaptive statements or indicate they are feeling undue guilt, the fathers openly and directly challenged these assumptions. An interesting intragroup dynamic was the relationship between the fathers more veteran to the group for whom more time had elapsed since their wives’ deaths and the fathers newer to the group who were earlier in their grieving and adaptation processes. At times, veteran members assumed mentorship roles, often describing their own struggles to help normalize newer members’ experiences.

Common themes emerged from the group on the challenges of being a sole parent following a wife’s death: (a) a lack of preparedness to be single parents, (b) coping with their grief and that of their children, and (c) adjustment to the demands of single parenthood. The group validated and supported the fathers’ attempts to gain confidence in addressing those issues and mastering new parenting responsibilities. To a large degree, the content and emotional tenor of the group discussions mirrored the fathers’ general improvement with working through the family grief and meeting the challenges of daily life as a single father. Progress was slow and uneven at times; however, the general trajectory has been toward better and more adaptive coping.

Conclusion

Fathers widowed by their wives’ cancer face considerable hurdles in their bereavement and adaptation to single parenting and appear to have unique needs that largely have been overlooked in clinical literature. The fathers expressed that their participation in the psychoeducational support group facilitated their adjustment to single parenthood and helped them manage their grief and that of their children. The support group has been characterized by a collaborative spirit in which the fathers have shaped the contours of the group so it best meets their needs. In the process, they have educated the group facilitators on the specific challenges relevant to fathers widowed by their wives’ cancer. The support group format was an excellent avenue for providing clinical services to that subset of the bereaved population.

The open-ended nature of the support group raises interesting questions about how long the fathers will choose to stay involved and to what degree the focus of the group may change as members continue to adapt and become comfortable managing the challenges they face. A survey of the fathers revealed that they are very interested in having new fathers join, even as the discussion content shifts to issues more relevant to men further along in their adjustment. The fathers have embraced the chance to help others and are drawn to the notion of mentoring fathers more recently widowed. Veteran group members carry much of the meeting and often bring content from their daily lives for focused discussions, which raises the prospect that future groups co-facilitated by a father and a mental health professional may expand care.

Empirical research on the benefits of support groups for fathers widowed by their wives’ cancer is needed to promote optimal adjustment for their lives and for the lives of young children who have lost their mothers. Areas in need of study are ideal group size, the benefits of open- or close-ended group composition, the appropriate amount of time following the wife’s death to join the group, and considerations of non-traditionally structured families (e.g., not married, same sex couples). The experiences of the current support group illustrated that men in crisis, when given a safe and supportive environment, express deep emotions, establish psychological bonds with other men, and use those connections and encouragement for healing.

The authors’ vision is that the experiences and information shared will spur the development of peer support groups at other cancer centers. Nurses and nurse educators in the oncology setting are well positioned to play vital roles in the expansion and facilitation of such support groups and to conduct research studies about the experiences of those families and how best to serve them. For more information on fathers widowed because of cancer visit www.singlefathersduetocancer.org.

The authors gratefully acknowledge the insightful contributions of the fathers in the support group. Their input has been invaluable and is very much appreciated.
References


