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Grief Adjustment in the Compulsive Personality

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GRIEF ADJUSTMENT IN THE COMPULSIVE PERSONALITY

by

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GRIEF ADJUSTMENT IN THE COMPULSIVE PERSONALITY

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Western Michigan University, 1984

Researchers in the field of grief (Parkes 1972, Bowlby 1980) theorized that personality is probably the major factor in determining how well one recovers from grief. Since Lindemann's (1944) study of surviving loved ones who died in a night club fire in Boston, most researchers have worked under the assumption that a survivor must go through the grief process in order to recover adequately, and that those who do not grieve will have poor recovery. Since the compulsive personality style has difficulty expressing emotions, it was hypothesized by this researcher that compulsives would recover more poorly than others in the general population. It was found by this researcher that there was lack of significant research that attempted to measure personality as a factor in grief recovery.

Letters requesting participation were sent to 908 surviving spouses of persons 65 years of age or younger who had died during the previous two to four years and whose death had been reported in the Battle Creek (MI) Enquirer or the Kalamazoo Gazette between January 1980 and June 1982. Only funerals handled by Caucasian funeral directors were included. Of these 908 requests for participation, 175 were returned as undeliverable. Either by return card or telephone 279 persons agreed to participate. As a result of this mailing a sample of 38 males and 155 females was achieved. The

Millon Clinical Multiaxial Inventory was used to classify persons by personality style. The Bereavement Questionnaire (BQ) (Martin 1981) augmented by items from the Texas Instrument of Grief (Faschingbauer, DeVaul, Zisook 1977) forming the Bereavement Recovery Questionnaire (BRQ), was used to measure grief recovery.

A two-tailed t test was used to compare the mean scores on both the BQ and BRQ of the 30 highest compulsives with a sample of 30 others drawn after removing all others scoring highest on the compulsive scale. The mean obtained for the compulsive group was actually higher (indicating better adjustment) on both scales, though not significantly so. Thus, the null hypothesis that there is no significant difference between compulsives and others was retained.

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James Lewis Young

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CHAPTER I

INTRODUCTION

Statement of the Problem

Of all persons in the helping professions, clergy are in the most advantageous position to follow up on those who have suffered a loss through death. They are often present before death, are almost always present at the time of death, at least in terms of the funeral service, and it is normal for them to call in the home of bereaved persons for a period of time after death. If the clergy-person could know which persons after suffering a loss are most prone to pathological grieving, they would be in a much better position to monitor the grief process of such persons and to provide help directly or to refer persons for help when this is appropriate.

As Martin (1981) pointed out in a study with a purpose similar to this one, if the busy minister, priest or rabbi can know which bereaved members of their congregations are likely to need more than usual help, the pastor can use his or her time more efficiently and effectively, giving more time and attention to those most likely to need it.

A number of factors have been identified that place some persons in a higher risk category. Parkes (1972) especially has reported extensively upon these factors. These are discussed in Chapter II.

It has been theorized by Parkes (1972) and Bowlby (1980)

that personality is a major factor affecting recovery. However, as Bowlby has pointed out, no research has yet been completed to test this. This writer could not find any research in this area either.

The purpose of this study will be to test whether personality is, in fact, a major factor affecting recovery from the loss of a spouse. More specifically this study will test whether the compulsive personality style has significantly more difficulty than other styles of personality in handling the loss of a spouse.

If personality is found to be a significant factor, then those seeking to provide help following bereavement will better know which persons will likely need the most help.

Limitations

It is possible that persons who are suffering the most who were requested to participate in the study did not choose to do so because of the pain being experienced at that time. Two of the stages of grief recovery are anger and depression. Angry persons might not have cooperated as a manifestation of their anger. Depressed persons might not have done so as a part of their general withdrawal from all activities. Thus, those who were doing the most poorly at the time of the study may be the very ones who did not participate. This researcher did not find a way of overcoming this potential difficulty.

Also, those for whom the death of the spouse created a financial hardship may have been forced to move their place of residence for financial reasons. In this study, measurement of how

well bereaved persons were handling grief was made between two and four years following the death of the spouses. Since the Postal Department cancels forwarding orders after two years, many, if not most, of such persons were lost to this study. Thus, bias against poorer subjects might have occurred.

Since participation involved the completion of a paper and pencil questionnaire and personality inventory, it is likely that persons who were unable to read and write well chose not to participate. It is a subjective judgment, but this investigator sensed in telephone conversations with potential participants that this was a factor in some person's refusing to become involved. It could also have been a factor for those who did not make any response to the request to participate and who could not be reached by telephone. Thus, again bias may have occurred against those of a lower socio-economic or educational level.

It is possible that some personality types or styles are less prone to participate than others, as for example, the "Active Independent" or the "Detached" in Millon's (1969) nosology. Fortunately, these are personality types of less interest to this study than most others. However, any consistent refusal to participate adds bias to the results.

Summary

Personality has been theorized to be a major factor in determining how well a person handles the loss of a loved one. However, no studies have tested this hypothesis. This study is intended to test whether the compulsive personality is a style that handles grief more poorly than others. The usual limitations found in doing research with humans are present in this study along with the possibility that some were not reached because they were forced to move for financial reasons.

CHAPTER II

REVIEW OF RELATED LITERATURE AND RESEARCH

The Grief Process

Grief is probably common to every culture and every historical period. Perhaps because it is so common, like the cold, it has largely been taken for granted and has not, at least until recently, been given a great deal of attention in studies or in literature.

Its symptoms have variously been described as those of emotional shock, as being similar to the symptoms of an anxiety state, as similar to a temporary depression (Jackson 1957). To this list could be added episodes of anger and guilt (Parkes 1972). Part of the problem in seeking to identify grief as an emotional state is that it is not a state, but a process (Lindemann 1944, Parkes 1972, Bowlby 1980). Grief is the series of reactions, emotional and behavioral, which one goes through after the loss of a significant person in his or her life, or after a love-tie with anything is broken. It is usually thought of as occurring in occasion with the death of a loved one. However, there are probably also grief reactions of more or less intensity involved with moving to a new location, changing jobs, with separation and divorce, the break-up of a romance, the loss of a pet, the loss of a limb or function, in fact, any significant loss in one's life. In this respect, grief has components of situational depression and one phase of normal grieving may be fruitfully compared with severe situational depression.

Causes of Grief

Bowlby (1961, 1980), in reviewing theories regarding the mourning process, noted that Freud made use of his construct of libido to explain grief. The purpose of mourning according to Freud (cited by Bowlby 1980) is to detach the survivor's memories and hopes from the dead. Once that reality testing has led to the conclusion that the loved object no longer exists, libido is then withdrawn from its attachment to that object and displacement to another.

A behavioral explanation is more direct. In death, a major source of reinforcement is lost. There are various attempts to regain the reinforcements - searching behavior, agitation, anxiety, crying, anger. When unsuccessful, there results a perception of helplessness and hopelessness resulting in depression. Then gradually as new reinforcers are gained, there is a diminishing of depression and a return to more normal behavior (Seligman 1975).

Stages of Grief

Following the New Year's Eve fire at the Coconut Grove Nightclub in Boston, Eric Lindemann (1944) conducted the first systematic follow-up study of persons' reactions following the death of loved ones. Although subsequent studies have been conducted, Lindemann's findings continue to receive near unanimous verification (Parkes 1972, Bowlby 1980). His major finding was that persons who had experienced intense distress, anxiety, depression, and anger had made a far more successful recovery than those who had

borne up and had not gone through the grieving process. Eli Wallach, narrating a film series, "Begin with Goodbye," (Weber 1978) used the illustration of persons on a plane having the pilot on the intercom announce that there is turbulance ahead, but that they will fly over it. To which an experienced passenger is overheard to remark, "Yes, but before we get over it, we will have to fly through it." Recovery from a severe loss is much like that. Most people get over it, but to do so, must go through it. And it is a painful process.

While there is a "normal grief reaction" it is not a neat one-two-three and out process. Not everyone experiences every stage. The length of time in each stage varies. The order sometimes varies (Lindemann 1944, Parkes 1972, Bowlby 1980, Worden 1982). What will be described, therefore, is a "typical" grief reaction which no one fits perfectly. Lindemann (1944) theorizes that what is taking place during such "grief work" is "emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships" (p. 143).

Different authors have outlined the process in different ways. Bowlby (1961) spoke of the three phases of mourning: (1) the urge to recover, (2) disorganization, and (3) reorganization. Pollock (1961) described two stages, the acute, including shock, grief, pain, reaction to separation, anger; and the chronic stage, which is the beginning of an adaptation to the reality of the new situation. Lindemann (1944) listed (1) sensations of somatic

distress - intense hurt coming in waves, (2) a sense of unreality with intense preoccupation with the image of the deceased, (3) a strong preoccupation with feelings of guilt, (4) feelings of hostility, and (5) restlessness with an inability to initiate and sustain organized patterns of activity (just going through the motions). These reactions Lindemann listed as pathognomonic. A sixth characteristic borders on the pathological - the bereaved taking on characteristics of the deceased.

Parkes (1972) included all the phases and stages of grief in his presentation and his outline will be followed in the discussion that follows. In addition to a thorough study of the literature, Parkes conducted one of the few scientific studies of grief - "The First Year of Bereavement - A Longitudinal Study of the Reaction of London Widows to the Death of Their Husbands" (1971).

Parkes' (1972) overall view of grief is summarized as follows:

> In the ongoing flux of life man undergoes many changes. Arriving, departing, growing, declining, achieving, failing - every change involves a loss and a gain. The old environment must be given up, the new accepted. People come and go; one job is lost, another is begun; territory or possessions are acquired or sold; new skills are learnt, old abandoned; expectations are fulfilled or hopes dashed - in all those situations the individual is faced with the need to give up one mode of life and accept another. If he identifies the change as a gain, acceptance may not be hard, but when it is a loss or a mixed blessing, he will do his best to resist change. Resistance to change, the reluctance to give up possessions, people, status, expectations - this, I believe, is the basis of Grief. (p. 11)

According to Parkes (1972), the first reaction to severe loss is episodic pangs, feelings of hurt, severe anxiety and psychological

pain. "Pangs of grief begin within a few hours or days of bereavement and usually reach a peak of severity within five to fourteen days" (p. 39). They are at first frequent but as time passes, become less so. Often they occur when something reminds the bereaved of the deceased or when sympathy is expressed - meeting a mutual friend, finding a picture. Sighing respiration, restless but aimless hyperactivity, difficulty concentrating, reviewing events leading up to the loss, are part of the picture. There seems to be a need to talk in great detail about the loved one's last hours and this is to be encouraged. Often there is expressed the feeling, "If I had only . . .," as if the death might not have occurred or at least it would have been better for the deceased if the bereaved had done something differently. There is also a difficulty in accepting the reality of the death. "It hasn't really hit me yet," "I really can't believe it," are often heard. It is as if there is an overload of shock and the reality cannot all be processed all at once.

Comparing adults' reactions with that of lower animals and with children, whose initial reaction is to search for a lost mother, to cry, to do anything that was successful in the past to bring her back at a time of separation, Parkes (1972) discussed the searching behavior of adults. Thus, the face of the deceased is looked for in a crowd, the deceased's footsteps are listened for, the grave is visited, the deceased is looked for in his bed. Because of a perceptual set for the lost person, the bereaved may think that he or she has seen him or heard him. Widows in the London study often

described illusions of having seen or heard their dead husband. Such illusions are normal and oftentimes persons need to be told that this is not an unusual feature - they are not losing their minds. Calling for the dead person may also be a part of the searching behavior. At this time, the most important thing that could happen is the return of the one who is lost. Searching for him, calling for him, crying for him, is therefore appropriate (though irrational) behavior, irrational because nothing will bring him back. Behaviorists describe how frustrated behavior is usually intensified before it gradually extinguishes, so that intense searching can be expected before it ceases (Karen 1974).

Parkes (1972) noted that when searching behavior fails to find the lost object in reality it is sometimes found anyway. In many species, when "seeking" behavior is evoked at high intensity, finding "behavior will often occur even in the absence of the object sought." Thus, often, in Parkes' (1972) London study, widows reported a sense of their husbands' presence. "He's with me all the time. I heard him and see him, although it's only imagination." Occasionally hypnogogic (half-waking) hallucinations occur. Such hallucinations are not necessarily pathological. Sometimes the "finding" is an unusually clear mental image of the deceased that may be so real as to border on being an hallucination. In a Welsh study by Rees (1971), 39 percent had a sense of the presence of the dead spouse and 14 percent experienced hallucinations or illusions of his or her presence from time to time.

Another form of grief mitigation has already been discussed in

this review and is frequently encountered - not to believe that the loss has actually occurred. This is not an outright disbelief, but a feeling that it just cannot be true. Viewing the body after death may be an important part of getting over this unreality feeling. This is especially true when death has come unexpectedly and apart from the bereaved.

Worden (1982) wrote of another technique sometimes used to avoid the pain of grief, that of avoidance - not to think of the lost person and to avoid situations, and places, and persons that act as reminders. There is real danger in this, especially if it is successful, for it effectively avoids the necessary grief work and may lead to a delayed grief reaction (discussed under "pathological grief"). Though necessary in some extreme circumstances, the use of drugs can also short-circuit necessary grief work. For this reason drugs are usually more harmful than helpful unless used quite temporarily (Worden 1982).

The various defenses discussed above help a person guard against the complete realization of his loss - which if it came all at once would probably be overwhelming. The psychic process seems to be that by allowing the reality of his situation to get through more slowly the loss can be dealt with in smaller, more manageable doses. Grief work must not be avoided, neither can it be done all at once.

Most authors (Lindemann 1944, Parkes 1972, Bowlby 1980) consider anger reactions as preceding depression. This author has sometimes found that anger follows the depressed phase, especially

in divorce cases.

Whenever it comes, however, anger could be thought of as a normal component of grief and is often bewildering to the bereaved (Bowlby 1980). Parkes (1972) reported that in the London study most of the widows reported intense anger at some time during the first year of bereavement, reaching its height during the first month. If anger is considered a normal reaction to frustration, then it is easy to understand why a bereaved person would feel anger. The attainment of many goals and of many reinforcers are frustrated by the death of a loved one.

To whom is the anger directed? The recipient may be anyone, especially anyone that may represent a safe target. A great deal of it may actually be toward the person who has died (Lindemann 1944, Parkes 1972).

Worden (1982) noted that anger is often mis-directed. Blame may be placed on a physician or hospital, or medical establishment, or nurses. Friends trying to help may receive the brunt of it. It may also be directed toward a therapist, who, hopefully, is able to understand misplaced anger and can help the client to understand what is going on, so that anger can be expressed with minimal harm. Often the death is personalized as something that has been done to the bereaved and he or she may seek someone to blame. One danger of excessive anger when expressed is that friends and relatives may be driven away just at the time when they are most needed.

Oftentimes guilt is also present, especially if the relationship

with the deceased had been an ambivalent one, as has already been noted. Thirteen of the 22 London widows (Parkes 1972) expressed self-reproachful ideas at some time during the course of the year, usually taking the form of wondering if all was done that could have been done to prevent the death. Two subjects in this study responded, "I should not have let him go." "I should have been there."

More serious to deal with is guilt in connection with death wishes in times of anger (Bowlby 1980). With children's magical thinking and resultant belief that their thoughts cause things to happen, it is always possible that they feel responsible for the death. Adults, however, also share in some of the same process. There is often also guilt about having done or not done something for or with the deceased that would have brought him more pleasure, and guilt over pains inflicted upon the loved one at some time in the past (Parkes and Weiss 1983).

Probably the stage of grief that most persons are familiar with is that of depression. When the death cannot be denied and when nothing will undo it, there comes the feeling, "I can't do anything about it." The concepts of hopelessness and helplessness are probably most useful in understanding depression. Seligman's (1975) work with dogs which led to the "learned helplessness" phenomenon helps to understand the depression of the bereaved. When dogs received unavoidable shock, in time they simply laid down and accepted it. Nothing they did made any difference anyway. Thus, doing nothing saved energy and was to that extent

adaptive. Their behavior in many ways mimics human depressive behavior. Humans, in time, following the death of a loved one, reach this phase. Nothing seems to make any difference. There has been a loss of all the reinforcement that was connected with the deceased. These reinforcements may have included companionship, financial rewards, sexual behaviors, the performance of many functions within the home, someone to converse with, a partner for social events, a parent for children, and even someone to warm one's feet at night.

During this depressive stage there is greater than normal risk of suicide. Matz (1978) pointed out that the appropriateness of despair does not mitigate the reality of suicidal risk.

In time, most persons do start rebuilding their lives, finding new relationships and gaining new meanings, which leads to the final stage of re-entry, or gaining a new identity, a time when the loved one can be remembered fondly without the strong hurtful feelings that came earlier. Such strong feelings may, from time to time, recur, especially on anniversaries, but they in time become less and less severe.

How long does the grieving process take? There is a great deal of variation. Most of the work is completed in three to six months, but it may easily take a year before it is mostly completed, and often takes longer. Up to two years is not abnormal (Parkes 1972, Bowlby 1980, Parkes and Weiss 1983).

Dysfunctional or Abnormal Grief Reactions

Healthy grief moves forward from one stage to another. Dysfunctional grief either does not get started (delayed grief) or gets stuck with an exaggeration of one of the phases of grief (Worden 1982). In Parkes' (1972) study of 35 bereaved people referred for help, 26 were referred for depression, six for alcoholism, five for hypochondrical symptoms, four for phobic symptoms, and others for panic attacks, asthma, loss of hair, depersonalization, insomnia, fainting or headaches, plus two cases of psychosis with hallucinations, delusions, etc. Many had multiple symptoms.

In Parkes' (1972) study, psychiatric patients generally experienced the same grief symptoms as did normal bereaved persons except that ideas of guilt or self-reproach were markedly more frequent in the psychiatric patients. In terms of intensity and duration, grief was more prolonged and/or tended to be delayed more often for psychiatric than for non-psychiatric patients. Some still suffered severe depression years after the bereavement.

Matz (1979) stated as follows:

> Symptomatology (of dysfunctional grief) can include denial and avoidance of aspects of reality relating to the loss, occasionally reaching psychotic proportions; ongoing preoccupation with undoing, including search behaviors, psychogenic illness, identification with the deceased, chronic anger and guilt, hallucinations, magical substitutions, and ongoing alterations of behavior, persisting feelings of depression and suicidal preoccupation: and a prolonged inability to cope with the basic task of living. (p. 229)

Excessive guilt is probably the factor most to be looked for in

arrested grief, especially when prolonged depression is the problem (Bowlby 1980). Another factor is social isolation and resultant loneliness. It is necessary for other persons and activities to take the place of the deceased, or in behavioral terms, for new reinforcers to take the place of those lost.

Physical illness is far from uncommon following bereavement (Jackson 1957), but may also be considered under atypical or pathological grief reactions. Heart disease, cancer, ulcerative colitis, asthma, headaches, digestive upsets and many other physical symptoms show significant increase following bereavement--as does death (Parkes 1972). In a study of ulcerative colitis, Lindemann (1944) found that 33 of 41 patients had developed the disease in close time relationship with the loss of an important person in their lives. There is evidence of connection between cancer and loss of a significant person (Parkes and Weiss 1983). It seems important that grief work be successfully carried through not only for the sake of psychological health and optimal functioning, but also for physical health and even life itself.

Factors that Affect the Grief Process

It has long been emphasized in psychological literature that persons who suffered the loss of a parent, particularly of a mother, during childhood may be more predisposed to excessive grief later in life (Bowlby 1961, 1963, 1980; Parkes 1972). To the degree that this is true, childhood loss may thus help to create a permanent personality characteristic toward depression and a predisposition to

pathological reaction to severe loss.

Women tend to come out of bereavement worse than men. Parkes (1972) quoted several studies that indicated this. However, the Harvard Study (Glick, Weiss and Parkes, 1974) while it tended to show the same thing, indicated that widowed women showed no greater decline in adjustment than widowed men in a two- to four-year follow-up after bereavement. The men were found to have taken longer to recover than women. What this seeming contradiction may be pointing to is that women show more outward signs after a loss, but because they tend more to get into the grieving process may come out better in the end. A key question relates to the time after death when a measurement is taken. Sex, then, of the bereaved, while apparently a factor in recovery, is somewhat ambivalent as a predictor.

Age of the bereaved at the time of the loss may be another significant but ambivalent factor. During the first six months after bereavement, younger widows in one of Parkes' (1975) studies consulted a physician more often for help with emotional problems than did those over 65. They also increased their consumption of sedative drugs by a factor of seven as opposed to no increase for older widows. Another study reported by Maddison and Walker (1967) yielded a higher illness score for younger widows among American women, but this was not consistent with their Sydney, Australia study. Sanders (1980-81) found that "younger spouses initially manifested greater grief intensities, but at 18 months a reverse trend was noted; older spouses showed exacerbated grief

reactions." (p. 227) The authors suggested that older persons' tendency to use denial as a defense mechanism makes them appear better off but bodes ill for actual long-term recovery.

According to Parkes (1972), foreknowledge of death, which allows a couple to work out unfinished business between them, if the time is in fact used to accomplish such work, is a positive predictor of good recovery. Both suddenness of death and perceived untimliness of death are negative indicators. Also, additional personal crises near the time of death, including the loss of more than one close person, and other factors such as family discord, change of domicile, loss of income, and problems with children, are associated with poor outcome.

Ambivalence in feeling toward the dead person has been identified by Parkes (1972) and Bowlby (1980) to be a predictor of negative outcome. Parkes (1972) stated, "Among the bereaved psychiatric patients studied, those who reported mixed feelings of hostility and affection towards the dead person had more pronounced grief than other psychiatric patients whose illness seemed less closely related to bereavement" (p. 135).

Maddison (1968) found that living in an environment or setting which discourages talking about the death of the spouse or freely expressing feelings or being a person taught not to express feelings or unable to do so, serves as a powerful deterrent to doing grief work and is a predictor of negative outcome. Persons with a history of previous psychiatric illness are also in the high risk group. Parkes (1972) reported that persons who had other close

relatives living nearby were more likely to make satisfactory recovery. Having support from others was thus found to be therapeutic. However, this was not found to be true for widows with children still living at home. At least in the short run this was associated with considerable strain. In a later study, Parkes (1975) found that low socio-economic status was a predictor of negative results and confirmed "short-term illness with little warning of impending death and multiple life crises" as indicators of poor prognosis.

Bowlby (1981), relying heavily upon the studies previously referred to, added additional factors such as closeness of the relationship (the closer the attachment, the greater the sense of loss) and suicide as important factors. Cain (1972) showed death of a loved one by suicide to pose serious psychosocial hazards to survivors.

Parkes (1972) also theorized, agreeing with Gorer:

> that the absence today of social expectations and rituals facilitating mourning is likely to contribute to the occurrence of pathological reactions to bereavement, although I would not go so far as he (Gorer) does in suggesting that this may be the chief cause of maladaptive behavior. I believe that there are many contributing factors and that the personality of the bereaved person and his or her relationship with the dead person are probably the main determinants of outcome. (p. 142)

The relationship factor that Parkes mentioned has been studied to some degree, especially ambivalence in the relationship. Personality, however, has not been researched (Bowlby 1980).

Personality and the Grief Process

Bowlby (1980), after discussing other factors that affect outcome, devoted an entire chapter to "Personalities Prone to Disordered Mourning," but qualified what he said by recognition that it is not based upon first-hand data or firm research. Bowlby (1980) states:

> Evidence at present available strongly suggests that adults whose mourning takes a pathological course are likely before their bereavement to have been prone to make affectional relationships of certain special, albeit contrasting, kinds. In one such group, affectional relationships tend to be marked by a high degree of anxious attachment, suffused with overt or covert ambivalence. In a second and related group there is a strong predisposition to engage in compulsive care-giving. People in these groups are likely to be described as nervous, overdependent, clinging or temperamental, or else as neurotic. Some of them report having had a previous breakdown in which symptoms of anxiety or depression were prominent. In a third and contrasting group there are strenuous attempts to claim emotional self-sufficiency and independence of all affectional ties; though the very intensity with which the claims are made often reveals their precarious basis. (p. 202)

Thus, both Parkes and Bowlby assume that the personality of the mourner is a major factor in determining whether or not a bereaved person will grieve normally or pathologically, but both acknowledge that there is almost no first-hand data to support this thesis. This author's search of the literature confirmed the paucity or almost total lack of research studies dealing with personalities that are prone to pathological grief. Indeed, only one quite recent study really dealt with the relationship at all. A doctoral dissertation by Martin (1981) in part examined whether subjects with a

narcissistic component to their personalities as measured by the Narcissistic Personality Disorder (NPD) scale were prone to pathological grief. Martin found a statistically significant ($p = .01$) correlation between response on the Bereavement Questionnaire (BQ) and the NPD.

There is, however, a serious question in this author's mind about the validity of Martin's findings, which seems to leave us again with really no significant research as to whether certain personality types are more prone to pathological grief reactions than are others. The major problem in the Martin study is that persons were measured between the fourth and eleventh months after the death of a spouse. Problems with this spread of time are acknowledged by Martin. A more serious problem, however, is the probability that persons measured this soon after the death of a loved one, if they are expressing a normal grief pattern, would be expected to be exhibiting severe signs of grief.

It has been generally accepted among those who have studied grief, since the time of Lindemann's (1944) classic study of grief following the Coconut Grove Night Club New Year's Eve fire, that in general, persons who seem at first to handle loss the worst, those who show the most emotional reaction, are the ones who after a year or so are doing better than those who "hold up" at the time of loss. The ones to worry about are the ones who do not do their grief work. In the four- to eleven-month period following loss in the Martin study, subjects may well have still been doing their grief work and might therefore be measured as doing poorly on a

grief recovery scale. A more significant measure would be how they were doing two or more years after the loss.

Parkes (1972, 1975), who has been involved in a great deal of the significant research on grief, found that younger (below 63) persons seem to do more poorly than older (over 65) persons. One reason for this, he argued, is the untimliness of death for younger spouses. It seems that if death can be accepted as the normal or expected thing, as it is in the seventies and eighties or older, then spouses do not have as difficult a time in adjusting. Parkes (1972), in his study of London Widows, measured recovery at 14 months.

Sanders (1980) designed a study specifically to compare the outcome as a result of the death of younger and older spouses. This appears to be a well designed study. Her conclusion was:

> Initially, younger spouses showed greater intensities of grief, and yet when this group was seen again eighteen months later, there were reductions in all scales except for 'Guilt' and 'Anger'. For older spouses, on the other hand, there was initially a relatively diminished grief response. Yet at the final interview there were elevations on twelve scales with significant differences noted on 'Denial' and 'Physical Symptoms'. Had grief been measured for either of these groups at either time period without taking process into account, these findings could have been interpreted differently. (p. 228)

Thus, the time after loss when measurements are taken is viewed by Sanders as being quite significant.

Assuming that personality styles are a relatively stable component, an outcome measurement made after most if not all normal grief would be expected to be worked through would be most likely to measure those who are adjusting poorly, i.e., chronic grief.

What personality types are most prone to pathological mourning? Bowlby (1980) suggested that persons whose mourning takes a pathological course are likely to have had either a history of ambivalent personal relationships, of strongly dependent relationships, or to be persons who claim independence of emotional ties.

The first category, those with a history of ambivalent personal relationships, may best fit the category in the Diagnostic and Statistical Manual of the American Psychiatric Association, Third Edition (DSM III) of the "Passive-aggressive Personality," or what Millon (1981) calls the "Active Ambivalent" or "Negativistic Pattern" frequently irritable and erratically moody. Because of the love-hate, dependent-independent, alternately suppressed and expressed anger, relationships with such persons could easily be described as "ambivalent." Guilt would likely be the major issue following the loss of a loved one. Fixation might therefore occur at either or both of the anger and depressed stages of the grieving process.

The second group Bowlby mentioned is quite likely the Dependent Personality Disorder of DSM III or the Passive Dependent in Millon's nosology. Having been highly dependent upon another person, when that person dies, the major source of emotional and other support is lost and depression is a likely result. Whether or not such persons recover adequately might well depend upon whether or not a new dependency relationship is established. The difficulty and failure to establish a new relationship may explain why older widows recover more poorly in the long run than do younger widows. There is little opportunity for such relationships

to develop, at least toward a male companion, since there are so many more widows than widowers in the older age groups. Fixation in the depressed stage of grief would likely be the difficulty for such persons.

Bowlby's (1980) third category, those who claim independency of emotional ties, could fit the "Antisocial," the "Narcissistic" or the "Compulsive" personality of DSM III or respectively the "Active Independent" or "Aggressive Pattern," the Passive-Independent" or "Egotistic Pattern" or the "Passive-Ambivalent" or "Confirming Pattern" of Millon. Based on Millon's (1969, 1981) conceptualization, it appears that the antisocial and narcissistic personalities are not likely to form deep personal relationships in the first place and because such "independent" persons are so self-reinforcing, would not have a great, lasting sense of loss should a mate leave or die. Grief would likely be mild and brief. Not so for the compulsive personality. Such persons do form close and intimate attachments, though not easily or without struggle. As noted by Salzman (1980):

> The obsessional has great difficulty in achieving such relationships, since he cannot abandon control.... His commitment is tenuous and conditional, permitting him to run when the going gets rough. Thus, he maximizes his control over his life, by limiting his commitments, but at the same time he tends to minimize his satisfactions in living. (p. 66)

However difficult and painful, such persons do often marry, and reasonably successfully. Salzman (1980) further stated:

> While marriage has legal binds, the marriage commitment may still be minimal. As time goes on, however, the

> obsessional comes to enjoy the commitment if the atmosphere offers some security. The marriage commitment may even encourage greater closeness. The early days of an obsessional marriage can be extremely difficult, but if the marriage survives, it may prove quite therapeutic. (p. 68)

Based on Salzman's (1980) description of the obsessional personality as well as that in DSM III, it may be concluded that the trap laid for this personality style following the loss of a mate appears to be the difficulty or almost inability to express emotions. Control over all aspects of life is the central issue, and there is the fear of being overwhelmed, of losing control, if the grieving process is allowed to start. Such persons are usually not conscious of this belief or feeling, but when examined usually acknowledge that it is so. Such personalities are therefore likely to postpone, delay, or actually seek to avoid grieving and often pay a heavy toll for having done so.

The hypothesis to be tested in this study is that the compulsive personality style is more prone to poor adjustment than is an average or control group.

The Compulsive Personality

DSM III (1980) describes the characteristics of the compulsive personality as follows:

> The essential feature is a Personality Disorder in which there generally is restricted ability to express warm, tender emotions....
>
> Individuals with this disorder are stingy with their emotions and material possessions.... Everyday relation-

> ships have a conventional, formal, and serious quality. Others often perceive these individuals as stilted and "stiff".
>
> Work and productivity are prized to the exclusion of pleasure and the value of interpersonal relationships. (pp. 326-27)

Millon (1968) added additional detail, including the more traditional view that such persons have special difficulty with anger:

> These individuals manifest extraordinary consistency, a rigid and unvarying uniformity in all significant things. They accomplish this by repressing urges toward autonomy and independence. They comply to the strictures and conform to the rules set down by others. Their restraint, however, is merely a cloak with which they deceive both themselves and others; it serves also as a straightjacket to control intense resentment and anger.... To bend their rebellious and oppositional urges, and to ensure that these do not break through their controls, compulsives become overly conforming and overly submissive. (pp. 217-18)

Millon (1969) also pointed out that compulsives use the intrapsychic mechanisms of reaction formation, isolation and undoing to submerge hostile feelings and keep them in check:

> Not daring to expose their true feelings of defiance and anger, they must bind these feelings so tightly that their opposite comes forth. Compulsive individuals also compartmentalize or isolate their emotional response to a situation. They block or otherwise neutralize feelings that are normally aroused by a stressful event and thereby ensure against the possibility of reacting in ways that might cause embarrassment and disapproval. (p. 228)

Salzman (1980) basically agreed with the above descriptions of the compulsive personality, emphasizing also the need to keep emotions under tight control. He stated, "All emotional responses must be dampened, restrained, or completely denied. Since he

approaches life in an intellectual fashion, the obsessional tries to appear unmoved by disburbing or rewarding experiences" (p. 35). Salzman further stated, "He would prefer to eliminate feelings entirely from his life; because he cannot achieve this end, he uses the techniques of displacement, isolation, and compartmentalization...." (p. 36).

Traditionally, it was thought that the compulsive most feared the expression of sexual and especially aggressive and hostile feelings. Salzman believes that these feelings have been overemphasized because they more often break through directly or indirectly. Salzman (1980) wrote:

> However, what the obsessional really wishes to avoid is the expression of feelings - tender or hostile. The freer expression of tender feelings might actually stimulate positive responses from others, rather than rejection. For the obsessional, such reactions might be more 'involving' and thus more dangerous than hostile ones. (p. 37)

In agreement with Salzman, it is this author's hypothesis that it is the inability to deal with feelings that makes the compulsive prone to pathological grief. One must go through the grieving process to come out safely on the other side and this is especially hard for such personalities.

Lindeman's study (1944) indicated that those who could express emotions fared far better in the long run than those who did not or could not. Subsequent studies (Parkes 1972) confirmed this. Salzman (1980) noted, "It is not the expression of feelings that is actually dangerous but the failure to express them and the tendency

to store them up".

Review of the literature leads this author to the hypothesis that since the compulsive personality has so much difficulty in expressing feelings and since it is necessary to do so to recover adequately following a significant loss, such persons will have more than normal difficulty in completing or even beginning the grieving process, so that this personality type is especially prone to poor grief adjustment.

Measuring Personality Style

This author's survey of all personality inventories listed in the Eighth Mental Measurements Yearbook (Buros 1978) allowed consideration of several instruments that could be used to differentiate the compulsive personality style from other styles. Lorr (in Buros 1978) stated that the Ai3Q: A Measure of the Obsessional Personality or Anal Character (Ai3Q) might usefully be used to differentiate the compulsive personality from others on Axis II of DSM III. The Ai3Q, however, was normed using high school and college students (Buros 1978). It would therefore be of limited validity for a sample of adults.

Based on Lachar's (1978) discussion of the Minnesota Multiphasic Personality Inventory (MMPI), this author concluded that this instrument does not contain any scales or combination of scales that differentiate the compulsive personality style. The MMPI is primarily used to measure pathology (Anastasi 1968) rather than for differential diagnosis.

Cattell and Eber (1957) used "compulsive" as one term to describe a high score on the Sixteen Personality Factor Questionnaire (16PF). Karson and O'Dell (1976) described a person scoring high on the Q3 scale of the 16PF as, "accustomed to keeping his emotions under control" (p. 71). This author concluded that the 16PF could be used as a useful tool in differentiating compulsives from others. It does not, however, appear to permit easy identification of other personality styles, which, while not essential for this study, could result, this author believes, in generating useful information for further studies of the relationship between personality and grief recovery.

Other widely used instruments, the California Psychological Inventory, the Edwards Personal Preference Schedule, and the Myers-Briggs Type Indicator, as described in Buros (1978) did not appear to this author to contain categories that would be useful for the purpose of this study.

One instrument too new to be included in the Eighth Edition of the Mental Measurements Yearbook (Buros 1978) is the Millon Clinical Multiaxial Inventory (MCMI), a test specifically designed to differentiate personality styles based on Millon's (1969, 1981) own nosology (Millon 1982).

Millon (1981, 1982) noted that his categories of personality style closely correspond with the system of classification used on Axis II of DSM III (1980). The MCMI is a 175-item true-false questionnaire (see Appendix E). In the test Manual, Millon noted that the scales were constructed in line with the DSM III model "to

distinguish the more enduring personality characteristics of patients (Axis II) from the clinical disorders they display (Axis I)..." (p.2).

The MCMI Manual (1982) reports on two test-retest experiments to check the reliability of the instrument. For the "Compulsive-Conforming" scale, scores of .81 and .77 are given. Using the Kuder-Richardson formula 20, the coefficient for this scale was .84. The Manual also reported that when the "Compulsive-Conforming" category was the most prominant syndrome, in a sample of 256 cross-validation patients, the percent of correct classifications was 82 when compared with the clinical judgment of "over 42 psychiatrists, psychologists and social workers" (p. 59). The percent of valid positives was 40 and of false positives, 11.

The Manual pointed out that, "Scale 7, Compulsive, is the weakest scale in the MCMI both in terms of correct classification percent and ratio of valid-to-false positives" (p. 17). In spite of this weakness, and since the purpose of classifying is for research rather than determining a person's future, this author determined that the MCMI was a useful instrument for the purpose of identifying compulsives and other personality styles.

Measuring Grief Adjustment

Almost all research reviewed by this author designed to measure progress in recovering from the loss of a loved one used the interview or structured interview approach. Since this was impractical for this researcher, and since a more objective measure-

ment was desired, a paper-and-pencil type instrument was sought.

Martin (1981) as part of his dissertation study tested whether the Bereavement Questionnaire (BQ), "is a valid measure of the extent of detachment or resolution of grief". The correlation obtained between clinicians' ratings and the BQ was .79, which is significant at the .001 level. Martin therefore concluded that the BQ is a valid instrument for this measure.

Faschingbauer, DeVaul, and Zisook (1977) designed a shorter instrument, the Texas Instrument of Grief (TIG), a seven-item scale designed to measure grief objectively. While this scale, according to its authors, needs further validation, the questions it contains have produced results that correlate well with the clinical experience of unresolved grief. Faschingbauer, et al, stated, "These items appear to reliably measure the same variable, one that behaves in keeping with the theoretical expectancy that grief will diminish as a function of time from death" (p. 697).

Summary

This author was disappointed in searching the literature to find no studies cited, except for the Martin (1981) study, that dealt with the relationship between personality and grief recovery. This, however, was consistent with what Bowlby (1980) had also found.

The experience of grieving is a process involving stages. While different authors do not fully agree on what these stages are, there is general agreement that normal grief involves shock, denial,

anger, depression and recovery, and that two years is an adequate time for persons to work through these stages. Becoming stuck in any stage or failure to begin the process is considered pathological and detrimental in the long run.

A number of factors have previously been found to affect poor recovery, such as multiple losses, sudden and unexpected loss, suicide and lack of support systems. It has been theorized that personality is also a major factor. This author hypothesizes that the compulsive personality is particularly prone to poor recovery because of the difficulty such persons have in allowing emotional feeling and expression. The MCMI appears to be an adequate instrument for differentiating the compulsive style from others. The BQ has been demonstrated to be useful in measuring grief recovery.

CHAPTER III

METHOD

Population

The population in this study was the surviving spouses of all persons 65 years or younger whose death was reported in the Battle Creek Enquirer and the Kalamazoo Gazette between January 1980 and June 1982, whose funeral was handled by Caucasion funeral directors. Thus, for the most part, Blacks are not represented in the sample obtained, though other ethnic groups probably are.

The assumption was made that the age of the surviving spouse did not vary greatly from that of the deceased. At the time the surviving spouse filled in the information requested, his or her mate had been dead between two and four years, weighted toward two years. This weighting occurred because during the duration of the study, letters requesting participation were sent as soon as the two years had lapsed. The goal was to receive approximately 200 responses from which to draw samples.

Battle Creek is a city in Michigan with a population of about 55,000 and a metropolitan area containing about 100,000 persons. Kalamazoo has a population of 80,000 with a metropolitan area containing about 279,000. The two papers from which names were obtained print obituaries of persons who have died within a radius of about 25 miles from the cities. Thus, the sample is drawn from both urban and rural areas.

Sample

A total of 908 letters (see Appendix A) was sent requesting participation in the study. Of these letters, 175 were returned as undeliverable because the person had moved and forwarding orders had been cancelled. Either by phone or return card (see Appendix A), 279 persons, 59 male and 220 female, agreed to fill in the personality inventory and questionnaire. For various reasons, 85 persons who had agreed to do so did not fulfill these requirements. A total of 193 responses was returned that were usable, 38 male and 155 female. Thus, a sample of 193 responses was obtained from the population of 908.

Procedures

The MCMI Form (see Appendix B) was chosen as the instrument to determine personality style since it seemed to this author the best test available to differentiate the compulsive personality style from others in a general adult population and also allow for the classification of the other personality styles in DSM III.

For purposes of this study the Bereavement Recovery Questionnaire (BRQ) (see Appendix C) was devised by this author. This instrument consisted of all items on the BQ plus six non-overlapping questions from the TIG. The first 11 items of the BRQ consist of the BQ. All items were cast in the format of the BQ, with possible responses being from "Strongly Agree" to "Strongly Disagree", rather than "Yes" or "No". One additional question was inserted in keeping with findings reported by Jackson (1957), that physical

illness is not an uncommon reaction to the stress of grief. This item is, "My health is as good (or better) since _____ died as it was before".

In a sample of 50 of the respondents selected at random the correlation between the BQ and the additional questions was .68, which is significant at the .001 level. Results of the full (BRQ) scale are reported in this paper along with results based on the BQ alone. However, conclusions are drawn based on the BQ alone since this scale has received greater validation.

Questions were also included on the questionnaire to determine whether other factors than personality might be contributing to a difference should the difference in means be found to be significant. These factors were (1) degree of support of close relatives, (2) degree of financial hardship created by the spouse's death, and (3) degree of religious participation.

The 279 persons who agreed by return card to participate in this study were sent the MCMI, the BRQ, and a note expressing appreciation for their willingness to participate (see Appendix D). Of these 279, 85 either did not return the material or returned it unanswered.

The MCMI forms were machine graded and computer interpreted by National Computer Systems of Minneapolis, publisher of the form. Three measures were reported, (see Appendix E) "Basic Personality Pattern", "Pathological Personality Disorder" and "Clinical Syndrome". For this study only the "Basic Personality Pattern" portion was used. All persons scoring above 85 on the

compulsive scale with no higher scale score were considered as compulsive for this study. The 30 scoring highest were selected and classified as the compulsive group. Before drawing a control group, all others scoring higher on the compulsive scale than on any other scale were also withdrawn. This was done to eliminate all with a predominantly compulsive style from the control group. From those remaining, a random sample of 30, using a table of random numbers, was drawn to form a control group.

To minimize the unlikely possibility that the measurement of personality style was contaminated by the grieving process, the measurement was made between two and four years following the death of the spouse. This does not completely avoid the possibility of contamination since theory would lead us to believe that the compulsive person might not have completed the grieving process by this time. Indeed they might not even have begun the process. But since personality style is a fairly rigidly fixed phenomenon (Millon 1969) any possible contamination should be very slight.

Measurement of where the person stood in the grieving process was also made between two and four years following the loss of a spouse. In normal grief, reasonable recovery is virtually completed by that time. If one is still grieving seriously after two years, this is generally considered to be abnormal (Parkes 1972).

Statistical Hypothesis

This researcher's general hypothesis was that persons with a compulsive personality style would do more poorly in recovering

from grief than would others. The following hypothesis was developed to test this basic research question and is presented here in the null form.

Null Hypothesis

There will be no difference between BQ mean scores of subjects classified by the MCMI as compulsive personality style and subjects not classified by the MCMI as compulsive personality style.

Statistical Analysis

A two-tailed t test of independent measures was used to compare the means of the compulsive and non-compulsive groups at a .05 level of significance. A two-tailed test was used since the results were opposite from what had been hypothesized.

Though the focus of this study was the compulsive personality, and asking questions of a significant difference between means of other personality styles and random samples was beyond the purpose of this study, data collected allowed such comparisons to be made. Thus, these analyses were also done using a two-tailed t test and the results will be reported. Bowlby (1980) theorized that the dependent personality and those with ambivalent relationships were likely to have more than usual difficulty. Therefore, the "dependent" and the "passive-aggressive" personalities in particular were looked at, the personalities that this writer believes correspond with those to which Bowlby referred. In addition, analyses based on the BRQ was made to provide additional data.

CHAPTER IV

RESULTS

The purpose of this chapter is to present the statistical results obtained from testing the null hypothesis. Additional analyses of the data for six other MCMI personality styles are also presented.

Null Hypothesis

There will be no difference between BQ mean scores of subjects classified by the MCMI as compulsive personality style and subjects not classified by the MCMI as compulsive personality style. A two-tailed t test of independent measures was used to test this hypothesis. The results of this analysis are presented in Tables 1 and 2.

Table 1

Means, Standard Deviations and Raw Scores of the 30 Highest Compulsives and Non-Compulsives on the Bereavement Questionnaire and the Bereavement Recovery Questionnaire

Compulsives		Non-Compulsives	
BQ	BRQ	BQ	BRQ
39	67	39	70
49	83	47	71
35	61	39	61
55	89	35	58
34	58	46	77
45	75	36	53
44	76	43	70
38	70	44	75
43	64	37	63
37	65	32	52
37	60	46	72
31	62	47	78
40	72	31	47
43	75	21	35
37	64	35	61
29	53	44	71
53	75	31	51
31	55	37	60
45	70	36	64
25	47	26	48
34	58	35	59
46	70	41	65
28	51	36	60
54	89	43	76
37	62	37	63
46	75	40	65
38	62	44	73
36	78	49	64
50	73	40	68
41	63	37	67
Mean = 40.03	Mean = 67.40	Mean = 38.13	Mean = 63.23
s.d. = 7.60	s.d. = 10.37	s.d. = 6.095	s.d. = 9.78

Table 2

Means, Standard Deviations, t Obtained and t Critical for Compulsives and Non-Compulsives on the Bereavement Questionnaire and the Bereavement Recovery Questionnaire

	Compulsives		Non-Compulsives	
	BQ	BRQ	BQ	BRQ
Mean	40.03	67.40	38.13	63.23
s.d.	7.60	10.37	6.10	9.78
	BQ t obt. = 1.07* t crit. = 2.01		BRQ t obt. = 1.60* t crit. = 2.01	

*Probability > .05
Note: N=30

In the comparison between compulsives and the control group, t obt. = 1.067; t crit. = 2.01 using the BQ scale. Using the BRQ Scale, t obt. = 1.60; t crit. = 2.01. Thus, the null hypothesis that there is no significant difference between mean scores of compulsive personalities and other personality styles is retained.

Results obtained using the same technique of comparing the highest thirty dependents with a control group drawn after eliminating all highest dependent scores before drawing a control group, and results obtained by using all scoring highest on the other basic personality patterns on the MCMI, since n < 30, are given in Tables 3-8. This information is included for the benefit of any who may wish to do research in the future on this or a similar topic.

Table 3

Means, Standard Deviations, t Obtained and t Critical for Dependents and Non-Dependents on the Bereavement Questionnaire and the Bereavement Recovery Questionnaire

	Dependents		Non-Dependents	
	BQ	BRQ	BQ	BRQ
Mean	35.37	57.83	40.60	67.97
s.d.	7.55	11.20	7.08	10.70
	BQ t obt. = 2.77*		BRQ t obt. = 3.59*	
	t crit. = 2.01		t crit. = 2.01	

*Probability < .05
Note: N=30

Table 4

Means, Standard Deviations, t Obtained and t Critical for Anti-Socials and Non-Anti-Socials on the Bereavement Questionnaire and the Bereavement Recovery Questionnaire

	Anti-Socials		Non-Anti-Socials	
	BQ	BRQ	BQ	BRQ
Mean	39.42	67.75	40.67	66.00
s.d.	6.54	8.80	6.28	10.86
	BQ t obt. = .58*		BRQ t obt. = .50*	
	t crit. = 2.02		t crit. = 2.02	

*Probability > .05
Note: N=12

Table 5

Means, Standard Deviations, t Obtained and t Critical for Narcissitics and Non-Narcissitics on the Bereavement Questionnaire and the Bereavement Recovery Questionnaire

	Narcissitics		Non-Narcissitics	
	BQ	BRQ	BQ	BRQ
Mean	41.57	67.21	39.83	65.57
s.d.	7.10	11.23	7.57	11.71
	BQ t obt. = .74*		BRQ t obt. = .45*	
	t crit. = 2.02		t crit. = 2.02	

*Probability > .05
Note: N=15

Table 6

Means, Standard Deviations, t Obtained and t Critical for Passive-Aggressives and Non-Passive-Aggressives on the Bereavement Questionnaire and the Bereavement Recovery Questionnaire

	Passive-Aggressives		Non-Passive-Aggressives	
	BQ	BRQ	BQ	BRQ
Mean	29.63	48.38	40.33	66.30
s.d.	4.53	8.63	6.81	10.13
	BQ t obt. = 4.18*		BRQ t obt. = 4.18*	
	t crit. = 2.03		t crit. = 2.03	

*Probability < .05
Note: N=8

Table 7

Means, Standard Deviations, t Obtained and t Critical for Schizoids and Non-Schizoids on the Bereavement Questionnaire and the Bereavement Recovery Questionnaire

	Schizoids		Non-Schizoids	
	BQ	BRQ	BQ	BRQ
Mean	38.57	64.00	40.23	67.10
s.d.	6.43	9.52	8.05	11.87
	BQ t obt. = .51*		BRQ t obt. = .64*	
	t crit. = 2.03		t crit. = 2.03	

*Probability > .05
Note: N=7

Table 8

Means, Standard Deviations, t Obtained and t Critical for Histrionics and Non-Histrionics on the Bereavement Questionnaire and the Bereavement Recovery Questionnaire

	Histrionics		Non-Histrionics	
	BQ	BRQ	BQ	BRQ
Mean	42.32	69.50	38.13	63.20
s.d.	5.70	8.09	7.60	12.26
	BQ t obt. = 2.17*		BRQ t obt. = 2.10*	
	t crit. = 2.01		t crit. = 2.01	

*Probability < .05
Note: N=22

The avoidant personality contained only three respondents. No tests were run on so small a sample, nor were those who were combination styles, i.e., those scoring equally high on two or more scales.

Support of the hypothesis that compulsives handle grief more poorly than do others was not obtained in this study. In fact, though the difference was not significant, the mean score of compulsives was higher than the mean of the control group (a high score indicates better recovery). This was true using the BQ alone and using the full BRQ Scale. This was true using the thirty highest compulsive scores and using all who scored highest on the compulsive scale (n=66).

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Parkes (1972) and Bowlby (1980) theorized that personality of the survivor is probably the most important factor in determining how well a person recovers from the loss of a loved one. However, there has been little if any research reported to test this theory. The purpose of the present study was to test whether persons with a compulsive personality style have greater difficulty than others in recovering following the loss of a spouse.

Measurement of personality style was made between two and four years following the loss of a spouse 65 years of age or younger. The Millon Clinical Multiaxial Inventory (MCMI) was used to make the classifications of personality style. The Bereavement Questionnaire (BQ) was also given at the same time to measure grief recovery. Non-overlapping questions from the Texas Instrument of Grief were added to the BQ, as well as a question on physical health. The full scale was entitled the Bereavement Recovery Questionnaire (BRQ).

It was hypothesized by this author that persons with a compulsive personality style would handle the loss more poorly because it is characteristic of such persons to keep feelings tightly under control (Salzmen 1980). Lindeman (1944) found in a study of surviving spouses of persons who had lost their lives in the Coconut

Grove Night Club Fire in Boston, that persons who had seemed to go to pieces during the first year after the loss did better in subsequent years. Those who "held up" did poorly subsequently. A number of studies have since confirmed this finding, many of which are reported by Parkes (1972) and Bowlby (1980). Since compulsives do not easily express feelings and since there seems to be a need to do so to recover from the loss of a loved one, a study was designed to test whether compulsives do in fact do more poorly in recovering following the death of a mate.

Though the results are not significant at the .05 level of significance, compulsives had higher (more favorable) scores than did others. Thus, the results of this study did not support the hypothesis. The null hypothesis that there is no significant difference between the mean scores of the compulsive group and of the control group was retained.

Conclusions

This author had formed the hypothesis that compulsive personalities would have more difficulty recovering following the death of a spouse, not only from the literature that seemed to him to indicate this, but also from personal experience in over 30 years as a clergyman. It had seemed to him that a disproportionate number of persons who had delayed grief reaction, physical ailments including cancer, and unresolved grief were compulsive persons who did not outwardly grieve for the first year or two after their loss. This study did not confirm that hypothesis, however.

Do the results of this study mean that the compulsive personality is not prone to more than normal problems in handling grief. The evidence so indicates, but other possibilities might be considered. The same explanation as to why this personality style is least reliably measured on the MCMI may also call into question results obtained in this study. As Millon (1982) pointed out, there is a "marked tendency for patients with this personality type to deny psychological difficulties or to attempt to appear emotionally controlled and socially admirable..." (p. 17). In other words, because compulsives are less aware of feelings and are desirous of appearing good, they may have scored higher on the Questionnaire than others who were actually doing as well or better.

It is also possible that grief work had not even begun for some of these persons, that they might be in a stage of "delayed grief". There is also a serious sampling problem involved in this study, probably greater than with most studies involving human subjects. Only 193 of the 908 persons to whom the letter requesting participation did actually participate. Some could not be located because they had moved, many perhaps for financial reasons. Since they and those who refused to participate because of fear of not being able to answer a paper-and-pencil test and questionnaire were lost to the study, it seems logical to conclude that there is bias against those of a lower socio-economic status. Some types of personality may be more prone to respond than others. Compulsives numbered 66 of the total of 193 which is 34%. In a cross-validation sample, the MCMI Manual (1982) reported 14% to be compulsive.

Thus, it appears that compulsives are over-represented in the sample obtained for the present study.

Because of the sensitive nature of this study, it was not feasible to ask those who did not participate why they had not done so. Therefore, since the sample is probably not random, few conclusions can be drawn that generalize to the general population.

It is also possible, of course, that persons with this personality style actually handle grief as well or better than does the average person and without evidence to the contrary, this assumption must be maintained.

Recommendations

The role of personality characteristics' influence upon a person's ability to handle the loss of a loved one needs a great deal more study. It seemed logical to this researcher that, since it has been shown that going through the grief process is necessary following significant loss, and since the compulsive personality style has difficulty dealing with feelings, that such persons would have greater difficulty in handling grief. This study did not obtain evidence that compulsive persons do have a more difficult time handling the loss of a mate. Additional studies utilizing different instruments to classify personality types and different techniques to measure recovery from loss would be beneficial, as well as repetition of this study.

Results obtained from the dependent, the histrionic and the passive-aggressive personality styles in this study indicate that this

might be a fruitful area of research in the future. Mean differences on both the BQ and BRQ compared with control groups were significant for each of these styles at the .05 level of significance. No conclusions are drawn at this time from the fact that the results with these personality styles were significant, though they do tend to support Bowlby's (1980) belief that those who have had an ambivalent relationship in marriage and those with a strongly dependent relationship likely will do poorly. This investigator recommends additional research in this area.

At present, however, non-personality factors need be accepted more than personality factors, as guidelines in determining which persons need greater help in dealing with the loss of a mate.

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APPENDICES

Appendix A

Letter Sent to Those Asked to Participate in the Study and Return Card Sent with Letter

143 Frelinghuysen Ave.
Battle Creek, MI 49017

I'm sure that the past few years have been difficult for you in having to adjust to the loss of your husband. However, you may be able to help others in the future to make this adjustment more easily by participating in a research project I am conducting to learn more about why some persons do adjust more easily to loss than do others.

I am a doctoral student in counseling at Western Michigan University as well as Pastor for the past 13½ years at the First Baptist Church of Battle Creek. Over the past thirty years I have known hundreds of persons like yourself at their time of bereavement and after. I have helped some of them make a successful readjustment. I would appreciate it very much if you would participate in this research and perhaps help me and others who try to assist and give comfort at the time of death.

What you are asked to do is to fill out a 175-question true or false personality inventory that will take about half an hour to complete, and to answer another very brief questionnaire designed to measure your progress in recovering from your loss.

You will be receiving a call from me in the next few days at which time I hope you will indicate your willingness to participate. If for some reason I am unable to reach you and you are willing to participate in this project, please call me days at 962-6214 or evenings at 968-9697.

All answers are kept strictly confidential. In fact, each personality inventory and questionnaire will be coded in such a way that even I will not connect names with answers. Those who participate will receive a summary of findings after the research has been completed.

Sincerely,

Rev. James L. Young

JLY/jk

☐ Yes, I will participate in your doctoral project on grief recovery. Please send me the two forms you mentioned.

☐ Sorry, I do not wish to participate.

Comments _____

_____

_____

Name _____

Appendix B

Millon Clinical Multiaxial Inventory (copy)

Appendix C

Bereavement Recovery Questionnaire

QUESTIONNAIRE

Your completing this questionnaire presumes you have lost a wife due to death. In an attempt to personalize the statements, a blank has been left so that you can mentally insert her name. You have five choices for each statement which you can indicate by circling the appropriate symbol:

A - You strongly agree with the statement

a - You agree somewhat with the statement

? - You neither agree nor disagree with the statement

d - You disagree somewhat with the statement

D - You strongly disagree with the statement

There is no time limit, but please answer all questions in the order in which they occur. There are no right or wrong answers, so please feel free to give your own leanings whether you feel strongly about the statements or not. Please erase completely any answer you may wish to change. Please try not to mark too many answers with a "?".

Your opinions will be kept confidential. By using the back of this question sheet you may make explanations or raise objections to any statements or make comments. Please number the item to which you refer.

1.	I feel good.	A	a	?	d	D
2.	I feel as if I have completely recovered from my bereavement.	A	a	?	d	D
3.	I miss _____ so much that I feel life is not worth living.	A	a	?	d	D
4.	My life is now back to normal after the loss of _____.	A	a	?	d	D
5.	I feel angry that _____ has died.	A	a	?	d	D
6.	The pain of my bereavement causes me to lie awake at night.	A	a	?	d	D
7.	I am strongly motivated to initiate new relationships now that my _____ has died.	A	a	?	d	D
8.	I am so upset about the loss of _____ that I can't eat.	A	a	?	d	D
9.	I now seldom think about _____.	A	a	?	d	D
10.	I look at the photograph of _____ all the time.	A	a	?	d	D
11.	I am now able to think about _____ without getting tears.	A	a	?	d	D
12.	At times I feel the need to cry for _____.	A	a	?	d	D
13.	I am unable to accept the death of _____.	A	a	?	d	D
14.	I have pain in the same area of my body as _____.	A	a	?	d	D
15.	Sometimes I feel just like _____.	A	a	?	d	D

16. I seem to get upset each year at about the same time that _____ died. A a ? d D

17. I weigh about the same now as when _____ died. A a ? d D

18. My health has been as good (or better) since _____ died as it was before. A a ? d D

How many months since _____ died? _____ months

How old was _____? _____ years

How long was _____ ill before dying? _____ weeks

Did you experience _____'s death as tragic? _____ yes _____ no

Do you have close relatives living in the area whom you see often? _____ yes _____ no

How many close relatives? _____

About how often do you see them? _____

Has _____'s death created a financial hardship for you? _____ yes _____ no

Were you forced to give up your home? _____ yes _____ no

Were you forced to give up sending children to college? _____ yes _____ no

How important is your religious faith to you? _____ very _____ somewhat

_____ little _____ none

How often do you attend religious services? _____ times per month

Church you identify with _____

How would you rate your marriage _____ very good _____ good

_____ fair _____ poor

Have you remarried or do you contemplate doing so soon? _____ yes _____ no

Appendix D

Note Enclosed with Personality Inventory and Questionnaire

Thank you for indicating a willingness to participate in my doctoral project on grief recovery. Enclosed are the forms mentioned in my previous letter. I would appreciate your completing them and returning them to me as soon as possible.

If for some reason after examining the forms you decide not to participate, please return the forms anyway. The personality inventory is quite expensive and if returned can be reused.

Thank you for your cooperation.

Sincerely,

Rev. James L. Young

JLY/jak
Enclosures

Appendix E

Millon Clinical Multiaxial Inventory Report Form

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