The Effect of Attending a Bereavement Support Seminar on the Level of Expressed Physical Symptoms of Bereaved Spouses within the First Year after the Spouses' Deaths: An Experimental Study

Susan Jean Zonnebelt-Smeenge
Western Michigan University

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THE EFFECT OF ATTENDING A BEREAVEMENT SUPPORT SEMINAR ON THE LEVEL OF EXPRESSED PHYSICAL SYMPTOMS OF BEREAVED SPOUSES WITHIN THE FIRST YEAR AFTER THE SPOUSES' DEATHS: AN EXPERIMENTAL STUDY

by

Susan Jean Zonnebelt-Smeenge

A Dissertation Submitted to the Faculty of The Graduate College in partial fulfillment of the requirements for the Degree of Doctor of Education Department of Counselor Education and Counseling Psychology

Western Michigan University
Kalamazoo, Michigan
April 1988
THE EFFECT OF ATTENDING A BEREAVEMENT SUPPORT SEMINAR ON THE LEVEL OF EXPRESSED PHYSICAL SYMPTOMS OF BEREAVED SPOUSES WITHIN THE FIRST YEAR AFTER THE SPOUSES' DEATHS: AN EXPERIMENTAL STUDY

Susan Jean Zonnebelt-Smeenge, Ed.D.
Western Michigan University, 1988

Morbidity and mortality have been identified as potentially negative outcomes for bereaved spouses. Intervention is theorized to be an important factor in bereavement outcome, but few investigators have reported relevant studies depicting a decrease in somatic symptoms relative to planned treatment. The present research was conducted to explore the effect of attendance at a 4-session bereavement support seminar on the expressed physical symptoms of the widowed, within the first year subsequent to spousal death.

Subjects were obtained for this experimental study by the random sampling without replacement method, utilizing the obituary notices appearing in local newspapers. To facilitate generalization of the data results, two locations were utilized, those being, Grand Rapids, Michigan and Pittsburgh, Pennsylvania. From the 240 bereaved spouses initially contacted to participate in the study, results from 62 widowed were analyzed as the existing database. All subjects completed both a Bereavement
Information form relating to demographic and illness related variables, as well as a pre-test administration of the Kincannon Mini-Mult, a short form of the Minnesota Multiphasic Personality Inventory. The designated experimental group then attended a 4-session Bereavement Support Seminar as the treatment intervention. At the conclusion of this support seminar series, both the experimental and control groups completed a posttest administration of the Kincannon Mini-Mult test instrument.

Data from these measures were analyzed by use of a nondirectional two-tailed t test for independent means. Scale 1 (Hypochondriasis) was the measure utilized to compare experimental and control groups expressed somatic complaints, with Scale 3 (Hysteria) analyzed as an adjunct to Scale 1. Both Scale 1 and Scale 3 mean scores of the experimental group posttest administration of the Kincannon Mini-Mult, were found to depict statistically significant differences (p < .05) in comparison to the mean scores of the control group on these measures.

These findings suggest there was a positive relationship between the treatment intervention and fewer reported physical symptoms.

It is important that further research be conducted to determine specific variables which facilitate improved health status in bereaved spouses, attempting to reverse some of the negative effects of becoming widowed.
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Zonnebelt-Smeenge, Susan Jean, Ed.D.
Western Michigan University, 1987

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DEDICATION

Dedicated with gratitude to my loving parents, whose belief in me gave me the courage to sprout wings

and to my husband and daughter whose presence and caring helped make this possible.
ACKNOWLEDGEMENTS

Many persons have supported and encouraged me in the research and writing of this dissertation. I would like to acknowledge and thank some of those who contributed to the successful completion of this endeavor.

Dr. Robert Oswald, chairperson of my committee, who provided a firm base of support throughout this process with his encouragement and understanding. Dr. Robert Brashear, Dr. David Cowden, and Dr. John Geisler, members of my doctoral committee, who supplied creative criticism in a helpful manner. C. J. Weidaw, my colleague and steadfast friend, who shared both the enthusiasm and anxiety of this research with me. Norma and Bill Zonnebelt, my parents, for their generous optimism regarding the completion of this dissertation, and practical help with home responsibilities to enable me time to write. Sarah Smeenge, my dear daughter, for the special, fun diversions we shared that provided me with a fresh perspective, and her understanding of my need to complete this project. Rick Smeenge, my husband and best friend, for his constant love, encouragement and presence which sustained me.

Susan Jean Zonnebelt-Smeenge
**TABLE OF CONTENTS**

ACKNOWLEDGEMENTS ........................................... ii  
LIST OF TABLES ............................................. vi  
LIST OF FIGURES ............................................ viii  

CHAPTER  

I. INTRODUCTION ....................................... 1  
   Statement of the Problem ..................... 1  
   Operational Definitions of Terms .......... 4  
   Statement of the Hypothesis ............... 5  
      Research Hypothesis ..................... 5  

II. REVIEW OF THE LITERATURE ......................... 7  
   Introduction of the Grief Process .......... 7  
   Definitions of Terminology ............... 12  
   Statistical Data ........................... 14  
   Physical Effects of Grief ................ 20  
   Risk of Death in the Widowed .......... 36  
   Factors Affecting Bereavement Reaction  
      and Adaptation to Loss ............... 40  
   Interventions and Their Effect on Mor-  
      bidity and Mortality in the Surviving  
      Spouse ................................... 51  
   Critique of Available Literature .......... 58  

III. METHODS AND PROCEDURES ........................... 61  
   Subjects .................................... 61  
   Instruments .................................. 80  
   Design ...................................... 87  

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# Table of Contents—Continued

## CHAPTER

<table>
<thead>
<tr>
<th>Procedure</th>
<th>89</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV. RESULTS</td>
<td>96</td>
</tr>
<tr>
<td>Introduction</td>
<td>96</td>
</tr>
<tr>
<td>Data Analysis: Scale 1</td>
<td>103</td>
</tr>
<tr>
<td>Data Analysis: Scale 3</td>
<td>110</td>
</tr>
<tr>
<td>V. SUMMARY, CONCLUSIONS, DISCUSSION, AND IMPLICATIONS</td>
<td>115</td>
</tr>
<tr>
<td>Summary</td>
<td>115</td>
</tr>
<tr>
<td>Conclusions</td>
<td>117</td>
</tr>
<tr>
<td>Discussion</td>
<td>121</td>
</tr>
<tr>
<td>Sample</td>
<td>121</td>
</tr>
<tr>
<td>Instrumentation</td>
<td>123</td>
</tr>
<tr>
<td>Implications</td>
<td>123</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>125</td>
</tr>
<tr>
<td>A. Coordinated Time Schedules for Experimental and Control Groups 1 and 2 in Michigan and Pennsylvania</td>
<td>126</td>
</tr>
<tr>
<td>B. First Mailing Cover Letter to 60 Bereaved Spouses in Michigan (Group 1)</td>
<td>130</td>
</tr>
<tr>
<td>C. Bereavement Information Sheet</td>
<td>132</td>
</tr>
<tr>
<td>D. Bereavement Questionnaire (The Kincannon Mini-Mult)</td>
<td>134</td>
</tr>
<tr>
<td>E. Follow-up Letter to 60 Bereaved Spouses in Michigan (Group 1)</td>
<td>137</td>
</tr>
<tr>
<td>F. Letter Inviting Experimental Group 1 to Bereavement Support Seminars</td>
<td>139</td>
</tr>
</tbody>
</table>
Table of Contents—Continued

CHAPTER

G. Letter Requesting Control Group 1 to Again Complete Bereavement Information Sheet and Questionnaire.............. 141

H. First Mailing Cover Letter to 60 Bereaved Spouses in Michigan (Group 2).......................... 143

I. Follow-up Letter to 60 Bereaved Spouses in Michigan (Group 2)............................. 145

J. Letter Inviting Experimental Group 2 to Bereavement Support Seminars.......................... 147

K. Letter Requesting Control Group 2 to Again Complete the Bereavement Information Sheet and Questionnaire.............. 149

L. Letter to Experimental Groups 1 and 2 Regarding Results of Study............................. 151

M. Letter to Control Groups 1 and 2 Regarding Results of Study.............................. 153

N. Kincannon's Mini-Mult Scoring Sheet.................................................. 155

O. Codebook for Data Analysis by Computer............................................ 160

P. Guidelines for the Bereavement Support Seminars........................................... 163

Q. Seminar Series Material Entitled "The Process of Recovering From Grief".......................... 165

R. Weeks 1 through 3, Bereavement Support Seminar Outlines........................................ 180

S. Reference List Given to Seminar Participants............................................. 184

BIBLIOGRAPHY............................................................................ 186
LIST OF TABLES

2. Marital Status of the Population by Sex and Age, 1985 ............................................. 18
3. Sample Size of Experimental Group .................. 67
4. Sample Size of Control Group ....................... 68
5. Age Comparisons of Michigan vs. Pennsylvania, Experimental and Control Group ............ 69
6. Sex Comparisons of Michigan vs. Pennsylvania, Experimental and Control Group ............ 72
7. Education Level Comparisons of Michigan vs. Pennsylvania, Experimental and Control Groups ................................................ 75
8. Length of Marriage Comparisons of Michigan vs. Pennsylvania, Experimental and Control Group ................................ 77
9. Length of Deceased Spouses' Illness Comparisons of Michigan vs. Pennsylvania, Experimental and Control Groups ........................................ 78
10. Mean Months of Spouse's Illness of Michigan vs. Pennsylvania, Experimental and Control Groups ................................................ 80
11. Perceived Prior Health of Surviving Spouse ...... 99
12. Perceived Health of Surviving Spouse Following Death of Mate .................................... 100
13. Mean Scores of Prior and Post-Spousal Death Health Status ........................................ 101
14. Receipt of Medical Treatment for Specific Diagnosis .................................................. 103
15. Means and Standard Deviations, Scale 1 - Pre-test: Experimental and Control Groups ......... 104
List of Tables—Continued


17. Means and Standard Deviations, Scale 1 - Pre-test: Michigan vs. Pennsylvania Control Group .................................................. 105

18. Means and Standard Deviations, Scale 1 - Post-test: Experimental and Control Groups ........... 108


21. Pretest-Posttest Scale 1: Mean Comparison and Probability of Experimental and Control Groups ........................................... 110

22. Means and Standard Deviations, Scale 3 - Pre-test: Experimental and Control Groups .......... 111

23. Means and Standard Deviations, Scale 3 - Post-test: Experimental and Control Groups .......... 112

24. Pretest-Posttest Scale 3: Mean Comparison and Probability of Groups ........................................... 113

vii
LIST OF FIGURES

1. Formula Representation of Hypotheses.................. 6
2. Experimental Design of Study.............................. 37
CHAPTER I

INTRODUCTION

Statement of the Problem

It has frequently been stated, that prior to the arrival of the 1980s, sex was the major taboo topic in our society. Now it seems that death has taken over that role. Considering the attention given to the subject by Freud half a century ago, it is remarkable that professionals have been so long in recognizing bereavement as a major hazard to both physical and mental health (Parkes, 1972a).

Unfortunately, just as society tends to deny death, it tends to deny mourning. The dynamics of mourning have received relatively little attention in the psychological literature. That bereavement has been studied so little, can most likely be attributed more to inertia, taboo, and inherent methodological difficulties than to the obscurity of the problem. Most studies to date have been based on case analysis, and are therefore limited. Sophisticated empirical studies are needed to examine more closely the effects of loss on surviving spouses after the death of their mate.

Many investigators who have studied various effects
of crisis have identified object loss, as occurs with the
death of a significant other, as a precipitating stressor
in the onset or exacerbation of illness (Holmes & Masuda,
1970). Not only has this stressor of object loss been a
contributor to illness, but it has also been found to
increase mortality rates in the bereaved widows(ers)
(Parkes, Benjamin, & Fitzgerald, 1969). Holmes and Rahe
(1967) have ranked the various stressors in a persons life
in their well-known "Social Readjustment Rating Scale."
They have identified the death of a spouse as the most
stressful life event to occur in one's lifetime.

As such, that event would seem deserving of
preventive intervention to decrease the risk of physical
illness and the likelihood of an earlier death in the
surviving spouse. It appears necessary for further inves-
tigation of various intervention strategies to decrease
symptoms in the bereaved.

Up to this point, the findings regarding bereaved
spouses fairly consistently conclude that there is a high
incidence of physical illness in the bereaved (Wilkes,
1982), however, there has been a lack of controlled
research testing to determine the efficiency of interven-
tions to effectively reduce physical symptoms, which
contribute to the etiology of illness in widows(ers).

This area of investigation is of particular interest
to this researcher with her background as a nursing
instructor. It is evident that more and more professionals are acknowledging that physical symptoms with related illness seem to be a cause-effect phenomenon in bereaved spouses which is directly associated with the recent death of their mate. If effective intervention strategies could be found through testing various possible methods to reduce stress and physical problems in the bereaved, that would undoubtedly decrease the high risk of illness and death in this population.

During the past decade, support groups have rooted and blossomed for many diverse concerns and/or problems experienced by people, who found it helpful to share thoughts and feelings with others with similar difficulties. Widows(ers) support groups have been among the groups developed with the purpose of providing assistance to those persons losing a spouse. Largely, from case studies and group questionnaires, those widows(ers) polled tended to confirm the belief that support through a group is of benefit. This researcher proposed to utilize that premise, of group support being of value, in her research. It has been well documented that in sharing thoughts and feeling with others in similar circumstances, anxiety and stress are reduced and the feeling of aloneness is diminished. Whether or not the group setting would have a positive effect in reducing physical symptoms in bereaved spouses, was the focus of this study as it has not been
investigated thus far by others. It was proposed that not only group support may be beneficial in this regard, but that in addition, the dissemination of knowledge related to the grief process be included to alleviate fears of the unknown and concerns of being abnormal. Thus emerged the idea to formulate a support seminar type setting.

The primary question, then, directing this research is: Does a support seminar, as an intervention strategy for bereaved spouses, make a difference in physical symptoms reported by widows(ers)? If this intervention is found to be effective in reducing physical symptoms, then it seems both necessary and important for health professionals and therapists to be aware of this preventative method, as well as to utilize this finding in providing help to the growing bereaved spouse segment of the population.

Operational Definition of Terms

Bereaved spouses: Those spouses who have recently (3-4 months postdeath) lost their partner through death, and who are now in the process of grieving which is experienced by persons following significant loss.

Bereavement support seminars: A one and one-half hour per week group session which is ongoing for four weeks; during this period of time didactic information regarding the grief process will be disseminated, and
support, through mutual sharing, will be given.

**Kincannon's Mini-Mult**: A short form of the Minnesota Multiphasic Personality Inventory (MMPI), covering 9 of the 10 scales of the MMPI, with a much reduced number of items (71 items rather than 566). (See Appendix D for a sample of this instrument.)

**Scale 1 - Hypochondriasis**: A scale which measures the number of bodily complaints claimed by a person and whether these complaints are used to manipulate others. (This scale does not distinguish actual from imagined physical difficulties.)

**Scale 3 - Hysteria**: A scale which measures both physical symptoms and denial of emotional difficulties.

**Statement of the Hypothesis**

**Research Hypothesis**

There is a significant difference in the level of expressed physical symptoms experienced by those bereaved spouses who attend a Bereavement Support Seminar and those bereaved spouses who do not attend.

**Null Hypothesis**

There is no difference in the mean score on Scale 1 (Hypochondriasis) of Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory of those bereaved spouses attending the bereavement support seminar.
and the mean score on Scale 1 (Hypochondriasis) of Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory of those bereaved spouses not attending the bereavement support seminar.

**Alternate Hypothesis**

There is a significant difference in the mean score on Scale 1 (Hypochondriasis) of Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory of those bereaved spouses attending the Bereavement Support Seminar and the mean score on Scale 1 (Hypochondriasis) of Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory of those bereaved spouses not attending the Bereavement Support Seminar.

**Definition of Symbols**

\[ \text{Ho: } \bar{x}_{IS} = \bar{x}_{INS} \]
\[ \text{Ha: } \bar{x}_{IS} \neq \bar{x}_{INS} \]

Ho = Null hypothesis  
Ha = Alternate hypothesis  
\( \bar{x} \) = Mean score  
I = Kincannon Mini-Mult Scale 1  
S = Subjects who attended bereavement seminars  
NS = Subjects who did not attend

**Figure 1. Formula Representation of Hypotheses**
CHAPTER II

REVIEW OF THE LITERATURE

Introduction to the Grief Process

It was not until the 1960s that scientists began to systematically investigate the effects of bereavement, which are now commonly referred to as the grief process. Many studies and articles indicate there are a wide constellation of behaviors, feelings, and symptoms attendant upon bereavement.

Death is a reality of life—no one can escape it for his/herself or for those they love. In a loving relationship where attachment has developed, grief is a normal by-product of that death (Bowlby, 1980). Bowlby's attachment theory postulates that there is an instinctive propensity for human beings to form strong and persistent affectional bonds. These are most commonly found between one or both parents and their offspring, and between adults of the opposite sex. The essential feature of this attachment is the tendency of the bonded partners to remain in close proximity to one another and to elicit "proximity-kept" behavior. Accordingly, separation anxiety with the activation of the grief process is seen as a natural and inevitable response to the loss of an attachment figure.
Therefore, the intensity of the symptoms relative to the grief process after the death of a spouse is largely dependent on how strong of an attachment was formed throughout the relationship. Obviously, there are other factors that contribute to the effect of loss of a partner on the surviving spouse, but one cannot discount the effect of attachment.

Grief, then, is the customary reaction to loss and is generally considered a painful, but self-limited process that ultimately allows the bereaved spouse to recognize that he/she has grieved, but now can get on with his/her life. There is no prescription for how to grieve properly for a lost spouse. Rather, grieving is a highly individualized phenomenon with differences among cultures as well as individuals.

The grieving process is not static. Grieving is not a point, but a process that does not approximate a simple linear trend. Grieving often begins with anticipatory grief, which is that point in time when the spouse who will survive learns that his or her mate is going to die in a foreseeable and predictable future. Various attempts to delineate the stages of grief have been made to help understand what happens to the surviving spouse in the loss of a mate, but it must be noted that most professionals concur these are not to be seen as rigid, irreversible or universal, but rather utilized to describe modal
behavior that can be viewed across time (Barrett & Schneweis, 1980-1981; Kalish, 1982; Parkes, 1972a).

Grief, can be an illusive term, but is typically used to describe the emotional and physical accompaniment to loss and bereavement. Grief is then translated into feelings and actions in a continuum with sorrow on one end, the absence of pain in the middle, and pleasure on the other end. The grief process hopefully facilitates the movement of a bereaved person in the direction of restoration of emotional and physical balance. Loss alters the normal pattern of life. When adjustments to a new status quo must be made, a process to facilitate transitions is necessary to reach a new normalcy in one's life.

Mourning, or the way in which a bereaved person handles ultimate grief, is necessary for mental and physical health. Grief does not fit into our world's present way of life, that being "to enjoy oneself." The dangers of failure to mourn include both physical and mental illness. Mourning may manifest itself differently depending on one's background and previous learning, in that it denotes a culturally defined style of expression (Ball, 1977; Margolis et al., 1985; Markson, 1983).

It is necessary to identify the grief process as a social construct which helps to link the grief and mourning of survivors. As is true of any social
construct, it is an invention which is created among social members and continues to be useful because it explains that which is not readily understood (Margolis et al., 1985). Social constructs, such as the grief process, are difficult to observe as they are so imbedded in the assumptions of community members, that participants do not question them. Wambach (1985-1986) conducted a study in which subjects perceived the grief process as an aid in the journey of a widow(er) who was seen in the image of a wayfarer going through the territory of grief. These subjects saw harm in constructing the grief process as a timetable to progress through, but found it beneficial if used as a guide. Society frequently attempts to stereotype and force bereaved spouses into "should" modes of behavior, that are often stressful to widows(ers).

In the over 40 years since Lindemann (1944) presented the first systematic effort to describe the human response to bereavement, several renditions of what has come to be known as "the grief process" have appeared in both scholarly and popular works. Lindemann described the process of mourning as being an acute grief with psychological and somatic components appearing immediately after a crisis or at a delayed point in time. He identified four major characteristics of normal grief: preoccupation with the image of the deceased, somatic distress, hostile reactions, and guilt (Richter, 1984).
Many of the stages or phases of the grief process that developed since Lindemann's time, have derived their origin or impetus, in part, by Kubler-Ross, who began studying the stages of dying in the 1960s. She pioneered the well-known five stages that a dying person supposedly goes through: (1) denial, (2) anger, (3) bargaining, (4) depression, and (5) acceptance (1969). With more attention focused on dying, other professionals eventually began to investigate the effects of loss on those surviving. Although there are many identified phases or stages which have been given different names, most of the theorists quite closely approximate the others in their descriptions of the grief process. To give an example of the general process of grieving, Bowlby (1969, 1973, 1980) has delineated three phases to the attachment-separation-loss process. The first phase he calls the Phase of Protest, in that the bereaved is yearning to reunite with the lost person and reproaches his abandonment. The Phase of Despair follows, during which time feelings are characterized by ambivalence, including both anger as well as profound sadness and pining. In the final phase, the Phase of Detachment, the bereaved spouse is no longer preoccupied and adapts to new surroundings.

In some cases, the grief process does not follow its usual course with successful readjustment. In these instances, grieving takes a pathological course in one of
two forms: delayed, in which case manifestations of the grief process are absent for a significant period of time; or distorted, in that symptoms of the grief process are prolonged or unusually intense (Bowlby, 1980). Freud, as early as 1917, distinguished between normal grief and pathological grief, which he termed melancholia. He characterized normal grief as a profound painful dejection, a cessation of interest in the outside world, a loss of capacity to love and inhibition of all activities (Freud, 1957). He differentiated melancholia from grief by describing additional aspects that included a lowering of self-regard, sometimes to a delusional degree. In reviewing a massive amount of literature in the field of bereavement, it is the general consensus of numerous researchers, that bereaved spouses can largely prevent pathological grief from occurring, if their thoughts and feelings of the bereaved are dealt with on an overt level when the death of the spouse occurs, and this is continued throughout the period of grieving.

Definitions of Terminology

It seems important to further clarify the meaning of several terms that will continue to be used related to the loss of a spouse and the effects of that life event. These are:

Bereave: To leave in a sad or lonely state, as by
loss or death. Bereave is derived from an old English word which meant "to deprive or rob" (Weizman & Kamm, 1985).

**Bereavement:** The total response pattern; psychological and physiological, displayed by an individual following the loss of a significant object, usually a loved one (Averill, 1968).

**Bereavement Reaction:** A process of realization, of making real inside the self, events which have already occurred in reality outside. This process has both internal and external orientations, as both preservation and protection of the damaged self and the revision of a personal working model of the world. During this process, the individual experiences in turn anxiety, frustration and depression before reaching a point where he/she can satisfactorily reinvest in external objects. The individual begins to look outward and makes attempts to develop new roles and activities. In this paradigm, it is only by progressing through these stages of inward-directed and outward-directed adaptation that a significant decrease in overall disturbance and dysfunction is achieved (Vachon, 1980; Parkes, 1972a).

**Grief:** The intense emotional, psychological and physiological responses caused by the loss of something or someone very significant. The word "grief" is derived from the Latin word meaning "to burden" (Graves, 1978;
Grief Process: The dynamic process that a bereaved person progresses through, which if successful, removes one from the stream of life to ponder one's own place in the world and one's relationship with the dead person, and finally returns the survivor to that stream having adjusted to living without the lost spouse (Raphael, 1977; Stroebe, 1982).

Mourn(ing): The way in which a bereaved person expresses grief; being able to feel and express emotions; the culturally determined procedure for behaving after loss (Graves, 1978; Margolis et al., 1985; Weizman & Kamm, 1985).

Widow(er): A woman/man who has had at least one marriage terminated by death of a mate (Goddard & Leviton, 1980).

Statistical Data

According to the 1987 edition of the Statistical Abstract of the United States, the total population for the United States in 1985 was 171.4 million. Of that total, 13.5 million were widowed, which comprised 7.9% of the total U.S. population. The Bureau of the Census for the year 1985 reported a total male population in the U.S. as being 81.5 million, with 2.1 million of that group widowed. Widowed females numbered 11.4 million of a total
of 89.9 million American women in 1985. There are approximately 800,000 Americans newly widowed every year (Raphael, 1977). Of that number, approximately 250,000 are widowers compared to an estimated 550,000 females who have become widows (Williams & Polak, 1979). As can be seen from these statistics, the large majority of widowed persons in the U.S. are women. Conjugal loss is a much more likely event for women than for men as a consequence of the differences in life expectancy of the two groups (Windholz, 1985). Women can expect to live between 12 and 15 years of their lives as widows (Morgan, 1979). For most women then, facing old age also means facing widowhood. One woman in six in the U.S. over age 21 is a widow. The majority of women tend to be widowed around age 60 and live into old age as widows. Remarriage is the exception rather than the norm, since women greatly outnumber men in the upper age groups of the population (Caine, 1974; Markson, 1983; Silverman, 1976). In the age group 65-74 years, widows outnumber widowers 5+:1 (Bureau of the Census, 1985). Please refer to Tables 1 and 2 for additional statistical comparisons.

In 1980, there were approximately 20 million people over age 65 years old in the U.S., comprising roughly 10% of the total population. By the year 2000, it is estimated that this age group will be 16 to 20% of the population, with the projection being made that by the
Table 1

Marital Status of the Population, By Sex: 1970 to 1985
(in Millions, Except Percent)

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<td>11.9</td>
<td>12.0</td>
<td>12.4</td>
<td>12.7</td>
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- Represents zero or rounds to zero

year 2015, 40% of the U.S. total population will be over 65 years old (Margolis et al, 1985; McKenzie, 1980). As lifespans lengthen and the population ages over the next 30 years, a growing legion of Americans could be living out their lives in prolonged widowhood. Currently, there are approximately 13.5 million widowed persons, but in the year 2050, if current age-specific death rates continue, there will be close to that number of widows aged 75 and over, alone (Evers, 1980).

The concerns of the widowed can no longer be discounted or ignored, as this group comprises a significant number of our population at present, with projections that the size of this group will only continue to increase. It would then seem of value to utilize more research time to investigate the rising number of those widowed, with the focus of exploring ways to prevent possible problems from occurring while concurrently promoting the quality of their lives.

Physical Effects of Grief

Throughout history, the side effects of death, grief, and mourning have been known to produce significant bodily changes in the bereaved. Early on, even in biblical times, the prophet Isaiah indicated to the Israelites that they were to "bind up the broken hearted." Literature of other cultures and eras also makes reference to the

The loss of a spouse through death is clearly one of the most devastating and potentially disruptive events an individual ever encounters and has been documented by many as a severe life event "stressor." A stressor is defined by Webster (1976, p. 2260) as "that which causes stress, or mental or physical tension." Much has been written about stress and how to cope with it in our present age of fast-paced pressures. Research has linked stress to an increase in morbidity and mortality rates (Clayton, 1974; Glick, Weiss, & Parkes, 1974; Kraus & Lilienfeld, 1959; Lindemann, 1944; Maddison, 1968, Parkes, 1970; Parkes, 1972a; Parkes & Brown, 1972; Raphael, 1977, Jacobs & Ostfeld, 1977; Selye, 1978; Vachon, 1976). The intense distress engendered by the major object loss of a spouse is considered to be a level of bereavement morbidity. Bereavement is perceived as extremely stressful, and as such, is a life change associated with a general predisposition to morbidity. Many studies have been done to document the death of a spouse as a life change associated with illness susceptibility (Holmes & Masuda, 1970, 1972; Holmes & Rahe, 1967; Shanas et al., 1968). Like other forms of stress, it is associated with subsequent disease development. Conjugal bereavement has been reported to not only lead to an elevated risk of physical deterioration, but also to increase the likelihood of death for the

Most researchers agree that the loss of a spouse is undoubtedly an extremely stressful life event. Some have described the loss as analogous to losing the trunk of a tree (Dracup & Breu, 1978). Holmes and Rahe (1967) ranked the death of a spouse as the most stressful life event, in their development of the Social Readjustment Rating Scale. Social readjustment includes the amount and duration of change in a person's accustomed pattern of life resulting from various life events. It considers the intensity and length of time necessary to accommodate to a life event irregardless of the desirability of the event. The Social Readjustment Scale was developed to examine the relationship between excessive stress and the onset of psychosomatic illness, or, in other words, to derive a score to indicate the chance of illness following a major life event. This scale assigns a numerical value to various life events, ranking the death of a spouse as the number one stressor, with a mean crisis value of 100 units. Over a period of two years, a person who accumulates a total of 0-149 life crisis units is not expected to have any significant psychosomatic problems within the foreseeable future. A rating of 150-199 means mild life crisis with a 33% rating of psychosomatic disturbance. A rating of 200-299 indicates a moderate life crisis with a 50% chance of
psychomatic illness. A rating of 300 carries a 80% probability of illness (Holmes & Rahe, 1967, p. 214). According to Drs. Holmes and Rahe, if any other "smaller" stressors are compiled with the death of a mate, the surviving spouse is highly susceptible to developing physical symptoms and illness. Studies have been done on the Social Readjustment Rating Scale relative to illness onset or major health changes. Health changes following a life crisis were greater than chance (Holmes & Rahe, 1967; Parkes, 1972a). The greater the magnitude of life change or life crisis, the greater probability the change will be associated with disease onset. It was postulated the "life change events lower bodily resistance and thereby increase the probability of disease occurrence" (Weizman & Kamm, 1985, p. 80).

Research into the continuum of which health and disease are near opposite ends, produced powerful evidence that stressful life events play an important role in the natural history of many diseases by evoking psycho-physiological reactions. The evidence, at this point, certainly suggests that the loss of a spouse contributes to physical reactions within the body (Lynch, 1979; Parkes, 1972b; Weizman & Kamm, 1985).

The identification of the precise link between spousal loss and deteriorating physical health is still somewhat elusive. At this point in time, we still know very
little of the physiological mechanisms which underlie the response to loss, mechanisms which account for affected individuals being more susceptible to a variety of insults, including physical symptoms (Eisdorfer & Wilkie, 1977; Reite, Short, Seiler, & Pauley, 1981). There is preliminary evidence that altered immune responsitivity is a possible mechanism mediating the impact of psychological loss on physiological functioning (Windholz, 1985). There are strong indications that a relationship exists between emotional stress and the onset of physical and emotional disease (including heart disease and cancer), resulting from a breakdown in the immune system of the body (Parkes, 1964a; Rosch, 1979; Schleifer, 1983). It is the immune system's function to fight off disease. Noted transient changes in immunological functioning have been observed during mourning (Bartrop, 1977). Specifically, bereaved individuals have been found to have lower activity levels of what are called "T cells," one of the blood cells that attack foreign invaders. Lower T cell levels contributed to a measurable weakening of the body's defense system following severe psychological stress. There is mounting evidence "that real organic diseases are linked to changing beliefs about oneself, to the nature of one's relationship with others, and to one's position in the social world" (Ornstein, 1987, p. 48).

Grief and bereavement affect the immune system by
numerous neurological connections allowing the mind to influence resistance or susceptibility to disease. Cells of the immune system appear equipped to respond to chemical signals from the central nervous system. Research shows that physical and psychological upsets release powerful neurohormones, including catecholamines, corticosteroids and endorphins, which in turn alter immune function. Both loneliness and life stress were associated with decreased immune cell activity (Ornstein, 1987; Windholz, 1985), which would in turn facilitate the onset of a variety of illnesses in the bereaved spouse.

That there is a physical counterpart of emotions is agreed on by most researchers and scientists. Physical sensation and tension are counterparts of emotion and demand release. If spontaneous expression of any kind is withheld for a period of time, the focus of the sensation may become a persistent pain. This spot may become a stress point and weaken, becoming a place where illness is more likely to develop (Weizman & Kamm, 1985). If bereavement actually causes illness or simply aggravates an existing condition or weakness is uncertain. What is known, is that when an individual internalizes emotions rather than releasing affect (i.e. anger, sadness, guilt), this stress accumulates and may be expressed by the body in physical symptoms. A study of Navajo bereavement revealed that vague aches, pains, and other somatic
distress are frequently observed in their culture. The Navajos prohibit mourning for the deceased four days subsequent to the death. Furthermore, their culture includes sanctions against expressions of anger in circumstances of bereavement (Clayton, Halikas, Maurice, & Robins, 1973; Dunlop, 1978).

The definition of grief includes not only a set of psychological reactions, but physiological responses related to bereavement as well (Averill, 1968; Silverman & Copperband, 1975). These grief reactions seem to appear in waves, involving various somatic and affective manifestations including: gastrointestinal problems, sleep disturbances, respiratory changes, fatigue, hyperactivity, restlessness, preoccupations about the deceased, inability to concentrate, lack of initiative and possibly guilt and hostility (Gauthier & Marshall, 1977). Raphael (1977) determined these reactions to grief from a study with widows under 60 years of age, finding that at 13 months post-bereavement, morbidity rates were significantly lowered with the control group who had not lost a spouse, than with the experimental group who had been widowed a year prior to the conclusion of the investigation.

In his now classic article on grief, Lindemann (1944) described numerous physical changes that occur in the very early stages of grief that are very similar to the list documented by Raphael and many other investigators years
later. Lindemann observed the following symptoms precipitated by grief: somatic distress occurring in waves of 20 minutes or more, tightness in the throat, choking and shortness of breath, a need to sign, an empty feeling in the abdomen, and lack of muscular power. Parkes (1972a) added loss of appetite, reduced sexual drive and restless, aimless hyperactivity to Lindemann's observed symptoms.

Several studies have shown that health problems accompany grief. In one study, 80 widows, ranging in age from 20-75 years, were interviewed between six and nine months after the death of their spouse. The physical symptoms most frequently mentioned were: 71% sleeping problems; 68% restlessness; 61% fatigue; 61% loss of appetite; and 48% drug usage. Approximately 30% of those widowed indicated the first three symptoms were of severe or frequent duration. Fourteen percent of the surviving spouses described loss of appetite and drug usage as severe and frequent (Ball, 1977). Two other investigations offered further confirmation to the discovery of increased physical symptoms after spousal loss. In these studies 40% of the widowed consulted a physician within eight weeks after the death of their spouse for the already mentioned complaints, as well as headaches, dizziness, menstrual irregularities, fainting spells, skin rashes, vomiting, chest pain and heart palpitations (Glick
et al., 1974; Maddison & Viola, 1968).

Raphael, of the Health Commission of New South Wales, Australia, has been studying the effects of bereavement for some time and is well-known in bereavement research. She found that 43% of the 200 widows studied in 1977, admitted to general health impairment in the year following their husband's death. There was a 240% increased utilization of medical services for those under 65 years, and a significant increase in somatic symptoms for those over 65 years. It was also reported that there was an increase in gastrointestinal pain, headaches and psychological symptoms in at least one-third of the widows in the first 13 months following spousal loss (Raphael, 1977; Ramsay & Noorberger, 1981). Their conclusions were supported by numerous other studies indicating similar patterns of increased symptoms with more frequent hospitalizations (Bornstein, Clayton, Halikas, Maurice, & Robins, 1973; Clayton, 1974; Glick et al., 1974; Parkes, 1972a).

Maddison and Viola (1968) studied 375 widows in Boston, Massachusetts and Sydney, Australia, aged 60 years and younger retrospectively, who reported statistically significant marked health deterioration. Of the group, 28% reported increased health problems compared with only 4.5% reporting similar difficulties in the matched married control group. One out of every eight widows consulted physicians in the first three months postspousal death.
An increased consumption of drugs (sedatives, hypnotics and minor tranquilizers) and lessened capacity for work were noted, along with sleeplessness, general nervousness, and excessive tiredness (Maddison & Viola, 1968; Maddison & Walker, 1967).

Almost 30 years ago, Morris (1958) evaluated the relationship between widowhood and physical health by interviewing 72 London widows after spousal death. The results indicated that one-half of them evaluated their general health as "poorer" when interviewed two years post spouse's death. In 1951, Stern, Williams and Prados found a preponderance of somatic illness in the older bereaved. Confrey and Goldstein (1959) concluded that illness in later life was significantly associated with marital status; both widowed and divorced were found to have more physical illnesses than married persons of the same age. Berardo (1967) found a significantly greater incidence of health problems in the widowed, with proportionately more men than women in poor health.

Parkes has conducted numerous studies with the widowed. In 1964, 44 London widows' records were reviewed, with the findings showing that consultations with physicians more than doubled with these subjects during the first six months of bereavement. A 1970 study by Parkes, of 22 London widows under 65 years, reported 27% of this sample experienced declining physical health for 13 months.
following their husband's death. One week following the spouse's death, 7 experienced numbness; 30 days after, 7 reported feelings of panic; at one month postdeath 77% reported being moderately upset compared to 13 months after the loss with 36% indicating they were moderately upset. Parkes and Brown (1972) studied 68 Boston widows(ers) (one-third male and two-thirds female) under age 45, and contrasted them with matched married controls. They reported 13 months after the mate's death there were increased somatic symptoms and hospitalizations in the bereaved group. Both widows and widowers consulted physicians and utilized psychotropic medications at higher rates than did controls. Parkes and Brown found the widowers had twice the amount of somatic symptoms as compared with married male controls, while fewer elevation differences were found in widows. These researchers reported that widows tended to report poorer health than do married women or widowers of the same age for as long as two years postspousal death. The complaints most commonly involved headaches, digestive upset, rheumatism and asthma (Parkes & Brown, 1972). Parkes & Brown's (1972) study also revealed that widows under 65 years of age take seven times as many sedatives following the loss of a spouse, compared with widows over 65 years who exhibit no increase in the consumption of these medications.

Clayton was another researcher who studied physical
effects of bereavement. Clayton, Halikas & Maurice (1971) studied 19 widows(ers), 86% of them reporting crying, sleeping and depression difficulties at one month post-spousal death, with 45% reporting eating difficulties. At four months after their spouse's death, 77% of those disturbed at one month indicated improvement of these symptoms. In 1974, Clayton investigated 109 widows(ers), comparing them with a matched married control group. He found 86% reported crying, sleeping and depression difficulties; 55% reported eating problems; 52% reported use of sedatives; and 45% were fatigued. The bereaved were reporting many more physical and psychological symptoms than were their nonbereaved counterparts.

Gerber, Rusalem, and Hannon (1975) studied 81 elderly bereaved persons in New York City, finding deterioration in physical health reflected by increased physician visits, and a higher use of psychotropic medications six months after spousal loss. He found an interaction between sex and chronicity of the deceased partner's illness, in that widowers were more severely affected than widows when the spouse had died following a lengthy course of illness.

Van Rooijen (1979) compared 194 Amsterdam widows with 72 matched married controls, finding that the widows as a group demonstrated greater physical deterioration in the first year of widowhood.
In 1980, Vachon interviewed 162 widowed women (51%) who agree to participate in interviews from a total of 319 women who were originally invited into the study. Ninety-nine women completed the course of four interviews over a 24 month period, which was one-third of the original group asked to be involved. The results showed that 41% of the widows experienced initial high distress/symptoms level that tapered off gradually and then returned to normal; 30% showed no distress/symptoms at any time during the study; and 29% reported initial high distress/symptoms which sustained over the course of the two year follow-up. One interpretation of these findings for approximately 70% of the widows who are symptomatic responders, is that a high proportion of those who do not begin to remit by four months postspousal death will continue to have difficulty at one year or longer after the loss.

In the same year, Blazer (1980) surveyed 997 elderly people, 65 years and over, by utilizing the Mini-Mult, a short form of the MMPI. He found the rate of significant dysphoric symptoms to be 14.7%. Sixty-five (6.5%) reported depressive symptoms associated with impaired physical health. Of the 147 subjects with depressive symptoms, 65 (44%) were found to have physical health impairment.

Sanders (1980) utilized a combination of the Grief Experience Inventory, the MMPI, and an interview to assess bereavement reactions in 102 newly bereaved individuals. 

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and 107 controls. A distinct number of physiological symptoms were noted in the bereaved group as compared to the controls. Widows were seen as having greater difficulty with somatic problems, as well as showing significantly more death anxiety. Sanders placed bereaved individuals in the "high risk" category physically. Means on Scale 1, Hypochondriasis, of the MMPI were 15.587 for the bereaved and 13.26 for the control group. On the Grief Experience Inventory the means on the somatization scale were 6.34 for the bereaved group as compared to 3.59 for the controls. The Physical Symptoms scale of this instrument showed means of 3.21 and 1.76 for the bereaved and control groups respectively.

Wilkes (1982) surveyed 34 bereaved widows(ers) at 6 and 12 months after their partner's death and found 15 to report poor health, 11 indicated reasonably good health, 12 were taking psychotropic meds, 14 had been hospitalized as out-patients, while 10 had been admitted to the hospital with in-patient status.

In 1984, Thompson studied 212 older widows(ers), between the ages of 55 and 83 years, two months following the loss of their spouse. These were contrasted with 162 controls. The format used was a structured interview setting inquiring as to perceived health status. The bereaved reported more illnesses than the control group (68% vs. 32%), and women indicated having more health
difficulties than men (64% vs. 36%). The majority of new or worsened disorders reported by the bereaved were those affecting the cardiovascular (20:4), gastrointestinal (13:2), musculoskeletal and EENT systems. From the bereaved group 77.55% reported new or increased medication use. Of this 77.55%, 23 were female and 15 male. Twelve deaths occurred among bereaved men (13% of that group), compared to only one death among bereaved women. Two men and no women died among the control group. This data suggests that bereaved males are likely to underestimate their health difficulties at two months after the death of their wives (Thompson, 1984), as well as adding support to the data already reviewed reporting increased morbidity and mortality in the bereaved.

In a study conducted with 70 widowed persons who were given the Hopkins Symptoms Checklist - Somatization Scale, the results showed that at least one-sixth of this population consistently endorsed somatic complaints at 1, 13, 25, 37, and 49 months. There was little change noted with this scale over time following spousal death (Glick, 1974; Klerman, 1977; Zisook & Shuchter, 1986). Somatic symptoms of distress seem to be a fairly universal part of the acute reaction to grief and may be the source of increased frequency with which the bereaved utilize health care.

The survivors of losing a spouse through death, have been found to have not only increased physical symptoms
which may well lead to specific illness, but studies have documented a higher risk of heart disease associated with a lack of strong social ties (Lynch, 1977) and stress (Selye, 1978). McNeil reported the bereaved are subject to excessive risk from cirrhosis of the liver and alcoholism in the second and third year after their mate's death. Parkes et al. (1969) reported a higher incidence of influenza, bronchitis and pneumonia within six months of their spouse's death. This data parallels other studies which have concluded that the survivor's risk of cardiovascular disease and disorders of suppressed immune function, such as infections and cancer, all appear to increase after the death of a spouse. These risks have been documented by many studies to be heightened particularly during the first year postloss, and then generally decrease over time (Clayton, 1974; Lynch, 1979; McNeil, 1973; Parkes et al., 1969; Shuchter, 1986).

The role of social interaction in health and illness is of special interest, because the sudden cessation of social interaction in the bereaved spouse is often implicated as a psychogenic factor in psychosomatic disorders. The APA Task Force on Health Research observed that during the first year following unresolved loss, a new disease is likely to appear in the bereaved, and that prophylactic psychotherapy may prevent such consequences to future physical and mental status (Small, 1979). A study of 18
widows between the ages of 25 and 84 years was conducted by Goddard and Leviton (1980). After interviewing these subjects, they found that widows ages 50-64 years experienced the most isolation. Fifteen of the 18 women suffered physical or mental illness following their husband's death. Sexual frustration was reported as a problem at all age levels, but the greatest difficulties were experienced by older women who believed any form of sexual activity outside of marriage to be immoral. Those who had affairs reported that the experience helped to relieve the tension and pain of loss, as well as some health problems. Social support and its relationship to distress were also investigated by Feinson (1982) in a study of 163 bereaved individuals composed of 73% widows and 27% widowers with a median age of 71. Of the bereaved, 20% were distressed compared to 11% of the non-bereaved (n = 313). Widows were significantly more distressed than widowers, 24% compared to 7%. The support variables that tended to influence the subjects' health were social support, religious preference and employment status. Absence of social support and intimacy may well intensify physical symptoms and illness in the bereaved.

Risk of Death in the Widowed

Numerous studies over the past 30 years in epidemiological literature reveal an excess mortality in newly
widowed individuals. Dr. Beverly Raphael, of the Health Commission of New South Wales, Australia, found that due to the stress of losing a spouse, the expected rate of death for a surviving spouse may be 10 times the normal rate in the year following bereavement (Ramsay & Noorbergen, 1981; Raphael, 1979). Some studies confirmed heart difficulties leading to death as a major cause of mortality in bereaved spouses within the first six months postspousal death. A study by Parkes, in 1970, revealed that the mortality rate among widows (ers) is higher than among married men and women of the same age. The death rate among widowers of 54 years and older during the year following bereavement was about 40% higher than would be expected when compared with married men; with those surviving the first year seeming to then experience the same mortality rate as married males of the same age. This study was conducted with 4,486 widowers aged 55 and over who were followed for nine years. The 40% increase in death rate for widowers also showed a 70% increase in death due to myocardial infarction. The death rate among bereaved persons during the first year following spousal loss was determined to be seven times that for nonbereaved persons matched for age and sex (Crisp, 1980; Parkes et al., 1969; Parkes, 1970; Ramsay & Noorbergen, 1981). The study by Young, Benjamin, and Wallis (1963) supports the above 40% increased mortality among bereaved men. A John
Hopkins University study of 4,000 widowed persons showed the mortality rate for widowers was 26% higher than for married men and 61% higher in the 55 to 64 year age group (Comstock, 1986).

Jacobs and Osterfeld (1977) confirmed with their study, that in the group of approximately 30 million Americans aged 50 and older, with an estimated 700,000 of them losing a spouse annually, there is an elevated risk of death among these bereaved, especially in the male population. The researchers are convinced that in investigating widowers, these men are more vulnerable to stressors, particularly those of social isolation and difficulty making necessary lifestyle adjustments, than widows, thus explaining the higher risk of mortality (Jacobs & Osterfeld, 1977).

Many other studies support the belief that recently widowed men and women are at a higher risk of mortality; than others (Cox, 1964; Epstein, Weitz, Roback, & McKee, 1975; Kastenbaum & Costa, 1977; Klermen & Izen, 1977; Kraus, 1959; MacMahon, 1965; McNeil, 1973; Rees, 1967; Rowland, 1977; Schulz, 1978; Ward, 1967; Young, 1963). Each study concludes the bereaved are at higher risk, particularly the males, but the duration of increased risk and the age group most susceptible have been found to vary. Cox and Ford (1967) found the risk to increase the second year of bereavement. Rees and Lutkins (1967)
determined after a six year survey, the seven times higher risk of mortality was greatest in the first six months for the bereaved as compared with their matched control samples. Ward (1967) concurred with Rees and Lutkins in their findings, in that in Ward's study, seven out of nine widowers died within the first six months following their spouse's death. Ward suggested that being married is more critical to well-being and life expectancy of men than women. McNeil's (1973) findings support Rees's for widowers, but determined that the second year post bereavement was of the most risk for widows. Although most studies conducted published similar findings as Helsing & Szklo (1980) in regard to the age of high risk for widowers being 55 to 74, Kraus and Lilienfeld (1959) found the 35 and younger age group to be in more danger of death.

In synthesizing the literature on mortality risk following the death of a spouse, in general, data among the replicated studies in both the United States and Europe showed that the risk of dying is at least two times as great for widows and widowers at all age levels for a great variety of diseases, including: cardiovascular illness, cancer, infections, and cirrhosis of the liver. Additionally, the majority of studies support widowers at higher risk than widows.

An additional factor to consider in conjunction with the mortality data is the incidence of suicide in the
bereaved. As early as 1897, Durkheim pointed out the relatively high-risk status of those who have lost a spouse, in his assumption that increased risks are due to domestic anomie. The widow(er) is not able to adapt to the new situation in which he/she is placed, and accordingly offers less resistance to suicide (Durkheim, 1951). Durkheim (1959) was the first to note rates of suicide for widowers as higher than for married men. Glenn (1975) notes the effect of marriage in dramatically lowering the probability that men will commit suicide. MacMahon and Pugh (1965) showed the relative risk of suicide in the first year after spousal death to be 2.5%. Men were found consistently to be at higher risk than women through age 80. Women's suicide rates peaked at age 50, declining thereafter. Marshall (1978) recently reviewed the literature on suicide in the bereaved, and noted a 60% drop in the suicide rate of white males between the ages of 64 and 74 (who have had the highest suicide rate in the country), finding a significant relationship between improved income status and reduced suicide rates.

Factors Affecting Bereavement Reaction and Adaptation to Loss

The fact that a significant proportion of persons suffer ill health and death following the death of their spouse has motivated investigators to search for individual or situational variables that would predict or
influence adjustment. This following section reviews factors that have been found to contribute to symptoms.

The way in which the transition to widow(er)hood occurs differs as a function of the age and of the stage in life of the individual experiencing the transition. It is fairly obvious that the transitions encountered by a 25 years old widow(er) differ in a variety of ways from the 45, 65 or 85 year old (Levinson, 1978). Ball (1977) found that young widows, under 46 years, had stronger grief reactions than middle-aged and elderly widows. She observed that for the younger widow(er), sudden death creates a more threatening situation; while in the older person, prolonged death puts more stress on the coping ability of the survivor and weakens physical and mental defenses (Ball, 1977). A study was conducted with 30 young widows, age 45 or less, which retrospectively gathered information at the time of death, as well as at one and two years post death. One important variable found to have an impact on the severity of symptoms, was the age at the time of bereavement. Younger widows reported more depressive symptoms, with physical symptoms present (Blanchard, 1976). Many investigations have supported the premise that young widows(ers) have more difficulty adjusting to the loss of a spouse than do older widowed (Carey, 1977; Clayton et al., 1971; Glick et al., 1974; Kraus & Lilienfeld, 1959; Maddison & Walker, 1967; Parkes,
Barrett and Becker (1978) studied 188 widows, ages 29-78 years, and found that younger, more affluent widows experienced more difficulty. They were assessed to lack a career outside the home during their marriage, have children at home, have had a greater duration of married years and thereby had developed a pessimistic attitude about the future. Maddison and Walker (1967) determined that the age of the widowed was statistically significantly related to illness, with the younger widows/ers reporting a greater deterioration in health following bereavement. There are a number of researchers that would take issue with the findings that younger widowed adjust with more difficulty (Clayton, 1968). Some recent studies have indicated that widowed people over 50 years old experience grief more intensely than younger spouses (Arling, 1976; Barrett, 1978; Dimond, 1981; Gerber, Rusalem, & Hannon, 1975; Sanders, 1980). Gerber, Rusalem, and Hannon (1975) suggested from their findings, that health professionals should be alerted to the older populations' special needs, since the majority of all deaths in American society occur with those over 50 years. There is certainly substantial evidence to document men over 50 years as a higher mortality risk, as was discussed in the section "Risk of Death." It seems from the literature that there is no clear cut support for one age over another as being the most difficult time in a person's
life to be widowed, however, all studies concur that losing a spouse is an extremely traumatic life event whenever it occurs.

The sex of the surviving spouse is another variable that has been investigated to determine the significance of being male or female, in affecting one's reaction and adaptation to spousal loss. Research suggests some sex differences in bereavement and mourning. Carey (1980) found adjustment was more difficult for widows than for widowers at all ages. He speculated that was so, because he felt a woman tends to lose part of her identity when her husband dies and encounters more problems generally with finances and decision-making, assuming those tasks to have been part of the male role. Carey's investigation concluded that women require a longer grieving period than men, and suggested this may be due to women forming deeper emotional attachments. He elaborated further on this concept, in speculating the possibility that men have been socialized largely to deny their grief and to more quickly restructure their lives. From statistics, it is evident that remarriage is more feasible for older men than for older women, in that they have more potential mates in their age group, with more freedom to select a mate from a younger age group as well (Carey, 1980). Health and mortality statistics, however, contradict the notion of easier adjustment for widowers. Widowers tend to be more
prone to illnesses, emotional disturbances, and early deaths than widows of a matched group (Markson, 1983). Berardo (1970) and Rees and Lutkins (1967) agreed that older men, from their studies, demonstrated more difficulty adapting to the death of their mate than did older women. Heyman and Gianturco (1973) observed few or no sex differences in adjustment following widowhood. Some discrepancies in the literature seem to have occurred as a result of the variance in the types of groups studied (some have been psychiatric patients), the sampling has not always had a suitable control group, and many investigations have been retrospective rather than longitudinal.

In a longitudinal study, which followed widowed from ages 55 to 90 years of age over a 24 month period, to assess the impact of spousal loss on physical and mental functioning, women did report greater distress than men on the Brief Symptom Inventory (BSI), but similar differences were apparent in both the bereaved and comparison samples. On all of the nine dimensions of the BSI, the bereaved had significantly higher mean scores. For bereaved women, the mean was 6.61 compared to a 4.85 mean for the controls. Bereaved men were found to have a 5.56 mean versus a 3.22 for the male control group (Gallagher, Breckenridge, Thompson, & Peterson, 1983). These findings support those of Heyman and Gianturco, in that the impact of bereavement is comparable for both men and women.
One's past grief experiences have been found to bear an affect on future losses. How a person adjusts to difficulties, in some ways, seems to be a lifelong phenomenon. Welch (1982) researched families' past grief experiences in comparison with the current death of an immediate family member from cancer. Past experiences with death appeared to be an important determinant of grief responses at the time of the study. Family members who had lost a significant other to cancer demonstrated lower mean total grief scores on the Faschingbauer's Texas Inventory of Grief than those family members who had not previously experienced an immediate family member's death. Welch hypothesized from this investigation, that knowledge and a decreased fear of the unknown may have contributed to lower grief scores. What has been termed intrapersonal coping by Lazarus (1977), and others, is directly related to how an individual has dealt with crisis in the past. Lazarus has indicated that cognitive processes are the basis of coping activities affecting one's emotional reactions, determined by an interplay of personality and environmental factors. Fromm (1972) described successful coping as some tangible evidence that unpleasant stressors had been reorganized into some tolerable or more satisfactory pattern. How well a person has developed effective coping strategies and can employ them, will impact an individual's reaction and adaptation to the
death of a spouse.

Freud (1957) initially suggested that a high level of ambivalence in the relationship between the bereaved and deceased was likely to complicate the process of mourning, and may lead to melancholia. Melancholia, according to Freud, contains something more than normal mourning. It is complicated by conflict due to ambivalence regarding the relationship. A study by Raphael (1978), to promote the resolution of the ambivalence within the mourning process by psychotherapeutic intervention, was conducted with a randomly selected group of women during the first three months following their husbands' deaths. The subjects were followed up independently by questionnaire method 13 months after spousal loss. The intervention subjects (n = 12) showed significantly better general health and a decreased level of depression than the controls (n = 10). This study suggested that preventive support at the time of crisis to deal with the marital relationship, may be helpful in lessening symptoms later. Winn (1981) in a study conducted through Northwestern University on "Retrospective Evaluations of Marital Interaction and Post Bereavement Adjustment in Widowed Individuals," explored the relationship of widowed persons' descriptions and evaluations of their marriages with several measures, one of them being physical health at one year after their spouse's death. The group was composed
of 44 men and women, with 87.8% female and 12.2% male, aged 23-81 with a mean age of 56.5 years. Among the variables found to be significantly (p < .05) related to lower self-ratings of physical health and the presence of symptoms were: feelings of guilt about the subject's role in problems within the marriage; the subject's memories of the marriage; and the subject's recollection of disagreements concerning sexual relations in the marriage. Weiss and Parkes in a Grand Rapids Press Release, January 3, 1984, regarding a Harvard Bereavement Study, concluded that those bereaved persons with unhappy marriages were found to grieve longer than do the survivors of loving partnerships. This data all contributes to support for the premise that one's marital relationship affects bereavement responses and adjustment.

Within the bereavement literature, the mode and timeliness of the spousal death has been considered to be a significant factor in the widowed's adjustment. Generally, researchers have found that sudden, unexpected death is more stressful for the surviving spouse (Ball, 1977; Cornwell, 1977; Lindemann, 1944; Parkes, 1983; Singh & Raphael, 1951) than an anticipated death. Sudden death has been defined by most investigators as occurring less than five days from the onset of the symptoms. Anticipatory grief has been conceptually discussed as a process characterized by cyclical periods of mental anguish and
feelings of loss that begin at the time of initial diagnosis. There is the expectation of the death of one's spouse in the future, therefore the loss of a significant relationship and social role (Welch, 1982). Ball (1977) in studying 80 widows, found that sudden death lead to stronger grief reactions in the widowed, as compared with those whose spouse had died from a more prolonged illness. Another study (Lundin, 1984) was composed of a group of close relatives (n = 32) who had suffered sudden and unexpected bereavement, to determine whether this resulted in an increase in morbidity in the two year period following the loss. Comparison was made with a control group of relatives who had also suffered bereavement, but where the deaths were not unexpected. Increased morbidity was found following sudden and unexpected bereavement, but not in the control group. Clayton et al. (1973) added to significant findings related to anticipatory death, in investigating those survivors whose spouses had a terminal illness for more than six months prior to death compared with those whose spouses had died within six months or less after diagnosis. Their research concluded that those widowed whose spouses lived longer did worse initially, but that at the end of a year, both groups had similar adjustments.

The importance of a perceived social network and support has been the focus of many recent bereavement
studies. It has been determined by some researchers that this variable can significantly mediate between the stressful event of the loss of a spouse and a positive adjustment outcome (Clayton et al., 1971; Dimond, 1982; Goldberg, Van Natta, & Comstock, 1985; Hirsch, 1980; Kaplan, 1977; Parkes & Brown, 1972; Walker, 1977). Both Raphael (1977) and Maddison and Walker (1967) conducted studies that looked at perceived supportive environments. Their findings concluded that widows experienced poorer adjustment outcomes, including increased symptoms when they viewed their environments as unhelpful and lacking in social support. Widows who were doing well, reported helpful interactions with other persons in the three month period following their loss. These interactions provided them with emotional support, information, material aids and services. Unhealthy outcomes in bereavement have been described by Hirsch (1981) as failure to find adequate expression and support in the social network. Narayan and Joslin (1980) described the loss of a spouse as depleting health potential. According to their findings, when a person experiences the loss of a mate, there is an alteration in need-resources dynamics. The extent to which both internal and external resources are available and used at this point, has a direct impact on one's health outcomes. So that again, a significant variable regulating the capacity to maintain the health of the surviving spouse is
the availability of supportive resources.

A final factor that affects a widowed individual's bereavement reaction, to be considered here, is that of religious-spiritual beliefs. This can be understood as being faith in a power(s) outside of oneself that is perceived as a resource because of being associated with meaningful death or a belief in a life after death (Richter, 1984). Stoner (1982) found that religiosity was associated with higher hope and was an important aspect in the lives of 87% of the people interviewed. The religious rituals related to death were determined to perform three functions, those being: "support in the expression of grief at the loss; approval of the renunciation of what was lost; and guidance in definition and reinvestment of self" (Nolan, 1974, p. 36). Nolan further reported that "rituals maintain a person near the reality of the situation, keep an explicit focus on the crisis, and assist with cognitive mastery of the situation by minimizing guilt feelings and feelings of inadequacy," (Nolan, 1974, p. 36). Additionally, Ball (1977) and Sanders (1980) both found that religious beliefs, or a philosophy of life, were considered important in the adjustment to loss as an important source of strength.

Obviously then, from the discussion of this section, there are many significant variables which affect the widowed person's reaction and adjustment to the death of
his or her mate. The variables attended to here, have been identified as the primary ones influencing bereavement by many researchers, but by no means is this intended to be an all inclusive list. However, the nature and extent of the identified factors will have a definite impact on physical symptoms and death in the surviving spouse.

Interventions and Their Effect on Morbidity and Mortality in the Surviving Spouse

Given the evidence that the death of a spouse may be followed by deterioration in physical and mental health, with an increased risk of mortality, intervention is beginning to be recognized as a potentially important preventive measure for the surviving spouse. Despite the fairly long history of scholarly interest in widowhood by the social and medical sciences, mental health practitioners are still not extensively involved in targeted intervention. The major sources of psychological assistance for those who have been widowed, remain with traditional structures of religious institutions and family. Veroff et al. (1981) found that despite a proportional increase from 1957 to 1976 in the number of Americans who sought psychotherapeutic help, only about 4% of those who had lost spouses sought out such service.

It would seem that the maintenance of health during widowhood would be a significant and valuable goal. The
question of whether positive states of mind enhance immunity and reduce stress is the subject of a growing amount of research. The older a person is, the less likely he/she is to show changes in immune function. Younger adults (50 years and less) have shown a small, but real increase in the responsiveness of their immune systems following hypnosis and relaxation training, by an increase in the number of lymphocytes that enhance cellular immune function (Ornstein, 1987).

Many researchers have found that in order to help the widowed cope with the death of a spouse, the bereaved need to develop an awareness of the grief process, of their feelings, and learn to verbally express these rather than internalize them. It is of utmost importance not to internalize feelings where they may be expressed in physical illness or contribute to a chronic condition (Hauser, 1983; Richter, 1984; Weizman & Kamm, 1985). Mental health practitioners can notably contribute to appropriate expression of feelings of the bereaved and in the education of the widower relative to the grief process (Small, 1979) so that they may better cope with their bereaved status. Coping in widowhood has been understood to mean that a surviving spouse is able to overcome the problems and difficulties associated with widowhood, and again function as a viable person; to be engaged in society and to be enjoying life and relationships with
others (Goddard, 1980).

Caplan (1964) observed that people were very susceptible to the influence of others during crisis states, and he suggested the development of helping services to aid people such that a minimal amount of effort would lead to a maximum amount of lasting response. Since then, various preventive helping services have emerged. There has been a significant increase in the interest, diversity, and utilization of self-help groups over the past 30 years, and even more so in the past decade. It has been estimated that there are currently over 500,000 such groups with over 15 million participants in the U.S. alone. It is anticipated that by 1990 the numbers of persons reached by self-help groups will have doubled (Gartner, 1982). Basically, self-help groups consist of people voluntarily gathering together for a treatment or to accomplish a specific purpose, which focuses on personal problems and the resolution of mutual individual needs (Katz, 1976; Withorn, 1980).

According to the literature, there are many potential benefits for those who attend self-help groups. Participants can gain hope, receive new ideas for solutions, receive information on locating additional sources for help (Silverman, 1980); improve skills in developing social relationships, become less lonely (Crosby, 1978); learn new role definitions, have an audience of listeners,
discover that others have similar difficulties, and re- ceive added social support (Hartford, 1971). Bereaved support groups might focus on grief, mourning, social isolation, hopelessness, loneliness (Hartford, 1971; Lopata, 1973); building a new life and social identify; or lowering morbidity in general (Hiltz, 1975).

There have now been some studies conducted on the effectiveness of intervention with the bereaved. The earliest one was a retrospective study of morbidity among widows in Sydney, Australia aged 60 years or younger (Maddison & Viola, 1968). In the 13 months following bereavement, 21.2% of the population demonstrated a marked health deterioration as assessed by a general health questionnaire. The population was divided into an intervention group (n = 27) and a control group (n = 29). The intervention group received at least one visit to their home by a mental health professional. Of this group, 21 subjects proceeded to a "good outcome" or improved health, and six widowed's health deteriorated. This was compared to the control group, in which 12 subjects' health improved and 17 persons' health did not (p < .02). Maddison and Viola concluded that intervention appeared to improve the widowed’s health, but that further detailed studies were needed.

Gerber, Wiener, Bottin, and Arkin (1975) investigated the effects of brief psychotherapy (one or two sessions)
for the aged experiencing spousal bereavement. Seventy percent of the 169 subjects were over 60 years old, with an n of 116 receiving treatment and 53 subjects in the control group. All subjects were interviewed at 2, 5, 8 and 15 months subsequent to spousal loss. The study represented a modest finding, in that it demonstrated that brief psychotherapeutic intervention had some effect upon the medical utilization patterns of the aged bereaved. The experimental group showed less medication and medical services utilized.

Barrett (1978) studied 126 subjects and randomly assigned them to one of four conditions: a self-help group, confidant group, consciousness-raising group and a control group. All three treatment groups met for seven weekly, two-hour sessions. Results showed no overall definite advantage for the three treatment groups when compared with the controls. All four groups demonstrated statistically significant increases in self-esteem, increases in grief intensity, a decrease in negative attitudes toward remarriages, and a trend toward an increased self-orientation.

While Gerber, Wiener, Bottin, and Arkin (1975) and Barrett (1976) found only slight positive results, Raphael (1977) found preventive interventions in the early bereavement period to be effective in a high risk population. Two hundred widows under age 60 were assessed
within seven weeks following spousal death. Subjects were selected on the basis of three risk predictors: a high level of perceived nonsupport from the widow's social network; a previous highly ambivalent relationship with the deceased; and the presence of at least three concurrent life stressors. The thrust of the study was primarily prevention, as identified widows were at risk, but not yet manifesting pathological grief. Treatment consisted of two to four, two-hour sessions with a psychiatrist in the widow's home within the first three months of bereavement. Treatment was selective to the individual's needs, but did encompass ego support, including expression of grieving affects (sadness, anger, anxiety, despair) and facilitation of the mourning process with its review of the positive and negative aspects of the lost relationship as a consistent factor. All were followed up 13 months later with a health questionnaire. There was a significant lowering of morbidity in the intervention group as compared with the control group (p < .02). In the experimental group, 77% improved while 23% did not; while with the untreated controls, 41% improved and 59% were unimproved. Controls were significantly more symptomatic along the following parameters: excessive tiredness, excessive perspiration, feelings of panic, swollen joints and more physician visits.

A two-year study of self-help intervention for
widows, including widow-to-widow outreach and support groups, was conducted by Vachon et al (1980). Of 162 widows ages 22-69 years (median = 52 years), 68 were paired with a widow contact who provided emotional support and practical assistance. Eighty-one percent of the total population had spouses that died of chronic disease, with the median length of the final illness being six months. The differences between the widows receiving intervention and the control group at 6, 12, and 24 months, as assessed by the Goldberg Health Questionnaire (Goldberg, 1978), found the experimental subjects more likely to perceive their health as better than average (less tired, less insomnia, decreased nervousness and depression), more likely to experience improvement in the intervening six months, less likely to be seeing old friends as much as usual, and less likely to anticipate further difficulty in adjusting to widowhood as compared with the controls. Another interesting outcome of Vachon's study suggested that those receiving intervention followed the same general course of adaptation as the control subjects, but that the rate of achieving landmark stages was accelerated for the intervention group.

Lieberman (1986) investigated 500 widowed persons who attended the THEOS (They Help Each Other Spiritually) self-help groups, and compared them to a normative sample of widows. The results of his study supported the premise
that self-help groups can be helpful in alleviating some of the distress experienced by those who have been widowed. He also concluded from his research that the mere passage of time did not alone account for positive changes in mental and physical health.

Critique of Available Literature

Even though we now have the results of a handful of studies dealing with the effectiveness of preventing health problems in the widowed with a variety of interventions, this area remains in the infancy stages of investigation. The Institute of Medicine review of bereavement concluded:

Very little is known about the ability of any intervention to reduce the pain and stress of bereavement, and shorten the normal process, or to mitigate long-term negative consequences. While the few controlled studies that have been conducted report contradictory findings, subjective reports attesting to the helpfulness of interventions abound. (Osterweis et al., 1984, p. 274)

Therefore, despite the increasing evidence of the debilitating effects of widowhood on both psychological and physical functioning, the widowed are rarely a targeted population of mental health professionals. This is partly due to the non-participation perspective of many widowed, which occurs for many varied reasons, a few identified are: they report feeling too badly, feeling too threatened, have no interest, or feel their
experiences are private (Williams & Polak, 1979; Sanders, 1980). Lund (1985) in contacting widowed individuals to take part in a study, found 60% of all the potential bereaved participants refused to be in the study due to early assessment and the sensitive nature of the study. Lund also concluded that with increasing age there was significantly less desire to participate in a group intervention. Of the 90 people between ages 50 and 69, 53% desired to be involved compared with only 27% of those over 70 years. There were no major differences between the two groups with respect to physical health, the degree of perceived stress, religion, socioeconomic status, or self-esteem level. Lund's research found that identifiable characteristics of those who would like to participate in bereavement groups, in addition to a younger age, were that they tended to be more educated, to have a confidant (but with less availability), to have higher depression, lower life satisfaction, and lower levels of perceived coping ability (Lund, 1985). Williams and Polak (1979) reported a refusal rate of involvement in their study to be 49% in the experimental group, 43% in Control 1 group, and 65% in Control 2 group. Sanders (1980) found that 47% of potential participants refused for one reason or another to participate in his study. He suggested that by use of a larger control group, the quality of the research results are more predictive and generalizable,
and that in his study, the increase in physical symptoms of the bereaved was better supported.

Accompanying the difficulty of obtaining a widowed population to research, comes the hindrances of methodological concerns including: small sample sizes; a self-report format; retrospective investigation; inconsistent selection procedures; and inadequately controlled studies.

In summarization of the literature, there is much support for the premise that conjugal bereavement is a significant stressor that may adversely affect the physical health status of survivors. There is also a limited amount of statistical evidence to substantiate the benefits of preventive intervention, although many more studies with specific conclusive findings are needed, in order to effectively reduce physical illness and related death in the widowed.

As Weizman and Kamm (1985) have stated so eloquently:

Although uninvited, loss and mourning present an opportunity for growth and motivation, an opportunity to develop a deeper aspect of self. It is an opportunity to reach into untapped reserves and to use them to grow in many dimensions. Many persons become strengthened through this experience.

Death can illuminate the importance of life. One of the major things that can be learned from death is that life is very precious. Hopefully, this can serve to reorder priorities and focus attention and energy where it can best be utilized by surviving spouses subsequent to the death of their mate. (p. 17)
CHAPTER III

METHODS AND PROCEDURES

Subjects

The sample for this study consisted of bereaved persons in the Grand Rapids, Michigan and Pittsburgh, Pennsylvania areas. The group to which the results of the study will be generalized is primarily bereaved persons in these two locales. Prior to requesting participation from the subjects, the project was approved by the University Committee on Research Involving Human Subjects.

Grand Rapids consists of a population of approximately 650,000 persons, and has a diverse distribution of socioeconomic status and a mixture of ethnic groups. It depicts primarily an urban atmosphere, including many surrounding suburbs, with only a very small percentage of the area being rural.

The Pittsburgh area, which was the other site utilized to obtain subjects for this study, has a population three to four times that of Grand Rapids. The Pittsburgh metropolitan area's population, which comprises many individual valleys that are suburban to Pittsburgh proper, totals approximately 2 million people. This major metropolitan area hosts a diversity of backgrounds in regard to
individual culture, race and economic levels.

These two populations, Grand Rapids and Pittsburgh, were utilized to potentially increase the number of subjects involved, as well as to enhance the generalizability of the data obtained. These two areas are not only located in different sections of the United States, with Grand Rapids, Michigan, in the Midwest approximately 550 miles from Pittsburgh, Pennsylvania in the East, but also the population size variance contributes to added diversity of the study. Grand Rapids is a moderately sized city compared with Pittsburgh, which could be described as a metropolis. This researcher investigated and obtained data from the Grand Rapids segment of the population, while concurrently, Weidaw (1988), conducted similar research in the Pittsburgh area and subsequently contributed that data to a collective research pool.

In an attempt to obtain a sample for this study, a total of 240 bereaved spouses were contacted by means of letter (mailed January 19 and April 6, 1987), one-half of that number derived from both geographical sites. The 120 subjects from each locale were contacted at two separate times, as the process of the study was completed twice, both in Grand Rapids and Pittsburgh. Therefore, the first group of subjects was obtained from 60 names in each locale found in the obituary columns of the Grand Rapids Press and Pittsburgh Press (December 8, 1986 to March 2,
1987), respectively, who were identified as the surviving spouse. These 60 persons from each site whose names appeared as having lost a spouse, were initially contacted by letter (see Appendix B) and invited to participate in the study by completing a Bereavement Information sheet and an instrument labeled "Bereavement Questionnaire" (see Appendices C & D).

From the 60 names found in the obituary column of the Grand Rapids Press on successive nights and contacted by letter, 44 were female and 16 male. Twenty-two persons responded to the first mailing sent to obtain a sample. A second mailing was sent out approximately two weeks later, a copy of which is found in Appendix E. The result was 9 additional responses, with a total then, including both mailings, of 31 bereaved persons returning information requested, plus three (5%) bereaved indicating that they did not wish to participate. Of those 31 respondents, or 52% of the initial group contacted, who indicated they would contribute to the study, 20 were female and 11 male. This sample comprised Group 1 of the Michigan subjects. The total response rate (34 return mailings) was 57% return for both mailings.

In Pittsburgh, the identical process was initiated by Weidaw (1988) contacting a total of 60 bereaved individuals, of which 25 were male compared with 35 being female, with names obtained from the Pittsburgh Press.
Including both the first and second mailing in Pittsburgh, there were 29 returns, comprising a 48% return rate. Of the 29 persons responding, 6 (10%) individuals refused to participate and 2 (3%) had moved with no forwarding address. There remained 21 interested participants who supplied valid data for this study, or 35% of the initial 60 persons contacted. These participants constituted Group 1 of the Pittsburgh sample.

Both the 31 Grand Rapids respondents willing to participate as well as the 21 individuals included in the study from Pittsburgh, were divided, by the random sampling method without replacement, into experimental and control groups. There were 15 persons designated to be in the experimental group in Grand Rapids, making them eligible to be invited to attend a four-week Bereavement Support Seminar Series. A letter was sent to them with information on the seminar series (see Appendix F). Of the 15 persons invited, 6 agreed to attend which was a 40% participation rate of those contacted. Of the six seminar members, three were female and three male. From those remaining from an initial 31 respondents, 16 persons were assigned to the control group. They were only recontacted by letter (see Appendix G) at the conclusion of the experimental group seminar series, and requested to again complete the test instrument, labeled the "Bereavement Questionnaire." Of the 16 controls sent a posttest, 12
responded by returning the information as requested, which comprised a return rate of 75%, including 10 females and 2 males.

The 29 bereaved spouses in Pittsburgh who were willing participants were randomly divided into experimental and control groups. There were 11 persons placed in the experimental group and thus invited to attend the seminar series. Of those invited, 3 persons agreed to be involved (two females and one male), comprising 27% of the total number who could potentially attend. There were 10 individuals assigned to the first Pittsburgh control group, with an 80% return rate (8 respondents) of the completed posttest Bereavement Questionnaire.

The identically described process was duplicated a second time beginning on April 6, 1987, in both locales, to obtain additional subjects to meet the objective of a larger sample population.

In the Grand Rapids, Michigan area, a total of 60 bereaved spouses, of which 44 were female and 16 male, were contacted by letter which can be found in Appendix H to obtain Group 2. There were 18 responses to this letter, with that number returning the requested completed information. Subsequent to the second mailing (the letter of which is found in Appendix I), 12 additional bereaved individuals responded, then totaling 30 respondents willing to participate, plus 2 persons who indicated refusal
to be involved in the study. Of the 30 positive responses from subjects, 10 of the group were male with 20 female. These 30 individuals were then divided by random sampling into experimental and control groups. Fifteen persons were assigned to the experimental group and invited to attend the Bereavement Support Seminar Series (letter invitation in Appendix J). Eight of these 15 people agreed to attend, 3 of whom were male and 5 female. These constituted a participation rate for the experimental group of 53%. Fifteen persons were assigned to the control group, with 10 of these individuals completing the posttest information as requested by letter (see Appendix K) at the conclusion of the experimental group's seminar series. The 10 persons completing the control group posttest comprised a 67% return rate, with 6 of the group being female and 4 of them male subjects.

Of the 60 Pittsburgh widowed (17 male and 43 female) contacted by letter to participate in the study, 26 individuals had responded by the second mailing. This was a return rate of 43% of the participants initially contacted. Of those 26 persons, 7 (12%) refused to participate; 2 (3%) had moved with no forwarding address; and 17 (28%) were agreeable to participate in the study. These 17 persons forming Group 2 were randomly divided into an experimental group of 9 persons, and a control group of 8. Eight of the 9 persons invited to attend the Bereavement
Support Seminars agreed to do so, comprising an 88% rate.

The total number of bereaved spouses who participated in this study was 62. The total experimental population of 25 individuals was comprised of 16 females and 9 males. All those subjects who initially agreed to attend the Bereavement Support Seminar Series completed all four sessions and the posttest assessment. The 37 subject control group who completed the study by returning the posttest instrument included 29 females and 8 males. The specific number of subjects obtained in both locales for the experimental groups in each of the two seminar series conducted, and the number of the control sample are found in Tables 3 and 4 respectively.

Table 3
Sample Size of Experimental Groups

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group 1</th>
<th>Experimental Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Totals</td>
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<td>16</td>
</tr>
<tr>
<td>Total of Both Groups</td>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>

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Table 4
Sample Size of Control Groups

<table>
<thead>
<tr>
<th></th>
<th>Control Group 1</th>
<th>Control Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Totals</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Total of Both Groups</td>
<td>37</td>
<td></td>
</tr>
</tbody>
</table>

From this point, in further discussion of the subjects, the experimental sample from Groups 1 and 2, as well as the controls from each of the two groups, will be combined into one experimental and one control group from Michigan, and one experimental and one control group from Pennsylvania. The rationale for doing this is that it seems to be more easily understandable, as there are no significant differences in the composition of Groups 1 and 2 in Grand Rapids. The same is true for Groups 1 and 2 of the Pennsylvania sample. It is important and necessary, however, to look at any similarities or differences that may exist in the Michigan sample as compared with those subjects from Pennsylvania. This information was obtained by one of the mailings, the Bereavement Information form (see Appendix C), sent to each of the participants in the experimental and control groups in both locales. The specific information comparisons are presented in Tables
5, 6, 7, and 8 in regards to age, sex, educational levels and years married, respectively.

Table 5
Age Comparisons of Michigan vs. Pennsylvania, Experimental and Control Group

<table>
<thead>
<tr>
<th>Ages</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Experimental Groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29 yrs.</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30-39 yrs.</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>40-49 yrs.</td>
<td>1</td>
<td>07</td>
<td>3</td>
</tr>
<tr>
<td>50-59 yrs.</td>
<td>4</td>
<td>29</td>
<td>4</td>
</tr>
<tr>
<td>60-69 yrs.</td>
<td>7</td>
<td>50</td>
<td>3</td>
</tr>
<tr>
<td>70-79 yrs.</td>
<td>2</td>
<td>14</td>
<td>-</td>
</tr>
<tr>
<td>80 yrs.</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Control Groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29 yrs.</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30-39 yrs.</td>
<td>1</td>
<td>05</td>
<td>-</td>
</tr>
<tr>
<td>40-49 yrs.</td>
<td>3</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>50-59 yrs.</td>
<td>3</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>60-69 yrs.</td>
<td>5</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>70-79 yrs.</td>
<td>10</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>80 yrs.</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
</tbody>
</table>

In looking at the age comparisons of the Grand Rapids...
subjects in contrast to those in Pennsylvania, the Pennsylvania experimental group was generally younger, with a mean age of 58.7 years compared with a 62.2 mean age for the Michigan sample. The Michigan group was found to have a 3.5 higher mean age value than the Pennsylvania experimental group. The Michigan experimental sample was composed of eight females with a mean age of 59.1 years, compared with a total of six male subjects with a 66.3 year mean age, indicating males in this sample displayed a 7.2 year higher mean age than the females. Fifty percent of the Michigan experimental group had actual ages in the 60-69 year range; with the highest percentage of the Pennsylvania experimental group being in the 50-59 age range with a 36% ranking.

In comparing the Michigan and Pennsylvania control groups, it is found that the Michigan participants had a lower mean age of 63.7 years than that of the Pennsylvania subjects with a 65.7 mean age. In noting from Table 5, 45% of the Michigan control group was found to be in the 70-79 age range, with the highest percentage (40%) of the Pennsylvania group in the 60-69 year grouping. In contrasting the Michigan control group's female mean age to that of the males, it was found to be 62.8 mean years and 66.3 mean years, respectively. Males were shown to have a 3.5 years higher mean age than the female subjects. The highest percentage of Michigan control group subjects was
found to be in the 70-79 year range (45%), with the Pennsylvania group's highest percentage in the 60-69 year category (40%).

The last comparison to be made regarding age, is that of the combined Michigan and Pennsylvania experimental groups as contrasted by the Michigan and Pennsylvania control groups. The mean age of the combined experimental groups is 60.5 compared with a 64.7 mean age of the control groups. This indicates that the total control group was slightly older, with 30% of the subjects found to be in the 60-69 year range as well as in the 70-79 year range, compared with the majority (40%) of the experimental group in the 60-69 year range and only 8% in the 70-79 year category.

Although there were some differences between the samples at each locale, as well as between the experimental and control groups, none of the differences were statistically significant. The fact that the groups were found to be similar is meaningful to the researcher, in order to more clearly isolate the variable of the intervention versus no intervention as the one significant difference between the experimental and control groups, which is the tested variable of this investigation.

In regard to the sex comparisons of the Michigan and Pennsylvania experimental and control groups, Table 6 may help to clarify the similarities and differences. In
general, there were more females (both in the experimental
and control groups) participating in this study. In the
total experimental group ($n = 25$), females comprised 64% of
the group, compared with a male percentage of 36%. In
the combined control group ($n = 37$), females made up 78%
of the group compared with a male percentage of 22%. This
would seem to fit with previous studies conducted, in
which male participation is generally lower than female
involvement, with much of past research exclusively inves-
tigating bereaved widows (please refer to Chapter II,
Review of Related Literature).

Table 6
Sex Comparisons of Michigan Versus Pennsylvania,
Experimental and Control Groups

<table>
<thead>
<tr>
<th></th>
<th>Michigan</th>
<th></th>
<th>Pennsylvania</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
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<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental Groups</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
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<tr>
<td>Female</td>
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<td>73</td>
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<td>16</td>
<td>73</td>
<td>13</td>
<td>87</td>
<td>29</td>
</tr>
</tbody>
</table>

Examining the comparison between the Michigan and Pennsylvania groups, it is evident that there were at
least twice as many males participating in both the Michigan experimental and Michigan control groups as there were males in either of the Pennsylvania groups.

The educational level of all of the subjects participating in the study was also determined by means of the Bereavement Information sheet (see Appendix C). With the information obtained from the sample, the researcher divided educational experiences into seven categories including: completion of grade school, high school, technical training, receipt of an A.A., B.A., M.A. or doctoral. Interestingly enough, the highest percentage in all of the groups, was in the high school graduate category. There was a slightly higher percentage of subjects who were high school graduates in the Michigan and Pennsylvania experimental groups (52%), compared with 46% in the Michigan and Pennsylvania control groups. The combined experimental group was slightly more educated than the controls, primarily because in the control group there were seven subjects who had not completed high school, contrasted by no subjects in this category of the experimental group. The combined experimental groups were found to have 48% of the subjects who had obtained education beyond high school, compared with 35% of the control sample. The fact that those who chose to be participants in the support seminars were slightly more educated than the controls, concurs with previous findings (refer to
Chapter II, Review of Related Literature) in that the education variable was significant for participation.

Comparisons of the educational levels of all the groups showed many more similarities than differences in the groups. (Refer to Table 7 for more specific data relative to educational levels of the groups).

Another factor that was examined relative to subject comparisons, was that of the duration of the marriage prior to the death of one of the partner's. The review of the literature indicated that the degree of attachment was a significant variable in predicting a bereaved spouse's grief reactions, so that the number of years a couple remained married to one another contributed, in part, to their attachment level. In computing the actual number of years married, without categorizing as has been discussed previously, the Michigan experimental group mean number of years married was 29.6, contrasted with the Michigan control group depicting a 37.2 mean number of years married. The Pennsylvania experimental sample displayed a 33.6 mean number of years married compared to that locale's control group with 39.0 mean years married. The total experimental mean number of years married was 31.6, in comparison with 38.1 mean number of years married for the control group, indicative of a 7.4 mean year difference between the two groups. Three 19-year ranges were formulated, in which were placed each of the experimental
<table>
<thead>
<tr>
<th>Educational Level</th>
<th>Michigan</th>
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<th>Pennsylvania</th>
<th>%</th>
<th>Total</th>
<th>%</th>
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</thead>
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<tr>
<td><strong>Experimental Groups</strong></td>
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</tbody>
</table>
and control group members. The specific number of years married categories were: 0-19 years, 20-39 years and 40-59 years. The number of years married category with the highest percentage of experimental subjects was the 20-39 years with 48% percent of the subjects in that grouping, compared with 57% of the control sample comprising the 40-59 year number of years married category.

Examining the specific comparisons between the two locales of this study, some differences were observed, but none that were statistically of importance. Both the Michigan experimental and control groups displayed slightly higher percentages in the 40-59 number of years married category than did the Pennsylvania experimental and control groups. These data are located in Table 8.

The final factor that was used to compare the experimental and control groups was the length of the spouse's illness. As was discussed in Chapter II (Review of the Literature), another variable that affects the surviving spouse's reaction toward the loss of his/her spouse is the length of time the partner was ill prior to death. With an anticipated death there may be some preparatory grieving completed, which would serve to lessen the intensity of the grief process when the death actually occurs. Sudden, unexpected death has been shown to generally elicit more difficulty in progressing through the grief process.
Table 8

Length of Marriage Comparisons of Michigan vs. Pennsylvania, Experimental and Control Groups

<table>
<thead>
<tr>
<th>No. of Years Married</th>
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<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td><strong>Experimental Groups</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs.</td>
<td>4</td>
<td>29</td>
<td>2</td>
</tr>
<tr>
<td>20-39 yrs.</td>
<td>5</td>
<td>36</td>
<td>7</td>
</tr>
<tr>
<td>40-59 yrs.</td>
<td>5</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td><strong>Control Groups</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0-19 yrs.</td>
<td>4</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>20-39 yrs.</td>
<td>5</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>40-59 yrs.</td>
<td>13</td>
<td>59</td>
<td>8</td>
</tr>
</tbody>
</table>

In computing comparisons between the combined Michigan and Pennsylvania experimental group and the combined control group from the two locales, the mean length of the spouse's illness was 28.2 months for the experimental group and 24.6 months for the control group. However, within the control group, four persons reported no warning of impending spousal death and four persons reported extended illnesses of 216, 96, 72, and 60 months duration for their spouse. Eliminating these extremes and calculating a mean with an $n = 29$, the mean of the spouse's
illness becomes 16.1 months. With the experimental group, two persons reported no warning of impending spousal death and two persons reported extended illnesses of 204 and 181 months. Eliminating these extremes and calculating a mean with an \( n = 21 \), the mean of the spouse's illness becomes 15.2 months. The highest percentage of deceased spouses in both the experimental and control groups died in the range of 25+ months (see Table 9).

<table>
<thead>
<tr>
<th>Length of Deceased Spouse's Illness</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 mo.</td>
<td>4 29</td>
<td>3 27</td>
<td>7 28</td>
</tr>
<tr>
<td>4-6 mo.</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td>7-9 mo.</td>
<td>1 7</td>
<td>1 9</td>
<td>2 8</td>
</tr>
<tr>
<td>10-12 mo.</td>
<td>1 7</td>
<td>2 18</td>
<td>3 12</td>
</tr>
<tr>
<td>13-15 mo.</td>
<td>1 7</td>
<td>1 9</td>
<td>2 8</td>
</tr>
<tr>
<td>16-18 mo.</td>
<td>1 7</td>
<td>- -</td>
<td>1 4</td>
</tr>
<tr>
<td>19-21 mo.</td>
<td>1 7</td>
<td>- -</td>
<td>1 4</td>
</tr>
<tr>
<td>22-24 mo.</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td>25+ mo.</td>
<td>5 36</td>
<td>4 36</td>
<td>9 36</td>
</tr>
</tbody>
</table>
Table 9—Continued

<table>
<thead>
<tr>
<th>Length of Spouse's Illness</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>0-3 mo.</td>
<td>6</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>4-6 mo.</td>
<td>3</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>7-9 mo.</td>
<td>1</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>10-12 mo.</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>13-15 mo.</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>16-18 mo.</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>19-21 mo.</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>22-24 mo.</td>
<td>2</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>25+ mo.</td>
<td>9</td>
<td>41</td>
<td>6</td>
</tr>
</tbody>
</table>

The data comparisons of the mean months of the spouse's illness for both the Michigan and Pennsylvania experimental and control groups is found in Table 10.

Therefore, it can be concluded from investigating both the combined experimental and control groups from the two locales, and comparing the groups from Michigan with those from Pennsylvania, there was no statistically significant difference in age, sex, education level, length of time married, or the length of the deceased spouse's illness.
Table 10

Mean Months of Spouse's Illness of Michigan vs. Pennsylvania, Experimental and Control Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>38.4</td>
<td>15.1</td>
<td>28.2</td>
</tr>
<tr>
<td>Control</td>
<td>24.5</td>
<td>24.7</td>
<td>24.6</td>
</tr>
</tbody>
</table>

Instruments

There were two separate instruments utilized in this study. One was an information form, entitled Bereavement Information (see Appendix C), developed by Weidaw (1988) and this researcher. Bereaved persons who wished to participate in this study were asked to initially complete this information form, along with the Kincannon Mini-Mult, and return them both to the researcher. The bereavement information sheet requested basic background information regarding the bereaved respondent's age, sex, educational level, and length of time married (Appendix C, Part I, questions 1-4), as well as more specific information regarding physical and emotional health. The bereaved spouse was asked to rate his/her health status prior to and following the death of his/her partner in one of the following categories: excellent = no physical problems; good = a few minor physical problems; fair = some physical problems that required medical attention and caused the
bereaved spouse concern; or poor = experienced major physical problems (refer to Appendix C, Part I, questions 5 and 6). Upon completion of these two questions related to the health status of the bereaved prior to and following spousal death, the subjects were asked if they had been treated for any specific medical diagnosis, and if so, to please explain in the space provided on the form (Appendix C, Part I, question 7). Concluding the information section to be completed by the bereaved spouse, were two questions relative to their current and past depression levels (please refer to Appendix C, Part I, questions 8 and 9).

The second portion of the Bereavement Information form consisted of questions regarding the deceased spouse. Again, basic background information such as age, sex, and educational level was requested (Appendix C, Part II, questions 1-3). The health status of the deceased spouse for the past three years was investigated, as well as the length of the deceased spouse's illness prior to death and the medical diagnosis relative to the cause of death (Appendix C, Part II, questions 4-6). The length of the deceased spouse's illness and health status information were utilized to determine the anticipatory versus sudden death impact on the surviving spouse, and to gain an understanding, in part, of the nature of the stressors affecting the widow(er) prior to and following their
spouse's death.

The data obtained from this Bereavement Information form, after being completed by each subject, was tabulated, organized by means of a codebook (see Appendix O), and analyzed by computer. A portion of the results were already discussed in regard to subjects (Chapter III, Method: Subjects). The remainder of the data obtained relative to the health status of the bereaved spouses will be dealt with in Chapter IV, Results.

The second instrument that was administered in this study was the Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory (MMPI). This test was completed by all of the participants in both the experimental and control groups in Michigan and Pennsylvania. The subjects each completed this test twice during the course of the study: initially (along with the Bereavement Information form); and at the conclusion of the 4-week Bereavement Support Seminar which constituted a time span of approximately 12 weeks between tests. The Kincannon Mini-Mult was administered to the experimental groups at the conclusion of the last seminar, and mailed concurrently to members of the control group. The tests were then held until all seminars at both sites were given, and the total n had an opportunity to respond. It was unnecessary to send a follow-up letter to the control groups encouraging compliance with the completion of the
test, as there were a sufficient number of subjects who responded to the first mailing.

The Kincannon Mini-Mult was chosen by the researchers following considerable investigation of possible instruments to be utilized in this study. It was necessary that the test selected be reliable and valid on both the physical-somatic manifestation and depression level scales, so that it would be feasible to combine the populations from Grand Rapids, Michigan, and Pittsburgh, Pennsylvania, as a means of enlarging the study. The MMPI, although the best choice in terms of reliability and validity for many populations, was deemed inappropriate due to its extreme length, for the targeted bereaved population of this study. The long form of the MMPI was not considered feasible because the grieving population would most likely be resistant to the test length of 566 items, and the need to take the test twice would promote noncompliance. As Kincannon's Mini-Mult (1968) was developed from the MMPI, using cluster analysis and proportionately selecting those items from each cluster with the greatest scale overlap until it was reduced to 71 test items, it was felt by the researchers to be the most desirable test for the focus of this study. The ability of the 71 item pool to predict the standard scale scores of the MMPI was contrasted with the ability of the retest of the MMPI to do the same. The loss in reliability and validity was not found sufficient
to mitigate against the use of the Mini-Mult when a standard test could not be obtained. Faschingbauer (1974) reported the Kincannon Mini-Mult useful for group studies and outpatient populations with a median reliability at .76 and a median predictive validity at .79.

Kincannon (1968) compared the Mini-Mult to the standard MMPI by utilizing first a sample of 50 male and 50 female recent admissions to the psychiatric service of a general hospital. "Product-moment correlations between the two sets of raw scores for this group ranged from .80 to .93 for the 11 clinical and validity scales. The median correlation was .87" (Kincannon, 1968, p. 320). A second comparison was carried out with 25 male and 25 female consecutive admissions to a community mental health center. Correlations were computed between the raw scores on the standard MMPI and Mini-Mult and ranged from .70 to .96 with a median of .87.

In correlating Scale 1 of the Mini-Mult with Scale 1 of the standard form, the standard form had a reliability coefficient of .87, and the comparison of standard form Scale 1 results with an independent administration of the Mini-Mult, resulted in a reliability coefficient of .72 (Kincannon, 1968, p. 321). If the Mini-Mult score for Scale 1 is obtained by drawing the appropriate items off an answered standard form, then the correlation is .93. The mean of the scale scores for Scale 1 was 10.23 on the
MMPI and 11.02 on the Mini-Mult, with the standard deviations of 6.97 and 6.63, respectively.

In correlating Scale 3 of the Mini-Mult with Scale 3 of the standard form of the MMPI, the standard form had a retest reliability of .80, and the comparison of standard form Scale 3 results with an independent administration of the Mini-Mult resulted in a reliability coefficient of .70. If the Mini-Mult score for Scale 3 is obtained by drawing the appropriate items off an answered standard form, then the correlation is .82 (Kincannon, 1968, p. 321). The mean scale score of the MMPI was 26.63 and 27.28 for the Mini-Mult, with 5.03 and 5.83 for the respective standard deviations.

Scale 1 of the Kincannon's Mini-Mult corresponds with the MMPI's Scale 1, named the Hs or Hypochondriasis Scale. It is "a straight-forward scale which measures the number of bodily complaints claimed by a person and whether these complaints are used to manipulate others. The scale does not distinguish actual from imagined physical difficulties," (Duckworth, 1979, p. 53). Elevations of this scale are characterized by preoccupation with the body, and often somatic complaints serve as a means to avoid emotional situations or difficulties. In times of stress, this scale has been found to be elevated, in that somatization is utilized as a defense in these instances (Dahlstrom et al, 1972). The MMPI Scale 1 consists of 33
items that are fairly obvious questions having to do with bodily concerns. The Kincannon Mini-Mult reduced the items in the short form to 14.

Scale 3, Hy or Hysteria on the Kincannon Mini-Mult, correlates with Scale 1, and was therefore utilized to obtain a 1-3 code on this test instrument. Elevations on Scale 3 indicate that an individual may be reacting to stress and avoiding responsibility by developing physical disorders. A 1-3 code elevation is indicative of bodily preoccupation and anxiety. The amount of denial of psychological problems is characterized by this scale, in that a person may prefer not to think about unpleasant things and therefore may develop physical complaints instead (Dahlstrom, et al., 1972). The Kincannon Mini-Mult selected 26 items from the 60 items on the MMPI to comprise this scale.

For the purpose of this research, the Kincannon Mini-Mult was retyped and titled Bereavement Questionnaire (Appendix D). It consisted of 71 items, to which participants were asked to respond by either circling "yes" or "no." From the completed and returned questionnaire, the answers were transposed to two scoring forms in the process of converting the raw scores to scaled scores. These scoring forms can be found in Appendix N. The scales that were investigated.
Design

The method utilized in this study is that of the Causal-Comparison type. The rationale for selecting this method is that all of the variables cannot be manipulated or controlled, and that only a relationship can be established; not necessarily a causal one. This particular method is utilized in this study to compare two groups, obtained by the random sampling method without replacement, which differ on an independent variable with comparison of the groups on a dependent variable.

The experimental design employed in the study then, represented a two group pretest - posttest experimental and control group design, graphically represented in Figure 2.

\[
\begin{align*}
R_1 & \quad X & \quad 0_1 \\
R_2 & \quad 0_2
\end{align*}
\]

- \(R_1\) indicates random assignment to experimental group
- \(R_2\) indicates random assignment to control group
- \(X\) indicates treatment
- \(0_1\) indicates outcome of experimental group
- \(0_2\) indicates outcome of control group

Figure 2. Experimental Design of Study

By random assignment without replacement, one-half of the sample who returned the pretest instrument, the Bereavement Questionnaire, were classified as the experimental group, and the other half were placed in the
control group. The experimental group received a planned intervention treatment, namely a 4-session, once per week Bereavement Support Seminar, whereas the control group received no treatment intervention. At the conclusion of the 4-week seminar series, the experimental and control groups were again given the Kincannon Mini-Mult (Bereavement Questionnaire) as a posttest instrument.

The researcher was interested in the effect of the Bereavement Support Seminars on the reported physical symptoms of the surviving spouses. The physical symptoms experienced by the widowed in both the experimental and control groups constituted the dependent variable, which is the consequent of the independent variable. Physical symptoms were determined by self report of the bereaved spouses as a baseline at the onset of the investigation, and measured again by the posttest at the conclusion of the study. The total population, experimental and control group participants alike, acknowledged or denied somatic concerns as specified by the Kincannon Mini-Mult instrument, utilizing the scores of Scale 1 and Scale 3 for the outcome measurement.

The hypothesis to be tested was: Did the planned professional intervention of the 4-session Bereavement Support Seminars have an effect on the physical symptoms reported by the experimental group in comparison to the control group?
To determine what effect, if any, the intervention contributed (assuming that the groups were similar on all other variables), the mean scores for the experimental and control groups pre- and posttests were computed. Using a nondirectional two-tailed t test for independent means at the .05 level of significance, the two groups, experimental and control, as well as the Michigan and Pennsylvania samples, were compared for differences on Scale 1, Hypochondriasis, on the Kincannon Mini-Mult. As an adjunct to this study, the identical process was completed to test for differences on Scale 3, Hysteria, on the same test instrument.

Procedure

With two separate locales involved in this study, it was of utmost importance to the quality of this research, that there be an identical procedure implemented by both researchers in their respective cities. To facilitate the attainment of that objective, a great deal of planning time was spent by Ms. Weidaw and this researcher to coordinate a format that would be specifically followed by each researcher in order to insure the consistency and validity of this study. Every effort was made to present identically organized and planned material to both the experimental and control groups alike, to prevent the site of data collection from becoming an uncontrolled
extraneous variable. Therefore, not only were all mailings and workshop contents developed conjointly, but a coordinated data collection schedule was formulated and followed religiously by both of the investigators (see Appendix A).

A time table was developed (see Appendix A). It was necessary to allow adequate time intervals for mailings to be returned and to maintain consistency between Group 1 and 2 and the groups in Grand Rapids and Pittsburgh. Events occurring in one locale were concurrently taking place in the other locale, with all the mailings sent on the same day, identically prepared and co-signed by both researchers.

So as to present the reader with a brief consecutive rendition of the procedure that was utilized for this research, but yet not be guilty of redundancy, the process that was implemented will be described for Group 1, with the understanding that the reader realizes this process was duplicated for Group 2 as well.

The Grand Rapids Press and Pittsburgh Press obituary columns were utilized to obtain names and addresses of 60 bereaved spouses in the combined Grand Rapids and Pittsburgh locales who had just experienced their spouse's death. These names were gathered on successive days until 60 names were collected in each locale. All of these surviving spouses were sent a letter explaining the
research (see Appendices B & H), a Bereavement Information sheet (see Appendix C), devised by the researchers to gain demographic information, and the Kincannon Mini-Mult test instrument labeled Bereavement Questionnaire, a short form of the MMPI (see Appendix D). These letters, including the bereavement information described above, were mailed to the bereaved spouses approximately one and one-half to two months following the death of their mate, with a self-addressed, stamped return envelope included in the mailing. Two weeks were allowed for the return mailing and then a follow-up letter was sent, again requesting cooperation in participating in the study by completing the bereavement information (see Appendices E & I). Three weeks subsequent to the second mailing, the return questionnaires were considered by the researchers to be the population of bereaved spouses to be utilized in the study.

By the random sampling method without replacement, one-half of the sample was classified as the experimental sample, and the remaining one-half of those returning questionnaires were designated as the control group. To the experimental group, an invitation to attend a 4-session Bereavement Support Seminar Series was extended (see Appendices F & J), with a self-addressed stamped postcard included for their convenience to respond regarding their intent. Two weeks after the invitation to attend the
seminar series was mailed, a follow-up phone call was made to those persons who had not acknowledged receipt of the seminar information by returning the enclosed postcard. This served as a means to not only determine the number of individuals planning on attending the seminar series, but to answer any specific questions and allay existing fears. The Bereavement Support Seminar Series was then conducted for the individuals who were willing to participate. These persons were identified as the experimental group to whom the treatment intervention was given. A more detailed description of these Bereavement Support Seminars will be given at the conclusion of this procedure outline. Subsequent to the termination of the fourth and final support seminar, but prior to the group members departure, the Kincannon Mini-Mult titled "Bereavement Questionnaire," was again administered to the experimental group bereaved spouses as a posttest instrument. The same week as the final support seminar, the designated control group members were each sent a letter explaining the importance of this follow-up portion of the research, and requesting them to complete and return, in the stamped envelope provided, the posttest instrument, the Bereavement Questionnaire. The test profiles were held until both of Group 1 and Group 2 Bereavement Support Seminar Series were completed and the total n had an opportunity to respond. It was tentatively planned, but not found to be
necessary, to send follow-up letters to the control group regarding return of the posttest instrument. This was not implemented, as they willingly complied.

With all the testing data completed by the bereaved spouses and returned to the researchers, the Kincannon Mini-Mult profiles were scored and computerized to analyze the data (see Chapter IV). The results were communicated by letter to those individuals, in both the experimental and control groups, who had indicated during the study, that they would like feedback regarding the results of the research. Copies of the letters to the experimental and control groups are found in Appendices L and M, respectively.

The independent variable of this research needs to be explained further, at this point, in that the Bereavement Support Seminar Series was mentioned intermittently earlier in this report by the researcher as the treatment intervention. Due to the importance of this treatment intervention, Ms. Weidaw and this researcher spent considerable time in joint effort to create the type of group felt desirable and necessary to meet the diverse needs of bereaved spouses. The group was identified as a bereavement support seminar in order to encompass the primary components the researchers felt essential; specifically, the elements of a supportive and sharing atmosphere coupled with didactic, educational material regarding
bereavement. The Bereavement Support Seminars were held for four consecutive weeks, with each of the four sessions one and one-half hours in length. In both the Grand Rapids, Michigan and Pittsburgh locales, the setting was that of a lounge-conversational area in a centrally located church, selected in order to project an informal and comfortable atmosphere. At the initial seminar session, guidelines for the group format and functioning were distributed to each group member and discussed. A copy of the Bereavement Support Seminar Guidelines can be found in Appendix P.

The Bereavement Support Seminar didactic material was written in the format that it was to be presented by the researchers (see Appendix Q), entitled The Process of Recovering From Grief. The didactic information was covered during the first three sessions as follows: Week 1 - What Is This Pain Called Grief? and The Stages of Grief Work; Week 2 - Anger, Guilt and What's Normal and Abnormal in Grief? and; Week 3 - Growing Thru Grief, Under Reconstruction, and What Does It Mean to be Single? The fourth and final session included a summarization of the first three weeks, and then dealt with "Where Do We Go From Here?" as part of the process of termination from the seminar series. Each of the weeks, 1 through 3, an outline of the material to be presented was given to each group member to further clarify and reinforce the
bereavement information. Copies of these three outlines utilized in the support seminars are found in Appendix R. Group discussion and sharing of the topics presented, as well as related concerns, were encouraged at each session with at least one-half of the time allotted for this purpose. Additionally, each person who attended the seminar series was given a reference list and encouraged to read sources relative to the grief process as well as to keep a personal journal. A copy of the reference list is found in Appendix S. All of the experimental group participants who began the Bereavement Seminar Series in both locales, completed the seminar series including the post-test instrument. Experimental Group 1 in Grand Rapids decided to continue meeting at the conclusion of the seminar series, but on a monthly basis. This researcher has recently been informed by a previous group member, that all six of the surviving spouses from Group 1 are still involved and actively participating in these planned meetings.
CHAPTER IV

RESULTS

Introduction

The results of the data analysis were obtained by use of the t test for independent means as the primary statistical tool for the outcome measures. The t test was the appropriate statistical procedure because it allowed comparison of the means of two or more groups. The conventional .05 alpha level was used. A nondirectional two-tailed significance test was employed, as it was expected that the results would lie on each end of the normal distribution, depending on the outcome measures. The degrees of freedom for the t tests in this study was 1 between groups (number of groups minus 1) and 60 within groups (number of subjects minus number of groups).

The dependent variable, that of reported physical symptoms, was measured by the Kincannon Mini-Mult, with a comparison of the means of the experimental and control groups on both the pre- and posttest administrations. By comparing posttest means of the two groups, it can be determined if there was a significant difference in the experimental groups' reported somatic complaints on the posttest following the treatment intervention (identified
as the independent variable), in contrast to the mean score of the control groups on Scale 1, Hypochondriases, of the test instrument. As an adjunct to this study, Scale 3 will be reported as well.

Prior to the analysis of the data pertaining to Scales 1 and 3 on the Kincannon Mini-Mult, it is necessary to report the findings related to the physical health of the subjects that were obtained from the Bereavement Information form (see Appendix C), which had been completed initially by all subjects participating in this study. Each person was asked three questions that necessitated a self-assessment of health status. Two of the questions asked bereaved spouses to rate their health status prior to and following their spouse's death in one of the following four categories: excellent (no physical problems); good (few minor physical problems); fair (some physical problems that required medical attention and caused you concern); and poor (experienced major physical problems). Each of these four categories were given a ranking by the researchers, with: 1 = excellent; 2 = good; 3 = fair; and 4 = poor. Mean scores were derived from these assigned values, so that comparisons could be made with the total experimental and control group population, as well as contrasting the subjects in both locales. The third question relative to the surviving spouse's health on the bereavement form inquired regarding
treatment for a special medical diagnosis (see Appendix C, question 7). If the person responded affirmatively, he/she was asked to explain further concerning the treatment and diagnosis in the space provided.

The responses to these questions on the Bereavement Information form, which dealt with the bereaved spouse's perceived health status, were regarded by the researcher as helpful baseline data prior to the interpretation of Scales 1 and 3, pre- and posttest of the Kincannon Mini-Mult.

Table 11 presents the tabulation of the n and percentages regarding the ratings of the bereaved spouse's health prior to their partner's death.

The mean score of the Michigan and Pennsylvania experimental group on the prior health variable was 1.84, with 1 = excellent and 2 = good, as shown in Table 11. This was compared with that of the combined locales control group, who were found to have a mean score of 2.216. The difference is significant (p = .048). This indicated that the experimental group at the beginning of the study, reported a 0.376 higher mean score for their health prior to their spouse's death than did the control group. In contrasting the Michigan and Pennsylvania experimental groups, with means of 1.714 and 2.00, respectively, p = 0.36, depicting no significant difference between these groups on the prior health variable. Likewise, for the
Michigan and Pennsylvania control groups, there was no statistically significant difference between the mean scores of 2.227 and 2.200, respectively ($p = .90$). The groups, both experimental and control in Michigan and Pennsylvania, were similar in their expressed prespousal death health. The difference was found initially to be in the total population comparison of experimental and control groups.

Table 11
Perceived Prior Health of Surviving Spouse

<table>
<thead>
<tr>
<th>Prior Health</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td><strong>Experimental Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent = 1</td>
<td>6</td>
<td>43%</td>
<td>3</td>
</tr>
<tr>
<td>Good = 2</td>
<td>6</td>
<td>43%</td>
<td>5</td>
</tr>
<tr>
<td>Fair = 3</td>
<td>2</td>
<td>14%</td>
<td>3</td>
</tr>
<tr>
<td>Poor = 4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Control Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent = 1</td>
<td>3</td>
<td>14%</td>
<td>1</td>
</tr>
<tr>
<td>Good = 2</td>
<td>12</td>
<td>55%</td>
<td>10</td>
</tr>
<tr>
<td>Fair = 3</td>
<td>6</td>
<td>27%</td>
<td>4</td>
</tr>
<tr>
<td>Poor = 4</td>
<td>1</td>
<td>5%</td>
<td>-</td>
</tr>
</tbody>
</table>

It is necessary, at this point, to ascertain the
reported health status of the bereaved spouse subsequent to their spouse's death. The summarization of the n and related percentages regarding postspousal death health status of the bereaved subjects can be found in Table 12.

Table 12

<table>
<thead>
<tr>
<th>Post-Spousal Death Health</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td><strong>Experimental Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent = 1</td>
<td>6</td>
<td>43</td>
<td>2</td>
</tr>
<tr>
<td>Good = 2</td>
<td>6</td>
<td>43</td>
<td>6</td>
</tr>
<tr>
<td>Fair = 3</td>
<td>2</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Poor = 4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Control Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent = 1</td>
<td>3</td>
<td>14</td>
<td>-</td>
</tr>
<tr>
<td>Good = 2</td>
<td>14</td>
<td>64</td>
<td>9</td>
</tr>
<tr>
<td>Fair = 3</td>
<td>4</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Poor = 4</td>
<td>1</td>
<td>5</td>
<td>-</td>
</tr>
</tbody>
</table>

The mean score of the total experimental group (1.920), was derived from tabulating the combined n value found in Table 12. In comparison, the mean score of the total control group population is 2.243, with $p = 0.10$.
indicative of no statistically significant difference between the two groups' postspousal death health status. In comparing the health status of the experimental and control groups prior to and following their spouses' death, it is interesting to note that in both groups, the means increased slightly, indicating that with the loss of a spouse, the surviving spouses' health deteriorated. Table 13 summarizes the means of both the experimental and control groups, prior to and postspousal death health status. It is necessary to again note in this table that health ratings are as follows: 1 = Excellent; 2 = Good; 3 = Fair; and 4 = Poor.

Table 13
Mean Scores of Prior and Post-Spousal Death Health Status

<table>
<thead>
<tr>
<th>Variable</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Health</td>
<td>1.714</td>
<td>2.000</td>
<td>1.84</td>
</tr>
<tr>
<td>Post-Spousal Death Health</td>
<td>1.714</td>
<td>2.182</td>
<td>1.920</td>
</tr>
<tr>
<td>Control Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Health</td>
<td>2.227</td>
<td>2.200</td>
<td>2.216</td>
</tr>
<tr>
<td>Post-Spousal Death Health</td>
<td>2.136</td>
<td>2.400</td>
<td>2.243</td>
</tr>
</tbody>
</table>

Both the Michigan experimental and control group
subjects did not report increased health problems subsequent to the death of their spouse, in contrast with the Pennsylvania group who did demonstrate a decrease in health status. The Michigan experimental groups health was reported to be the same.

The final factor that was examined was whether or not the participating subjects had been treated for any specific medical diagnosis. It was found that the groups were fairly well matched, in comparing the percentage of the control group who had received treatment with those of the experimental group. This was found to be true for comparison of the Michigan and Pennsylvania sites of the study as well. Table 14 delineates the various percentages for all the groups on the variable designated as receipt of medical treatment.

This completes the summarization of the health status data results derived from the Bereavement Information form, obtained from the subjects at the onset of the study. From these data, the experimental and control groups have been found to rate their health status similarly, particularly in regard to their perceived health following their spouse's death and receipt of medical treatment.
Table 14
Receipt of Medical Treatment for Specific Diagnosis

<table>
<thead>
<tr>
<th>Receipt of Medical Treatment</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Experimental Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>50</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>50</td>
<td>6</td>
</tr>
<tr>
<td>Control Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>55</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>45</td>
<td>7</td>
</tr>
</tbody>
</table>

*Reported with n and percentages based on each group's n

Data Analysis: Scale 1

The Kincannon Mini-Mult was administered to both the experimental and control groups as a pre- and posttest instrument (see Chapter III, Instrument). Scale 1, Hypochondriasis, was discussed previously as being a valid measurement of an individual's somatic complaints, and as such was utilized in this study to denote differences in reported physical manifestations of grief. A pretest administration was implemented by this researcher with the intent of determining a baseline for comparison between the experimental and control groups. The mean score for the combined Michigan and Pennsylvania experimental group
was 56.88, compared with a mean of 58.62 for the total control group (Table 15). It was determined that there was no statistically significant difference between these groups, with $t = -0.077$ and a $p$ value of 0.44. In computing comparisons between the two locales, both the Michigan and Pennsylvania experimental and control groups depicted no significant differences in reported physical symptoms assessed by this scale, with $t = 1.68$ and $p = 0.11$ for the Michigan-Pennsylvania experimental group comparison; and $t = 0.38$ and $p = 0.70$ for the Michigan-Pennsylvania control group.

The means and standard deviations of Scale 1 pretest for the total experimental and control group population, as well as for the separate locales, are provided in Table 15 and 16-17, respectively.

Table 15

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>56.88</td>
<td>7.82</td>
<td>25</td>
</tr>
<tr>
<td>Control</td>
<td>58.62</td>
<td>9.91</td>
<td>37</td>
</tr>
</tbody>
</table>

The Scale 1 interpretation of the mean is based on the test instrument by delineated T score ranges that signify various levels of somatic complaints. With a 45
or below T score, the individual may be denying bodily complaints; in the 45-60 range a person is reporting an average amount of physical symptoms, with the majority of the population scoring in this area; 60 through 70 is usual for persons with valid bodily complaints; and 70 or above the individual tends to use bodily complaints to avoid emotional situations, which may be employed in a manipulative manner. It can be noted from Table 15, that both the experimental and control groups were found to be in the high-average range (45-60), which is indicative of valid bodily complaints.

Table 16
Means and Standard Deviations, Scale 1 - Pretest: Michigan vs. Pennsylvania Experimental Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>54.57</td>
<td>6.61</td>
<td>14</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>59.82</td>
<td>8.54</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 17
Means and Standard Deviations, Scale 1 - Pretest: Michigan vs. Pennsylvania Control Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>58.09</td>
<td>9.66</td>
<td>22</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>59.4</td>
<td>10.6</td>
<td>15</td>
</tr>
</tbody>
</table>
The similarity of the two locales expressed somatic complaints can be identified by Tables 16 and 17. The groups, both experimental and control, displayed mean T scores in the same range, with the Pennsylvania groups having a slightly higher (but not statistically significantly so) mean than the Michigan groups.

A posttest administration of the Kincannon Mini-Mult was given to both the experimental and control groups. The results of the data analysis of this test administration determined whether or not the null hypothesis of this study could be rejected. The null hypothesis stated that "there is no difference in the mean score on Scale 1 (Hypochondriasis) of Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory of those bereaved spouses attending the Bereavement Support Seminar and those not attending." The experimental group comprised those subjects who attended the Bereavement Support Seminars and the control group did not participate in the seminars. Therefore, the mean score of the experimental group needed to be different from that of the control group in order to reject the null hypothesis and accept the alternate hypothesis.

The posttest mean of Scale 1 for the total experimental population was 52.80, contrasted by the control group subject mean of 62.5. This difference in the two group means is statistically significant, with $t = -3.88$
and \( p = 0.0003 \). Not only did this signify a significant difference in the two groups, but it depicted the experimental group with fewer expressed physical symptoms on the post-test than pretest administration, contrasted by an increase in reported somatic complaints by the control group. The experimental group mean decreased by 4.08 T scores, whereas the control group mean increased by 3.88 T scores. The results of this data analysis were contrary to the statement of the null hypothesis, therefore it can be rejected, with a 95% probability being correct in accepting the alternate hypothesis. The alternate hypothesis stated that "there is a difference in the mean score on Scale 1 (Hypochondriases) of Kincannon's Mini-Mult Short Form of the MMPI of those bereaved spouses attending the bereavement support seminar and the mean score of those not attending the bereavement support seminar," or \( H_a: \mu_{IS} \neq \mu_{INS} \) (please refer to Chapter I, Statement of Hypothesis for definition of symbols).

The means and standard deviations of Scale 1 - post-test for the total experimental and control group population are provided in Table 18.

The T score range for the mean of the experimental group was 45-60, representing an average amount of physical symptoms, compared with the control group mean T score range of 60-70 indicating valid but above average bodily complaints.
Table 18

Means and Standard Deviations, Scale 1 - Posttest:
Experimental and Control Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>52.86</td>
<td>7.22</td>
<td>25</td>
</tr>
<tr>
<td>Control</td>
<td>62.5</td>
<td>12.4</td>
<td>37</td>
</tr>
</tbody>
</table>

In comparing the mean scores of the posttest instrument, Scale 1, with the two different locales of the study, it is noted that there is not a statistically significant difference between the Michigan and Pennsylvania groups. The experimental group from Michigan's mean score was 50.86, contrasted by Pennsylvania's mean score of 55.27, with $t = 1.56$ and $p = 0.13$. The Michigan control group was found to have a 63.1 mean compared to a 61.5 mean score for the Pennsylvania control group, with $p = 0.67 > \alpha$ reflecting no significant difference. The following two tables, Table 19 and 20 are given for further clarification of this data.
Table 19
Means and Standard Deviations, Scale 1 - Posttest: Michigan vs. Pennsylvania Experimental Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>50.86</td>
<td>6.90</td>
<td>14</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>55.27</td>
<td>7.14</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 20
Means and Standard Deviations, Scale 1 - Posttest: Michigan vs. Pennsylvania Control Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>63.1</td>
<td>9.66</td>
<td>22</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>61.5</td>
<td>10.6</td>
<td>15</td>
</tr>
</tbody>
</table>

Pretest-posttest comparisons were then analyzed by means of a correlated sample t test to determine if there were statistically significant differences. The total experimental and control populations were investigated, as well as the individual Michigan and Pennsylvania locales. The pretest-posttest data is presented in Table 21.

In summarization of the analysis of data for Scale 1 of the Kincannon Mini-Mult, it was found that in the total experimental group, as well as in both the Michigan and Pennsylvania sub-groups, there was a decrease in expressed physical complaints; whereas, in the total control groups...
somatic complaints increased.

Table 21

Pretest-Posttest Scale 1: Mean Comparison and Probability of Experimental and Control Groups

<table>
<thead>
<tr>
<th>Kincannon’s Mini-Mult</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale 1 Pretest</td>
<td>54.47</td>
<td>59.82</td>
<td>56.88</td>
</tr>
<tr>
<td>Scale 1 Posttest</td>
<td>50.86</td>
<td>55.27</td>
<td>52.80</td>
</tr>
<tr>
<td>Scale 1 Pretest/Posttest</td>
<td>t = 1.45</td>
<td>t = 1.35</td>
<td>t = 1.92</td>
</tr>
<tr>
<td></td>
<td>p = 0.167</td>
<td>p = 0.19</td>
<td>p = 0.061</td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale 1 Pretest</td>
<td>58.09</td>
<td>59.4</td>
<td>58.62</td>
</tr>
<tr>
<td>Scale 1 Posttest</td>
<td>63.1</td>
<td>61.5</td>
<td>62.5</td>
</tr>
<tr>
<td>Scale 1 Pretest/Posttest</td>
<td>t = -1.41</td>
<td>t = -0.55</td>
<td>t = -1.48</td>
</tr>
<tr>
<td></td>
<td>p = 0.17</td>
<td>p = 0.59</td>
<td>p = 0.14</td>
</tr>
</tbody>
</table>

Data Analysis: Scale 3

Scale 3 is presented as a complement to Scale 1 of the Kincannon Mini-Mult. Scale 3, Hysteria, is divided into two different categories, one centering around physical symptoms and one measuring denial. When Scale 3 is moderately elevated (T 60 to 70), a denial of problems may
be all that is seen, whereas when this scale becomes markedly elevated (T 70 or above), physical complaints and denial become more prominent. The majority of people score in the T 45-60 range, with those scoring 45 or below typically tending to be caustic and tough.

It is important to note that an individual with an elevated 1-3 profile tends to convert his or her psychological difficulties into physical problems (Duckworth, 1979).

The pretest administration of Scale 3 found the total experimental group mean to be 62.60, compared with the control group mean of 63.46. The p value of 0.71 indicated there was no statistically significant difference between the two groups with t = -0.38. There also was no significant difference between either of the locales, when comparing T score means of the experimental and control sub-groups. The means and standard deviations of the Scale 3 pretest for the total experimental and control populations is presented in Table 22.

Table 22
Means and Standard Deviations, Scale 3 - Pretest: Experimental and Control Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>62.60</td>
<td>8.62</td>
<td>25</td>
</tr>
<tr>
<td>Control</td>
<td>63.46</td>
<td>9.13</td>
<td>37</td>
</tr>
</tbody>
</table>
As can be seen from the means of the T scores from both the experimental and control groups (Table 21) they are found to be in the T 60-70 range, indicative of a denial of problems.

The posttest, Scale 3 mean score differences were found to be statistically significant, with $t = 0.237$ and $p = 0.021$. This directly corresponded with the pattern and findings of Scale 1. The mean score of Scale 3 for the experimental group was 59.56, a decrease of 3.04 from the pretest Scale 3 mean score. In contrast, the mean score for the control group increased to 65.1, an increase in the mean of 1.64. There were no significant differences in the mean scores of the individual Michigan vs. Pennsylvania experimental and control groups. The means and standard deviations of the Scale 3 posttest for the experimental and control groups are provided in Table 23.

Table 23
Means and Standard Deviations, Scale 3 - Posttest: Experimental and Control Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>$n$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>59.56</td>
<td>8.02</td>
<td>25</td>
</tr>
<tr>
<td>Control</td>
<td>65.1</td>
<td>10.3</td>
<td>37</td>
</tr>
</tbody>
</table>

Pretest-posttest comparisons of each group were analyzed by means of a correlated sample $t$ test to
determine if there was a statistically significant difference within any of the groups (experimental, control, or in either locale) on the pretest-posttest. No differences were found of statistical significance according to the probability comparisons with the alpha level. Specific information regarding the derived mean scores and probability levels of each group is provided in Table 24.

Table 24
Pretest-Posttest Scale 3: Mean Comparison and Probability of Groups

<table>
<thead>
<tr>
<th>Kincannon's Mini-Mult</th>
<th>Michigan</th>
<th>Pennsylvania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale 3 Pretest</td>
<td>60.36</td>
<td>65.5</td>
<td>62.60</td>
</tr>
<tr>
<td>Scale 3 Posttest</td>
<td>57.27</td>
<td>62.45</td>
<td>59.56</td>
</tr>
<tr>
<td>Scale 3 Pretest/Posttest</td>
<td>( t = 1.25 )</td>
<td>( t = 0.72 )</td>
<td>( t = 1.29 )</td>
</tr>
<tr>
<td></td>
<td>( p = 0.22 )</td>
<td>( p = 0.48 )</td>
<td>( p = 0.20 )</td>
</tr>
<tr>
<td><strong>Control Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale 3 Pretest</td>
<td>62.95</td>
<td>64.2</td>
<td>63.46</td>
</tr>
<tr>
<td>Scale 3 Posttest</td>
<td>66.4</td>
<td>63.13</td>
<td>65.1</td>
</tr>
<tr>
<td>Scale 3 Pretest/Posttest</td>
<td>( t = -1.12 )</td>
<td>( t = 0.32 )</td>
<td>( t = -0.72 )</td>
</tr>
<tr>
<td></td>
<td>( p = 0.27 )</td>
<td>( p = 0.75 )</td>
<td>( p = 0.48 )</td>
</tr>
</tbody>
</table>
In reviewing the data presented relative to Scale 3 on the Kincannon Mini-Mult, it is significant to note that the experimental group reported fewer physical symptoms and denial on the posttest than they had on the pretest administration. The total control group, however, reported an increase in somatic complaints on the posttest instrument. This finding paralleled the data derived from the interpretation of Scale 1, with the occurrence of similar dynamics demonstrated by the test instrument.
CHAPTER V

SUMMARY, CONCLUSIONS, DISCUSSION AND IMPLICATIONS

Summary

This investigation was an attempt to evaluate the effectiveness of attending a bereavement support seminar on the level of expressed physical symptoms of bereaved spouses within the first year after the spouse's death.

The sample for this experimental study was obtained from obituary columns of both the Grand Rapids Press in Grand Rapids, Michigan and the Pittsburgh Press in Pittsburgh, Pennsylvania. In both locales 60 names were collected for the first group to complete the research process, and subsequently this procedure was repeated a few months later so that a total of 240 subjects were obtained.

Each of the surviving spouses were sent a letter approximately one and one-half to two months post-spousal loss to explain the research; a questionnaire devised by the researchers to gain demographic information; and Kincannon's Short Form of the Minnesota Multiphasic Personality Inventory to provide baseline data. Subsequent to a follow-up mailing, the subjects who responded by completing the requested data were considered to be the...
sample of bereaved spouses to be utilized in the study.

By the random sampling method without replacement, one-half of the sample population was classified as the experimental group and invited to attend a 4-week Bereavement Support Seminar Series, and the remaining on-half of the subjects comprised the control group.

The seminar series consisted of four, one and one-half hour sessions which included didactic information relative to bereaved spouses as well as providing a supportive milieu for group members. At the last session, the Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory was administered to the seminar membership and was concurrently mailed to members of the control group. The profiles were held until both of the seminar series had been given and the total n had an opportunity to respond. The total n completing the research process consisted of 62 subjects; 25 of whom were in the experimental group, with 37 subjects in the control sample.

Mean scores for experimental and control groups were computed utilizing a nondirectional two-tailed t-test for independent means. Scale 1, Hypochondriasis, of the Kincannon's Mini-Mult was the measure employed to compare experimental and control groups' expressed somatic complaints. Scale 3, Hysteria, was analyzed as an adjunct to Scale 1. Both Scales 1 and 3 mean scores of the
experimental group posttest administration of the Kincannon's Mini-Mult were found to depict statistically significant differences ($p < .05$) in comparison to the mean scores of the control group on these measures. Not only did the experimental group express fewer somatic complaints as measured by the posttest instrument, but the control group's reported physical symptoms increased from that of the pretest administration.

These findings suggest that there was a positive relationship between the treatment intervention and fewer reported physical symptoms.

At this point in time, this researcher remains unaware of any study that encompasses similar methodology as this investigative study, including the experimental group support seminar, closed session format facilitated by a professional, in combination with the Kincannon Mini-Mult (short form of the MMPI) pre- and posttest administration. Chapter III, Methods and Procedures, may be referred to for detailed information on both the support seminar and the test instrument employed.

Conclusions

This study found a statistically significant difference in the mean score on Scale 1 (Hypochondriasis) of Kincannon's Mini-Mult Short Form of the MMPI of those bereaved spouses who attended the Bereavement Support
Seminar, and the mean score on Scale 1 (Hypochondriasis) of Kincannon's Mini-Mult short form of the MMPI of those bereaved spouses who did not attend the Bereavement Support Seminar. The results of the data led to a rejection of the null hypothesis, at the .05 alpha level, with a 95% probability of being correct in accepting the alternate hypothesis. In rejecting the null hypothesis, which stated that there would be no difference in the mean score on Scale 1, the alternate is accepted, indicative of a difference in the mean score on Scale 1 of the experimental and control groups. The mean score for the pretest measurement on Scale 1 between groups demonstrated no statistically significant difference ($p = 0.44$). The posttest measurement on Scale 1 found a statistically significant difference between the experimental and control groups' mean scores ($p = 0.0003$ at the .05 level of significance. The mean for the experimental group decreased by 4.08 T scores, while the control group posttest, Scale 1 mean score increased by 3.88 T scores.

These findings are reinforced by the data derived from Scale 3, Hysteria, which complements the Scale 1 analysis. Scale 1 and 3 of the Kincannon Mini-Mult were found to parallel each other relative to the mean scores on the pre- and posttest administrations. Scale 3 pretest mean scores for both experimental and control groups were indicative of no significant differences with $p = 0.71$. 

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The posttest mean score measurements were statistically significant with \( p = 0.021 \). The posttest mean score on Scale 3 of the experimental group decreased 3.04 T scores, whereas, the control group mean score increased 1.64 T scores.

It can be concluded from the data obtained from this experimental study, that the experimental group improved in terms of fewer expressed somatic complaints, while the control group's physical symptoms increased, indicative of a decline in reported health status as measured by the Kincannon Mini-Mult Scale 1. The only known intervening variable was that of the independent variable introduced by the researchers, that being, the Bereavement Support Seminar Series. The experimental and control group subjects demonstrated no statistically significant differences in regard to their age, sex, educational level, length of marriage, or length of their deceased spouse's illness. The mean age of the experimental sample was 60.5 years, compared to 64.7 for the control group. The experimental group composition was 64% female and 36% male; as compared with the control group which was comprised of 78% female and 22% male. The educational level was slightly higher for the experimental group, but both experimental and control groups were found to have the highest percentage of subjects in the high school graduate category. The length of time married for both groups fell
in the 20-39 year range. Both the experimental and control groups' highest percentages for the length of their spouse's illness prior to death were found to be in the range of 25+ months.

The Bereavement Information form detected one difference which was found to be statistically significant between the experimental and control groups, that of the bereaved spouse's health prior to being widowed. The experimental group reported a 0.376 higher mean score in perceived health than did the control group, with a \( p = 0.048 \). The experimental group's mean score was placed in the "excellent" category, as contrasted with the control group's score found to be in the "good" category. This does not appear to be a factor which would have much effect, if any, on the research findings of this study. This is primarily due to the subsequent postspousal death perceived health of the surviving spouses of both groups, which depicted no statistically significant difference. The questions posed on the Bereavement Information form were retrospective, and as such, have little weight in comparison with the current results of the Kincannon Mini-Mult test instrument, where health status was well-matched between the experimental and control groups at the onset of this study.

It would appear, then, that the significant difference having an effect on the experimental group's decrease
in somatic concerns was the Bereavement Support Seminar Series, as this was the one identifiable variance.

Discussion

The most obvious conclusion from the data analysis was that the treatment did make a difference. The study found a relationship between the treatment intervention and a decrease in expressed physical symptoms in bereaved spouses. Regardless of the promising results of this study, it seems important in retrospect, to evaluate general areas of this study that could be improved with future investigation. The two areas that were identified are: sample and instrumentation.

Sample

Although the final sample size of 62 subjects did not yield results as powerful as a larger sample could have, the sample size was adequate to perform the planned analysis. It is significant to mention that there was no attrition in the experimental population once the subjects had initially attended a bereavement support seminar. This speaks to the difficulty in getting bereaved spouses to agree to attend the first time. A factor to be considered regarding this study is that there may have been significant differences between those potential subjects (n = 240) contacted initially to participate in this study.
who agreed to be involved (n = 62) as opposed to those who did not respond to the first and second mailings (n = 178). In discussing the issue of willingness to participate among the experimental group members, it seemed evident that one needed to have either enough self-esteem to be venturesome, or desperately hurting and feeling a need to do something for oneself, in order to agree to attend. It was frequently mentioned by the experimental group, that society does not advocate attendance of a bereavement group, but rather reinforces the state of denial and letting time take care of it. With a low energy level characteristic of the grief process, the bereaved may find it an effort to do anything.

A suggestion from group members was that a bereavement group be recommended, and the necessity of it discussed, by both the attending physician and the funeral director at the time of spousal death. Many of the experimental subjects commented that had they been invited to attend a group at an earlier point after their loss, rather than at the 3-4 month postspousal death period, they would have felt even more of a need, and less reluctance to participate.

These factors may need to be examined more closely prior to further research, in that the power of the study would have been increased with a larger sample size.
Instrumentation

The Kincannon Mini-Mult, short form of the MMPI, was the only standardized measure used in this study. Although this test measurement reports generally good reliability, it may have overlooked the identification of some of the physical aspects of grief experienced by bereaved spouses, because it is not specifically for grieving persons. The subjects' mean scores on both the pretest and posttest administrations of the test instrument were not in the excessively high T score range, but did depict generally valid bodily complaints with some concurrent denial of problems.

The test instrument did effectively measure the outcome necessary for this investigation, but it may be interesting in future research to correlate the Kincannon Mini-Mult with a test instrument specifically related to grief.

Implications

The positive outcome of this experimental study reinforced for this researcher the importance of a treatment intervention for bereaved spouses. It could be implied that the combination of increased information regarding the grief process, in conjunction with a supportive environment conducive to sharing feelings, promoted both a reduction of expressed physical symptoms and less
denial of the problem for those persons who agreed to participate in the Bereavement Seminar Series.

It would seem to follow, that if the goal of health professionals, therapists, and other supportive care givers is to reduce the threat of physical illness and death in the surviving spouse subsequent to the death of his/her mate, these professionals must be cognizant of the latest research, and willing to employ these findings in their work with bereaved spouses. It is necessary that those professions interfacing with the bereaved, be aware of the physical symptoms displayed in the survivors and utilize this knowledge in providing therapy and support to them.

Further research continues to be necessary as a means of increasing understanding of effective interventions for bereaved spouses. It would be of interest to this researcher, to conduct a follow-up investigation with the existing sample of this study at the one-year postspousal death point, to evaluate the continuing effectiveness of the treatment intervention, as determined by the administration of the Kincannon Mini-Mult, Scale 1.

The more research undertaken in the area concerned with reversing the negative effects of becoming widowed, the closer we are to eliminating morbidity and mortality in the surviving spouse.
Appendix A

Coordinated Time Schedule for Experimental and Control Groups 1 and 2 in Michigan and Pennsylvania
Coordinated Time Schedule for Experimental and Control Groups 1 & 2, Michigan

8 December 1986  Begin to collect names of bereaved spouses from the obituary column to form Group 1.

19 January 1987  Send out letter and initial assessment packet to 60 participants of Group 1.

23 February 1987  Send out follow-up letter and initial assessment packet to participants of Group 1 who have not responded.

2 March 1987  Send out letter inviting experimental Group 1 participants to attend the bereavement support seminar.

16 March 1987  Send out letter and initial assessment packet to 60 participants of Group 2.

27 April 1987  Begin to collect names of bereaved spouses from obituary column to form Group II.

2 March 1987  Send out follow-up letter and initial assessment packet to participants of Group 2 who have not responded.

6 April 1987  Begin Bereavement Support Seminar for experimental Group 1 to continue for four weeks.

6 April 1987  Send out letter inviting experimental Group 2 participants to attend the bereavement support seminar.

This week administer post-test assessment and terminate bereavement support seminar for Group 1.

Send out letter and post-test assessment to control Group 1.

27 April 1987  Begin bereavement support seminar for experimental Group 2 to continue for four weeks.
18 May 1987
This week administer post-test
assessment and terminate bereavement
support seminar for Group 2.

Send out letter and posttest assessment
to control Group 2.

August 1987
Send out letter of thanks and results
of study.
## Timetable for Data Collection

<table>
<thead>
<tr>
<th>Week</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>Collect Names</td>
<td>Collect Names</td>
</tr>
<tr>
<td>6-12</td>
<td>Initial Assessment Packet Sent</td>
<td>Initial Assessment Packet Sent</td>
</tr>
<tr>
<td>13-15</td>
<td>Follow-up Letter Sent</td>
<td>Follow-up Letter Sent</td>
</tr>
<tr>
<td>16-20</td>
<td>Invite to Bereavement Seminar</td>
<td>Invite to Bereavement Seminar</td>
</tr>
<tr>
<td>21-22</td>
<td>Bereavement Support Sessions</td>
<td>Bereavement Support Sessions</td>
</tr>
<tr>
<td>23-24</td>
<td>Bereavement Support Sessions</td>
<td>Bereavement Support Sessions</td>
</tr>
<tr>
<td>25-28</td>
<td>Bereavement Support Sessions</td>
<td>Bereavement Support Sessions</td>
</tr>
<tr>
<td>29-31</td>
<td>Bereavement Support Sessions</td>
<td>Bereavement Support Sessions</td>
</tr>
</tbody>
</table>

### Dates
- August 1987
- September 1987
Appendix B

First Mailing Cover Letter to 60 Bereaved Spouses in Michigan (Group 1)
Dear

We know that this is a difficult period of time for you with the recent loss of your spouse, and that is specifically why we are requesting your assistance at this time. It is our hope to better understand how to meet the needs of persons experiencing this type of loss.

As doctoral students at Western Michigan University, doing dissertation research, we are interested in the grief process and how to better assist those who are newly bereaved. You have been selected as part of a sample, and your responses are crucial to the outcome of the study. We would greatly appreciate you taking a short period of time to thoughtfully check your responses on the enclosed information sheets.

Your responses will be held in the strictest confidence. The code number in the right-hand corner is used only to check off surveys as they return and keep track of who needs a friendly reminder. Only group data will be reported, protecting your identity.

Please take a few minutes, answer the questions and return in the envelope provided by January 30, 1987. Your answers will be an important contribution to an area in need of investigation. If you would like a summary of the findings, please check the box so indicating on the information sheet.

Thank you for your time and caring. You have helped expand our knowledge of the grief process.

Sincerely,

Susan J. Smeenge, R.N., M.A.
Doctoral Candidate

Approved By:

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson

Counselor Education and Counseling Psychology
(616) 383-1975
19 January 1987
Appendix C

Bereavement Information Sheet
BEREAVEMENT INFORMATION

This section is general information about YOU, a bereaved spouse:

1. Your age 2. Your sex: [ ] Male [ ] Female

3. Your educational level [ ] grade completed [ ] high school graduate [ ] years in college [ ] degree

4. Length of time married to deceased spouse

5. Your health status PRIOR to spouses' death:
   [ ] EXCELLENT (no physical problems)
   [ ] GOOD (few minor physical problems)
   [ ] FAIR (some physical problems that required medical attention and caused you concern)
   [ ] POOR (experienced major physical problems)

6. Your health status FOLLOWING your spouses' death
   [ ] EXCELLENT (no physical problems)
   [ ] GOOD (few minor physical problems)
   [ ] FAIR (some physical problems that required medical attention and caused you concern)
   [ ] POOR (experienced major physical problems)

7. Have you been treated for any specific medical diagnosis? [ ] No [ ] Yes (If Yes, please explain ____________)

8. Have you experienced "blue days" prior to spouses' death? [ ] No [ ] Yes (If Yes, _____Rarely _____Monthly _____Weekly)

9. Have you received treatment for depression? [ ] No [ ] Yes (If Yes, Inpatient hospitalization Outpatient therapy Medication)

   When did you receive this treatment? _______________________________

This section of general information is about YOUR DECEASED SPOUSE:

1. Age of deceased spouse 2. Sex [ ] Male [ ] Female

3. Educational level [ ] grade completed [ ] high school graduate [ ] years in college [ ] degree

4. Health status of deceased spouse for the past 3 years:
   [ ] EXCELLENT (no physical problems)
   [ ] GOOD (few minor physical problems)
   [ ] FAIR (some physical problems that required medical attention and caused concern)
   [ ] POOR (experienced major physical problems)

5. Length of deceased spouses's illness prior to his/her death?

6. Medical diagnosis and/or cause of death:

   _______________________________

   [ ] I would like a report of the findings of this study.
Appendix D

Bereavement Questionnaire (The Kincannon Mini-Mult)
BEREAVEMENT QUESTIONNAIRE

Please circle YES or NO in response to each question as it relates to you and the way you are living at this time. Try to respond to all the questions.

YES NO 1. Do you have a good appetite?
YES NO 2. Do you wake up fresh and rested most mornings?
YES NO 3. Is your daily life full of things that keep you interested?
YES NO 4. Do you work under a great deal of tension?
YES NO 5. Once in a while, do you think of things too bad to talk about?
YES NO 6. Are you troubled by constipation?
YES NO 7. Have you, at times, very much wanted to leave your home?
YES NO 8. At times, do you have fits of laughing and crying that you cannot control?
YES NO 9. Are you troubled by attacks of nausea and vomiting?
YES NO 10. Does it seem that no one understands you?
YES NO 11. At times do you feel like swearing?
YES NO 12. Do you have nightmares every few nights?
YES NO 13. Do you find it hard to keep your mind on a task or job?
YES NO 14. Have you had very peculiar and strange experiences?
YES NO 15. Would you have been much more successful if people had not had it in for you?
YES NO 16. During one period when you were a youngster, did you engage in petty thievings?
YES NO 17. Have you had periods of days, weeks or months when you couldn't take care of things because you couldn't "get going"?
YES NO 18. Is your sleep fitful and disturbed?
YES NO 19. When you are with people are you bothered by hearing very queer things?
YES NO 20. Are you liked by most people who know you?
YES NO 21. Have you often had to take orders from someone who did not know as much as you did?
YES NO 22. Do you wish you could be as happy as others seem to be?
YES NO 23. Do you think a great many people exaggerate their misfortunes to gain sympathy and help of others?
YES NO 24. Do you sometimes get angry?
YES NO 25. Are you definitely lacking in self-confidence?
YES NO 26. Are you troubled with your muscles twitching or jumping?
YES NO 27. Much of the time, do you feel as if you have done something wrong or evil?
YES NO 28. Are you happy most of the time?
YES NO 29. Are some people so bossy that you feel like doing the opposite of what they request even though you know they are right?
YES NO 30. Are you being plotted against?
YES NO 31. Will most people use somewhat unfair means to gain profit or advantage rather than lose it?
YES NO 32. Do you have a great deal of stomach trouble?
YES NO 33. Have you often been cross or grouchy without understanding why?
YES NO 34. At times have your thoughts raced ahead faster than you could speak them?
YES NO 35. Is your home life as pleasant as that of most people you know?
YES NO 36. Do you certainly feel useless at times?
YES NO 37. During the past few years, have you been well most of the time?
YES  NO  38. Have you had periods in which you carried on activities without later knowing what you have been doing?
YES  NO  39. Do you feel that you have been punished without cause?
YES  NO  40. Have you ever felt better in your life than you do now?
YES  NO  41. Are you bothered by what others think of you?
YES  NO  42. Is your memory all right?
YES  NO  43. Do you find it hard to make talk when you meet new people?
YES  NO  44. Do you feel weak all over much of the time?
YES  NO  45. Are you troubled by headaches?
YES  NO  46. Have you had difficulty in keeping your balance in walking?
YES  NO  47. Do you like everyone you know?
YES  NO  48. Is anyone trying to steal your thoughts and ideas?
YES  NO  49. Do you wish you were not so shy?
YES  NO  50. Do you believe your sins are unpardonable?
YES  NO  51. Do you frequently find yourself worrying about something?
YES  NO  52. Have your parents often objected to the kind of people that you went around with?
YES  NO  53. Do you gossip a little at times?
YES  NO  54. Do you, at times, feel that you can make up your mind with unusually great ease?
YES  NO  55. Are you troubled by your heart pounding and by a shortness of breath?
YES  NO  56. Do you get mad easily and then get over it soon?
YES  NO  57. Do you have periods of such great restlessness that you cannot sit long in a chair?
YES  NO  58. Do your parents and family find more fault with you than they should?
YES  NO  59. Does anyone care much what happens to you?
YES  NO  60. Do you blame a person for taking advantage of someone who lays himself open to it?
YES  NO  61. Are you full of energy at times?
YES  NO  62. Is your eyesight as good as it has been for years?
YES  NO  63. Do you often notice your ears ringing or buzzing?
YES  NO  64. Have you ever felt that someone was making you do things by hypnotizing you?
YES  NO  65. Have you had periods in which you felt unusually cheerful without any special reason?
YES  NO  66. Even when you are with people, do you feel lonely much of the time?
YES  NO  67. Do you think nearly anyone would tell a lie to keep out of trouble?
YES  NO  68. Are you more sensitive than most other people?
YES  NO  69. Does your mind seem to work more slowly than usual, at times?
YES  NO  70. Do people often disappoint you?
YES  NO  71. Have you used alcohol excessively?

This completes the questionnaire. Thank you for taking the time to contribute information to this study. Your participation is very valuable and we appreciate your effort.

Yes, please send me a copy of the report of this study.
Appendix E

Follow-up Letter to 60 Bereaved Spouses in Michigan (Group 1)
Western Michigan University  
Kalamazoo, Michigan 49008-3899

Counselor Education and Counseling Psychology  
(616) 383-1975

2 February 1987

Dear

We have not received any response to our request for information regarding your bereavement experience. This is to remind and encourage you to complete and return the enclosed information sheets. It is crucial, if this study is going to be of value in increasing knowledge of the grief process, that all of the bereaved spouses, who are willing to do so, take a short period of time to check responses on the enclosed information sheets.

If you need more information, or would like to discuss the study in more detail, please feel free to call me at Thank you for your time and caring. You have helped expand our knowledge of the grief process.

Sincerely,

Susan J. Smeenge, R.N., M.A.  
Doctoral Candidate

Carole Jeanne Weidaw, R.N., M.A.  
Doctoral Candidate

Approved By:

Dr. Robert Oswald, Professor  
Doctoral Committee Chairperson
Appendix F

Letter Inviting Experimental Group 1 to Bereavement Support Seminars
Dear

You may recall completing a bereavement information packet approximately six weeks ago. We know that being recently bereaved is undoubtedly very difficult for you in many ways, and realize it was an effort for you to take the time to answer the questions and return it. We thank you and appreciate the contribution you have made to our increased understanding of the grief process.

As the second and final phase of this study, we would like to invite you to a four-week Bereavement Support Seminar. The seminar will provide information on how to cope with your grief and begin to recover. This group will also give you an opportunity to meet in a small group with other recently bereaved spouses to discuss mutual concerns related to the death of your mate. The seminar is being given in a location we hope to be convenient for you. We encourage you to carefully consider being a part of the group to assist you during this difficult period of time.

Specifics you will need to know:
Dates:
Time:
Location:

Please feel free to contact me if you have any further questions regarding this seminar. My phone number is [insert phone number]. Please return the enclosed postcard and include your phone number if time schedules are creating a problem. We are looking forward to meeting you.

Sincerely,

[Signature]

Susan J. Smeenge, R.N., M.A.
Doctoral Candidate

Approved By:

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson

Carole Jeanne Weidaw, R.N., M.A.
Doctoral Candidate
Appendix G

Letter Requesting Control Group 1 to Again Complete Bereavement Information Sheet and Questionnaire
Dear

You may recall completing bereavement information forms approximately three months ago. We would like to thank you for taking the time to answer the questions and return the information to us. The data is now being compiled and will contribute to an increased understanding of the grief process.

As the final phase of this study, we would greatly appreciate you taking a short period of time to thoughtfully check your responses on the enclosed bereavement questionnaire and return it to us in the envelope provided by April 18, 1987. Your answers again will be an important contribution to an area in need of investigation. You may at this time, request a summary of the findings by so indicating on the questionnaire.

Thank you for your time and caring. You have helped expand our knowledge of the grief process.

Sincerely,

Susan J. Smeenge, R.N., M.A.
Doctoral Candidate

Carolane Jeanne Weidaw, R.N., M.A.
Doctoral Candidate

Approved By:

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson
Appendix H

First Mailing Cover Letter to 60 Bereaved Spouses in Michigan (Group 2)

143
Dear

We know that this is a difficult period of time for you with the recent loss of your spouse, and that is specifically why we are requesting your assistance at this time. It is our hope to better understand how to meet the needs of persons experiencing this type of loss.

As doctoral students at Western Michigan University, doing dissertation research, we are interested in the grief process and how to better assist those who are newly bereaved. You have been selected as part of a sample, and your responses are crucial to the outcome of the study. We would greatly appreciate you taking a short period of time to thoughtfully check your responses on the enclosed information sheets.

Your responses will be held in the strictest confidence. The code number in the right-hand corner is used only to check off surveys as they return and keep track of who needs a friendly reminder. Only group data will be reported, protecting your identity.

Please take a few minutes, answer the questions and return in the envelope provided by March 14, 1987. Your answers will be an important contribution to an area in need of investigation. If you would like a summary of the findings, please check the box so indicating on the information sheet.

Thank you for your time and caring. You have helped expand our knowledge of the grief process.

Sincerely,

Susan J. Smeenge
Susan J. Smeenge, R.N., M.A.
Doctoral Candidate

Approved By:

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson

Carolé Jeanne Weidaw, R.N., M.A.
Doctoral Candidate
Appendix I

Follow-up Letter to 60 Bereaved Spouses in Michigan (Group 2)
Dear 

We have not received any response to our request for information regarding your bereavement experience. This is to remind and encourage you to complete and return the enclosed information sheets. It is crucial, if this study is going to be of value in increasing knowledge of the grief process, that all of the bereaved spouses, who are willing to do so, take a short period of time to check responses on the enclosed information sheets.

If you need more information, or would like to discuss the study in more detail, please feel free to call me at

Thank you for your time and caring. You have helped expand our knowledge of the grief process.

Sincerely,

Susan J. Smeenge
Susan J. Smeenge, R.N., M.A.
Doctoral Candidate

(Approved By)

Carole Jeanne Weidaw, R.N., M.A.
Doctoral Candidate

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson
Appendix J

Letter Inviting Experimental Group 2 to Bereavement Support Seminars
Dear

You may recall completing a bereavement information packet approximately six weeks ago. We know that being recently bereaved is undoubtedly very difficult for you in many ways, and realize it was an effort for you to take the time to answer the questions and return it. We thank you and appreciate the contribution you have made to our increased understanding of the grief process.

As the second and final phase of this study, we would like to invite you to a four-week Bereavement Support Seminar. The seminar will provide information on how to cope with your grief and begin to recover. This group will also give you an opportunity to meet in a small group with other recently bereaved spouses to discuss mutual concerns related to the death of your mate. The seminar is being given in a location we hope to be convenient for you. We encourage you to carefully consider being a part of the group to assist you during this difficult period of time.

Specifics you will need to know:

Dates:

Time:

Location:

Please feel free to contact me if you have any further questions regarding this seminar. My phone number is Please return the enclosed postcard and include your phone number if time schedules are creating a problem. We are looking forward to meeting you.

Sincerely,

Susan J. Smeenge, R.N., M.A.
Doctoral Candidate

Approved By:

Carole Jeanne Weidaw, R.N., M.A.
Doctoral Candidate

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson
Appendix K

Letter Requesting Control Group 2 to Again Complete the Bereavement Information Sheet and Questionnaire
Dear

You may recall completing bereavement information forms approximately three months ago. We would like to thank you for taking the time to answer the questions and return the information to us. The data is now being compiled and will contribute to an increased understanding of the grief process.

As the final phase of this study, we would greatly appreciate you taking a short period of time to thoughtfully check your responses on the enclosed bereavement questionnaire and return it to us in the envelope provided by May 30, 1987. Your answers again will be an important contribution to an area in need of investigation. You may at this time, request a summary of the findings by so indicating on the questionnaire.

Thank you for your time and caring. You have helped expand our knowledge of the grief process.

Sincerely,

Susan J. Smeenge, R.N., M.A.
Doctoral Candidate

Carole Jeanne Weidaw, R.N., M.A.
Doctoral Candidate

Approved By:

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson
Appendix L

Letter to Experimental Groups 1 and 2
Regarding Results of Study
Dear

The process of compiling the bereavement data has just been completed and we wanted to share the results with you. We appreciate your willingness to cooperate by completing the bereavement forms and attending the four-week bereavement workshops. Your input has been very valuable to us in understanding the grief process, and the effect of group and professional intervention early in the period of mourning.

We examined the research data from those of you who had attended the four-week bereavement support seminars compared with another group of bereaved spouses who had only completed the bereavement questionnaires, in relation to feelings of depression and physical symptoms. Those of you who agreed to attend the workshops, as a group, tended to be slightly younger (average range of 50 to 65 years old); better educated, and having reported better physical health than those not attending. Although the studied population was largely female, a male participant was more likely to choose to attend the seminars than not. The combined workshops were composed of 64% female and 36% male. The majority of participants in the study had advanced warning of the death of their spouse, with the average length of illness being 13 to 15 months. The results indicate that 75% of the participants had experienced some "blue" days, but 92% had not previously required medical help.

As indicated on the Bereavement Questionnaire, those attending the four-week seminar displayed lower physical symptomatology compared with those not attending who were found to show an increase in physical symptoms during the time period. The number of items endorsed to indicate depression suggest that those not attending the seminar became more depressed over time, while those who attended the bereavement groups did not increase their level of depression. These results are encouraging that early intervention in the grief process may be helpful in reducing the illness and mortality rate, as well as providing coping skills to deal with the depressive aspects of the grief process.

This research indicates that the bereavement workshops were a positive influence in reducing symptomatology early in the process of grieving, and it is our hope that it was and will continue to be of benefit to you.

Our best wishes,

Susan Smeenge & C.J. Weidaw
Appendix M

Letter to Control Groups 1 and 2 Regarding Results of Study
Dear

As you may recall, shortly after the death of your spouse, you completed two bereavement questionnaires and the results have now been compiled and we wanted to share with you the results of this study.

We examined the research data from those persons who had attended a four-week bereavement support seminar and those who had not, in relation to feelings of depression and physical symptoms. It appears that those persons who attended the support seminars experienced fewer symptoms than those who did not. Therefore, the data obtained supports group and professional intervention in assisting those spouses who are bereaved.

We hope this information will be helpful to you as you progress through the grief process, as well as others who lose a spouse. Again, we want to express our appreciation for your willingness to participate in our doctoral dissertation research. Your participation was of value and has made a contribution to knowledge about the grief process.

Our best wishes,

Susan Smeenge
Susan J. Smeenge, R.N., M.A.
Doctoral Candidate

Carole Jeanne Weidaw, R.N., M.A.
Doctoral Candidate
Appendix N

Kincannon's Mini-Mult Scoring Sheets
<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
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<tbody>
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<td>41. Are you bothered by what others think of you?</td>
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<td>42. Is your memory all right?</td>
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<td>43. Do you find it hard to make talk when you meet new people?</td>
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<td>44. Do you feel weak all over much of the time?</td>
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<td>45. Are you troubled by headaches?</td>
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<td>46. Have you had difficulty in keeping your balance in walking?</td>
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<td>47. Do you like everyone you know?</td>
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<td>48. Is anyone trying to steal your thoughts and ideas?</td>
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<td>49. Do you wish you were not so shy?</td>
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<td>50. Do you believe your sins are unpardonable?</td>
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<td>51. Do you frequently find yourself worrying about something?</td>
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<td>52. Have your parents often objected to the kind of people that you went around with?</td>
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<tr>
<td>53. Do you gossip a little at times?</td>
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<td>54. Do you, at times, feel that you can make up your mind with unusually great ease?</td>
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<tr>
<td>55. Are you troubled by your heart pounding and by a shortness of breath?</td>
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<td>56. Do you get mad easily and then get over it soon?</td>
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<td>57. Do you have periods of such great restlessness that you cannot sit long in a chair?</td>
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<tr>
<td>58. Do your parents and family find more fault with you than they should?</td>
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<tr>
<td>59. Does anyone care much what happens to you?</td>
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<tr>
<td>60. Do you blame a person for taking advantage of someone who lays himself open to it?</td>
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<td>61. Are you full of energy at times?</td>
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<td>62. Is your eyesight as good as it has been for years?</td>
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<td>63. Do you often notice your ears ringing or buzzing?</td>
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<td>64. Have you ever felt that someone was making you do things by hypnotizing you?</td>
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<td>65. Have you had periods in which you felt unusually cheerful without any special reason?</td>
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<td>66. Even when you are with people, do you feel lonely much of the time?</td>
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<td>67. Do you think nearly anyone would tell a lie to keep out of trouble?</td>
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<td>68. Are you more sensitive than most other people?</td>
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<td>69. Does your mind seem to work more slowly than usual, at times?</td>
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<td>70. Do people often disappoint you?</td>
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<td>71. Have you used alcohol excessively?</td>
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The Minnesota Multiphasic Personality Inventory

Starke R. Hathaway and J. Charnley McKinley

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* K to be added
* Raw Score with K
Appendix O

Codebook for Data Analysis by Computer
Data Stored: DEP-PHY LOSS
Format (10F 1.0, 6F3.0)

**CODEBOOK**

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Appendix P

Guidelines for the Bereavement Support Seminars
GUIDELINES FOR THE BEREAVEMENT SUPPORT SEMINAR

Facilitated by CJ Weidaw, RN, MA and S. Smeenge, RN, MA

1) Each of the experiences is unique and valid. No one is here to criticize or analyze.

2) Feel free to share your feelings and experiences. We will not probe. If you had a similar experience and care to relate to what others share, feel free to do so.

3) Paper is available for you to write down anything which comes to mind. It is okay to write while others are talking. Notes are for yourself and you will not be asked to share them.

4) It is acceptable to cry. There are tissues available and we ask that you be sensitive to your neighbor's needs.

5) If you feel the need to leave, feel free to go. One of us will follow you out of the room to be sure that you are ready to drive before you leave.

6) Should you wish to share a bad experience you have had with a hospital, nurse or doctor, feel free to relate the experience. We would ask that you not use the name in the discussion.

7) After the initial presentation, you may respond to what has been presented or open with anything you wish to bring up. We encourage you to respond to each other.
Appendix Q

Seminar Series Material Entitled "The Process of Recovering From Grief"
The Process of Recovering From Grief

Presented at a 4 week Bereavement Support Seminar
by: CJ Weidaw, RN, MA, and Susan Smeenge, RN, MA, Psychology Doctoral Candidates

Loss - part of life which we must all painfully learn to cope with

- not all losses of equal magnitude - one of most profound loss of one loved thru death

- loss of a spouse particularly acute because spouse is person with whom you are most intimate and from whom you gain much of identity

- information helps dispel fear

Workshop #1

I. What Is This Pain Called Grief? (hurting, sadness, loneliness, crying, anger, bitterness, feeling inadequate=identifying feelings that are part of process called grief).

A. Grief work = Sigmund Freud called process this: is hardest work one will ever be called on to do = tremendous expenditure of emotional and physical energy
   The work doesn't just happen=it means having to be intimately involved in the process and work at it.

B. How long? Isn't a single event in time, but is a process. Difficult because our society wants everything instant.
   Length of grief depends on many things - nature of relationships-each unique
   Pressure from society to hurry up and return to "normal". Society wants things resolved in 3-6 months.
   Death usually happens in an instant - in a moment your loved one is gone, but your love is not gone.
   Life will never be the same again, but it can be good.

C. Don't avoid the pain - when anything is extremely painful, we try to avoid it.
   Don't avoid the painful feelings and emotions of bereavement.
   Unresolved grief is like a festering deep wound covered by a superficial scar.

D. Getting death out of closet - every minute death occurs in 2 American families.
   Over 6 million widows in U.S. alone.
   Loss = being deprived of or without something or someone that you've valued and cherished. Bereavement = the act of separation.
   Bereavement sets in motion a process called grief.

E. Well-meaning friends - grief doesn't occur in a vacuum, but in the midst of everyday life, including others.
   Grief cries out to be shared, but is hard to find the right person to share it with.
   Someone who will listen and is slow to give advice.
**Growth Challenge:** Keeping a Journal - jot down real feelings when feeling overwhelmed—a release
Much later will serve as measure of how far you've come and how much you've grown.

II. **Stages of Grief Work**

Unknown always more terrifying than known. If you know what to expect in your grief process, the anxiety will be lessened.

4 Stages of Grief Recovery

Phase 1 - Shock
2 - Suffering
3 - Recovery
4 - Growth = lifelong process of personal stretching and development

Don't expect phases of grief to be a neat orderly progression. Grief spirals down; it spirals up - unpredictable moods.

A. Phase 1 - Shock = "a sudden or violent impact" (can't believe it)

-is somewhat affected by way you found out about the death
Hopefully news of death will be communicated with understanding and compassion.
-part of shock is an involuntary physical reaction (automatic reaction in effort to protect itself from further assault) . . . rapid breathing, rapid pulse, tensing of muscles, perspiration, dry mouth, pain, nausea, insomnia, involuntary bowel/bladder responses.
- psychological numbness - feel like a mechanical person going thru the motions like in a fog
- loss of spouse has been called psychological amputation - "phantom limb" phenomenon = image spouse still alive, expecting to return at any moment.

B. Phase 2 - Suffering = realization loved one is not coming back; life is never going to be the same; that grief work is going to take a long, long time and be painful.

-don't suppress feelings
-normal to feel a sense of utter despair and hopelessness

C. Phase 3 - Acceptance = a gradual process of coming to accept not only the fact of your loss, but also the fact of your own continuing existence.

Reinhold Niebuhr's "Serenity Prayer" - God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.

Letting go does not mean forgetting - your life is forever different, forever enriched, because of the relationship.

Grief is not like this:

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Loss
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Rather, it is like this:

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Loss
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Anniversaries, birthdays, holidays are particularly difficult - try to view with thanksgiving for time shared and appreciate/focus on meaning of holiday. Plan ahead for these dates. Realize, you do have a future. It will be different, but it can be good.

D. Phase 4 - Growth - lifelong process of growth and development

**Questions:

1. How was death communicated?
2. What is your experience with phases of grief?
3. What are some ways your spouse's life touched yours and in so doing, made you forever a better person?
I. Anger and Grief - It's okay to feel angry. Feelings are neither right nor wrong; they just are.

- Anger is a very real part of grief.

- Closely related to word grief - grieve is word "grievance" which the dictionary describes as "being in a state of anger." Corporations realize if they want their organization to run smoothly, angry employees must have somewhere to take their anger, so they have grievance boards so the anger can be expressed, dealt with and resolved.

- Anger needs to be recognized. It won't just go away because we wish it would. Anger is a part of grieving. It's normal to be angry when something or someone important to you is taken away - it leaves a gaping hole and all the controls of "proper social behavior" don't work anymore. Raw emotions come thru, often with very little sensoring. If there is anger it needs to come out - can't hold it in. * If you do, it will come out in other, destructive ways, including physical illnesses.

- Expressing your anger is the quickest way to get rid of it.

- You wonder why things that ordinarily would not be any big deal seem overwhelming. Because emotions are raw, things will seem larger than life for awhile.

- Words meant to console can make us angry, ie, "be glad it happened quickly; he didn't suffer."

A. Free-floating anger = being angry with no one in particular; anything can set you off. No real focus for your anger. The feeling of anger is there, and when we find a target, any target, it just pops out.

- If you can understand these feelings of free-floating anger are part of your grief work, you won't be as frustrated by them or feel as powerless.

B. Direct anger - might be toward God, doctor, nurse, minister, funeral director, your children or relatives. May feel they have been negligent, "should have's"

- Because this type of anger has a direct target, you can deal with it, if you decide to. When you find a way to express your anger and make an opportunity to deal with it, you can resolve the situation, put it away, and continue with your life.

- Other family members may affect you and make you angry. They are also dealing with their feelings of loss.

- You may not feel like dealing with situation now, but at some point, do deal with it.

C. Anger at the loved one who has died - it's okay to be angry with that person. No relationship is perfect. You were sometimes angry at that person when he/she was alive, so why should you no longer be angry just because he/she has died?

Angry because spouse left? Anger here seems illogical - the person couldn't help dying. But grieving isn't a time to be logical - feelings need to be expressed.

D. Believe you can get thru - ie., pilot flying on beautiful day - all of a sudden clouds cover him and couldn't see a thing. Storm came and beat upon the plane. Pilot kept his course - he didn't give up. He believed he would get thru and he did. Grief is like that. Ominous feelings of anger are like that. Believe you'll get thru and they will pass.
E. How Do I Cope?

- Most productive way of dealing with feelings is always to think "outward."

Emotions have to go somewhere - better to direct them outward than inward. If you keep thinking outward, you'll be better able to direct feelings into some satisfying forms of expression. If your emotions are out where you can see them, you can cope with them more easily and can gain a greater sense of control.

F. How to Deal with Anger

1.) Repeat in your mind that feelings ARE. They are neither right or wrong - that includes anger. So it's okay to feel angry.

2.) Repeat to yourself it's okay to be angry.

3.) Direct your emotions outward rather than inward.
   - Talk to friends. Tell them you need to talk and what responses you'd like from them.
   - Support group
   - Journal

4.) Find several things that help you feel release in directing anger (or other emotions) outward - always have plan A and a back-up in mind, i.e., jog, clean, paint, mow, play piano, play sports (tennis, soccer, etc.)

5.) Understand that intense feelings like anger can be handled in these ways:
   a. Expressed - to get your feelings out in the open and rid yourself of them; to help others understand how you feel.
   b. Suppressed- To consciously and deliberately push down feelings so as not to let them get out. (Packing and shutting a suitcase) May explode.
   c. Repressed - to unconsciously push your too painful feelings deep into your subconscious because you can't deal with them. Eventually they will push their way out of hiding, perhaps erupting in unhealthy ways.

6.) Anticipate a positive outcome. Expect it, plan for it, and it will happen.

** Questions: 1.) What have been sources of anger for you throughout your grief?
   2.) Do you feel changes in your anger?
   3.) How are you dealing with anger?

II. Guilt and Grief

- Guilt is the coat of anger turned inside out. Anger directed outward can be released and gotten rid of. Anger turned inward upon ourselves can become guilt. (Like a coat, anger is not meant to be turned around).
- Like anger, guilt will not disappear just because we wish it away.
- Although some guilt is normal, it can also be abnormal = difference is how we handle feelings of guilt.
- May feel we were somehow responsible, that we could somehow have prevented the death.
A. 2 kinds of guilt associated with grief:

1. Guilt over aspects of the relationship which were not what they might have been, ie., deeds done, words spoken, arguments left unresolved.

"If Only..." - it is important to understand no relationship is perfect. You have already set a pattern for taking care of disagreements in your relationship. If your loved one had not died, you would have taken care of this someday, just as you'd always done before. In your own mind you can resolve the disagreement and in time find some peace about it, ie., write a letter to the one who has died. Sit down and write just what you would say to him or her if she/he were here. Explain what happened. Ask for the person's forgiveness. You can keep the letter and refer back. You'll find that it helps you to verbalize what you would say and imagine what would be said back.

"I should have..." we all like to think we have more power than we do. Responsibility doesn't mean making choices for another person.

* Snagged by a Moment - many times guilt comes down when we are snagged by a moment rather than looking at the whole picture, by all the facts, we focus and refocus on that single moment. We relive it and analyze it and become snagged by it.

We need to realize we can only do the best we can for the moment, based on the knowledge we have.

Possible to work thru guilt and come to conclusion: I did everything that I could do. It was something over which I had no control. And so you are able to let go of your guilt.

"How could you?..." Sometimes friends and relatives can say something that makes you feel guilty - be careful to whom you listen - don't have energy to defend yourself at this point. Look out for yourself.

How to sort out guilt - feelings of guilt are usually most intense during the suffering phase of grief. Share feelings, get them out, express them and write them.

2. Guilt over the circumstances of death

"But I was responsible" - maybe you needed to make a choice about another treatment or machine - a difficult decision and now think you made the wrong choice.

If committed a crime - guilt may be very real - seek professional help. Guilt doesn't resolve itself-it doesn't just go away - has to be dealt with - not easy to do.

B. How to Let Healing Happen:

1. Accept that what has happened has happened. You can't, no matter how much you wish, turn back hands of time.

   If you were to blame - accept the blame.
   If it was an accident, accept that it was an accident.
   If it was a decision to remove machines or not seek further Rx, accept that a decision that had to be made and you made the best decision you could.

2. Confess your share of any blame

3. Mourn the death of the person involved and the incident.
4. Allow yourself to be forgiven and allow yourself to forgive yourself.

5. Let go of the person who is gone, of the incident, and of your involvement.

6. Determine that some good is going to come out of this terrible experience - in the sense of choosing to find the good in a bad situation.

7. If necessary, find a counselor/therapist who can help you thru this process and in moving on with your life.

**Questions:**
1. What are your should-haves?
2. Write a note asking (spouse, God) to forgive you for all your should-haves to lift your guilt and release you from it.

III. What's Normal and Abnormal in Grief

"My whole life is falling apart! Nothing's the same. I can't eat, sleep, and I think I'm losing my mind. I forget where I put things. I do something, then go back and do it again. What's happening to me?"

Most people who are grieving go thru similar turmoil. The loss of your loved one has totally changed your life and nothing is the same, nor will it ever be the same. Your lives touched in a beautiful way that has profoundly influenced you forever. After a while things will seem "normal," but they will never be the same.

Much of what is normal behavior in grief goes contrary to what is generally thought of as normal, good, adjustive behavior. This adds to the pressure. Not only are you suffering from the loss of your loved one, but you are also suffering the additional anxiety of not understanding your own confusing behavior. Family and friends don't understand either.

- Crying = most common, normal part of grieving process.
  Many taught not to cry (men especially)
  "Don't cry, snap out of it" not helpful: Respond: "I need to cry. It's part of my healing."
  Don't allow others, your culture define what is normal.
  Each grieving person is different, each grieving process is different.

- "I can't sleep" - grief causes wide array of physical symptoms.
  Insomnia is most common physical complaint.
  - maybe would feel even less control and even more vulnerable when sleeping.
  - may need medication to help with this for awhile because your body needs strength - energy.

- Tension = relaxation exercises helpful
  [ verbalize to image of loved one ]

- "Everything tastes like sand" = no appetite or the opposite - eat constantly.
  Changes in eating habits normal
  Body is undergoing a lot of stress from demands of your grief work.

- Identification = helpful process in grief for some people: take up special interests or causes of the deceased
- not unusual to feel symptoms similar to ones felt by person who died (i.e., if spouse had heart attack, you may have chest pain).
- If after long time, you find yourself obsessed with doing what your loved one did, might want to get help.
- You are very vulnerable - (parallel to major surgery)
  The loss of your loved one is a major emotional wound.
  Like a physical wound it takes time to heal and during this healing, you are very vulnerable - physically and emotionally.

* London psychiatrist C. Murray Parkes has conducted extensive studies with widows/widowers and has proved conclusively a close relationship between grief and physical illness. Study showed widows/widowers death rate during 1st six months of bereavement was 40% higher than the expected rate for married men of the same age. Also higher incidence of mental illness, suicide and accidents.
This is not intended to alarm you - is considerable evidence that persons who have most physical and mental problems and complications are those who have not understood the grief process and have resisted going thru it.

- Suicide = the pain of their loss is so great that many bereaved persons think about suicide. Suicide seems a way of "joining" the one who is gone. Now, that doesn't make rational sense, but let's face it - bereavement isn't a rational time of life. Feelings are not always rational.
  People feel..."I just can't go on," and that feeling is normal. It is also normal to have occasional thoughts about suicide, i.e., escape the pain.
  Is a difference between occasional thinking of it and actively contemplating it.
  If you are contemplating suicide as a viable alternative, seek help immediately.

- Relief = some people feel sense of relief from death of a loved one; especially true when had to watch someone you love suffer thru a debilitating illness.
  A unique aspect of love is that you don't want the person you love to suffer.
- "If it weren't for the kids and the dog, I probably wouldn't get up."
- feeling suspended and aimless is normal - seems to be no purpose or meaning anymore.
- "Grief is not wanting to do anything. There is no longer anybody to share with."

Relate this to major surgery - then M.D. would say take it easy for awhile; get lots of rest; pamper yourself. We all understand major surgery creates a wound that requires lots of time to heal. We must understand that bereavement is a major emotional wound that requires much time, rest and inactivity too.
The aimlessness felt by the bereaved person is, in part, the body's way of protecting itself and providing time for emotional healing. Take your time: can't rush it (i.e., 9 months pregnant - can't rush it no matter how impatient you feel). Some things can't be rushed.
A different expression of aimlessness is seen in frenzied activities- seeming to get involved for the sake of activity rather than for the purpose of the activity. (If carried to an extreme, this can be a way of running away from the work of grief).
"I just felt as though I wanted to crawl into a lap...but there was no lap big enough."

Helplessness — unable to do anything about your loss
- unable to carry out normal tasks formerly taken care of by spouse (car, checkbook)

One of the most obvious solutions to problem of helplessness is to become dependent on another person. Society values independence; may not be to best interest long-term to be dependent.

With each new accomplishment you will feel just a little more self-confident.

- Sensory confusion - strange odors (smell of death)
- Depression = part of the essence of your grief is that you're not happy, that you feel sad and depressed.
  Most common in early stages in severe form.

Betha G. Simos, A Time to Grieve: Loss as a Universal Human Experience (New York: Family Service Association of America, 1979) p.190

Re: Difference between normal depression in grief and abnormal psychological dysfunction of depression:

The normally bereaved, despite their sadness, can laugh and show a variety of emotions appropriate to environmental shifts. For example: they can laugh at the antics of an infant even in the midst of grief. Depressives remain downcast regardless of what is going on about them. The bereaved respond to reassurance, support, comfort; depressives, if they respond at all, require urging, promises, or strong pressure. The bereaved retain the capacity for pleasure; depressives have lost capacity to have fun. The bereaved dwell on that which was lost; depressives dwell on themselves. The bereaved may be openly angry; depressives may be irritable, critical, complaining; but open anger is missing. The bereaved feel the world is empty, but realize their sense of personal emptiness is temporary; depressives feel a prolonged, intense inner emptiness. Both may have physical complaints, insomnia and changes in sexual interest. The bereaved project a feeling of sadness in others; depressives project a feeling of helplessness, if not hopelessness.

- "Give Sorrow Words"

Shakespeare wrote, (Macbeth, Act 4, Scene 3, Line 209.)

Give sorrow words: the grief that does not speak whispers the o'er-fraught heart, and bids it break.

Shakespeare put his finger on what psychologist later would discover — people must work thru their grief. Grief, unexpressed, leads to physical and emotional illness. Grieving is a hard and painful process. It is so painful that there is a tendency to avoid it. But flight from grief and its various manifestations offers only temporary and illusionary relief. Grief is one of those things that, if it doesn't kill you, will make you stronger.

- When is grief excessive?

- Distinguishing normal from abnormal grief is primarily a matter of degree
When your grief interferes with your taking care of yourself or finding any enjoyment in life; when you find yourself consistently withdrawing from life and people; when you see your personality changing and you can't control the changes; when your doctor tells you that you're sick and there is nothing physically wrong; when you suffer from unresolved guilt; and when these symptoms continue for a long period of time - seek professional help.
Workshop #3:

I. Growing Thru Grief

A. Grief is a process, not a sentence. The most painful phase, suffering will pass.

Light at the end of the tunnel but in some ways grief recovery is a lifelong process.

Phrase - 'This, Too, Shall Pass' -

If you could choose, you'd never go thru this! But since you have to go thru it, instead of just going thru it, why not grow thru it?

Like any growth process, growing thru grief takes time - doesn't happen over night.

To identify elements of growth in your life - keep a journal.

B. Ways to Grow Thru Grief:

1.) Learn to accept and deal with feelings
2.) Discover how capable they are - more than thought.
3.) Become more independent; reached out and stretched in new ways.
4.) Discovered more about self and who they are.

- Your Particular Passage

For the widowed person, this period of change, of growth, is a "passage" from one stage of life to another. Movement from a married state to a single state. Now requires establishment of new and separate identities.

Gail Sheehy in her book, Passages "with each passage from one stage of human growth to the next, we, too, much shed a protective structure. We are left exposed and vulnerable - but also yeasty and embryonic again, capable of stretching in ways we hadn't know before.

I am a widowed person
I'm single

Reaffirmation
I'm okay
I'm a good person
I have a future

** Question: How have you been able to grow thru your grief thus far?
II. Under Reconstruction - at times feels more like 'under demolition,' but as you move thru grief process you need to create a new identity—may not want one, but an essential part of the letting go process is to let go of the identity you had as your spouse's "other half." Letting go means that you accept the reality of your new situation. It doesn't mean that you deny the existence of the one you loved, or forget, or cut off the past.

You BUILD on the past because that past is part of you.

A. "Who Am I?" - You face a number of choices in shaping a new identity.

Most often self-image and lifestyle, marriage choices are made early in life and rest just sort of happens - so your self-image and life-style become molded by circumstances, instead of being chosen by you.

You have unique opportunity that most people don't have - opportunity to build a new self-image and freedom to choose a new lifestyle.

Now it's your future and your responsibility.

Not something you do early in your grief. Early in grief, want to keep things the way they are and not make radical changes.

B. To establish a new self-image and lifestyle:

Ask these questions:

1.) What makes for happiness? (Introspection)
2.) What is important to me? (Test values)
3.) What part of me is me and what's someone else?
4.) What do I want to do with my life?
5.) What were my dreams back then when I was alone?

Set positive goals for future:

Here's where I am — — Here's where I want to be.

C. What Does It Mean to Be Single?

- One of the most difficult aspects of your new single identity is your role as a sexual person.


"I was sitting torn by grief. Someone came and talked to me of God's dealings, of why it happened, of hope beyond the grave. He talked constantly; he said things I knew were true."
I was unmoved, except to wish he'd go away. He finally did. Another came and sat beside me. He didn't talk. He didn't ask leading questions. He just sat beside me for an hour and more, listened when I said something, answered briefly, prayed simply, left. I was moved. I was comforted. I hated to see him go.
Workshop #4:

I. Summarization of workshops #1 thru #3

II. Group sharing of concerns

III. Completion of Post-Kincannon's Mini-Mult

IV. Termination of this group in this format.

Deal with resources now available for support.
(answer question: Where can I go from here?)
Appendix R

Weeks 1 Through 3, Bereavement Support Seminar Outlines
WEEK I

I. What Is This Pain Called Grief?

A. Grief work
   1. Grief is emotional suffering as a result of bereavement.
   2. Bereavement is taking away or depriving, especially by death.

B. How long?

C. Don't avoid the pain

D. Getting death out of the closet

E. Well-meaning friends

II. Stages of Grief Work

   A. Phase 1: SHOCK

   B. Phase 2: SUFFERING

   C. Phase 3: ACCEPTANCE

   D. Phase 4: GROWTH
I. Anger and Grief
   A. Free-floating anger
   B. Direct anger
   C. Anger at the loved one who has died
   D. Believe you can get through this
   E. How do I cope?
   F. How to deal with anger

II. Guilt and Grief
   A. Two kinds of guilt associated with grief
      1. Guilt over aspects of the relationship
      2. Guilt over circumstances of death
   B. How to let healing happen:
      1. Accept that what has happened has happened.
      2. Confess your share of any blame.
      3. Mourn the death of the person involved and the incident.
      4. Allow yourself to be forgiven.
         Allow yourself to forgive yourself.
      5. Let go of the person who is gone, the incident, and your involvement.
      6. Determine that some good is going to come out of this terrible experience.
      7. If necessary, seek professional help in a counselor/therapist to help you with this process.

III. What's Normal and Abnormal in Grief?
   Barring normal from abnormal grief is primarily a matter of degree.

   When is grief excessive?
BEREAVEMENT SUPPORT SEMINAR

Presented By: Susan J. Smeenge, R.N., M.A.
Carole Jeanne Weidaw, R.N., M.A.
Doctoral Candidates

WEEK III

I. Growing Thru Grief

A. "This, too, shall pass"

B. Ways to grow thru grief:
   1. Learn to accept and deal with feelings.
   2. Discover how capable you are--more so than you thought.
   3. Become more independent; reach and stretch in new directions.
   4. Discover more about yourself and who you are.

II. Under Reconstruction

A. "Who am I?"

B. To establish a new self-image and life-style:
   Ask these questions--
   1. What makes for happiness?
   2. What is important to me?
   3. What part of me is really me and what is someone else?
   4. What do I want to do with my life?
   5. What were my dreams back so long ago?

III. What Does It Mean To Be Single?
Appendix S

Reference List Given to Seminar Participants


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